CORRECTIVE ACTION PROCEDURES

AND

FAIR HEARING PLAN

ADDENDUM

TO THE BYLAWS OF THE MEDICAL STAFF

OF

SAINT CLARE'S HOSPITAL OF WESTON, INC.

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SECTION 1 - CORRECTIVE ACTION

The executive committee of the medical staff (MEC) shall be the disciplinary body of the medical staff. Corrective action may be requested by any member of the MMT, by the chair of any standing or special committee, by the CMO, by the CEO or COO, or by the governing body. Corrective action is appropriate when collegial and educational efforts such as those outlined in the Medical Staff Code of Conduct Policy have been ineffective or when the behavior is so egregious or presents such a serious risk of harm to patients or others as to warrant more formal action from the outset. Except when a suspension under Section 1.4, 1.5 or 1.6 has been imposed, all requests for corrective action shall be in writing to the MEC, and the request shall contain a detailed description of the activity or conduct upon which the request is based.

1.1 Grounds for Request.

Conduct or activity upon which the request for corrective action may be based shall include, but not be limited to, conduct or activity by a practitioner considered to lower the standards or aims of the medical staff or which is disruptive to the operations of the Hospital or conduct that adversely reflects upon the reputation of the medical staff or the Hospital as a whole in the community or may pose a threat to patient care. Such conduct may include, but is not limited to:

(a) Conviction of a crime.

(b) Unethical practice.

(c) Incompetence.

(d) Failure to keep adequate records.

(e) Any limitation of practitioner's license by the State Medical Examining Board or Dental Examining Board or voluntarily by practitioner.

(f) Loss or limitation of practitioner's DEA registration.

(g) Exercising privileges while the practitioner's professional ability is impaired, whether through illness, accident, addiction or from any other source.

(h) Significant misstatement in or omission from any application for membership or privileges or any misrepresentation in presenting the practitioner's credentials.

(i) Violation of the Bylaws, Rules and Regulations of the medical staff, Hospital bylaws, Medical Staff Code of Conduct or Conflict of Interest Policy, the principles of ethics of the American Medical, Osteopathic, Dental or Podiatric Association, as appropriate, the Ethical and Religious Directives for Catholic Health Care Services or State of Wisconsin Rules.

(j) Conduct involving moral turpitude.

(k) Harassment, mistreatment or otherwise degrading any patient, employee of the Hospital, member of the medical staff, a member of the governing body.

(l) Commission of an offense that would bar the practitioner from providing services in the Hospital under Chapter HFS 12 of the Wisconsin Administrative Code if verified by a governmental unit.

(m) Breach of confidentiality.

1.2 Procedure to Determine Request.

(a) Except when suspension under Section 1.4, 1.5 or 1.6 has already occurred, following receipt of a request for corrective action, the MEC (or the CMO if time or special circumstances do not permit review by the MEC) shall conduct an investigation. While investigation of requests for corrective action shall principally be performed by the MEC, the CMO may appoint a special ad hoc committee to investigate the matter and report the results to the MEC.

(b) The investigation should include an interview, if possible, with the practitioner involved, who should be informed of the general nature of the charges that have been brought and that this may result in corrective action.

(c) The practitioner shall be permitted to discuss and explain the conduct. The practitioner's appearance at the interview shall not constitute a formal hearing and is considered preliminary in nature and not subject to procedural rules. A record of the interview shall be made by the party conducting the interview.

(d) The investigation, if performed by anybody other than the MEC, shall not be considered concluded until a report of the investigation is received by the MEC.

(e) The CMO shall promptly notify the COO of any request for corrective action and shall keep the COO fully informed of all action taken in connection with it.

1.3 MEC Action.

(a) Within 30 days following the conclusion of the investigation, the MEC shall take one or more of the following actions:

(1) Issue a warning letter to the staff member.

(2) Issue a letter of reprimand to the staff member.

(3) Require consultation without limiting clinical privileges.

(4) Impose probation that does not limit clinical privileges.

(5) Reject or dismiss the request for corrective action.

(6) Require a physical or mental examination and report by a physician or a psychologist chosen by and acceptable to the MEC and compliance with restrictions as recommended as a result of such examination.

(7) Recommend that the governing body:

(i) Require mandatory concurring consultation.

(ii) Impose probation that limits clinical privileges, for a specified term.

(iii) Deny reinstatement from a leave of absence.

(iv) Reduce clinical privileges.

(v) Suspend clinical privileges.

(vi) Revoke clinical privileges.

(vii) Suspend staff membership.

(viii) Revoke staff membership.

(8) Recommend that other appropriate action be taken, including any combination of the above.

(b) If the MEC makes a recommendation to the governing body under Section 1.3(a)(7), it shall also recommend the interval status of the practitioner during the fair hearing process, if invoked.

(c) The MEC shall make a written report of its action on the request for corrective action, including its reasons for the action taken and any minority views, and shall forward the report to the CMO for submission to the governing body. If the action taken by the MEC is not a professional review action, as defined in Section 3.2 of this Plan, the governing body, in its sole discretion, may conduct its own investigation through whatever means and may impose any of the sanctions set forth in Section 1.3 above. Before imposing any such sanctions, the governing body shall refer the matter to the Medical Staff/Hospital Board Liaison Committee as provided in Section 9 of this Plan. The governing body's action on the matter following the Medical Staff/Hospital Board Liaison Committee's

recommendation shall not be final until the affected practitioner has exercised or waived his or her rights, if any, to hearing and review.

(d) A recommendation by the MEC or action by the governing body pursuant to this subsection that constitutes a professional review action, as defined in Section 3.2 of this Plan, shall entitle the affected practitioner to the hearing rights as provided in this Plan.

1.4 Suspension of Privileges.

(a) Immediate Precautionary Suspension Available. Any one of the following—the CMO, any member of the MMT, the MEC, the CEO, the COO or the executive committee of the governing body—shall each have the authority, whenever precautionary action must be taken in the best interest of patient care in the Hospital, to suspend all, or any portion of, the clinical privileges of a practitioner, and the suspension shall become effective immediately upon imposition. When possible, consultation with another individual or entity with suspension authority should be sought before action is taken.

(1) A precautionary suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate action that may be taken with respect to the suspended individual, but it is not a complete professional review action in and of itself.

(2) If the conduct forming the basis for the precautionary suspension has not been investigated by the CMO or MEC prior to imposition of the suspension (including an interview, if possible, with the practitioner involved), the matter shall be investigated pursuant to the procedures set forth in Section 1.2.

(3) Until the MEC receives and considers the results of the investigation and takes or recommends corrective action, a precautionary suspension shall not imply any final finding adverse to the suspended practitioner.

(4) The precautionary suspension shall be reported in writing to the COO, the CMO and the appropriate department chair, and the affected practitioner shall be notified by special notice of the terms of the precautionary suspension. Other departments (such as the emergency department) that need to know of the affected practitioner's unavailability will be informed that the practitioner is not available for patient care during the relevant time period. A copy of the report of the precautionary suspension shall be placed in the practitioner's medical staff file. The practitioner may submit a written response to this report for inclusion in the practitioner's file.

