

**BYLAWS OF THE MEDICAL STAFF  
MARSHFIELD MEDICAL CENTER –  
RICE LAKE**

*February 27, 2020*

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## **PREAMBLE**

Marshfield Medical Center – Rice Lake (the “Hospital”) is a voluntary hospital established as a Wisconsin not-for-profit corporation licensed under the laws of the State of Wisconsin. The mission of the Hospital is to improve the health of the communities its health care institutions serve with a commitment to providing the highest quality clinical care.

In accordance with the Hospital’s mission, the Hospital is committed to accomplishing the following objectives:

- To ensure that all patients admitted to or treated in any of the facilities, campuses, departments or services of the Hospital shall receive the best possible care, irrespective of their race, color, creed, religion, gender, national origin, sexual orientation, veteran’s status, marital status, age, disability, or ability to pay for such care.
- To provide reliable and valid measures for the continuous evaluation of the overall quality of care provided to all patients of the Hospital and to make recommendations thereon to the Governing Board so that all patients admitted or treated at any of the facilities, departments or services of the Hospital receive safe, high quality care.
- To ensure a high level of professional performance of all members of the Medical Staff through the appropriate delineation of Privileges to practice in the Hospital and the regular review and evaluation of the activities of all individuals granted Privileges in the Hospital.
- To initiate and maintain rules and regulations for the governance of the Medical Staff.
- To maintain avenues of meaningful communication between the Medical Staff, the Medical Executive Committee, the Hospital administration and the Governing Board.
- To support programs associated with community public health needs.
- To conduct all of the above activities with an overriding concern for the Hospital's care of each patient and the recognition of his or her dignity as a human being.
- To render other services as are reasonably necessary to carry out the foregoing purposes as well as any other related purposes.

It is recognized that the Medical Staff of the Hospital shares responsibility for the quality of patient care and performance improvement at the Hospital and must accept and discharge that responsibility, subject to the ultimate authority of the Governing Board, with input from Hospital administration.

In order to further the aims and purposes of the Hospital, therefore, practitioners at the Hospital have organized themselves into a Medical Staff in conformity with these Bylaws, and the Rules and Regulations, which are subject to and shall not conflict with the Bylaws of the Hospital Corporation.

## DEFINITIONS

1. The term "Hospital" means Marshfield Medical Center – Rice Lake.
2. The term "Governing Board" means the board of directors of Lakeview Medical Center, Inc. of Rice Lake.
3. The term "Medical Staff" or "Staff" means the Hospital's organized component of Practitioners appointed by the Governing Board and granted specific Clinical Privileges for the purpose of providing health care to Hospital patients.
4. The term "Allied Health Professional" or "AHP" means an individual, who is: (a) admitted to practice in the Hospital either through the Bylaws process or an alternate approval process; (b) either licensed, certified or registered in Wisconsin, or trained and qualified in a recognized health care discipline to exercise judgment within an area of professional competence; and (c) authorized by the State of Wisconsin to render medical care either independently or under the supervision of or collaboration with a Practitioner, who has been accorded Privileges to provide such care in the Hospital.
5. The term "CAO" means the Chief Administrative Officer of the Hospital appointed by the CEO of MCHS Hospitals, Inc. to act on his or her behalf in the overall management of the Hospital.
6. The term "Hospital Medical Director" means a physician appointed by the CEO of MCHS Hospitals, Inc. to act on his or her behalf in the overall management of the Hospital.
7. The term "Medical Executive Committee" or the abbreviation "MEC" means the Medical Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Governing Board.
8. The term "Code of Conduct" means the guidelines and expectations for professional behavior by each Member of the Medical Staff.
9. The term "Ex Officio" means an individual's service as a Member of a body by virtue of an office or position held.
10. The term "Corrective Action and Fair Hearing Plan", "Fair Hearing Plan" or "Plan" refers to the Corrective Action and Fair Hearing Plan adopted by the Governing Board, a copy of which is attached hereto as Exhibit 1 and incorporated herein by reference. The Corrective Action and Fair Hearing Plan provides mechanisms for addressing adverse decisions regarding reappointment, denial, reduction, suspension or revocation of Privileges that relate to quality of care, treatment and services issues. For the avoidance of doubt, all capitalized terms in the Plan shall have the

- meanings ascribed to them in these Bylaws unless otherwise provided in the Plan.
11. The term “Health Status” means the physical, emotional, and mental health status (including stability) of an individual that would significantly impact a Practitioner’s ability to perform the Privileges requested.
  12. The term “In Good Standing” for the purpose of these Bylaws means an individual who, at the time the issue of standing is raised, has no restrictions on their Privileges.
  13. The term “Telemedicine” means responsibility (either total or shared) for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services) through a telemedicine link.
  14. The term “Service Line” means a clinical section of one (1) or more specialties as determined by the Governing Board.
  15. The term "Medical Staff Year" means the twelve (12)-month period beginning January 1 and ending December 31.
  16. The term “Member” or “Membership” means the prerogative of Medical Staff participation and does not necessarily include as an incident thereto any Clinical Privilege whatsoever.
  17. The term “Physician” means a Wisconsin licensed medical or osteopathic physician (MD/DO).
  18. The term “Practitioner” means an appropriately Wisconsin licensed Physician, dentist, podiatrist, or Allied Health Professional applying for or exercising Clinical Privileges in the Hospital.
  19. The term “Chief of Staff” means the medical officer elected by the voting Members of the Medical Staff.
  20. The term “Privileges” or “Clinical Privileges” means the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric or surgical services, which may or may not include permission to admit patients, based upon an individual’s license, scope of practice, education, training, experience, competence, Health Status and judgment.
  21. The term “Rules and Regulations” means a statement or statements describing an action that is required by law, by an accrediting body, or by a licensing body; required to implement a specific provision of these Bylaws; or deemed otherwise advisable by the Medical Staff. These Rules and Regulations may be general in nature, applicable to the whole Staff or they may be service specific. For the avoidance of doubt, all capitalized terms

in the Rules and Regulations shall have the meanings ascribed to them in these Bylaws unless otherwise provided in the Rules and Regulations.

