BYLAWS
OF THE MEDICAL STAFF
OF
AURORA MEDICAL CENTER – BAY AREA
VOLUME II
CORRECTIVE ACTION PROCEDURES
AND
FAIR HEARING PLAN
3/15/2021
**Table of Contents**

**ARTICLE I. CORRECTIVE ACTION** ................................................................. 1  
  Section 1.1. Grounds for Request .................................................................. 1 
  Section 1.2. Procedure to Determine Request .............................................. 2 
  Section 1.3. MEC Action ............................................................................. 2 
  Section 1.4. Precautionary Suspension of Privileges ................................ 3 
  Section 1.5. Temporary Suspension ............................................................. 5 
  Section 1.6. Automatic Suspension ............................................................... 5 
  Section 1.7. Time Periods for Processing ...................................................... 9

**ARTICLE II. HEARING PREREQUISITES** ...................................................... 9  
  Section 2.1. Recommendations or Actions Entitling Practitioner to a Hearing .... 9 
  Section 2.2. When Deemed a Professional Review Action .......................... 10 
  Section 2.3. Basis for Professional Review Action ....................................... 10 
  Section 2.4. Notice of Professional Review Action ...................................... 10 
  Section 2.5. Request for Hearing ................................................................. 10 
  Section 2.6. Effect of Waiver by Failure to Request a Hearing .................. 11 
  Section 2.7. Notice of Hearing .................................................................... 11 
  Section 2.8. Appointment of Hearing Committee ....................................... 12 
  Section 2.9. Service on the Hearing Committee ......................................... 12 
  Section 2.10. Hearing Conducted by Independent Consultant .................. 12 
  Section 2.11. Presiding Officer ................................................................. 13

**ARTICLE III. PRE-Hearing PROCEDURE** ...................................................... 13  
  Section 3.1. Representation ......................................................................... 13 
  Section 3.2. Discovery .............................................................................. 14 
  Section 3.3. Pre-Hearing Conference ......................................................... 15

**ARTICLE IV. HEARING PROCEDURE** ......................................................... 15  
  Section 4.1. Failure to Appear for Hearing ............................................... 15 
  Section 4.2. Rights of Parties ..................................................................... 16 
  Section 4.3. Record of Hearing .................................................................. 16 
  Section 4.4. Postponement ......................................................................... 16 
  Section 4.5. Participation ........................................................................... 16 
  Section 4.6. Procedure and Evidence ......................................................... 16 
  Section 4.7. Official Notice ....................................................................... 17 
  Section 4.8. Burden of Proof ..................................................................... 17 
  Section 4.9. Recesses and Adjournment ..................................................... 17

**ARTICLE V. HEARING COMMITTEE REPORT AND FURTHER ACTION** .... 17  
  Section 5.1. Hearing Committee Report ..................................................... 17 
  Section 5.2. Action on Hearing Committee Report .................................... 18 
  Section 5.3. Favorable Result ..................................................................... 18 
  Section 5.4. Unfavorable (Adverse) Result ............................................... 18 
  Section 5.5. Notice of Result ..................................................................... 18
ARTICLE VI. INITIATION AND PREREQUISITES OF APPELLATE REVIEW

Section 6.1. Request for Appellate Review
Section 6.2. Waiver by Failure to Request Appellate Review or to Submit Written Statement
Section 6.3. Notice of Date of Appellate Review
Section 6.4. Appellate Review Committee

ARTICLE VII. APPELLATE REVIEW PROCEDURE

Section 7.1. Nature of Proceedings
Section 7.2. Written Statements
Section 7.3. Presiding Officer
Section 7.4. Oral Statement
Section 7.5. Consideration of New or Additional Matters
Section 7.6. Powers
Section 7.7. Participation
Section 7.8. Recesses and Adjournment
Section 7.9. Action Taken
Section 7.10. Conclusion

ARTICLE VIII. FINAL DECISION OF THE GOVERNING BODY

Section 8.1. Governing Body Action

ARTICLE IX. JOINT CONFERENCE COMMITTEE REVIEW

Section 9.1. Membership and Time Limits

ARTICLE X. GENERAL PROVISIONS

Section 10.1. Number of Hearings and Reviews
Section 10.2. Hearing Officer Appointment and Duties
Section 10.3. Waiver
Section 10.4. Confidentiality
Section 10.5. Release
Section 10.6. Waiver of Time Limits
Section 10.7. Substantial Compliance

ARTICLE XI. AMENDMENT

ARTICLE XII. ADOPTION
ARTICLE I. CORRECTIVE ACTION

The executive committee of the medical staff (the MEC) shall be the disciplinary body of the hospital medical staff. Corrective action may be requested by any officer of the medical staff, by the chairman of any department, the chairman of any standing or special committee, by the chief executive officer, or by the Governing Body. Except when a suspension is imposed pursuant to Section 1.4, 1.5 or 1.6, all requests for corrective action shall be in writing to the MEC, and the request shall contain a detailed description of the activity of conduct upon which the request is based.