(b) Right to Expedited Hearing. If the precautionary suspension under Section 1.4(a) is for more than 14 days, the practitioner shall be entitled to request that a hearing be held on the matter within such reasonable time period as a Hearing Committee may be convened in accordance with Section 3.8 of this Plan, not to exceed ten

business days after receipt by the CMO of a request for expedited hearing, unless the practitioner requests more time. The expedited hearing shall be held in general accord with the procedures set forth in Section 3 of this Plan, but with timelines adjusted as needed to facilitate expedited review while still affording due process to the practitioner. The practitioner may extend the time for holding the expedited hearing, at his or her option. If an expedited hearing is held at the practitioner's request, it shall replace and not be an addition to any right to hearing otherwise available to the practitioner under this Plan.

(c) Review by Executive Committee. The MEC may, upon the practitioner's request, and as soon as practicable, afford the practitioner an opportunity to meet with the MEC in special session to informally discuss the precautionary suspension, whether or not a hearing is requested. The MEC shall be authorized to lift, maintain or modify the suspension, except a suspension imposed by the governing body or the executive committee of the governing body. If the suspension:

(1) is lifted or modified but the CMO or COO objects in writing to the MEC's action; or

(2) is not lifted and the practitioner requests a hearing on the professional review action, but not an expedited hearing as provided in subsection (b), and also requests removal of the suspension until hearing;

the suspension shall remain in effect and the executive committee of the governing body shall be convened within four business days of receipt of the request for hearing or the written objections from the CMO or COO. The executive committee of the governing body shall consider the written position of the practitioner and the MEC, as well as the recommendation of the COO on the sole issue of maintenance of the suspension pending hearing and appellate review. The executive committee of the governing body shall be authorized to maintain, modify or lift the suspension pending hearing and shall reduce its determination to a written finding.

(d) Appellate Review by Board. After hearing, the MEC may recommend modification, continuance, or termination of the terms of the precautionary suspension. If, as a result of the hearing, the MEC does not recommend immediate termination of the suspension, the affected practitioner shall, also in accordance with this Plan, be entitled to request an appellate review by the governing body; but the terms of the suspension as sustained, or as modified, by the MEC shall remain in effect pending a final decision by the governing body.

(e) Violation of Medical Staff Code of Conduct. A suspension of all privileges of up to 14 days may be imposed by the CMO, COO, CEO or MEC for violation of the Medical Staff Code of Conduct.

(1) A practitioner whose privileges are suspended under this subsection shall be entitled to request an interview to discuss and explain the conduct with the CMO, the COO and the CEO.

(2) The request for an interview must be in writing and must be filed with the CMO within five days of the actual notice to the practitioner of imposition of the suspension. If the practitioner wishes to be accompanied by legal counsel, the request for interview must identify the name, address and telephone number of the attorney.

(3) The interview shall be scheduled as soon as practicable after receipt of the request for an interview and in no event later than ten business days after that date except for good cause. Notice of the date, time and place of the interview shall be given to the practitioner by telephone, in writing or in person. The practitioner shall be informed in writing prior to the interview of the specific basis for the suspension.

(4) At the interview, the practitioner shall be permitted to discuss and explain his or her conduct. His or her appearance at the interview shall not constitute a formal hearing and shall not be subject to procedural rules. A record of the interview shall be made by the CMO or his or her designee.

(5) After the interview, the suspension shall be continued, lifted or modified only upon the concurrence of the officials conducting the interview. Any suspension imposed under this subsection that is not lifted shall remain in effect indefinitely or until the CMO, the COO and the CEO decide to alter or lift the suspension.

(6) Any suspension pursuant to this subsection which remains in effect for more than 14 days or which includes a recommendation that membership be terminated shall entitle the practitioner, upon written request, to a hearing conducted by the governing body as provided in subsection (b) or Section 3.5

(f) Alternate Medical Coverage. Immediately upon the imposition of a suspension, the CMO, or his or her designee, or department chair shall assign to another practitioner with appropriate clinical privileges responsibility for care of the suspended practitioner's patients, or if the patients are medically stable, have them transferred to another facility if no practitioner with suitable clinical privileges is available. The assignment shall be effective until the patients are discharged or appropriately transferred to the care of another practitioner. The wishes of the patients shall be considered in the selection of an alternative practitioner. Any practitioner suspended pursuant to this Section 1.4 shall remain available to confer with the alternative medical practitioner to the extent necessary to safeguard the patient(s).

(g) All medical staff members shall cooperate with the CMO, the appropriate department chair, the MEC and the COO in enforcing all precautionary suspensions.

(h) Report to Data Bank. Suspensions under this subsection still in effect after 30 days will be reported to the appropriate licensing body for reporting to the National Practitioner Data Bank whenever reporting is required by law.

1.5 Temporary Suspension for Incomplete Records.

A temporary suspension in the form of withdrawal of a practitioner's admitting privileges effective until medical records are complete shall be imposed automatically after warning of delinquency for failure to complete medical records as required in the medical staff rules and regulations. The suspension shall continue in effect until the records are completed. This suspension will not affect the privileges of the practitioner to continue to treat his or her patients who are in the Hospital at the time of the suspension, nor does it give rise to any hearing or review rights.

1.6 Automatic Suspension.

(a) State Action Requires Suspension. Action by the applicable licensing board or by a court of competent jurisdiction revoking or suspending a practitioner's license shall automatically suspend all of the practitioner's clinical privileges. Suspension shall occur whether the action of the licensing board is unilateral or agreed to by the licensee. Any practice restrictions, limitations or other special conditions imposed by an applicable licensing board short of suspension shall automatically be considered conditions of the practitioner's medical staff appointment and of the exercise of clinical privileges. A practitioner who has special conditions imposed by a licensing authority shall, within 15 days of the action, have his or her privileges reviewed by the MEC, which shall immediately submit a report and recommendation to the governing body regarding the continued medical staff status and clinical privileges of the practitioner.

(b) DEA Restrictions. A practitioner whose DEA number is revoked or restricted or voluntarily surrendered shall automatically be divested of the right to prescribe medications controlled by that number. Further, all the practitioner's clinical privileges which require the ability to prescribe these medications shall be automatically suspended.

(c) Felony Conviction. An automatic suspension of all clinical privileges of a practitioner shall be imposed upon notification of the conviction of a practitioner of a felony. The MEC may, upon request of the affected practitioner, convene to review the matter and shall submit a recommendation to the governing body regarding the continuation of the membership and privileges of the practitioner.

(d) Caregiver Background Check Suspension.

(1) Unless proof of rehabilitation review approval is submitted, an automatic suspension of all privileges of a practitioner shall be imposed upon notification and confirmation by the CMO that the practitioner:

(i) Has been convicted of a serious crime, act or offense or has pending charges for a serious crime, act or offense as defined in Chapter HFS 12 of the Wisconsin Administrative Code;

(ii) Has been found by a unit of government to have abused or neglected a client or misappropriated a client's property; or

(iii) Has been determined under the Children's Code to have abused or neglected a child.

(2) As soon as possible after an automatic suspension under subsection (1) above, the MEC shall convene to review and consider the facts under which the individual was barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code. The MEC may then take such further corrective action as is appropriate under the circumstances. If the practitioner provides evidence that rehabilitation review approval has been received, the MEC must determine whether the rehabilitation review approval placed any limits the practitioner's ability to practice the privileges granted, whether the MEC wishes to retain the practitioner on the medical staff and whether it can accommodate any restrictions imposed as a condition of rehabilitation review approval. The MEC may then take such further corrective action as is appropriate under the circumstances.

