NCH HEALTHCARE SYSTEM

MEDICAL STAFF
CODE OF CONDUCT POLICY

Revised May 12 , 2020

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1. POLICY STATEMENT

A. Scope of Policy

(1) This Policy applies to all practitioners who provide patient care services at NCH Healthcare System. For purposes of this Policy, "practitioner" means a member of the Medical Staff or a member of the Allied Health Staff.

(2) Issues of employee conduct will be addressed in accordance with the Hospital's Human Resources policies. If the matter involves an employed practitioner, Hospital leaders, in consultation with appropriate Medical Staff Leaders and legal counsel, will determine which policies apply.

(3) A flow chart of the process for addressing concerns regarding professional conduct pursuant to this Policy is set forth in **Appendix A**.

B. Expectations for Professional Conduct

(1) Collegiality, collaboration, and effective communication are essential for the provision of safe and competent patient care and the creation of a culture of safety. As such, all practitioners are expected to treat others with respect, courtesy, and dignity, and to conduct themselves in a professional and cooperative manner.

(2) In dealing with incidents of inappropriate conduct, the following are paramount concerns:

(a) the protection of patients, employees, practitioners, and others and the orderly operation of the Medical Staff and Hospital;

(b) establishing a culture of safety;

(c) complying with the law and providing an environment free from sexual harassment; and

(d) assisting practitioners to resolve conduct issues in a constructive, educational, and successful manner.

C. Policy Objectives and Guidelines

(1) This Policy outlines collegial efforts and progressive steps (e.g., meetings, counseling, warnings, and behavior modification education) which can be used by Medical Staff and Hospital leaders to address concerns about inappropriate conduct by practitioners. The goal of these efforts is to arrive at voluntary, responsive actions by the practitioner to resolve the concerns that have been raised in a constructive manner.

(2) These efforts are encouraged, but are not mandatory, and will be within the discretion of the Leadership Council.

(3) All collegial efforts and progressive steps are part of the Hospital's confidential performance improvement and professional practice evaluation activities.

(4) Collegial efforts are encouraged; a single incident of inappropriate conduct or a pattern of inappropriate conduct will generally not result in referral of a matter to the Medical Executive Committee or the elimination of any step in the Policy, but the circumstances should help direct the process. However, a pattern of inappropriate conduct may be of such a concern that more significant action is required.

(5) In order to promote the objectives of this Policy, discussions and meetings with a practitioner whose conduct is at issue will not directly involve the participation of legal counsel. However, an individual's legal counsel shall always be available to him or her with regard to any questions or advice the individual seeks from the counsel during any discussions and meetings.

(6) Medical Staff and Hospital leaders will educate practitioners regarding appropriate professional behavior, make employees and other personnel aware of this Policy, and encourage the prompt reporting of concerns about inappropriate conduct.

(7) When a function in this Policy is to be carried out by a person or a committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified individuals.

D. Definitions

The definitions set forth in the Credentials Policy and the Professional Practice Evaluation Policy apply to this Policy as well.

E. Coordination with Other Policies

If a report of inappropriate behavior described in Section 2 involves an issue that is also governed by another Hospital policy (including, but not limited to, alleged violations of the Hospital's HIPAA or corporate compliance policies by a practitioner), the Chief Medical Officer will notify the person or committee responsible for that other policy of the substance of the report. Efforts will be made to coordinate the review that occurs under this Policy with the review under such other policy. For example, individuals responsible for such other policies (such as the Hospital's HIPAA Privacy Officer or Corporate Compliance Officer) may be invited to take part in the witness interviews described in this Policy or may discuss the matter with the Leadership Council or its representatives.