Section 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:

a. Conduct or activity by a practitioner considered to lower the standards or aims of the medical staff or to adversely reflect upon the reputation of the medical staff or hospital as a whole in the community or which is disruptive to the operations of the hospital or may pose a threat to patient care.

b. Conduct involving moral turpitude.

c. Conviction of a crime.

d. Unethical practice.

e. Incompetence.

f. Failure to keep adequate records.

g. Revocation, suspension, or limitation of practitioner’s license by the appropriate licensing board or voluntarily by practitioner.

h. Loss or limitation of practitioner’s narcotics (DEA) license.

i. Exercising privileges while practitioner’s professional ability is impaired, whether through illness, accident, addiction, or from any other source.

j. Significant misstatement in or omission from any application for membership or privileges or any misrepresentation in presenting the practitioner’s credentials.

k. Violation of the bylaws, rules and regulations of the medical staff, hospital bylaws, the Medical Staff Code of Conduct, the Compliance and Ethics Code of Conduct, Conflict of Interest Policy or other medical staff policies, the Code of Ethics of the applicable professional association, or State of Wisconsin rules.

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

m. Harassment, mistreatment or otherwise degrading any patient, employee of the hospital, member of the medical staff or a member of the Governing Body.

n. Breach of confidentiality.
Section 1.2. Procedure to Determine Request

a. Except when a suspension under Section 1.4, 1.5 or 1.6 has already been imposed following receipt of a request for corrective action, the MEC (or the president of the medical staff if time or special circumstances do not permit review by the MEC) shall forward such request to the chairman of the practitioner’s primary clinical department. The department chairman or an ad hoc committee appointed by him shall conduct an Investigation and report its findings to the MEC within 30 days of receipt of the request for corrective action. The matter need not be referred to the department if the president of the medical staff determines that special circumstances require alternate review or if the request for corrective action originated in the department and is supported by a written report of the department. While Investigation of requests for corrective action shall principally be performed within departments, the president of the medical staff or the MEC may elect to review the requests or 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. The practitioner shall be informed of the general nature of the charges that have been brought and that such charges may result in action entitling the practitioner to formal hearing.

c. The practitioner shall be permitted to discuss and explain his conduct. His 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 investigating body.

d. The president of the medical staff shall promptly notify the chief executive officer of all requests for corrective action received by the MEC and shall continue to keep the chief executive officer fully informed of all action taken.

Section 1.3. MEC Action

a. Within 30 days following receipt of the report of the Investigation made by the department chairman or the ad hoc committee, the MEC shall take one of the following actions:

1. Issue a warning letter to the staff member.

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

3. Reject, modify or dismiss the request for corrective action.

4. 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.

5. Recommend that the Governing Body:
   (a) Require mandatory concurring consultation.
   (b) Impose probation for a specified term.
   (c) Deny reinstatement from a leave of absence.
   (d) Reduce privileges.
   (e) Suspend privileges.
   (f) Revoke privileges.
   (g) Suspend staff membership.
   (h) Revoke staff membership.
6. Any other appropriate action, including any combination of the above.

b. If the MEC makes a recommendation to the Governing Body under a.5, 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 chief executive officer for submission to the Governing Body. If the action taken by the MEC is not a professional review action, as defined in Sections 2.1 and 2.2 of this Fair Hearing Plan, the Governing Body, in its sole discretion, may conduct its own Investigation through whatever means, and, after receipt of the report of the Investigation, impose any of the sanctions set forth in subsection 1.3.a above. Before imposing any such sanctions, the Governing Body shall refer the matter to a joint conference committee as provided in Article IX of the Plan. The Governing Body’s action on the matter following receipt of the joint conference committee’s recommendation shall not be final until the affected practitioner has exercised or waived his rights, if any, to hearing and review.

d. Any recommendation by the MEC or action of the Governing Body that constitutes a professional review action, as defined in Sections 2.1 and 2.2 of this Fair Hearing Plan, shall entitle the affected practitioner to a hearing, and the procedures identified in Section 2 of this Fair Hearing Plan shall control.