22. The term “Special Notice” means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee.

## **ARTICLE I NAME**

The collective name for the organized Medical Staff shall be “Medical Staff of Marshfield Medical Center – Rice Lake”.

## **ARTICLE II PURPOSE AND RESPONSIBILITIES**

### **Section 1. The Purpose of the Medical Staff**

The purpose of the Medical Staff is to bring qualified health care providers who practice at the Hospital together into a cohesive body to promote high quality care. To this end, among other activities, it will assist in screening applicants for Staff Membership; review Privileges of and evaluate and assist in improving the work done by the Practitioners; provide education, and offer advice and recommendations to the Governing Board; provide leadership in activities related to patient safety; and provide oversight in the process of analyzing and improving patient satisfaction.

### **Section 2. The Responsibilities of the Medical Staff Members**

Each Member of the Medical Staff shall:

- A. Provide their patients with care at the generally recognized professional level of quality, efficiency and safety.
- B. Participate in the care of indigent and needy patients.
- C. Abide by the Medical Staff Bylaws, Rules and Regulations and by all other adopted standards, policies, rules and procedures of the Hospital and Medical Staff.
- D. Fulfill such Staff, Service Line, committee, and Hospital functions for which the Member is responsible by Staff category assignment, appointment, and election or otherwise.
- E. Prepare and complete the patient medical records in a timely manner, no more than thirty (30) days following discharge or death, for all patients they admit or in any way provide care to in the Hospital.



- F. Participate in Hospital peer review activities, including ongoing professional practice evaluation and focused professional practice evaluation, as necessary.
- G. Agree to subject their performance to and faithfully participate in the Hospital's quality improvement programs, as the same may from time to time be in effect in accordance with requirements of external regulatory and accrediting agencies.
- H. Act in an ethical and professional manner at all times by the ethical principles of the Practitioner's profession and in accordance with the Code of Conduct.
- I. Educate patients and their families.
- J. Be expected to attend all Medical Staff meetings.
- K. Satisfy continuing medical education requirements.
- L. Work with and relate to other Practitioners, AHPs, medical affiliates, Members of professional review organizations and accreditation bodies in a manner essential for maintaining Hospital operations.
- M. Pledge not to receive from or pay to another Practitioner, either directly or indirectly, any part of any fee received for professional services not actually rendered personally or at the Medical Staff Member's direction, to the extent prohibited by law, accreditation standards or policy.
- N. Provide for continuous care and supervision of patients, and refrain from delegating the responsibility for diagnosis or care of Hospital patients to any individual who is not qualified to undertake the responsibility and who is not adequately monitored.
- O. Seek and accept consultations as necessary.
- P. Discharge such other responsibilities as may be required by the Medical Staff, subject to the Governing Board's approval.
- Q. Perform history and physical examinations as required by Article V, Section 8 of these Bylaws and as further required by policy.

### **ARTICLE III MEMBERSHIP**

#### **Section 1. Nature of Medical Staff Membership**

Membership on the Medical Staff shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and

requirements set forth in these Bylaws. Members of the Medical Staff shall have only such Privileges as have been granted by the Governing Board in accordance with these Bylaws.

## **Section 2. Qualifications for Membership**

- A. Only Practitioners licensed to practice in the State of Wisconsin, who can provide documentation of continued DEA registration, if applicable; and who can document their background, experience, training; demonstrate competence, an ability to perform the Privileges requested, adherence to the ethics of their profession, and their ability to work with others competently and cooperatively to assure the Medical Staff and Governing Board that any patient treated in the Hospital will be given quality medical care, shall be qualified for Membership on the Medical Staff. No Practitioner shall be entitled to Membership on the Medical Staff or to exercise particular Privileges in the Hospital merely by virtue of being duly licensed to practice medicine, dentistry, or podiatry in this or any other state, or because of Membership on any professional organization, or in the past or present having had such Privileges at another hospital.
  - 1. To qualify for Membership on the Medical Staff, the individual must not be barred from providing services under Wisconsin Administrative Code Chapter DHS 12.
  - 2. No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff Membership.
- B. As a part of their appointment and reappointment to the Medical Staff, or at any other time upon the request of the Governing Board or Medical Executive Committee, Practitioners must certify that their current Health Status does not in any way impair their ability to safely exercise the Privileges requested or to care for patients, and the Governing Board may precondition appointment, reappointment, or the continuing exercise of any or all Privileges upon the Practitioner undergoing a health examination by a physician acceptable to the Governing Board or upon submission of any other reasonable evidence of current Health Status that may be requested by the Medical Executive Committee or the Governing Board. The presence of a physical or mental condition which can reasonably be accommodated shall not constitute a bar to the granting of Medical Staff Membership or Privileges.
- C. Practitioners must submit and maintain on file at all times current evidence of continued licensure, DEA registration (with Wisconsin

address), if applicable, and professional liability insurance in amounts and of the kind which shall be determined to be acceptable by the Governing Board after consultation with the Medical Executive Committee.

- D. As part of their appointment and reappointment to the Medical Staff, Practitioners have a continuing obligation to immediately notify the Credentialing and Privileging Office of the following:
1. The revocation, limitation or suspension of his or her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal government agency relating to his or her professional license, or the imposition of terms of probation or limitation by any state.
  2. Loss of Staff Membership or Privileges at any hospital or other health care institution whether temporary or permanent, including all suspensions.
  3. Limitation, restriction or reduction in one or more Clinical Privileges that arose as a result of quality concerns at any hospital or other health care institution.
  4. Cancellation or change of professional liability insurance or employer self-insurance coverage.
  5. Receipt of an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation by any federal, state or local health care regulatory agency.
  6. Receipt of notice of any claim against the Practitioner alleging professional negligence or misconduct in connection with the treatment of any patient or other issues relevant to Hospital operations.
  7. Any criminal conviction or pending criminal charge, or any investigation of caregiver misconduct by a governmental agency.
  8. Any proposed or actual exclusion from or bar from participation in any federally-funded health care program, or any notice to the individual or his or her representative of proposed or actual exclusion or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid.