(3) A suspension of all privileges of a practitioner may be imposed upon notification received by the CMO after consultation with the COO that the practitioner:

(i) Is under investigation for a serious crime, act or offense as defined in Chapter HFS 12 of the Wisconsin Administrative Code;

(ii) Is being investigated by a unit of government or an entity subject to Chapter HFS 12 of the Wisconsin Administrative Code for abuse or neglect of a client or misappropriation of a client's property; or

(iii) Is being investigated under the Children's Code or an entity under Chapter HFS 12 of the Wisconsin Administrative Code for abuse or neglect of a child.

(4) As soon as possible after a suspension under subsection 1.6(d)(3) above, the MEC shall convene to review and consider the facts under which the individual was suspended and determine whether or not to continue the suspension pending the outcome of the investigation, terminate the

suspension subject to monitoring or other safeguards pending the outcome of the investigation, or to take such further corrective action as is appropriate under the circumstances.

(e) Exclusion From Federally-Funded Health Care Program.

(1) All clinical privileges of a practitioner shall be automatically suspended if the practitioner is excluded in whole or in part from any federally-funded health care program. If the practitioner immediately notifies the CMO of any proposed or actual exclusion from any federally-funded health care program as required by the bylaws, a simultaneous request in writing by the practitioner for a meeting with the COO and the CMO, or their designees, to contest the fact of the exclusion and present relevant information will be granted. This meeting shall be held as soon as practicable but not later than five business days from the date of the written request. The COO and the CMO or their designees shall determine within ten business days following the meeting, and after such follow-up investigation as they deem appropriate, whether an exclusion has occurred, and whether the practitioner's staff membership and privileges will be immediately terminated. The determination of the COO and the CMO or their designees regarding the matter shall be final, and the practitioner will have no further procedural rights. The practitioner will be given special notice of the termination decision.

(2) A member who does not immediately notify the CMO of any proposed or actual exclusion from any federally-funded health care program as required by the medical staff bylaws will have his or her staff membership and privileges terminated immediately, upon the CMO or his designee's receipt of reliable information of the member's exclusion. The member will be given special notice of the termination as soon as practicable.

(f) Failure to Notify of Sanction. An automatic suspension of all privileges may be imposed upon a practitioner's failure to notify the CMO within five days of receipt by the practitioner of an initial sanction notice of a gross and flagrant violation, or of the commencement of a formal investigation or the filing of charges, by a Medicare quality improvement organization, the Department of Health and Human Services, the Wisconsin Department of Health and Family Services, the Office of the Inspector General, or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin. The MEC shall promptly review the matter and submit a recommendation to the governing body regarding the continued medical staff status and clinical privileges of the practitioner. The MEC shall, if concurred in by the COO, be authorized to lift or modify this automatic suspension pending final determination by the governing body.

(g) Failure to Provide Requested Information. An automatic suspension may be imposed upon a practitioner's failure without good cause to supply information or

documentation requested by any of the following: the CMO or his or her designee, the COO or his or her designee, the MEC or the governing body. A suspension shall be imposed only if: (1) the request for information or documentation was in writing, (2) the request was related to evaluation of the practitioner's current qualifications for membership or clinical privileges, (3) the practitioner failed to either comply with the request or to satisfactorily explain his or her inability to comply, and (4) the practitioner was notified in writing that failure to supply the requested information or documentation within 15 days from receipt of the notice would result in automatic suspension. Any automatic suspension imposed pursuant to this paragraph may be a suspension of any portion or all of the practitioner's privileges and shall remain in effect until the practitioner supplies the information or documentation sought or satisfactorily explains his or her failure to supply it.

(h) Data Bank Report in Contradiction of Application Information. A practitioner whose appointment or reappointment is conditioned upon subsequent receipt of a National Practitioner Data Bank report that does not contradict information known at the time of appointment or reappointment shall be automatically suspended upon receipt of a Data Bank report that contradicts that information. The suspended practitioner shall, within 15 days of suspension, have his or her privileges reviewed by the MEC, which shall immediately submit a report and recommendation to the governing body regarding the continued medical staff status and clinical privileges of the practitioner. The MEC shall, if concurred with by the COO, be authorized to lift or modify this automatic suspension pending final determination by the governing body.

(i) Failure to Meet Financial Responsibility. If at any time a practitioner fails to maintain acceptable malpractice insurance coverage or provide other evidence of financial responsibility in the minimum amounts determined by Wisconsin Statutes covering all clinical privileges granted, the practitioner's privileges that are no longer covered shall be automatically suspended until acceptable coverage or evidence of financial responsibility is secured. The practitioner must provide proof of coverage or of financial responsibility before the suspension can be lifted.

(j) Repeated Policy Violations. A practitioner will be automatically suspended for up to 14 days upon the third violation of a specific policy and procedure or rule and regulation in accord with the following process:

(1) The practitioner will receive a verbal warning for the first violation from the appropriate department chair (or the CMO if the department chair is the offender).

(2) The practitioner will receive a written warning for the second violation from the CMO with a copy to the appropriate department chair.

(3) The practitioner will receive written notice, sent by special notice, from the CMO of a third violation, imposing an automatic suspension of up to 14 days to be effective on the date and for the duration specified in the notice, with a copy being sent to the appropriate department chair.

(4) A copy of each notice will be placed in the practitioner's medical staff file.

(k) Practitioner's Duty to Inform CMO. Each practitioner shall have the duty to notify the CMO of any action which may constitute a cause for automatic suspension. Failure to report such action will result in automatic suspension.

(l) Automatic Suspension Not Professional Review Action. Automatic suspension activated pursuant to this subsection shall not be a professional review action and thus not give rise to any right of hearing or appellate review, including the maintaining of any suspension instituted as a result of licensing board or DEA action.

1.7 Time Periods for Processing.

Requests for corrective action shall be considered in a timely and good faith manner by all individuals and groups required by this Plan to act on such requests and, except for good cause, shall be processed within the time periods specified in this Plan. The time periods specified for corrective action are to guide the acting parties in accomplishing their tasks and shall not be deemed to create any right for the practitioner to have a suspension lifted or to have a request for corrective action dismissed within those time periods.

SECTION 2 - REMOVAL FROM OFFICE OF MEDICO-ADMINISTRATIVE OFFICER

2.1 General Manner of Removal.

Removal from office of a medico-administrative officer for grounds unrelated to his or her professional clinical capability, or to his or her exercise of clinical privileges, may be accomplished in accordance with the usual personnel policies of the Hospital or the terms of such officer's employment agreement, contract, or other arrangement, if any. To the extent that the grounds for removal include matters relating to competence in performing professional clinical tasks, in supervising the professional activities or practitioners under his or her direction, or in exercising clinical privileges, resolution of the matter shall be in accordance with this Plan.

2.2 Statement of Grounds.

Prior to removal of a medico-administrative officer, the governing body, through the COO, shall transmit to such medico-administrative officer and to the MEC, a written notice of the proposed removal from office, together with a statement specifying the grounds for such removal. To the extent that such grounds explicitly relate to professional clinical capability or to the exercise of clinical privileges, the notice to the officer whose removal is sought shall be sent by a special notice and, for hearing

purposes, the proposed removal shall be deemed equivalent to an adverse recommendation of the medical staff. If the stated grounds for dismissal are based solely on nonclinical matters, the procedure specified in Section 2.3 shall apply. Permissible bases for removal include, without limitation, failure to continuously meet the qualifications for office and failure to timely and appropriately perform the duties of the office held.