2. CONDUCT THAT IS INAPPROPRIATE, UNPROFESSIONAL, AND MAY UNDERMINE A CULTURE OF SAFETY

To aid in both the education of practitioners and the enforcement of this Policy, conduct that is inappropriate, unprofessional, and may undermine a culture of safety includes, but is not limited to:

(a) threatening or abusive language directed at patients, nurses, other Hospital personnel, or other practitioners (e.g., belittling, berating, or non-constructive criticism that intimidates, undermines confidence, or implies incompetence);

(b) degrading or demeaning comments regarding patients, families, nurses, other practitioners, Hospital personnel, or the Hospital;

(c) refusing or failing to answer questions, return phone calls or pages in connection with the care of a patient;

(d) using condescending language;

(e) using profanity or similarly offensive language while in the Hospital or while speaking with patients, families, nurses, other practitioners, or other Hospital personnel;

(f) retaliating against any individual who may report a quality or behavior concern;

(g) engaging in inappropriate physical contact with another individual that is threatening or intimidating;

(h) making comments, outside of appropriate Medical Staff, Hospital or administrative channels, that are unfairly critical and unfairly demeaning regarding the quality of care being provided by another practitioner;

(i) making medical record entries inconsistent with the Medical Staff Rules and Regulations;

(j) inappropriate access, use, disclosure, or release of confidential patient information;

(k) recording (audio or video) a conversation or interaction that is not consented to by others present, including patients, other members of the care team, or other practitioners;

(l) refusing to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Credentials Policy, Rules and Regulations, or other Medical Staff policies (including, but not limited to, emergency call issues, response times, medical recordkeeping, other patient care responsibilities);

(m) an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and Hospital employees; or

(n) engaging in any verbal or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:

(i) Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, or suggestive or insulting sounds;

(ii) Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; or obscene gestures;

(iii) Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, or assault; and

(iv) Other: making or threatening retaliation as a result of an individual's complaint regarding harassing conduct.

3. REPORTING CONCERNS ABOUT CONDUCT

A. Reports of Concerns about Conduct

Any Hospital employee or practitioner who observes, or is subjected to, inappropriate conduct by a practitioner is encouraged to report the incident in a timely manner. The concern can be reported by submitting a completed Professional Conduct Reporting Form, or similar document, to the PPE Support Staff. A copy of the Professional Conduct Reporting Form is included as **Appendix B**.

B. Follow-up to Reports of Concerns about Conduct

(1) The PPE Support Staff, Medical Staff Services Department, Physician Advisor, or Chief Medical Officer will follow up with the individual who made the initial report and will:

(a) inform the individual that the matter will be reviewed in accordance with this Policy and that the Leadership Council may need further information;

(b) inform the individual that retaliation will not be tolerated and that any retaliation and other incidents of inappropriate conduct should be reported immediately; and

(c) advise the individual that due to confidentiality requirements, details regarding the outcome of the review cannot be provided.

A letter that can be used for this purpose is attached as **Appendix C**. As an alternative to sending a letter, the content of the letter may be used as talking points to discuss with the individual who reported the concern.

(2) The PPE Support Staff, Medical Staff Services Department, Chief Medical Officer, or Physician Advisor will interview Hospital employees who are witnesses or are otherwise involved in the incident, as necessary, in order to fully understand the circumstances.

(3) Based on the information that has been received, the President of the Medical Staff and the Physician Advisor, in consultation with the Chief Medical Officer, may determine that:

(a) no further review or action is required;

(b) a face-to-face collegial intervention should be held with the involved practitioner; or

(c) further review or action is required by the Leadership Council.

(4) Any action taken above will be logged into the confidential peer review data base. Reports of inappropriate conduct that are closed with no further review necessary will be provided to the Leadership Council.

4. LEADERSHIP COUNCIL PROCEDURE

A. Initial Review

The Leadership Council will review the summary and all supporting documentation. If necessary, the Leadership Council may meet with the individual who submitted the report and any witnesses to the incident. The Leadership Council may also consult with or include the appropriate department chairperson or may appoint an ad hoc committee to review the incident and report back to it.

B. Obtaining Input from the Practitioner

The Leadership Council will notify the practitioner that a report has been submitted. Prior to the Leadership Council concluding its review it will invite the practitioner to provide his/her perspective.