Section 1.4. Precautionary Suspension of Privileges

a. Any of the following: the MEC or its chairman, the chairman of the credentials committee, the president of the medical staff, any department chairman, the chief executive officer, the executive committee of the Governing Body or the Governing Body shall each have the authority whenever precautionary action must be taken in the best interests of patient care in the hospital, to suspend all or any portion of the clinical privileges of a practitioner and such 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 department chairman 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 chief executive officer, the president of the medical staff and the appropriate department chairman, 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. A practitioner whose precautionary suspension pursuant to this Section is for more than 14 days 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 the bylaws, not to exceed 10 days after receipt by the chief executive officer of a request for expedited hearing unless the practitioner asks for more time. Such hearing shall be held in general accord with the procedures set forth in this Fair Hearing Plan, except timelines will be shortened due to the expedited nature of a hearing under this subsection. If an expedited hearing is held at the practitioner’s request, it shall be in lieu of and not in addition to, any right to hearing otherwise available to the practitioner under this Fair Hearing Plan. The practitioner’s ineligibility for or failure to request an expedited hearing under this section does not affect the practitioner’s right to request a hearing pursuant to Section 2.1 of this Plan.

c. If corrective action that otherwise would give rise to hearing rights is taken during a precautionary suspension and the practitioner requests a hearing on both the precautionary suspension and the corrective action, a single consolidated hearing shall be held on the matter provided the reasons for the subsequent corrective action include the acts, omissions or issues that resulted in the precautionary suspension. The timelines for scheduling the consolidated hearing may be adjusted at the request of the practitioner, including postponement of an already scheduled hearing that has not yet begun, so as to afford the practitioner with 30 days to prepare for the hearing following the date of the subsequent corrective action.

d. 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 under subsection 1.4.b. The MEC shall be authorized to lift, maintain or modify the suspension, except a suspension imposed by the Governing Body or its executive committee. If the suspension:

1. is lifted or modified by the MEC but the chief executive officer or the president of the medical staff objects in writing to such action; or
2. is not lifted by the MEC and the practitioner requests a hearing on the professional review action (but not an expedited hearing as provided in subsection 1.4.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 of the written objections of the chief executive officer or president of the medical staff. The executive committee of the Governing Body shall consider the written position of both sides on the sole issue of maintenance of the suspension pending hearing and appellate review. The chief executive officer, the president of the medical staff and the chairman of the practitioner’s primary department may each submit their recommendations. 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.

e. After hearing held pursuant to subsection 1.4.b, the MEC may recommend modification, continuance or termination of the terms of the suspension. If, as a result of such hearing, the MEC does not recommend immediate termination of the suspension, the affected practitioner shall, in accordance with this Fair Hearing Plan, be entitled to request an appellate review by the Governing Body. The terms of the suspension as sustained or as modified by the MEC shall remain in effect pending a final decision on it by the Governing Body.

f. Immediately upon the imposition of a suspension, the president of the medical staff or responsible department chairman shall provide for alternate medical coverage for patients of the suspended practitioner still in the hospital at the time of the suspension. The patient’s preference will be considered in assigning an alternate practitioner. The suspended practitioner shall confer with the alternate practitioner to the extent necessary to safeguard the patients.
Section 1.5. Temporary Suspension

A temporary suspension of a practitioner’s admitting privileges 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 until the records are complete. This suspension will not affect the privileges of the practitioner to continue to treat his patients who are in the hospital at the time of the suspension. A delay in completion of training to use electronic records that is unexcused by the MEC will result in automatic relinquishment of some or all privileges without a hearing until such training is complete.

Section 1.6. Automatic Suspension

a. Action by the applicable licensing board revoking or suspending a practitioner’s license shall 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 had special conditions attached to his license by any licensing board shall within 15 days of the Hospital’s receipt of notice of such action have his privileges reviewed by the Chief of Staff, who shall promptly review the matter and submit a recommendation to the MEC regarding corrective action should be taken against the practitioner based upon the licensing board action.

b. A practitioner whose DEA number is revoked or restricted or voluntarily surrendered shall automatically lose the right to prescribe medications controlled by that number. Further, all the practitioner’s clinical privileges which require the ability to prescribe those medications shall be automatically suspended.

c. All privileges of a practitioner will be automatically suspended upon receipt of notice that the practitioner has been convicted of a felony. The MEC may, upon request of the affected practitioner, convene to review the matter and 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 provided, all privileges of a practitioner will be automatically suspended upon receipt of notice that the practitioner:

   (a) 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 DHS 12 of the Wisconsin Administrative Code.

   (b) Has been found by a unit of government to have abused or neglected a client or misappropriated a client’s property.