2.3 Advisory Panel Review.

(a) Within 30 days of receipt by the medico-administrative officer of the notice as provided in Section 2.2, an Advisory Panel of equal members each from the medical staff and the governing body shall be convened. The governing body members shall be selected by the voting members of the medical staff, but shall not include governing body members who are members of the medical staff.

(b) This Advisory Panel shall review the statement of dismissal and conduct such other inquiry as it may deem appropriate for the purpose of rendering an advisory opinion on the categorization of the grounds for removal. Within ten business days of its deliberations, the Advisory Panel shall, by written memorandum to the medico-administrative officer and to the governing body, submit its opinion in the matter. The Advisory Panel's deliberations shall not be deemed a hearing as that term is used in Section 3 and shall not be conducted as such, but a record shall be kept.

(c) Within 30 days of receipt of the Advisory Panel's recommendation, the governing body shall render its final decision in the matter.

SECTION 3 - HEARING PREREQUISITES

3.1 Recommendations or Actions Entitling Practitioner to Hearing.

(a) The following recommendations or actions shall, if deemed a professional review action pursuant to Section 3.2, entitle the practitioner affected (whether already on staff or a new applicant requesting staff membership and privileges) to a hearing:

(1) Denial of initial staff appointment, except an administrative denial as provided in Section 4.2 of the Bylaws.

(2) Denial of staff reappointment.

(3) Suspension of staff membership, except for automatic suspensions under Section 1.6 of this Plan.

(4) Revocation of staff membership, except revocations under Section 1.6(e) of this Plan.

(5) Denial of requested appointment to or advancement in staff category.

(6) Reduction in staff category.

(7) Limitation of admitting prerogatives, except for temporary suspension due to medical record delinquency.

(8) Denial of requested clinical privileges, except an administrative denial as provided in Section 4.2 of the Bylaws.

(9) Reduction in clinical privileges.

(10) Suspension of clinical privileges (other than automatic suspensions pursuant to Section 1.6 of this Plan) for more than 14 days.

(11) Revocation of clinical privileges, except revocations under Section 1.6(e) of this Plan.

(12) Terms of probation or preceptorship which limit clinical privileges.

(13) Requirement of mandatory concurring consultation (meaning that a practitioner must obtain a second opinion regarding the appropriateness of the proposed treatment or procedure before the practitioner can provide the treatment or procedure).

(14) Denial of reinstatement following a leave of absence.

(b) Both voluntary and automatic relinquishments of clinical privileges and/or medical staff membership as identified in this Plan or the medical staff bylaws shall take effect without hearing or appeal and shall not entitle a practitioner to the hearing and appellate review procedures set forth in this Plan.

3.2 When Deemed a Professional Review Action.

(a) An adverse recommendation or action listed in Section 3.1 shall be deemed a professional review action only when it has been:

(1) recommended by the MEC; or

(2) taken by the governing body contrary to a favorable recommendation by the MEC under circumstances where no right to hearing existed; or

(3) a suspension imposed pursuant to Section 1.4 of this Plan; or

(4) taken by the governing body on its own initiative without benefit of a prior recommendation by the MEC.

(b) Only the actions identified in Section 3.2 shall constitute professional review action for the purpose of this Plan. Only activity deemed an adverse professional review action shall entitle a practitioner to the hearing and appellate review procedure set forth in this Plan. All actions and recommendations made by other

medical staff committees or officials are preliminary in nature, and do not of themselves constitute adverse professional review action

(c) A warning or a letter of admonition or a letter of reprimand or imposition of terms of probation or requirement for consultation or extension of provisional status are not recommendations that will adversely affect the practitioner's appointment to or status as an appointee of the medical staff or the practitioner's exercise of clinical privileges.

3.3 Basis for Professional Review Action.

In formulating any professional review action or recommendation, the acting body should conclude that:

(a) There is a reasonable belief that the action is in furtherance of quality health care; and

(b) Reasonable efforts are taken to obtain the pertinent facts; and

(c) A reasonable belief exists that the action is warranted by the facts.

3.4 Notice of Adverse Professional Review Action.

A practitioner against whom professional review action has been taken pursuant to Section 3.2 shall within ten business days be given special notice of the action by the CMO. The notice to the practitioner shall state:

(a) That a professional review action has been taken or is proposed to be taken against the practitioner.

(b) The reasons for the professional review action.

(c) That the practitioner has a right to a hearing pursuant to this Section 2 and must submit a request a hearing within 30 days from the date of receipt of the notice and that the request must meet the requirements of Section 3.5 or the hearing right shall be waived.

(d) A summary of the hearing procedures and rights of the practitioner, which summary can be accomplished by furnishing the practitioner a copy of this Plan with the notice.

(e) That the practitioner will be notified of the date, time, and place of the hearing after making a timely and proper request.

(f) That the practitioner has the right to review the hearing record and report, if any, and to submit a written statement on his or her own behalf as part of the hearing.

3.5 Request for Hearing.

A practitioner shall have 30 days following the receipt of the notice required under Section 3.4 within which to file a written request for a hearing. The request must be in writing and must be received by the CMO with delivery either in person or by special notice within the time specified. If an effective date is specified for the professional review action, the professional review action shall take effect as of that date unless the practitioner submits a hearing request before the effective date. Receipt by the CMO of a request for hearing shall toll the effective date of the action and maintain the status quo of the practitioner unless the MEC (or the executive committee of the governing body if it initiated the action) imposes limitations on the privileges or membership of the practitioner pending completion of the hearing and review process.

3.6 Effect of Failure to Request Hearing.

A practitioner who fails to request a hearing within the time and in the manner specified in Section 3.5 waives any right to hearing and to any appellate review to which the practitioner might otherwise have been entitled. The consequences of a waiver of the right to hearing are:

(a) A professional review action taken by the governing body shall constitute acceptance of that action, which shall become effective as the final decision of the governing body.

(b) An adverse action or recommendation by the MEC shall constitute acceptance of that recommendation, which shall become and remain effective pending the final decision of the governing body. At the governing body's next regular meeting following waiver, it shall:

(1) Consider the MEC's recommendation, review all the information and material considered by the MEC, and consider all other relevant information received from any source.

(2) If the governing body's action on the matter is in accord with the MEC's recommendation, its action shall constitute the final decision of the governing body.

(3) If the governing body's action has the effect of changing the MEC's recommendation, the matter shall be submitted to a joint conference of this Plan. The governing body's action on the matter following receipt of the joint conference committee's recommendation shall constitute its final decision.

(c) The president of the governing body shall promptly send the practitioner notice informing him or her of each action taken pursuant to this subsection and shall notify the MEC and the CMO of each action.

(d) Within 15 days of the date of final action, as defined above, the president of the governing body shall file a report with the appropriate licensing body for reporting to the National Practitioner Data Bank whenever reporting is required by law.

3.7 Notice of Hearing.

(a) Scheduling of Hearing. Upon receipt of a timely request for hearing, the CMO (or chair of the governing body if the governing body's action prompted the request for hearing) shall promptly schedule a date and arrange for a hearing. The hearing date shall be sufficiently far in advance so as to be able to give the practitioner at least 30 days advance notice of the date of the hearing, except as provided in subsection (b) or (c).