9. Any required report made by a Practitioner about the conduct of another Practitioner with Privileges at the Hospital to the Department of Safety and Professional Services including, but not limited to, the Medical Examining Board and the Board of Nursing.
- E. No person who is otherwise qualified shall be denied Medical Staff Membership or Privileges by reason of race, age, color, creed, handicap, disability, sex, gender identity, or national origin, or on the basis of any criteria unrelated to the delivery of quality patient care in the Hospital.
- F. As part of their appointment and reappointment to the Medical Staff, Practitioners have a continuing obligation to comply with federal and state laws and regulations applicable to the practice of their profession including, but not limited to, proof of immunity against rubella, mumps and varicella zoster, compliance with blood borne pathogen standards, and annual tuberculosis assessment.
- G. The Governing Board reserves the right to select or reject Medical Staff based on the limitations of facilities, space, services, equipment, Staff, support capabilities, and/or financial resources. After consultation with the Medical Staff, the Governing Board may further decide not to appoint or reappoint or grant Privileges to an otherwise qualified Practitioner: (a) in accord with criteria of a Medical Staff development plan; or (b) due to the existence of any contracts for the provision of clinical services, whether exclusive or not, with other Practitioners; or (c) for other reasons when consistent with the Hospital's purposes, needs and capabilities or with community need; provided, however, that the Governing Board's decisions shall be in accordance with all laws including, but not limited to, the prohibition on tortious interference with contracts and arrangements violating applicable antitrust laws.
- H. The requirements set forth in this section are not exclusive of other requirements or best practices that may be considered in the appointment and privileging process.

### **Section 3. Term of Appointment and Reappointment**

- A. Appointment and reappointment shall be for a period of up to two (2) years.
- B. Appointment and reappointment to the Medical Staff shall be granted by the Governing Board on or before the expiration date of any prior appointment or reappointment, in accordance with the Bylaws of the Governing Board and in the Governing Board's discretion, upon recommendation by the Medical Executive Committee.

#### **Section 4. Conditions of Appointment and Reappointment**

- A. All Medical Staff Members and Allied Health Professional Staff shall participate in and be subject to the peer review, quality assessment, and improvement activities of the Hospital and Medical Staff.
- B. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Board. The Governing Board shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Executive Committee as provided in these Bylaws.
- C. During the first six (6) months of appointment the Practitioner will go through a focused professional practice evaluation. During this time the Practitioner's performance and clinical competence shall be evaluated via a specific monitoring process within his/her Service Line as defined by the Credentials Committee. The Service Line Medical Director or designee will provide written documentation to the Credentials Committee regarding the Practitioner's performance.

#### **Section 5. Procedure for Appointment and Initial Granting of Privileges**

- A. Practitioners desiring appointment to the Medical Staff shall obtain an application and Privilege request form from the Credentialing and Privileging Office which will supply the applicant with an electronic link to the Medical Staff Bylaws and Rules and Regulations.
- B. All applications for appointment to the Medical Staff shall be in writing (which may include electronic submissions) and shall be signed by the applicant. The application shall require detailed information concerning the applicant's professional qualifications including, but not limited to:
  - 1. The name of at least three (3) professional references who have worked with the applicant in the last twenty-four (24) months and have had extensive experience in observing and working with the applicant, preferably within the same skill set.
    - a. In order to determine the applicant's current level of competency, professional references must have had direct contact with the applicant within the preceding twenty-four (24) months. Such references must have personal knowledge of the applicant's scope of performance, current clinical competence (including clinical judgment and technical skills), ethical character, and ability to work cooperatively with others and be willing to provide specific written comments on these matters upon request from the Hospital. The

named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time and must have had organizational responsibility for supervision of the applicant's performance as a department chair, service chief, training program director, or similar role. Professional references from residents and fellows in training programs, and relatives of the applicant are not acceptable as references. Reasonable effort [two (2) written requests] will be made to secure replies from individuals/institutions listed on the application. It is the applicant's responsibility to secure the necessary references within sixty (60) days after notification of deficiencies in the application. Exceptions may be made when information is not otherwise available. If the requested information is still not received at the end of the sixty (60)-day period, the application will be considered withdrawn and will not be processed further.

2. A full summary of the applicant's education and training, documented experience including all pertinent Hospital and clinic practice affiliations, past and present state licensure, information regarding time gaps more than one (1) month, board certification and recertification, and a listing of all Hospital Medical Staff Memberships held prior to the application.
3. Information regarding the applicant's Membership status and/or Privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or institution, or whether the applicant resigned or voluntarily reduced Privileges while under or to avoid an investigation of professional competence or conduct.
4. Evidence of minimum professional liability insurance or employer self-insurance in such amounts as required by the state; and information concerning the applicant's malpractice experience, including past and pending claims, final judgments or settlements (including descriptions of the claims and outcome), and whether or not the applicant has ever been refused liability insurance or had same cancelled.
5. Information as to any past or pending involvement in any quality inquiry, sanction action or formal investigation by a Medicare quality improvement organization.