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

2. As soon as possible after automatic suspension under subsection 1.6.d.1 above, the MEC shall convene to review and consider the facts under which the individual was barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code. If the practitioner demonstrates that rehabilitation review approval covering his medical staff appointment and clinical privileges has been received, the MEC may reinstate the practitioner after determining whether it 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. The chief executive officer may impose a suspension of all privileges of a practitioner upon receipt of notice that a practitioner:

   (a) is under investigation for a serious crime, act or offense as defined in Chapter DHS 12 of the Wisconsin Administrative Code.

   (b) is being investigated by a unit of government or an entity subject to DHS 12 for abuse or neglect of a client or misappropriation of a client’s property.

   (c) is being investigated under the Children’s Code or an entity under DHS 12 for abuse or neglect of a child.

4. As soon as possible after 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 to 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 take such further corrective action as is appropriate under the circumstances.

e. Suspension for Exclusion from Federally Funded Health Care Program

1. All privileges of a practitioner shall be automatically suspended if the practitioner is excluded from a federally funded health care program. If the practitioner immediately notifies the chief executive officer 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 chief executive officer and the president of the medical staff, 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 chief executive officer and the president of the medical staff or their designees shall determine within 10 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 chief executive officer and the president of the medical staff 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 chief executive officer of any proposed or actual exclusion from any federally funded health care program as required by the medical staff bylaws will have his staff membership and privileges terminated immediately, upon the chief executive officer 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. The chief executive officer may impose a suspension of all privileges of a practitioner for misconduct that does not directly involve clinical issues. Misconduct not involving clinical issues can consist of, but is not limited to: sexual harassment or abuse of others; drug, alcohol or other addictions; criminal, fraudulent or other improper business conduct; or health problems of the practitioner.

1. A practitioner whose privileges are suspended under this paragraph shall be entitled to request a joint interview to discuss and explain the conduct with the chief executive
officer, the president of the medical staff and the chairperson of the Governing Body or his designee.

2. The request for an interview must be in writing and must be filed with the chief executive officer within five days of the actual notice to the practitioner of imposition of a 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 10 days after such 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 conduct. His 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 chief executive officer or his/her designee.

5. After the interview, the suspension shall be continued, lifted or modified only upon the concurrence of two or more of the officials conducting the interview. Any suspension imposed under this paragraph that is not lifted shall remain in effect indefinitely or until the majority of the chief executive officer, the president of the medical staff and chairperson of the Governing Body decide to alter or lift the suspension.

6. Any suspension pursuant to this Section 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 Section 2.8 of this Fair Hearing Plan.

g. The chief executive officer may impose a suspension of all privileges, after consultation with the president of the medical staff and chairman of the credentials committee, for a practitioner’s failure to notify the chief executive officer within five days of receipt by the practitioner of an initial notification of potential sanction, or of the commencement of a formal investigation or the filing of charges, by a Medicare Peer Review or Quality Improvement Organization (including but not limited to MetaStar), the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin. Any suspension in accord with this Section may be reviewed in the same manner as provided in subsection 1.6.f.6 above.

h. The chief executive officer may impose a suspension upon a practitioner’s failure without good cause to supply information or documentation requested by any of the following: the chief executive officer or his designee, the credentials committee; the executive committee or the Governing Body. Such 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 either to comply with such request or satisfactorily explain his 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 such notice would result in suspension. Any 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 failure to supply it.

i. 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 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 chief executive officer, be authorized to lift or modify this automatic suspension pending final determination by the Governing Body.

j. 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.

k. 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 chairman (or the president of the medical staff if the department chairman is the offender).

2. The practitioner will receive a written warning for the second violation from the president of the medical staff with a copy to the appropriate department chairman.

3. The practitioner will receive written notice, sent by special notice, from the president of the medical staff 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 chairman.

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

l. Failure to Complete Mandatory Training. If a practitioner fails to complete any training required by the MEC (with MEC following recommendations of the department and/or service line) within the timeframe required by the MEC, the practitioner’s membership and clinical privileges shall be automatically suspended and shall remain so suspended until the practitioner completes the required training. The failure of the practitioner to complete the training within thirty (30) days after the date the automatic suspension became effective shall be deemed to be a voluntary relinquishment of the practitioner’s membership and clinical privileges.

m. Failure to Provide Proof of Influenza Immunization. A practitioner’s failure to provide proof of influenza immunization or a granted exception in accordance with the Advocate Aurora Health ‘Influenza Vaccination-Team Member and Physician’ policy after a written warning of delinquency and a specified time frame not to exceed thirty (30) days shall be deemed a voluntary relinquishment of the practitioner’s membership and clinical privileges.

n. Each practitioner shall have the duty to notify the chief executive officer of any action which may constitute a cause for automatic suspension under subsections 1.6.a through 1.6.e. Failure to report such action will result in automatic suspension.

o. Automatic suspension activated pursuant to this Section 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.
Section 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 these bylaws to act on them and, except for good cause, shall be processed within the time periods specified in this Fair Hearing 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.