(b) Notice of Hearing Sent to Practitioner. The CMO shall send the practitioner special notice of the time, place and date of the hearing. Unless otherwise agreed to by the practitioner in writing and by the CMO, the hearing date shall not be less than 30 days from the date the practitioner receives the notice of the hearing.

(c) Expedited Hearing For Suspended Practitioner. For a practitioner who is under suspension that will be continued in effect at least until hearing can be held, at the practitioner's specific request for an expedited hearing, a hearing shall be held as soon as the arrangements for it may reasonably be made. Such expedited hearing shall be held no later than ten business days from the date of the CMO's receipt of the request for expedited hearing, and the 30-day notice requirement set forth above in subsection (b) is deemed waived. The CMO shall instead send the practitioner notice of the time, place and date of hearing as soon as practicable after the hearing is scheduled.

(d) Required Contents of Hearing Notice. The notice of hearing required by this subsection shall be accompanied by a concise statement of the practitioner's alleged acts or omissions; a list by number of the specific or representative patient records in question; a preliminary list of witnesses, if any, expected to testify on behalf of the body whose action prompted the request for hearing; the other reasons or subject matter, if any, forming the basis for the professional review action; and the list of those individuals from which the Hearing Committee members will be selected.

3.8 Appointment of Hearing Committee.

(a) Hearing Occasioned by MEC. A hearing occasioned by MEC recommendation or action pursuant to subsection 3.2(a)(1) or 3.2(a)(3) of this Plan shall be conducted by a Hearing Committee appointed by the CMO and composed of at least three but no more than five members of the active medical staff. The CMO shall designate one of the appointees as chairperson. If a Hearing Officer is appointed in accord with Section 10.2, the Hearing Officer shall preside as committee chair. Voting members of the Hearing Committee shall not be practitioners in direct

economic competition with the practitioner, unless, due to the size of the medical staff, it is otherwise impossible or impractical to select a representative group. For purposes of this subsection 3.8(a), direct economic competition shall be defined to mean those practitioners actively engaged in practice in the primary medical community of the practitioner and who practice in the same medical specialty. The Hearing Committee may use, on a consulting basis, members of the same medical specialty as the practitioner.

(b) Hearing Occasioned by Governing Body. A hearing occasioned by professional review action of the governing body pursuant to subsections 3.2(a)(2), 3.2(a)(3) or 3.2(a)(4) shall be conducted by a Hearing Committee appointed by the chair of the governing body and composed of at least three but no more than five persons. At least two active medical staff members, not in direct economic competition with the practitioner, shall be included on this Hearing Committee, when feasible. The chair of the governing body shall designate one of the appointees to serve as chairperson of the committee or the role may be filled by a Hearing Officer appointed pursuant to Section 10.2. The Hearing Committee may use, on a consulting basis, members of the same medical specialty as the practitioner.

(c) Members of the Hearing Committee. Prior to final selection of the Hearing Committee, the affected practitioner shall be given a list of seven individuals from which the Hearing Committee will be appointed. The practitioner may strike two persons from the list. The practitioner must inform the CMO in writing of the names to be stricken within five days of receipt of the list of names, or the practitioner will be deemed to have waived any objections to the composition of the Hearing Committee. The Hearing Committee will then be chosen from the remaining individuals as provided above.

(d) Prior Knowledge Not Disqualifying. A member of the active medical staff or of the governing body shall not be disqualified from serving on a Hearing Committee because he or she has heard of the case or has knowledge of the facts involved, or what he or she supposes the facts to be, or has participated in the review or investigation of the matter at issue. No member of the medical staff or governing body who requests corrective action pursuant to Section 1.1 of this Plan shall serve as a voting member of the Hearing Committee. However, the individual may appear before the committee if requested by either of the parties concerned. In any event, all members of a Hearing Committee shall be required to consider and decide the case with good faith objectivity.

(e) Use of Outside Independent Consultants. If in the judgment of the CMO, there are not enough active staff members who are not in direct economic competition with the practitioner to form a committee under subsection (a), the committee may be composed of other practitioners (whether or not medical staff members) or an administrative hearing officer as may be designated by the CMO with the concurrence of the COO. The governing body or the MEC with the governing body's approval, at their sole discretion but with written notice to the affected practitioner, may elect to contract with an independent consultant to perform the

functions of the Hearing Committee as set forth in this Section 3.8. In that event, the composition of the Hearing Committee shall be determined by the governing body in its arrangements with the independent consultant. The governing body may require the affected practitioner to pay a share of the independent consultant's fees, up to one-half of the total charges.

3.9 Presiding Officer.

(a) The chair of the Hearing Committee shall be the presiding officer at the hearing, unless a Hearing Officer is appointed pursuant to Section 10.2 of this Plan, in which case the Hearing Officer shall be the presiding officer at the hearing. Unless the presiding officer is a Hearing Officer appointed pursuant to Section 10.2 of this Plan, the presiding officer shall also vote on any final recommendations as well as on any other matters giving rise to a vote of the Hearing Committee.

(b) The presiding officer shall:

(1) act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross-examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

(2) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay;

(3) maintain decorum throughout the hearing;

(4) determine the order of procedure throughout the hearing;

(5) have the authority and discretion, in accordance with this Plan, to make rulings on all questions that pertain to matters of procedure and to the admission of evidence;

(6) act in such a way that all information relevant to the appointment or clinical privileges of the individual requesting the hearing is considered by the Hearing Committee in formulating its recommendations; and

(7) conduct argument by counsel on procedural points outside the presence of the Hearing Committee unless the Hearing Committee wishes to be present.

(c) The presiding officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

SECTION 4 PRE-HEARING PROCEDURE

4.1 Representation.

(a) By a Member of the Active Medical Staff. The practitioner who requested the hearing shall be entitled to be accompanied by and represented at the hearing by an active medical staff member in good standing, who shall be identified in the practitioner's request for hearing or appellate review. The MEC or the governing body, depending on whose professional review action prompted the hearing, shall appoint at least one of its members and/or another person of its choosing to represent it at the hearing to present the facts in support of the professional review action, and to examine witnesses. Both the practitioner and the MEC or the governing body shall designate their medical staff representative at least ten days prior to the hearing and shall provide notice to each other as set forth under subsection 4.2(b).

(b) By Legal Counsel. If the affected practitioner desires to be represented by an attorney at any hearing or appellate review appearance pursuant to this subsection 4.1(b), his or her request for hearing or appellate review must so state. The request for hearing or review must also include the name, address and phone number of the attorney. The Committee may preclude participation by legal counsel in the hearing or adjourn the hearing for a period not to exceed 20 days if the practitioner fails to notify the Hearing Committee in accord with this subsection. The MEC or the governing body may also be allowed representation by an attorney. While legal counsel may attend and assist the respective parties, due to the professional nature of these review proceedings, it is intended that the hearing and review proceedings are not judicial in form but a forum for professional evaluation and discussion. Accordingly, the Hearing Committee and any appellate review body retains the right to limit the role of counsel's active participation in the hearing. Any practitioner who incurs legal fees in his or her behalf shall be solely responsible for payment of those fees.