The Leadership Council will take appropriate steps to maintain the confidentiality of the information, as well as to ensure a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, the following procedure will be used in obtaining the practitioner's input:

(1) The practitioner will first be requested to review and sign the "Confidentiality and Non-Retaliation Agreement" that is attached as **Appendix D**. This agreement permits the practitioner to participate in the review process, but in a manner that both protects the information under the Florida peer review statute and fosters the Medical Staff's and Hospital's culture of safety.

(2) If the agreement is signed, the practitioner will be provided with a summary of the facts and circumstances. The identity of the individual who reported the inappropriate conduct will not be disclosed to the practitioner, unless the Leadership Council determines that it is appropriate to do so. In any case, the practitioner will be reminded that any retaliation against the person reporting a concern would be a violation of the agreement, and will lead to more formal review by the Medical Executive Committee.

(3) The practitioner will then be requested to provide a written explanation of what occurred. The practitioner may also meet with one or more members of the Leadership Council to discuss the circumstances further, if the Leadership Council or the practitioner believes that would be helpful.

(4) If the practitioner refuses to sign the "Confidentiality and Non-Retaliation Agreement," the practitioner will not be provided with any written documentation of the concerns. The practitioner will be requested to

provide a written statement in response to the verbal description of the concerns that have been shared.

C. Leadership Council's Determination

Based on all of the information received, the Leadership Council may:

(1) determine that no further review or action is required;

(2) send the practitioner a letter of guidance or counsel about the conduct;

(3) engage in face-to-face collegial intervention, education, and coaching efforts with the practitioner, including, when appropriate, education about administrative channels that are available for registering concerns about quality or services;

(4) identify other sources of support for the practitioner;

(5) require the practitioner to meet with the Leadership Council, the Physician Advisor, the Medical Executive Committee, or another group of Medical Staff and Hospital leaders to discuss the concerns about the practitioner's conduct;

(6) send a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing;

(7) recommend that the practitioner complete a behavior modification course acceptable to the Leadership Council;

(8) develop a Personal Code of Conduct; or

(9) refer the matter to the Medical Executive Committee.

The Leadership Council will also inform the relevant department chairperson of its determination and intervention.

Consistent with the Credentials Policy, none of the above actions would entitle the practitioner to a hearing or appeal, nor are any reports required to be made to the Florida Medical Licensing Board (or to the Florida Board of Nursing, as applicable) or to the National Practitioner Data Bank. (**Appendix E** provides additional guidance regarding these and other options for conduct and their related implementation issues.)

D. Practitioner's Refusal to Meet with Leadership Council

If the practitioner fails or refuses to meet with the Leadership Council, the Physician Advisor, or other specified individuals when requested to do so, the practitioner's clinical privileges may be automatically relinquished until the meeting occurs, pursuant to the provisions in the Credentials Policy.

E. Letters Placed in Practitioner's Confidential File

Copies of letters sent to the practitioner as part of the efforts to address the concerns about conduct will be placed in the practitioner's confidential file. The practitioner will be given an opportunity to respond in writing, and any response will also be kept in the practitioner's confidential file. If a report cannot be substantiated, or is determined to be without merit, the matter will be closed as requiring no further review. False reports will be grounds for disciplinary action and will not be included in the practitioner's file. False reports by practitioners will be referred to the Leadership Council. False reports by Hospital employees will be referred to human resources.

F. Additional Reports of Inappropriate Conduct

If additional reports of inappropriate conduct are received concerning a practitioner, the Leadership Council may continue to use the collegial and progressive steps outlined above as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

G. Determination to Address Concerns through Practitioner Health Policy

If the Leadership Council believes that there may be a legitimate, underlying health issue, that is causing the concerns that have been raised, it may address the issue pursuant to the Practitioner Health Policy.

5. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

A. Referral to the Medical Executive Committee

At any point, the Leadership Council may refer a matter to the Medical Executive Committee for review and action. The Medical Executive Committee will be fully apprised of the actions taken previously by the Leadership Council to address the concerns. When it makes such a referral, the Leadership Council may also recommend a course of action.

B. Medical Executive Committee Review

The Medical Executive Committee will review the matter and take appropriate action.

C. Recommendation That Entitles Practitioner to a Hearing

If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing pursuant to the Credentials Policy, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer for further action consistent with the Credentials Policy.