6. Information as to whether Membership in local, state or national medical societies, or license to practice any profession in any jurisdiction, or DEA registration, has ever been suspended, terminated, or subject to any terms of probation or limitation.
  7. Information as to any currently pending challenges to any licensure or registration of the applicant or the voluntary relinquishment of such license or registration, and as to the applicant's ability to safely exercise the Privileges requested.
  8. Information as to whether the applicant has any criminal conviction or pending criminal charge, any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient.
- C. The applicant must provide a fully completed Background Information Disclosure form with the completed application and must cooperate with the Hospital in obtaining any additional information required for the Hospital to comply with the requirements of Chapter DHS 12 of the Wisconsin Administrative Code.
- D. Information on current Health Status will be obtained on a separate form and will not be reviewed or considered until after a preliminary recommendation to appoint is made by the Medical Executive Committee, unless the applicant elects to volunteer health information at an earlier point.
- E. Every initial application for Staff appointment must contain a request for the specific Privileges desired by the applicant. The evaluation of such request shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the Service Line in which such Privileges are sought. The applicant shall have the burden of establishing both qualifications and competency in the Privileges requested.
- F. The applicant shall have the burden of producing adequate information for a proper evaluation of current clinical competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. Failure to adequately complete the application form, the withholding of requested information, omitting material information necessary for a complete assessment of the applicant's qualifications, or providing false or misleading information shall be a basis for denial of Membership on or removal from the Medical Staff.

- G. The completed application shall be submitted to the Credentialing and Privileging Office which shall: verify the applicant's Wisconsin license to practice, education, training and current competence; perform National Practitioner Data Bank (NPDB) query, Office of Inspector General of the Department of Health and Human Services (OIG), and General Services Administration (GSA) queries; obtain verifying information from the appropriate state licensing boards and related sources; and undertake a criminal background check, including, but not limited to, a caregiver criminal background check, as is required by Wisconsin law. The Hospital shall verify the applicant's licensure, relevant training, and current competence in writing, from the primary source whenever feasible, or from a credentials verification organization. If required, the applicant will authorize any special releases of information or waivers of liability to facilitate the credentialing or privileging process. The Hospital shall verify that the Practitioner requesting approval is the same Practitioner identified in the credentialing documents by viewing one (1) of the following: a current picture Hospital ID card or valid picture identification issued by a state or federal agency (e.g., driver's license or passport). The CAO/designee shall transmit the application and all supporting materials to the Credentials Committee for evaluation.
- H. The Credentialing and Privileging Office may administratively reject an application for appointment to the Medical Staff or for Privileges without forwarding the application to the Credentials Committee, if it determines that the applicant does not hold a valid Wisconsin license, does not have adequate professional liability insurance, is not eligible to receive payment from the Medicare or Medical Assistance Program, is currently excluded or otherwise barred from participation in any health care program funded in whole or in part by the federal government, or is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code, there is a lack of need for the specialty in the Service Line, or otherwise does not meet the requirements for Membership set out in Article III, Section 2 hereof.
- I. Applicants who are administratively denied under Article III, Section 5(H) do not have a right to a fair hearing under the Fair Hearing Plan.
- J. By applying for appointment to the Medical Staff or for Privileges, the applicant thereby signifies willingness to appear for interviews regarding the application; authorizes the Hospital to consult with any and all members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on competence, character, experience and ethical qualifications of the applicant; consents to the Hospital's inspection of all records and documents that may be material to an



evaluation of professional qualifications and competence to carry out the Clinical Privileges requested, as well as moral and ethical qualifications for Staff Membership; releases from any liability all representatives of the Hospital and its Medical Staff for acts performed in good faith and without malice in connection with evaluating the applicant's credentials; and releases from any liability all individuals and organizations who provide information at the request of the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for Staff appointment and Privileges, including otherwise privileged or confidential information.

- K. Applicants agree that any lawsuit brought by the applicant against an individual or organization providing information to a Hospital representative, or against any Hospital representative, shall be brought in a court, federal or state, in the state in which the defendant resides or is located. For purposes of this Section 5(K), the term "representative of the Hospital" includes the Governing Board and its Members and Committees; the CAO; the Medical Staff organization; all Staff Members, Service Lines, and committees which have responsibility for collecting, evaluating, or acting upon the applicant's credentials or application; and any authorized representative of any of the foregoing.

## **Section 6. Appointment Process**

- A. Within one hundred twenty (120) days after the Credentials Committee receives a completed application for Membership, the Credentials Committee shall deliver a report to the Medical Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, licensure, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the Credentials Committee, including an appraisal from the Service Line in which Privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of Staff Membership and the Privileges requested as set forth in Articles IV and V of these Bylaws. Every Service Line in which the applicant seeks Privileges shall provide the Credentials Committee with specific, written recommendations for delineating the applicant's Privileges and these recommendations shall be made part of the report. Together with its report, the Credentials Committee shall transmit to the Medical Executive Committee, the completed application and a recommendation that the applicant be either appointed to the Medical Staff or rejected for Medical Staff Membership, or that the application is deferred for further consideration.

- B. While the recommendation on appointment to the Medical Staff is based primarily on the professional competence or conduct of the applicant, the Governing Board may also consider the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his or her patients and patient care needs for additional Staff Members with the applicant's skill and training, and the geographic location of the applicant and his or her practice to the extent it affects the applicant's ability to provide effective continuity of care for Hospital patients. If the applicant is not appointed on this basis, the applicant shall not have the right to a hearing under the Fair Hearing Plan.
- C. At its next regular meeting after receipt of the Credentials Committee's recommendation, the Medical Executive Committee shall determine whether to defer the application for further consideration or to recommend to the Governing Board appointment of the Practitioner to the Medical Staff or rejection of the Practitioner for Medical Staff appointment. All recommendations to appoint must also specifically recommend the Privileges to be granted, which may be qualified by probationary conditions relating to such Privileges. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, the recommendation shall state the basis for deferral and shall specify the date of the meeting at which the application will be reconsidered.
- D. Any recommendation for appointment will be conditioned upon the applicant completing documentation of his or her current physical, mental and emotional ability to safely perform the Privileges requested, with or without reasonable accommodation. Such documentation will be completed by the applicant and assessed by the Medical Executive Committee prior to any referral of the recommendation to the Governing Board. The Practitioner, upon request of the Governing Board, or the Medical Executive Committee, may be required to undergo such examinations as are deemed necessary to show that the Practitioner's mental or physical health will not negatively impact the Practitioner's ability to provide an adequate level of patient care. When so requested, a Practitioner shall authorize the reviewing committees and Governing Board of the Hospital to have full access to any and all medical records or treatment information concerning his or her Health Status.
- E. Unless the health information obtained requires further evaluation and reconsideration, when the recommendation of the Medical Executive Committee continues to be favorable, the Chief of Staff or designee shall promptly forward the recommendation, together with all supporting documentation, to the Governing Board. If a Member of the Medical Executive Committee files a written objection to the recommendation with the Governing Board prior to the date the

Governing Board acts on the recommendation, the Governing Board must return the application to the Medical Executive Committee for further consideration.