4.2 Discovery.

(a) The hearing is not a trial but a hearing among peers. The right to discovery is limited as outlined in this Section and no other discovery rights exist outside of this Plan. The individual requesting the hearing shall be entitled, upon specific written request, to the following (provided that the written request indicates that all documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing):

(1) copies of, and/or reasonable access to, all patient medical records referred to in the notice of hearing, at the individual's expense;

(2) reports of experts relied upon by the MEC or the governing body;

(3) redacted copies of reviews relative to the affected practitioner's performance;

(4) redacted copies of relevant committee or department meeting minutes; and

(5) copies of any other documents relied upon by the MEC or the governing body.

(b) Exchange of Witness Lists. At least ten business days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals that party intends to call as witnesses at the hearing and the name of the medical staff member chosen as their representative under subsection 4.1(a) (if any). Each party shall update its witness list if and when additional witnesses are identified prior to hearing, and neither party shall call witnesses not named in advance except in rebuttal.

(c) Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(d) Prior to the hearing, on dates set by the presiding officer, the individual requesting the hearing shall, upon specific request, provide the MEC and/or the governing body copies of any expert report or other documents relied upon by the individual.

(e) If the Hearing Committee determines to require the parties to submit written statements of the case as allowed by subsection 5.7(b), notice to that effect shall be provided to each party at least ten business days prior to the hearing. The written statements of the case shall be supplied both to the Committee and to the other party at least two business days prior to the commencement of the hearing.

(f) There shall be no discovery regarding other individual practitioners.

(g) Neither the affected individual, nor his or her attorney, nor any other person on behalf of the affected individual, shall contact Hospital employees appearing on the Hospital's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

(h) Neither the Hospital nor its attorney nor any other person on behalf of the Hospital shall contact those persons appearing on the affected individual's witness list concerning the subject matter of the hearing, unless such witness is also listed as a witness for the Hospital or unless specifically agreed upon by counsel.

4.3 Pre-Hearing Conference.

(a) The presiding officer shall require counsel for the individual and for the MEC (or the governing body) to participate in a pre-hearing conference for the purposes of resolving all procedural questions in advance of the hearing. At this conference, counsel for the individual may state his or her objections (and the grounds

therefore) to any person named to serve on the Hearing Committee or to the Hearing Officer. The presiding officer shall have the sole authority to rule on the objections; counsel for the individual may preserve his or her objections on the record.

(b) The presiding officer may specifically require that:

(1) all documentary evidence be exchanged by the parties prior to this conference and any objections to the documents be made at this conference and be resolved by the presiding officer;

(2) evidence unrelated to the reasons for the adverse recommendation or unrelated to the individual's qualifications for appointment or the relevant clinical privileges by excluded;

(3) any objections to hearing panel members and the basis for those objections be made at the pre-hearing conference; the presiding officer may recommend to the CMO that a panel member be replaced for reasonable cause;

(4) the names of all witnesses and a brief statement of their anticipated testimony be exchanged by the parties if not previously provided;

(5) the time granted to each witness's testimony and cross-examination be agreed upon, or determined by the presiding officer, in advance; and

(6) witnesses and documentation not provided and agreed upon in advance of the hearing shall be excluded from the hearing, except upon a showing of good cause and agreed to by all parties.

SECTION 5 – HEARING PROCEDURE

5.1 Personal Appearance Required.

Failure without good cause of the practitioner to appear in person and proceed at a hearing shall constitute voluntary abandonment of the appeal and the professional review action involved shall become final and effective immediately when approved by the governing body.

5.2 Rights of Parties.

"Parties" for the purpose of this Section 5.2 shall be the affected practitioner and the body whose action prompted the request for hearing. During a hearing, each of the parties shall have the right to:

(a) Call, examine and cross-examine witnesses, including expert witnesses.

(b) Introduce exhibits and present relevant evidence as determined by the Hearing Officer or presiding officer.

(c) Submit a written statement at the close of the hearing.

(d) Record the hearing by use of a court reporter or other mutually acceptable means of recording.

5.3 Examination of Practitioners.

If the practitioner who requested the hearing does not testify in his or her own behalf, the practitioner may be called by the other party or the Hearing Committee and examined as if under cross-examination.

5.4 Record of Hearing.

A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee may select the method to be used for making the record, such as a court reporter, electronic recording unit, detailed transcription, or any combination of these. If an electronic recording unit is used, each person speaking should identify himself or herself each time he or she speaks. A practitioner electing an alternate method shall bear its cost.

5.5 Postponement.

Requests for postponement of a hearing shall be granted by the Hearing Committee only upon a showing of good cause and only if the request is prompt. A hearing shall be postponed no more than two times, whether at the request of the practitioner or the other party.

5.6 Continued Presence Required.

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from any significant part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision, unless otherwise agreed to by both parties.

5.7 Presentation of Evidence.

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admissible if, in the judgment of the presiding officer, it is the sort of evidence on which responsible persons rely in the conduct of serious affairs. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and these memoranda shall become a part of the hearing record. The presiding officer may, but is not required to, order that oral evidence be taken only on oath or affirmation.

(a) Matters Allowed to be Considered. The Committee shall be entitled to consider any pertinent material contained on file in the Hospital and all other information that can be considered, pursuant to the medical staff bylaws, in connection with applications for appointment or reappointment to the medical staff or for clinical privileges. The Hearing Committee shall be entitled to conduct independent review, research and interviews, but may use the products of this in its decision only if the parties are aware of and have the opportunity to rebut any information so gathered.

(b) Deliberations and Written Statements. The Hearing Committee may meet outside the presence of the parties to deliberate and/or establish procedures. The Hearing Committee may require that the parties submit written, detailed statements of the case to the Committee and to each other. Statements of the case may consist of a recitation of all the facts of the case. If so, the hearing can consist of clarification and explanation of the written statements of the case. If a party is ordered by the Hearing Committee to supply a detailed statement of the case and fails to do so, the Hearing Committee can conclude that this constitutes a waiver of the party's case.

(c) Witness Statements. Statements from members of the medical staff, nursing or other Hospital staff, other professional personnel, patients or others may be distributed to the Hearing Committee and the parties in advance of or at the hearing. The statements shall be made a part of the record of the hearing and given such credence as may be appropriate. These statements must be available to all parties. When time and distance allow, the authors of the statements should be available at the hearing for questioning by either party, if so requested.

5.8 Official Notice.

In reaching a decision, the Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the State of Wisconsin. Parties present at the hearing shall be informed of the matters to be noticed and those matters shall be noted in the hearing record. Any party may request on a timely basis that a matter be officially noticed and to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of refutation to be determined by the Hearing Committee.

5.9 Burden of Proof.

The body whose professional review action occasioned the hearing shall have the initial burden of going forward to present evidence in support of its action. The practitioner shall then be responsible for supporting his or her challenge to the professional review action by clear and convincing evidence that no substantial factual basis exists for the action or the conclusions drawn from the facts are arbitrary, unreasonable or capricious.

The other party shall then have an opportunity to rebut the evidence provided by the practitioner. The burden of proof shall at all times remain with the practitioner.

5.10 Recesses and Adjournments.

The presiding officer or the Hearing Committee as a whole may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may, at a time convenient to itself, conduct its subsequent deliberations outside the presence of the parties. Upon conclusion of its deliberations, which shall not exceed 30 days after the close of the hearing, the hearing shall be declared finally adjourned.