6. REVIEW OF REPORTS OF SEXUAL HARASSMENT

All reports of sexual harassment will be reviewed by the Leadership Council in the same manner as set forth above. However, because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions:

A. Personal Meeting and Letter of Admonition and Warning

Two or more members of the Leadership Council will personally meet with the practitioner to discuss the incident. If the practitioner acknowledges the seriousness of the matter and agrees that there will be no repeat of such conduct, the meeting will be followed with a letter of admonition and warning to be placed in the practitioner's confidential file. This letter will also set forth any additional actions or conditions imposed on the practitioner's continued practice in the Hospital.

B. Referral to Medical Executive Committee

The matter will be immediately referred to the Medical Executive Committee if:

(1) the practitioner refuses to acknowledge the concern, does not recognize the seriousness of it, or will not agree that there will be no repeat of such conduct, or

(2) there are confirmed reports of retaliation or further incidents of sexual harassment, after the practitioner agreed there would be no further improper conduct.

The Medical Executive Committee will conduct its review in accordance with the Credentials Policy. Such referral will not preclude other action under applicable Hospital Human Resources policies.

Adopted by the Medical Executive Committee on October 13, 2014.
Approved by the Board of Trustees on January 28, 2015.

Revisions adopted by the Medical Executive Committee on May 11, 2020.
Revisions approved by the Board of Trustees on May 12, 2020

APPENDIX B

PROFESSIONAL CONDUCT REPORTING FORM

For Employees, Medical Staff Members, and Allied Health Staff Members

Instructions: Please use this form to report an incident involving conduct that you are concerned is inappropriate, unprofessional or that otherwise jeopardizes our culture of safety. Attach additional sheets if necessary. Please provide the following information as **specifically** and as **objectively** as possible and submit the completed form to the PPE Support Staff.

DATE, TIME, AND LOCATION OF INCIDENT			
Date of incident:	Time of incident:	a.m.	
		p.m.	
Location of incident:			
Range of dates if your concerns are not limited to one particular event: _____/_____/20_____ to _____/_____/20_____			
PRACTITIONER INFORMATION			
Name of practitioner about whose conduct is at issue: _____			
PATIENT INFORMATION			
Was a patient involved in the event?	**Yes** ❑	**No** ❑	Medical Record # _____
Patient's Last Name: _____		Patient's First Name: _____	
DESCRIPTION OF INCIDENT			
Describe what happened as specifically and objectively as possible: _____ _____ _____			
OTHER INDIVIDUALS INVOLVED/WITNESSES			
Name(s) of other practitioner(s) or Hospital employee(s) who witnessed this event: _____ _____ _____ _____			
Name(s) of any other person(s) who witnessed this event (e.g., visitors; family members): _____ _____ _____ _____			

EFFECT OF CONDUCT		
How do you think this behavior affected patient care, Hospital operations, your work, or your team members' work? _____ _____ _____		
RESPONSE TO CONDUCT	**Yes**	**No**
Are you aware of any attempts that were made to address this behavior with the practitioner when it occurred?	❑	❑
If yes, please explain and indicate by whom: _____ _____ _____		

CONTACT INFORMATION	
Your name:	Department:
Phone #:	Date this form completed:
E-mail address:	

APPENDIX C

LETTER TO RESPOND TO INDIVIDUAL WHO REPORTS CONCERN ABOUT CONDUCT*

Dear _____:

Thank you for reporting your concerns. We appreciate your participation in our efforts to promote and maintain a culture of safety and quality care at our Hospital.

Your concern will be reviewed in accordance with the Medical Staff Code of Conduct Policy and we may need to contact you for additional information. Because your report may involve confidential matters under Florida law, we may not be able to inform you of the specific outcome of the review. However, please be assured that your report will be fully reviewed and appropriate steps will be taken to address the matter.

As part of our culture of safety and quality care, retaliation against any individual who reports a concern is not tolerated. Therefore, if you believe that you have been subjected to any retaliation as a result of raising your concern, please report that immediately to me or the Chief Medical Officer.