ARTICLE II. HEARING PREREQUISITES

Section 2.1. Recommendations or Actions Entitling Practitioner to a Hearing

The following recommendations or actions shall, if deemed a professional review action pursuant to Section 2.2 of this Plan, entitle the practitioner affected (whether presently on staff with privileges or a new applicant requesting staff membership and privileges) to a hearing:

a. Denial of initial staff appointment, except an administrative denial under Section V.1.1 of the medical staff bylaws and except denial of a limited-term locum tenens appointment.

b. Denial of staff reappointment.

c. Suspension of staff membership, except for automatic suspensions under Section 1.6 of this Plan.

d. Revocation of staff membership, except for revocation under Section 1.6.e of this Plan.

e. Limitation of admitting prerogatives, except for temporary suspension due to medical record delinquency.

f. Denial of requested service affiliation.

g. Denial of requested clinical privileges, except an administrative denial under Section V.1.1 of the medical staff bylaws and except for denial of temporary privileges (including privileges to work as a locum tenens).

h. Reduction in clinical privileges.

i. Suspension of clinical privileges (other than suspensions pursuant to Section 1.5 or Section 1.6 of this Plan) for more than 14 days.

j. Revocation of clinical privileges, except revocation under Section 1.6.e of this Plan.

k. Terms of probation or preceptorship which limit clinical privileges.

l. Requirement of mandatory consultation (where the practitioner must obtain a concurring second opinion regarding the appropriateness of the proposed treatment or procedure before proceeding).

m. Denial of reinstatement following a leave of absence.

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.
Section 2.2. When Deemed a Professional Review Action

An adverse recommendation or action listed in Section 2.1 shall be deemed a professional review action only when it has been:

a. recommended by the MEC; or
b. taken by the Governing Body contrary to a favorable recommendation by the MEC under circumstances where no prior right to hearing existed; or
c. a suspension imposed pursuant to Section 1.4 of this Fair Hearing Plan; or
d. taken by the Governing Body on its own initiative without benefit of a prior recommendation by the MEC.

Only the foregoing shall constitute professional review action for the purpose of this Fair Hearing Plan. Since only the MEC and Governing Body have the authority necessary to adversely affect a practitioner’s status, only activity deemed a professional review action shall entitle a practitioner to the hearing and appellate review procedure set forth in this Fair Hearing Plan. All actions and recommendations made by other medical staff committees or officials are preliminary in nature and do not of themselves constitute professional review action.

Section 2.3. 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.

Section 2.4. Notice of Professional Review Action

A practitioner against whom professional review action has been taken pursuant to Section 2.2 shall within 10 business days be given special notice of such action by the chief executive officer. 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 of hearing pursuant to this Fair Hearing Plan and must submit a request for hearing in the manner specified in Section 2.5 within 30 days from the date of receipt of the notice or such hearing right shall be waived; and
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 Fair Hearing Plan with the notice.

Section 2.5. Request for Hearing

A practitioner shall have 30 days following the receipt of a notice pursuant to Section 2.4 of this Plan within which to file a written request for a hearing. Such request must be delivered to the chief executive officer either in person or by certified or registered mail so that he receives it within the 30 day time limit. If an effective date is specified for a professional review action taken pursuant to Section 2.2, the recommended action shall take effect as of that date unless the practitioner submits a hearing request before that date. Receipt by the chief executive officer of a
request for hearing shall toll the effective date of the action and maintain the status quo of the practitioner unless the executive committee of the Governing Body, with appropriate medical staff recommendation, imposes limitations on the privileges or membership of the practitioner pending completion of the hearing and review process.

Section 2.6. Effect of Waiver by Failure to Request a Hearing

A practitioner who fails to request a hearing within the time and in the manner specified in Section 2.5 of this Plan waives any right to a hearing and to any appellate review to which the practitioner might otherwise have been entitled. A waiver of the right to hearing shall result in the following:

a. A professional review action taken by the Governing Body shall constitute acceptance of that action, which shall become effective pending 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 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 as provided in Article IX of the 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 chief executive officer shall promptly send the practitioner special notice informing him of each action taken pursuant to this Section 2.6 and shall notify the president of the medical staff and the MEC of each action.