- F. If the health information obtained reveals a condition that warrants further investigation or evaluation, the Medical Executive Committee shall refer the application back to the Credentials Committee. The Credentials Committee shall investigate the matter and report its findings back to the Medical Executive Committee with any change in its recommendation on appointment or Privileges within sixty (60) days. The Medical Executive Committee shall consider whether the condition can be reasonably accommodated and shall then affirm or revise the previous recommendation.
- G. When the recommendation of the Medical Executive Committee is unfavorable to the Practitioner, either in respect to appointment or Clinical Privileges as identified in Article V of the Bylaws, the Chief of Staff shall promptly notify the Practitioner by Special Notice. When the recommendation of the Medical Executive Committee is adverse to the Practitioner under the Corrective Action and Fair Hearing Plan, the adverse recommendation shall be forwarded to the Governing Board, but the Governing Board shall not take any action on the recommendation until after the Practitioner has exercised or has been deemed to have waived his or her right to a hearing, as provided under the Fair Hearing Plan.
- H. At its next regular meeting after receipt of a final recommendation from the Medical Executive Committee, after a Practitioner has waived or exhausted his or her due process rights, the Governing Board shall act on the matter. All decisions to appoint shall include a delineation of the Privileges the Practitioner may exercise.
- I. The CAO or designee shall notify the applicant of the Governing Board's final decision within fifteen (15) days. If the applicant is granted Membership and/or Privileges, the notice shall state the specific Medical Staff category and Privileges granted.
- J. To help ensure that all individuals with Privileges provide services within the scope of Privileges granted, information regarding credentials and Privileges will be available through the Hospital intranet.

## **Section 7. Reappointment Process and Renewal of Clinical Privileges**

- A. Each Member of the Medical Staff and individuals with Privileges will be provided with a reappointment form applicable to their Medical Staff category at least ninety (90) days prior to expiration of the Member's current reappointment date. Each Staff Member who

desires reappointment shall submit the completed reappointment form within forty-five (45) days of receipt. Failure, without good cause, to return the completed application for reappointment within forty-five (45) days may be deemed a voluntary resignation resulting in automatic termination of Membership effective at the expiration of his or her current term. Such voluntary resignation shall not entitle the Member to the procedural rights set forth in the Fair Hearing Plan.

- B. A Practitioner's reappointment for Membership and Privileges will be granted for a period no longer than twenty-four (24) months.
- C. The Credentials Committee shall review all pertinent information available on each Practitioner scheduled for periodic appraisal, including ongoing and focused professional practice evaluation information, for the purpose of determining its recommendations for reappointments to the Medical Staff and for the granting of Clinical Privileges for the ensuing period, and shall transmit its recommendations in writing to the Medical Executive Committee through the Chief of Staff. Where non-reappointments or a change in Privileges is recommended, the reason for such recommendation shall be stated and documented.
- D. Reappointment will be based upon current licensure and DEA registration, if applicable, board certification/recertification, professional performance, professional liability coverage, current Health Status as it relates to the Practitioner's ability to safely perform the Privileges requested, participation in continuing education, the maintenance of timely, accurate and complete medical records, service on Staff and Hospital committees when requested, and the individual's patterns of care, based on such reliable information as may be available. It will also be based on the individual's ethics and conduct, cooperation with Hospital personnel, use of the Hospital's facilities for patients, relations with other Practitioners and the Practitioner's general attitude toward patients, the Hospital and its Staff. The applicant for reappointment and renewal of Clinical Privileges is required to submit any reasonable evidence of current Health Status relevant to the performance of duties that may be requested by the Medical Executive Committee or Chief of Staff.
  - 1. The Credentialing and Privileging Office may administratively reject an application for reappointment to the Medical Staff or for Clinical Privileges without forwarding the application to the Credentials Committee, if it determines that the applicant does not hold a valid Wisconsin license, does not have adequate professional liability insurance or employer self-insurance, is not eligible to receive payment from the Medicare or Medical Assistance Program, is excluded from

any health care program funded in whole or in part by the federal government, or is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code, or otherwise fails to meet any of the requirements set out in Article III, Section 2 hereof.

2. Applicants who are administratively denied under Article III, Section 7(D)(1) do not have a right to a fair hearing under the Fair Hearing Plan.
- E. Prior to reappointment to the Medical Staff, the applicant must report all information necessary to update the information contained in the applicant's initial application for appointment since the last time such information was supplied including, without limitation:
1. Changes in Medical Staff Membership or Privileges at any other hospital or institution including, without limitation, any revocation, suspension, reduction, limitation, denial or non-renewal, whether voluntary or involuntary.
  2. Suspension or revocation of any licensure or registration (state or DEA) or any reprimand or imposition of sanctions, or suspension or revocation of Membership or imposition of other sanctions by any local, state or national professional society.
  3. Any malpractice claims, suits, settlements or judgments, whether pending or finally determined, and any refusal or cancellation of professional liability insurance.
  4. Any additional training, education or experience relevant to the Privileges sought on reappointment.
  5. Any criminal conviction or pending criminal charges.
  6. Current evidence of licensure and DEA registration and of professional liability insurance coverage.
  7. Documentation of the health assessment required under state regulations for persons providing direct patient services in the Hospital and reporting of any adverse findings relevant to the applicant's exercise of Clinical Privileges.
  8. Updated information regarding any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient.