Once again, thank you for bringing your concern to our attention. If you have any questions or wish to discuss this matter further, please do not hesitate to call me at _____.

Sincerely,

PPE Support Staff, Medical Staff Services Department, or Chief Medical Officer

*** As an alternative to sending a letter, the content of this letter may be used as talking points to respond verbally to the individual who reported a concern regarding conduct.**

APPENDIX D

CONFIDENTIALITY AND NON-RETALIATION AGREEMENT

Concerns have been raised about my professional conduct at the Hospital. As part of the review process, the Leadership Council would like me to be fully aware of the concerns, as well as have the ability to provide my perspective and any response that I believe may be necessary or appropriate.

However, the Leadership Council also wants to take appropriate steps to maintain the confidentiality of the information, as well as to facilitate a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, I agree to the following:

1. I will maintain all the information that I review in a **confidential** manner. Specifically, I will not disclose or discuss this information except to the Leadership Council or my legal counsel. I will not discuss this information with any other individual(s) without first obtaining the express written permission of the Hospital.

2. I understand that this information is being provided to me as part of the Medical Staff's Code of Conduct Policy. In addition to discussing these matters with the Leadership Council, I understand that I may also prepare a written response and that this response will be maintained in my file.

3. I understand that the Hospital and Medical Staff have a responsibility to provide a safe, non-threatening workplace for members of the Medical Staff and the Allied Health Staff and for Hospital employees. Therefore, **I will not discuss this matter with any individual who may have expressed concerns about me or provided information in this matter. I will not engage in any retaliatory conduct with respect to these individuals**. This means that I will not approach, confront, ostracize, discriminate against, or otherwise mistreat any such individual who may have provided information that led to the concern being raised about me.

4. I understand that any retaliation by me would be a very serious matter and will not be tolerated. Any such conduct by me will be grounds for immediate referral to the Medical Executive Committee for its review and for action pursuant to the Credentials Policy.

By signing this Agreement, I understand that I am **not waiving** any of the rights or privileges afforded to me under the Medical Staff Bylaws or Credentials Policy.

I also understand that I am permitted to raise any question or concern that I may have regarding the care being provided by a nurse or other Hospital employee, another member of the Medical Staff or Allied Health Staff, or the Hospital itself. **However, I understand that I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.** These mechanisms are part of the Hospital's ongoing performance improvement and peer review activities, and permit the appropriate Medical Staff or Hospital leadership to fully review the matter and take action to address the issue, as may be necessary.

_____ _____

Date

[Include the following signature line only if a Medical Staff Leader(s) personally reviews the content of this agreement with the practitioner]

Approved by:

_____ _____

Appropriate Medical Staff Leader Date

APPENDIX E

OPTIONS TO ADDRESS CONDUCT ISSUES AND IMPLEMENTATION CHECKLIST

OPTION	*IMPLEMENTATION ISSUES*
Meeting with Leadership Council, Medical Executive Committee, or Designated Group	***Who Should Attend Meeting with Practitioner?*** ❑ Leadership Council ❑ Medical Executive Committee ❑ Other designated group (may include Board Chair or other Board members), including: _____ ***May Practitioner Bring Representative (Not Legal Counsel) to the Meeting?*** ❑ Yes ❑ No Is pre-meeting to plan intervention necessary? ❑ Yes ❑ No If yes, where and when: _____ _____ ***Scheduling Meeting with Practitioner*** ❑ Date of meeting: _____ ❑ Time of meeting: _____ ❑ Location of meeting: _____ ***Notice of Meeting*** ❑ Notice of meeting sent ❑ Letter to practitioner states that meeting is part of the peer review process, therefore ❑ No attorneys allowed ❑ No audio or video recording ❑ Should notice state that failure to appear will result in automatic relinquishment of clinical privileges? ❑ Yes ❑ No ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____ ***Documentation*** If not already provided, will documentation of reports regarding concern be shared before meeting? ❑ Yes ❑ No If yes, has practitioner signed an agreement not to retaliate? ❑ Yes ❑ No ***Follow-Up***. Monitor for additional incidents ❑ Through reported concerns process ❑ Through more focused process (e.g., interviews with Hospital personnel or Medical Staff Leaders at designated intervals): _____