Section 2.7. Notice of Hearing

a. Upon receipt of a timely request for hearing, the chief executive officer shall deliver such request to the president of the medical staff or to the chairman of the Governing Body, depending on whose recommendation or action prompted the request for hearing.

b. The president of the medical staff, or the chairman of the Governing Body, shall schedule a date and arrange for a hearing.

c. The chief executive officer shall send the practitioner notice of the time, place and date of the hearing. Unless otherwise agreed to by the practitioner in writing and by the chief executive officer, the hearing date shall not be less than 30 days from the date the practitioner receives the notice of the hearing.

d. For a practitioner who would remain under suspension at least until a 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, but no later than 10 days from the date of the chief executive officer’s receipt of the request for expedited hearing unless the practitioner authorizes a longer period in the request. In such event, the 30 day notice requirement is deemed waived. The chief executive officer shall instead send the practitioner special notice of the time, place and date of hearing as soon as practicable after scheduling same.

e. The notice of hearing 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, if
any; 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 which is the subject of the hearing; and the list of those individuals from which the Hearing Committee will be selected.

Section 2.8. Appointment of Hearing Committee

a. By Medical Staff

A hearing occasioned by an MEC recommendation or action pursuant to subsection 2.2.a of this Plan shall be conducted by a Hearing Committee appointed by the president of the medical staff and composed of at least three but no more than five members of the active medical staff. The president of the medical staff shall designate one of the members so appointed as chairman unless a Hearing Officer is appointed in accord with Section 10.2. Voting members of the Hearing Committee shall not be in direct economic competition with the practitioner. For purposes of this Fair Hearing Plan, 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 or subspecialty. The Hearing Committee may use, on a consulting basis, members of the same medical specialty or subspecialty.

b. By Governing Body

A hearing occasioned by professional review action of the Governing Body pursuant to subsection 2.2.b, 2.2.c or 2.2.d shall be conducted by a Hearing Committee appointed by the chairman of the Governing Body and composed of five persons. At least two active medical staff members, not in direct economic competition with the practitioner, shall be included on this Hearing Committee whenever feasible. The chairman of the Governing Body shall designate one of the appointees to the committee as chairman of the committee or the role unless a Hearing Officer is appointed pursuant to Section 10.2. The Hearing Committee may use, on a consulting basis, members of the same medical specialty or subspecialty.

c. 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 chief executive officer 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.

Section 2.9. Service on the Hearing Committee

A member of the active medical staff or of the Governing Body shall not be disqualified from serving on a Hearing Committee because he has heard of the case or has knowledge of the facts involved, or what he 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 Article I of the Fair Hearing Plan shall serve as a voting member of the Hearing Committee. However, such individuals 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.

Section 2.10. Hearing Conducted by Independent Consultant

If there are not sufficient active staff members who are not in direct competition with the practitioner to form a committee under subsection 2.8.a, the committee may be composed of other physicians (whether or not medical staff members) or an administrative hearing officer as may be designated by the president of the medical staff. The Governing Body or the MEC with the Governing Body’s approval, at its sole discretion but with the written consent
of the affected practitioner, may elect to contract with an independent consultant to perform the functions of the Hearing Committee as set forth in this Fair Hearing Plan. In such 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.

Section 2.11. Presiding Officer.

a. The chairman 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.

ARTICLE III. PRE-HEARING PROCEDURE

Section 3.1. 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 3.2.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 3.1.b, his 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 behalf shall be solely responsible for payment of those fees.

Section 3.2. 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 10 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 3.1.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 4.6.c, 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 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.

Section 3.3. 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 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 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 be 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 chief executive officer 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 with the agreement of all parties.

ARTICLE IV. HEARING PROCEDURE

Section 4.1. Failure to Appear for Hearing

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. A hearing may be postponed for good cause if mutually acceptable to the parties concerned.
Section 4.2. Rights of Parties

“Parties” for the purpose of the Fair Hearing Plan 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.

b. Introduce exhibits and present relevant evidence.

c. Rebut any relevant evidence.

d. Submit a written statement at the close of the hearing.

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

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

Section 4.3. Record of Hearing

A record of 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, detailed transcription, or any combination of these. If electronic recording is used, each person speaking should try to identify himself each time he speaks. A practitioner electing an alternate method under subsection 4.2.e shall bear its cost.

Section 4.4. 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 at the request of the practitioner or the other party.

Section 4.5. Participation

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 shall not be permitted to participate in the deliberations or the decision.