9. A statement that the applicant is not currently excluded from any health care program funded in whole or in part by the federal government.
- F. At its next meeting following receipt of the report from the Credentials Committee, the Medical Executive Committee shall summarize and provide recommendations from the evaluation of the Service Line Medical Director on its individual Members, and shall make written recommendations to the Governing Board, through the Chief of Staff, concerning the reappointment, non-reappointment and/or Privileges of each Practitioner then scheduled for periodic appraisal. Where non-reappointment or a change in Privileges is recommended, the reasons for such recommendations shall be stated and documented.
- G. Thereafter, the procedures in Article III, Section 6 relating to recommendations on applications for initial appointment shall be followed.

#### **Section 8. Continuing Medical Education**

- A. Applicants for Medical Staff Membership shall satisfy the continuing education requirements established by the State of Wisconsin for their profession. Applicants must be able to provide CME documentation within fourteen (14) days of the request from the Medical Staff Office.
- B. Each individual's participation in continuing education is documented and considered at the time of reappointment to the Medical Staff and/or renewal or revision of Privileges.

#### **Section 9. Modification of Membership Status or Privileges**

A Member of the Medical Staff may, either in conjunction with the reappointment process or at any other time, request modification of Staff category, Service Line assignment, or Privileges by submitting a written application on the prescribed forms. Such application shall be processed in the same manner as provided in Article III, Sections 5 and 6 hereof. Any granting of new, extended or increased Privileges shall be subject to evaluation as set forth in Article III, Section 5. If a request for new Privileges is approved, the Member will go through a focused professional practice evaluation. During this time, the Practitioner's performance and clinical competence shall be evaluated via a specific proctoring process within his/her Service Line, as defined by the Credentials Committee. The Service Line Medical Director or designee will provide written documentation to the Credentials Committee on the Practitioner's performance.

**ARTICLE IV  
CATEGORIES OF THE MEDICAL AND DENTAL STAFF**

**Section 1. The Medical Staff**

- A. The Medical Staff shall include the categories of Active, Consultant Active, Associate, Courtesy, Limited, and Allied Health Professional. Residents and Medical Students are not categories of the Medical Staff. Certain aspects of the Dental and Podiatric Staff roles are described in this Article IV.
- B. All Members of the Active Staff of any discipline or specialty are eligible for Membership on the Medical Executive Committee.

**Section 2. The Active Staff**

Active Staff will consist of those Physicians and podiatrists who regularly admit patients to, or are otherwise regularly involved in the care of patients in the Hospital, and who assume all the functions and responsibilities of Membership on the Medical Staff including, where appropriate, emergency service care and consultation assignments. Active Staff are required to participate in call arrangements as established by Service Line group and/or Hospital Policy.

- A. Active Staff shall be responsible for the continuous care of their Hospital patients. They shall continually meet all of the requirements in Article III, Section 2 hereof.
- B. Active Staff Members may exercise such Privileges as have been specifically delineated in accordance with Article III hereto and defined by the Service Line.
- C. Only Members of the Active Staff shall be eligible to be an officer of the Medical Staff. All Active Staff Members are eligible to vote on all matters presented at general and special meetings of the Medical Staff and committees to which such Member is assigned.
- D. Members of the Active Staff shall be a Member of a Service Line.
- E. The Active Staff shall perform all organizational duties pertaining to the Medical Staff. These shall include, but are not restricted to:
  - 1. Transaction of all business of the Medical Staff.
  - 2. Promotion and maintenance of the quality of all medical care and treatment provided in or as a part of the Hospital.
  - 3. Organization of the Medical Staff including the adoption of Bylaws and Rules and Regulations, as may be approved by the Governing Board; the election of officers; the development

of Service Lines and assignment of all Medical Staff Members to a Service Line, the appointment of committees; development and maintenance of a qualified Staff, and the granting and withdrawal of Privileges.

4. Making recommendations to the Governing Board upon matters within the purview of the Medical Staff.

F. Locum Tenens Physicians shall have the responsibilities of Active Staff but shall not be entitled to vote, hold office or be appointed to Medical Staff committees.

### **Section 3. The Consultant Active Staff**

A. It is recognized that there are Physicians or podiatrists who may not be permanently located in this area, but are willing to practice at the Hospital for limited periods of time to meet specific needs, as specified by the Medical Staff. These Practitioners may become Members of the Consultant Active Staff.

B. The Consultant Active Staff shall consist of Physicians or podiatrists who provide a specific service to Hospital patients. They have Privileges limited to their specific area of service and limited call responsibility.

C. Consultant Active Staff shall be responsible for developing a sufficient plan for continuous care of their patients when they are not in the area.

D. Members of the Consultant Active Staff shall be appointed to a specific Service Line, but they shall not be eligible to vote or hold office.

E. Except as modified by the above, Members of the Consultant Medical Staff shall continually meet all of the requirements in Article III, Section 2 hereof.

### **Section 4. The Associate Medical Staff**

A. The Associate Medical Staff shall consist of resident physicians of the Marshfield Clinic, Inc. who are Privileged and licensed to practice independently in the Hospital. They shall be appointed to a specific Service Line and shall be responsible for the continuous care of their Hospital patients either independently or through arrangements with another qualified Active Staff Member.

B. Members of the Associate Medical Staff shall be appointed to a specific Service Line, but shall not be eligible to vote at committee meetings, nor to hold office or serve as chair for any of the same.



- C. Members of the Associate Medical Staff may exercise such Privileges as have been specifically delineated in accordance with Article III.
- D. Throughout the period of associate appointment, it will be the responsibility of the appropriate Service Line Medical Director to orient the Practitioner to the Service Line, and to oversee performance and quality.
- E. Except as modified by the above, Members of the Associate Medical Staff shall continually meet all of the requirements in Article III, Section 2 hereof.