SECTION 6 - HEARING COMMITTEE REPORT AND FURTHER ACTION

6.1 Report by Hearing Committee.

Within 30 days after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward it, together with the hearing record and all other documentation considered by it, to the body whose professional review action occasioned the hearing. The written report should include an explanation of the Hearing Committee's findings and recommendations that makes a rational connection between the issues to be decided, the evidence presented and the conclusions reached.

6.2 Action on Hearing Committee Report.

By its next regular meeting after its receipt of the report of the Hearing Committee, the MEC or the governing body, as the case may be, shall consider the report and affirm, modify or reverse its recommendation or action in the matter. The results of that consideration shall be transmitted in writing to the CMO, together with the hearing record, the report of the Hearing Committee and all other documentation considered.

6.3 Favorable Result.

(a) By Governing Body. If the governing body's action occasioned the hearing and its result pursuant to Section 6.1 is favorable to the practitioner, the result shall become the final decision of the governing body and the matter shall be considered finally closed.

(b) By Executive Committee. If the MEC's action occasioned the hearing, then:

(1) If the MEC result is favorable to the practitioner, the CMO shall, within seven business days of his or her receipt thereof, forward it together with all supporting documentation to the governing body for action.

(2) The governing body shall, by its next regular meeting following receipt of the favorable result of the MEC, take action by adopting or rejecting the MEC's result in whole or in part or by referring the matter back to the MEC for further reconsideration. Any referral back shall state the reasons for the referral back, set a time limit within which a subsequent recommendation to the governing body must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of the subsequent recommendation and any new evidence in the matter, the governing body shall take final action.

(3) Any favorable action by the governing body shall become its final action and the matter will be finally closed. Any unfavorable action by the governing body shall be controlled by Section 5.2 of this Plan.

6.4 Unfavorable Result.

If the result of the MEC or of the governing body is or remains adverse to the practitioner as set forth in Section 3.1, the affected practitioner shall have the right to request an appellate review by the governing body as provided in Section 7 of this Plan. If it is the result of the MEC, the result will not be forwarded to the governing body for final action until the practitioner either exercises or waives his or her right to appellate review.

6.5 Notice of Result.

(a) Notice to Practitioner. The CMO shall promptly send a copy of the result to the practitioner by special notice. The practitioner shall be furnished a copy of the Hearing Committee report with the notice as well as the written decision or recommendation of the body acting on the Hearing Committee report.

(b) Contents of Notice. If the result sent to the practitioner is or continues to be unfavorable to the practitioner in any of the respects listed in Section 3.1 of this Plan, the special notice shall state, in addition to the result:

(1) that the practitioner has a right to request an appellate review by the governing body.

(2) that the practitioner has 15 days following the mailing of the notice required by this subsection to file a written request for appellate review and that failure to properly request review shall constitute a waiver of the right to review.

(3) a summary of the appellate review procedures, which summary can be accomplished by furnishing the practitioner a copy of this Plan with the notice.

SECTION 7 - APPELLATE REVIEW

7.1 Request for Appellate Review.

(a) The grounds for appellate review shall be limited to one or more of the following:

(1) there was substantial failure to comply with this Plan or the medical staff bylaws during or prior to the hearing so as to deny a fair hearing;

(2) the recommendations of the Hearing Committee were made arbitrarily, capriciously or with prejudice; or

(3) the recommendations of the Hearing Committee were not supported by any substantial evidence.

(b) A practitioner shall have 15 days following the mailing of a notice pursuant to Section 6.5 within which to file a written request for appellate review, identifying the grounds for review. The request must be delivered to the CMO within the time specified either in person or by certified or registered mail and may include a request for a copy of the record of the hearing and all other material that was considered in reaching the adverse result, whether favorable or unfavorable, if not previously forwarded to or in the possession of the practitioner.

7.2 Failure to Request Review Constitutes Waiver.

A practitioner who fails to request an appellate review within the time and in the manner specified in Section 7.1 of this Plan waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 3.6 of this Plan.

7.3 Scheduling and Notice of Appellate Review.

Upon receipt of a timely request for appellate review, the CMO shall deliver the request to the chairman of the governing body. Within ten business days after receipt of the request, the chairman of the governing body shall schedule and arrange for an appellate review which shall be conducted not more than 35 days from the date the CMO received the appellate review request. As soon as practicable after the date is selected, the CMO shall send the practitioner special notice of the date of the review. An appellate review for a practitioner who is under a suspension or revocation then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than 20 days from the date the CMO received the request for review. In such cases, the practitioner shall be afforded notice of the date of review as soon as practicable. The time for the appellate review may be extended by the Appellate Review Body for good cause. The appellate review can occur at a regular meeting of the governing body.

7.4 Appellate Review Body.

The governing body shall determine whether the appellate review shall be conducted by the governing body as a whole or by an Appellate Review Committee composed of three

to five members of the governing body, appointed by the chair of the governing body. If a committee is appointed, the chair of the governing body shall designate one of its members as chair.

7.5 Nature of Review Proceedings.

The proceedings by the Appellate Review Committee shall not be a new or additional hearing but shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, that committee's report, and all subsequent results and actions. The Appellate Review Committee shall also consider the written statements submitted pursuant to Section 7.6 and other material as may be presented and accepted under Sections 7.8 and 7.9 of this Plan.

7.6 Submission of Written Statements.

The practitioner seeking the appellate review must submit a written statement detailing the findings of fact, conclusions and procedural matters with which he or she disagrees, and the reasons for disagreement. This written statement may cover matters raised at any step in the hearing process. The statement shall be submitted to the Appellate Review Committee through the CMO at least ten business days prior to the scheduled date of the appellate review. Failure to timely submit this written statement shall be deemed a withdrawal of the request for review. A written statement in reply may be submitted by the MEC or by the governing body, as the case may be, and if submitted, the CMO shall provide a copy to the practitioner at least three business days prior to the scheduled date of the appellate review. These filing deadlines do not apply to the expedited review permitted in Section 7.3 of this Plan. In that case, the written statement will be submitted with the request for appellate review. In any event, failure to submit a written statement by the applicable deadline shall constitute a waiver of the right to appellate review and the appellate review shall be cancelled.

7.7 Presiding Officer.

The chairman of the Appellate Review Committee shall be the presiding officer. He or she shall determine the order of the procedure during the review, make all required rulings, and maintain decorum.

7.8 Oral Statements.

The Appellate Review Committee, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions directed to him or her by any member of the Appellate Review Committee. If personal appearance is allowed, the parties shall be given written notice of the place and time for appellate review.

7.9 New Matters.

New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The Appellate Review Committee, in its sole discretion, shall determine whether new matters or evidence shall be considered or accepted. The party requesting the consideration of new matters or evidence shall explain the reasons for not presenting it earlier.

7.10 Powers.

The Appellate Review Committee shall have all the powers granted to the Hearing Committee, and those additional powers as are reasonably appropriate to the discharge of its responsibilities.

7.11 Presence Required for Participation.

A majority of the Appellate Review Committee must be present throughout the review and deliberations. If a member of the review committee is absent from any significant part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision.

7.12 Recesses and Adjournments.

The Appellate Review Committee may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The Appellate Review Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

7.13 Report of Findings.

(a) Within ten business days following final adjournment, the Appellate Review Committee shall submit a written report of its findings and recommendations in the matter to the governing body. If appellate review is conducted by the governing body as a whole, its conclusions shall be the governing body's final action unless otherwise provided in this subsection 7.13(b).