Section 4.6. Procedure and Evidence

a. 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 are accustomed to 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 such 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.

b. 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 this information in its decision only if the parties are aware of and have the opportunity to rebut any information so gathered.

c. 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. Such statements of the case may consist of a rendering 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 failure constitutes a waiver of the party’s case.

d. 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. They 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. If possible, the authors of the statements should be available at the hearing, either in person or by telephone, for questioning if requested by either party.

Section 4.7. 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 prior to the close of the hearing, 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 such refutation to be determined by the Hearing Committee.

Section 4.8. Burden of Proof

The body whose professional review action occasioned the hearing shall have initial obligation to present evidence in support of its actions. The practitioner who requested the hearing shall then be responsible for presenting clear and convincing evidence demonstrating that the professional review action lacks any substantial factual basis or that such basis 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.

Section 4.9. Recesses and Adjournment

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 conduct its 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.

ARTICLE V. HEARING COMMITTEE REPORT AND FURTHER ACTION

Section 5.1. Hearing Committee Report

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 the same, 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 conclusion reached.
**Section 5.2.  Action on Hearing Committee Report**

Within 30 days after receipt of the report of the Hearing Committee, the MEC or Governing Body, as the case may be, shall consider the same and affirm, modify or reverse its recommendation or action in the matter. The results of that consideration shall be transmitted in writing to the chief executive officer together with the hearing record, the report of the Hearing Committee and all other documentation considered.

**Section 5.3.  Favorable Result**

a. **By the Governing Body**

If the Governing Body’s result pursuant to Section 5.2 of this Plan 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 the MEC**

1. If the MEC result is favorable to the practitioner, the chief executive officer shall, within seven days of his receipt of the result, forward it, together with all supporting documentation, to the Governing Body for action.

2. The Governing Body shall, within 10 days following its Chairman’s 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 consideration. Any referral back shall state the reasons for the referral, 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 5.4 of this Plan.

**Section 5.4.  Unfavorable (Adverse) Result**

If the result of the MEC or of the Governing Body pursuant to Sections 5.2 or 5.3 of this Plan is or remains adverse to the practitioner as set forth in Section 2.2, the affected practitioner shall have the right to request an appellate review by the Governing Body as provided in Article VI of this Plan. If it is the result of the MEC, the result will not be forwarded to the Governing Body for final action independent of the appellate review process unless the practitioner waives the right to appellate review.

**Section 5.5.  Notice of Result**

a. The chief executive officer shall promptly send a copy of the result under Section 5.2 of this Plan to the practitioner by special notice. The practitioner shall be furnished a copy of the Hearing Committee report with the notice.

b. If the result sent to the practitioner is or continues to be unfavorable to the practitioner in any of the respects listed in Section 2.1 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 of the decision made pursuant to Section 5.2.
2. that the practitioner has 15 days from the date of mailing of the notice required by this Section to file a written request for appellate review and that failure to properly request such review shall constitute a waiver of the right to review, and

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

ARTICLE VI. INITIATION AND PREREQUISITES OF APPELLATE REVIEW

Section 6.1. Request for Appellate Review

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

1. there was such a 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 or capriciously; 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 5.5 of this Plan within which to file a written request for appellate review. Such request shall be delivered to the chief executive officer 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 Committee and all other material that was considered in making the adverse action or result, whether favorable or unfavorable, if not previously forwarded.

Section 6.2. Waiver by Failure to Request Appellate Review or to Submit Written Statement

A practitioner who fails to request an appellate review within the time and in the manner specified in Section 6.1 or who fails to submit the written statement required by Section 7.2 of this Plan waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 2.5 of this Plan.

Section 6.3. Notice of Date of Appellate Review

Upon receipt of a timely request for appellate review, the chief executive officer shall deliver the request to the chairman of the Governing Body. Within 10 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 chief executive officer received the appellate review request. At least 20 days prior to the appellate review, the chief executive officer shall send the practitioner 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 chief executive officer received the request for review. In such case, 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.

Section 6.4. Appellate Review Committee

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 chairman of the Governing Body. If a committee is appointed, the chairman of the Governing Body shall designate one of its members as chairman.

ARTICLE VII. APPELLATE REVIEW PROCEDURE
Section 7.1. Nature of 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 7.2 of this Plan and such other material as may be presented and accepted under Sections 7.4 and 7.5 of this Plan.