**Section 5. The Courtesy Medical Staff**

- A. The Courtesy Medical Staff shall be those Practitioners (excluding AHPs) who are eligible for Medical Staff Membership and privileged to admit patients to the Hospital, but who do not consider Marshfield Medical Center – Rice Lake as their primary affiliated Hospital. The Courtesy Medical Staff shall consist of Practitioners (excluding AHPs) who treat a maximum of twelve (12) patients per year in the Hospital. If this number is exceeded at any time during the Medical Staff Year, the Member must apply for an advancement of Membership. A Member of the Courtesy Medical Staff must be a Member of the Active Staff (or an equivalent category or a category of provisional Staff) of another hospital where he or she is subject to peer review process and other quality assessment and improvement activities similar to those required of the Medical Staff of this Hospital.
- B. The Courtesy Medical Staff shall be responsible for the continuous care of their Hospital patients.
- C. Courtesy Medical Staff Members shall be appointed to a specific Service Line, but shall not be eligible to vote or hold office on the Medical Staff. The Courtesy Medical Staff are not eligible to serve as at-large Members of the Medical Executive Committee, but may be assigned to serve as Members of other Medical Staff committees, as determined by the Chief of Staff. They shall be encouraged to attend the annual Medical Staff meeting.
- D. Members of the Courtesy Medical Staff may exercise such Privileges as have been specifically delineated in accordance with Article III.
- E. Except as modified by the above, Members of the Courtesy Medical Staff shall continually meet all of the requirements in Article III, Section 2 hereof.

## **Section 6. The Limited Medical Staff**

- A. The Limited Medical Staff shall consist of those Practitioners who are members of the Active Staff of another hospital where the Practitioner actively participates in quality assessment and improvement activities similar to those required of the Members of the Active Staff of this Hospital and who seek Staff Membership for the limited purpose of performing admitting history and physicals or referring patients for admission.
- B. Members of the Limited Medical Staff shall:
  - 1. Not be eligible to serve on Medical Staff committees.
  - 2. Not be eligible to vote at Medical Staff meetings, committee meetings or Service Line meetings (except for MEC if they are a Member).
  - 3. Not be eligible to hold office or serve as chair for any of the foregoing.
  - 4. Not be required to attend general Medical Staff meetings or Service Line meetings, but may do so, except they shall not be eligible to attend and participate in those portions of meetings devoted to peer review of Medical Staff Members in other categories of the Medical Staff.
  - 5. Not have admitting or treating Privileges.
  - 6. Not perform outpatient diagnostic procedures (although may order them).
  - 7. Be assigned to a Service Line.
  - 8. Continually meet all of the requirements in Article III, Section 2 hereof.

## **Section 7. The Dental and Podiatric Functions**

- A. The Dental and Podiatric Staff shall consist of members of the dental and podiatry professions eligible as herein provided for Membership on the Medical Staff. Members of these professions must seek and maintain status as an Active or Courtesy member of the Medical Staff, and shall be subject to the qualifications, limitations and prerogatives for its specific category, as described above.
- B. The Dental and Podiatric Staff shall conform to the standards established for the Medical Staff.

- C. Inpatients for dental and podiatry services shall be admitted by and be under the care of a physician Member of the Medical Staff unless the patient is admitted by an Oral Surgeon with admitting Privileges.
- D. An adequate history and physical by a physician Member of the Active Staff shall be required on each dental and podiatry patient scheduled for surgery unless the patient is admitted by an Oral Surgeon with Privileges to perform the history and physical examination in accordance with Article V, Section 8 below.
- E. A physician Member of the Active Staff shall be responsible for the care of any medical problems that may be present or may arise during hospitalization.
- F. A complete dental or podiatry record shall be maintained and shall be signed by the dentist or podiatrist.
- G. Responsibility for the development and presentation of history and physical examinations and its implications on the patient's health are as follows:
  - 1. The physician Member is responsible for the medical history and the medical physical examination in accordance with all requirements of these Bylaws.
  - 2. The dentist or podiatrist is responsible for the dental or podiatric history and examination in accordance with all requirements of these Bylaws.
  - 3. The physician Member shall chart medical progress notes.
  - 4. The dentist or podiatrist shall chart dental or podiatric progress notes.
  - 5. Prior to major, high-risk diagnostic or therapeutic interventions, the physician Member will confirm the dental or podiatric history, physical examination, findings, conclusions and assessment of risk.
  - 6. Complete records, both dental and medical, shall be required on each patient and shall be part of the Hospital record.
  - 7. At the time of surgery scheduling and at the time of admission, the name of the attending physician must appear on the appropriate forms. This physician shall be responsible for pre- and post-operative medical evaluation and care of the patient.
- H. Members of the Dental and Podiatric Staff shall be appointed in the same manner as other Members of the Medical Staff and have those

Privileges as determined by the Medical Executive Committee and the Governing Board.

- I. Dental and Podiatric Staff Members of the Medical Staff are not required to attend any specific number of Medical Staff meetings per year.

## **Section 8. The Allied Health Professional Staff**

- A. Allied Health Professionals ("AHPs") are classes of health care professionals other than physicians, dentists, and podiatrists who deliver varying levels of patient care services. AHPs who wish to provide treatment to patients at the Hospital must apply for appointment and Privileges as an AHP. Those professionals who are granted Privileges may provide treatment in the Hospital within the scope of their Wisconsin licenses and in accordance with individually granted Clinical Privileges. Where required by law, AHPs shall provide services under the supervision of, or in collaboration with, a physician or Practitioner who is permitted by law to provide such collaboration or supervision.
- B. The categories of AHPs shall consist of psychologists, speech pathologists, physician assistants, certified registered nurse anesthetists, advanced practice nurse prescribers, optometrists, certified nurse midwives, clinical social workers and dieticians who are licensed, registered or certified, as appropriate, in the State of Wisconsin.
- C. The process by which an AHP applies for and is granted appointment as an AHP and Privileges (or changes to or reappointment of privileges) is largely the same as described in Article III hereof, except as modified below.
  1. All individuals who are determined by the Credentials Committee as appropriate for categorization as Allied Health Professional Staff shall complete an individual application form as is approved by the Medical Executive Committee and the Governing Board and submit a copy of same to the Credentialing and Privileging/Medical Staff Office. After verification of the information on the application form, the application and Privilege lists for Allied Health Professional Staff shall be reviewed by the appropriate Service Line Medical Director in the specialty in which the Allied Health Professional Staff or responsible Staff Member is assigned. The Service Line medical director shall submit a recommendation as to Privileges to the Credentials Committee.