(b) The Appellate Review Committee may recommend that the governing body affirm, modify or reverse the adverse result or action taken by the MEC or by the governing body pursuant to Section 6.2 and subsection 6.3(b)(2) of this Plan. In its discretion, the Appellate Review Committee may refer the matter back to the Hearing Committee for further review and require a recommendation to be returned to the Appellate Review Committee within 20 days. The recommendation shall be in accordance with the Appellate Review Committee's instructions. Any written report following referral shall be shared with the practitioner. Within ten days after receipt of such recommendation after referral,

the Appellate Review Committee shall make its recommendations to the governing body to affirm, modify or reverse the professional review action of the body that occasioned the review.

7.14 Conclusion of Review.

The appellate review shall not be deemed concluded until all of the procedural steps specified have been completed or waived.

SECTION 8 - FINAL DECISION OF THE GOVERNING BODY

8.1 Notice of Governing Body Decision.

By no later than its next regular meeting after receipt of the recommendation of the Appellate Review Committee, the governing body shall render its final decision in the matter in writing and the CMO shall send notice of its decision to the practitioner by special notice.

8.2 Effect of Decision.

(a) If the governing body's decision is to affirm its last adverse recommendation in the matter, if any, it shall be immediately effective and final.

(b) If the governing body's decision is to affirm the MEC's last adverse recommendation in the matter, if any, it shall be immediately effective and final.

(c) If the governing body's action has the effect of changing the MEC's last adverse recommendation, if any, the governing body shall refer the matter to the Medical Staff/Hospital Board Liaison Committee of this Plan. The governing body's action on the matter following receipt of the Medical Staff/Hospital/Board Liaison committee's recommendation shall be immediately effective and final.

8.3 Final Decision.

When a final decision is made by the governing body, a copy of the decision shall be sent by the CMO to the practitioner by special notice. If the decision is adverse, a report will also be filed within 15 days with the appropriate licensing body for reporting to the National Practitioner Data Bank whenever reporting is required by law.

SECTION 9 – MEDICAL STAFF/HOSPITAL BOARD LIAISON

9.1 Composition.

Composition of the Medical Staff/Hospital Board Liaison Committee shall be in accord with Section 8 of the Bylaws.

9.2 Meeting to Consider Matter Referred.

Within ten business days following receipt of a matter referred to the Medical Staff/Hospital Board Liaison Committee by the governing body pursuant to the provisions of this Section 9, the Committee shall convene to consider the matter.

9.3 Submission of Recommendation.

Within ten business days, the Medical Staff/Hospital Board Liaison Committee has finished considering the matter, it shall submit its recommendation to the governing body.

9.4 Governing Body Action.

The governing body's action on the matter following receipt of the Medical Staff/Hospital Board Liaison Committee's recommendation shall be immediately effective and final.

SECTION 10 – GENERAL PROVISIONS

10.1 Only One Hearing.

Notwithstanding any other provision of the medical staff bylaws or this Plan, no practitioner shall be entitled as a right to more than one evidentiary hearing and one appellate review with respect to any professional review action.

10.2 Hearing Officer.

The use of a Hearing Officer to preside at a hearing held in accord with this Plan is optional. The use and appointment of a Hearing Officer shall be determined by the CMO after consultation with the chairman of the governing body if applicable. A Hearing Officer may or may not be an attorney-at-law but must be experienced in conducting hearings. The Hearing Officer shall act in an impartial manner as the presiding officer of the hearing. If requested by the Hearing Committee, the Hearing Officer may participate in its deliberations and act as its advisor, but shall not be entitled to vote.

10.3 Failure to Comply Deemed Consent and Waiver.

If at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to request further action or to appear or otherwise fails to comply with this Plan, he or she shall be deemed to have consented to the professional review action or result and to have voluntarily waived all rights to which he or she might otherwise have been entitled under the medical staff bylaws then in effect or under this Plan with respect to the matter involved.

10.4 Confidentiality.

(a) All actions taken and all recommendations made pursuant to this Plan shall be considered confidential and are not to be disclosed to individuals (other than legal counsel) not directly involved or authorized by the MEC, the CMO, the COO, the Hospital's legal counsel or the governing body to receive the information. This shall not preclude the CMO or COO from filing reports of actions taken to regulatory agencies in compliance with regulatory requirements or from disclosing practice restrictions to others within the Hospital as necessary to assure or monitor compliance with the restrictions.

(b) All records and other information generated in connection with or as a result of professional review activities are part of the Hospital's program organized and operated to help improve the quality of health care. As such, they shall be confidential, and each individual or committee member participating in such review activities shall agree not to disclose such information except as authorized expressly in this Plan or the medical staff bylaws or as authorized, in writing, by the COO or by legal counsel for the Hospital. Any breach of confidentiality by an individual or committee member may result in corrective action.

10.5 Agreement to be Bound by Bylaws.

By requesting a hearing or appellate review under this Plan, a practitioner agrees to be bound by the provisions of the medical staff bylaws and this Plan in all respects.

10.6 Time Limits.

Any time limits set forth in this Plan may be extended or accelerated by mutual agreement of the practitioner and the CMO or the MEC. The time periods specified in this Plan for action by the medical staff, the governing body and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of the professional review action if the fair hearing process or corrective action procedures are not completed within the time periods specified.

10.7 Technical Deviations.

Technical or insignificant deviations from the procedures set forth in this Plan shall not be grounds for invalidating the action taken.

10.8 Amendment.

(a) This Plan may be amended by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists, provided that:

(1) the written recommendations of the MMT concerning the proposed amendments shall have first been received and reviewed by the MEC;

(2) notice of all proposed amendments shall be distributed to the medical staff at least 30 days prior the MEC meeting;

(3) any medical staff member shall have the right to submit written comments to the MEC regarding the amendment. Such comments shall be addressed to the CMO. All written comments on the proposed changes received prior to the meeting shall be brought to the attention of the MEC before the change is voted upon; and

(4) no such amendment shall be effective unless and until it ahs been approved by the governing body.

(5) This policy may not be unilaterally amended. In the event that the Medical Staff shall fail to exercise its responsibility and authority as required by Section **Error! Reference source not found.** of this section, and after notice from the governing body to such effect, including a reasonable time for response, the governing body may, upon its own initiative, formulate amendments to these Bylaws. In such event, Medical Staff recommendations and views will be carefully considered by the governing body during its deliberations and in its actions.

10.9 Medical Staff Responsibility and Governing Body Initiative.

The principles stated in the medical staff and governing body bylaws regarding medical staff responsibility and authority (but not the methodology) to formulate, adopt and recommend medical staff bylaws and amendments, and the circumstances under which the governing body may resort to its own initiative in accomplishing those functions shall apply as well to the formulation, adoption and amendment of this Plan.

10.10 Adoption.

(a) Medical Staff. The foregoing Plan Addendum was adopted and recommended to the governing body by the medical staff with, and subject to, the medical staff bylaws, Rules and Regulations on _____, 20___.

_____
Chief Medical Officer

Date:_____

(b) Governing Body. The foregoing Plan Addendum was approved and adopted by resolution of the governing body after considering the medical staff's recommendation, and in accordance with, and subject to, the Hospital Corporate Bylaws on _____, 20__.

_____
Secretary, Governing Body

Date:_____