Section 7.2. Written Statements

The practitioner seeking the appellate review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Appellate Review Committee through the chief executive officer at no less than 10 days after the filing of the request for appellate 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 chief executive officer shall provide a copy to the practitioner at least five days prior to the scheduled date of the appellate review. These filing deadlines do not apply to an expedited review as permitted in Section 6.3 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.

Section 7.3. Presiding Officer

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

Section 7.4. Oral Statement

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 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 the appellate review.

Section 7.5. Consideration of New or Additional 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 such matters or evidence shall be considered or accepted. The party requesting the consideration of such matter or evidence shall explain the reasons for not presenting it earlier.

Section 7.6. Powers

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

Section 7.7. 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 shall not be permitted to participate in the deliberations or the decision.
Section 7.8. Recesses and Adjournment

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 then, 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.

Section 7.9. Action Taken

a. Within 10 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 Plan.

b. The Appellate Review Committee may recommend that the Governing Body affirm, modify or reverse the adverse result or action taken by the executive committee or by the Governing Body pursuant to Sections 5.2 and subsection 5.3.b.2 of this Plan. In its discretion, the Appellate Review Committee may refer the matter back to the MEC or Hearing Committee for further review and require a recommendation to be returned to the Appellate Review Committee within 20 days. Such recommendation shall be in accordance with the Appellate Review Committee’s instructions. Any written report following referral shall be shared with the practitioner. Within 10 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 who occasioned the review.

Section 7.10. Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Article VII have been completed or waived.

ARTICLE VIII. FINAL DECISION OF THE GOVERNING BODY

Section 8.1. Governing Body Action

a. Within 10 days after receipt of the recommendation of the Appellate Review Committee or following adjournment of the appellate review process if conducted by the Governing Body as a whole, the Governing Body shall render its final decision in the matter in writing and shall send notice of it to the practitioner by special notice and to the president of the medical staff and the MEC.

b. If the Governing Body’s decision is to affirm its last adverse recommendation in the matter, it shall be immediately effective and final.

c. If the Governing Body’s decision is to affirm the MEC’s last adverse recommendation in the matter, it shall be immediately effective and final.

d. If the Governing Body’s action has the effect of changing the MEC’s last adverse recommendation, the Governing Body shall refer the matter to a joint conference committee as provided in Article IX of this Plan. The Governing Body’s action on the matter following receipt of the joint conference committee’s recommendation shall be immediately effective and final.

e. When a final decision is made by the Governing Body, a copy of the decision will be sent by the chief executive officer to the practitioner, the president of the medical staff and the MEC.
f. Following conclusion of the proceedings, the chief executive officer will make any required report under state or federal law, indicating any final adverse action involving the membership or privileges of the affected practitioner.

ARTICLE IX. JOINT CONFERENCE COMMITTEE REVIEW

Section 9.1. Membership and Time Limits

a. Within seven days following receipt of a matter referred to it by the Governing Body pursuant to the provisions of this Plan, the joint conference committee shall convene to consider the matter.

b. Within seven days following the conclusion of its consideration, the joint conference committee shall submit its recommendation to the Governing Body.

c. The Governing Body’s action on the matter following receipt of the joint conference committee’s recommendation shall be immediately effective and final.

ARTICLE X. GENERAL PROVISIONS

Section 10.1. Number of Hearings and Reviews

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

Section 10.2. Hearing Officer Appointment and Duties

The use of a Hearing Officer to preside at a hearing held in accord with this Plan is optional. The use and appointment of such Officer shall be determined by the chief executive officer after consultation with the chairman of the body whose action or recommendation precipitated the hearing. 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.

Section 10.3. Waiver

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

Section 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 president of the medical staff, the chief executive officer, the Hospital’s legal counsel or the Governing Body to receive the information. This shall not preclude the president of the medical staff or the chief executive officer 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 chief executive officer or by legal counsel for the Hospital. Any breach of confidentiality by an individual or committee member may result in corrective action.

Section 10.5. Release

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

Section 10.6. Waiver of Time Limits

Any time limits set forth in this Plan may be extended or accelerated by mutual agreement of the practitioner and the chief executive officer 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.

Section 10.7. Substantial Compliance

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

ARTICLE XI. AMENDMENT

This Fair Hearing Plan may be amended or repealed, in whole or in part, through the process outlined in Article XV of the Medical Staff Bylaws.
ARTICLE XII. 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 March 3, 2021.

Mohamed El-Jack, MD
President of the Medical Staff

Francisco Gamez, MD
Secretary of the Medical Staff

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 March 15, 2021.

Edward A. Harding, FACHE,
President
Aurora Medical Center – Bay Area

Dennis Potts
Chair, Advocate Aurora Health Wisconsin Hospital Board