OPTION	IMPLEMENTATION ISSUES
Letters of Warning or Reprimand	***Content of Letter of Warning or Reprimand*** ❑ Practitioner informed that he/she may provide response for inclusion in file ❑ Copy included in practitioner's credentials/quality file ***Review/Signature*** Letter review and approved by: ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ Leadership Council ❑ MEC ❑ Individuals: _____ Who signs/sends the letter? ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ Hospital Chief Executive Officer ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up*** Monitor for additional incidents ❑ Through standard reported concerns process ❑ Through more focused process (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

OPTION	IMPLEMENTATION ISSUES
Behavior Modification Course	***Scope of Requirement*** ❑ Acceptable programs include: _____ _____ Leadership Council or MEC approval required before practitioner enrolls: ❑ Program approved: _____ ❑ Date of approval: _____ Who pays for the behavior modification course? ❑ Practitioner ❑ Medical Staff ❑ Hospital ❑ Combination _____ Time Frame ❑ Practitioner must enroll by: _____ Date ❑ Program must be completed by: _____ Date ***Practitioner's Responsibilities*** ❑ Sign release allowing Leadership Council or MEC to provide information to the behavior modification course (if necessary) and course to provide report to Leadership Council or MEC _____ _____ Physician must submit ❑ Documentation of successful completion signed by course director ❑ Other: _____ _____ ***Follow-Up*** Monitor for additional incidents ❑ Through standard reported concerns process ❑ Through more focused review (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

OPTION	IMPLEMENTATION ISSUES
Personal Code of Conduct ***(Conditional Continued Appointment/ Conditional Reappointment)***	***Content of Personal Code of Conduct*** ❑ Practitioner informed that he/she may provide response for inclusion in file. ❑ Copy of personal code of conduct included in practitioner's credentials/quality file. ❑ Is practitioner required to agree in writing to abide by the personal code of conduct? ❑ Yes ❑ No If yes, written agreement to abide by personal code of conduct received on: _____ Date ❑ Does the personal code of conduct describe consequences of a confirmed violation? ❑ Yes ❑ No ***Consequence of first violation (e.g., final warning):*** _____ ***Consequence of second violation (e.g., short-term suspension):*** ***Consequence of third violation (e.g., recommendation for disciplinary action):*** ***Review/Signature*** Letter outlining the personal code of conduct reviewed and approved by: ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ Leadership Council ❑ MEC ❑ Other Individuals: _____ Letter outlining the personal code of conduct signed by: ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ Hospital Chief Executive Officer ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up***. Monitor for additional incidents ❑ Through standard reported concerns process ❑ Through more focused process (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

OPTION	IMPLEMENTATION ISSUES
Short-Term Suspension That Does Not Trigger a Hearing or Reporting ***(for use by Medical Executive Committee only)***	***Date/Duration of Suspension*** ❑ Suspension begins on: _____ Date ❑ Suspension ends on: _____ Date ***Patient Care Arrangements*** ❑ If suspension begins immediately, what arrangements are made for patients currently admitted? _____ ❑ What arrangements are made for on-call responsibilities? _____ ***Contents of Notice of Suspension*** ❑ Practitioner informed that he/she may provide response for inclusion in file. ❑ Copy of notice included in practitioner's credentials/quality file. ***Review/Signature*** Notice of suspension reviewed and approved by: ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ Medical Executive Committee ❑ Other Individuals: _____ Notice of suspension signed by: ❑ President of the Medical Staff ❑ Chief Medical Officer ❑ Hospital Chief Executive Officer ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up*** Monitor for additional incidents ❑ Through standard reported concerns process ❑ Through more focused review (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

OPTION	*IMPLEMENTATION ISSUES*
"Other" ***Examples:*** • ***Chaperone;*** • ***CME;*** • ***Grand rounds on teamwork or creating culture of safety;*** • ***Letter of apology (review and approval of letter is imperative before it is sent).***	