2. Upon approval by the Credentials Committee, the application shall be submitted to the Medical Executive Committee and Governing Board of the Hospital for their respective approvals.
- D. Allied Health Professional Staff Members have neither the duties nor rights of Members of the Medical Staff. Such individuals may, with the approval of the Chief of Staff, serve on Medical Staff committees or on Service Line committees, without vote. Allied Health Professional Staff are encouraged to attend such Medical Staff meetings in which matters of interest in their profession may be discussed, and may be required to attend such meetings of the Medical Staff or its committees which entail a discussion or review of cases in which they participated in clinical care. All Allied Health Professional Staff Members must apply for reappointment to the Allied Health Professional Staff and Privileges, and are subject to the ongoing and any focused review of their practice as well as the quality improvement processes of the Hospital.
  - E. All appointments and Privileges granted to AHPs shall be for a period of two (2) years or shorter.
  - F. Each Hospital patient's general medical condition and care shall be the ultimate responsibility of a qualified physician Member of the Medical Staff.
  - G. Removal for Cause.
    1. The Privileges of an Allied Health Professional Staff Member may be suspended, effective immediately, by the Chief of Staff or the CAO. Upon such suspension, the AHP:
      - a. Shall receive notice of the adverse decision including a statement of the basis for the decision.
      - b. Shall, within ten (10) days of receiving notice of an adverse decision, have an opportunity to request to present evidence on their own behalf to an ad-hoc committee of the Medical Executive Committee. Such Committee will consist of three (3) Active Medical Staff Members appointed by the Chief of Staff. The Ad-Hoc Committee will communicate its decision to the Chief of Staff, who shall communicate it to the AHP.
      - c. The Allied Health Professional Staff Member may, within ten (10) days of receipt of an adverse decision by the Ad-Hoc Committee, request appeal of the

decision to the full Medical Executive Committee, whose decision will then be final.

2. The Privileges of an Allied Health Professional Staff Member will be automatically terminated or suspended, effective immediately, in the event and to the extent that the AHP's licensure, registration(s) or certification expires, is suspended or revoked by the applicable authority, or in the event of any other grounds for automatic termination or suspension under the Fair Hearing Plan. The AHP shall have no right to review or appeal of such automatic suspension or termination.
- H. Should any Member of the Medical Staff whose duties or responsibilities include the collaboration with or supervision of an Allied Health Professional Staff Member be terminated or suspended, the Allied Health Professional Staff Member shall be summarily terminated or suspended from his or her duties, unless and until the supervision or collaboration responsibility is transferred to another Member of the Medical Staff.
  - I. The sponsoring Medical Staff Member will be responsible for (a) ensuring that each sponsored individual meets the same standards for physical examinations as other comparable Hospital personnel; (b) securing the basic Hospital orientation process in addition to affected Service Line policies; and (c) initiating the process of credentialing for adding or deleting of Privileges for each individual.
  - J. Allied Health Professionals are not entitled to the fair hearing and appellate review rights set forth in the Fair Hearing Plan.

## **ARTICLE V CLINICAL PRIVILEGES**

### **Section 1. Delineation of Clinical Privileges**

- A. Every Practitioner at this Hospital by virtue of Staff Membership or otherwise, shall be entitled to exercise only those Clinical Privileges specifically granted by the Governing Board, except as provided in Sections 2, 3 and 5 of this Article V.
- B. At no time shall a Practitioner provide a medical level of patient care within the Hospital without Privileges.
- C. Every initial application for Staff appointment must contain a request for the specific Clinical Privileges desired by the applicant. Determination of initial Privileges shall be based upon an applicant's training, experience, demonstrated ability, references and other relevant information. The applicant shall have the responsibility to

establish his or her qualifications and competency for the Privileges requested. It is the Practitioner's responsibility to provide all documentation necessary to support the application.

- D. Each Service Line shall be responsible for developing the category of Privileges to be practiced within their scope of service and criteria for extending Privileges for each of those categories. Such criteria are subject to the approval of the Medical Executive Committee and the Governing Board. The Service Line shall offer each applicant a list of potential specific procedures, treatments or Privileges they may provide in the specific clinical service.
- E. A Practitioner may request an increase or decrease in Privileges at any regular meeting of the MCHS System Credentials Committee. Periodic redetermination of Clinical Privileges and the increase or curtailment of same shall be based upon the criteria set forth in Article V, Section 1(D) above and on the ongoing evaluation of care provided at the Hospital, review of the records of patients treated in this or other hospitals, clinics or offices, and review of the records of the Medical Staff, in accordance with these Bylaws.
- F. The exercise of Clinical Privileges within any Service Line is subject to any policies and procedures of the Service Line and Hospital and falls under the authority of the Service Line Medical Director.
- G. Dentists and podiatrists may write orders within the scope of their license, as limited by applicable statutes, regulations or accreditation standards. Dentists and podiatrists shall agree to comply with all applicable Medical Staff Bylaws, Rules and Regulations.

## **Section 2. Temporary Privileges**

- A. Upon receipt of an application for Medical Staff Membership from an appropriately licensed and insured Practitioner, the CAO may, upon the basis of information then available (which may reasonably be relied upon as to the competence and ethical standing of the applicant) and with the written concurrence of the applicable Service Line Medical Director and the Chief of Staff, grant temporary Clinical Privileges to the applicant. However, in exercising such Privileges the applicant shall be responsible to the respective Service Line Medical Director or his or her designee.
- B. Temporary Clinical Privileges may be granted by the CAO, provided the Practitioner first signs a statement acknowledging the Practitioner has received and read copies of the Medical Staff Bylaws, Rules and Regulations and agrees to be bound by their terms in all matters relating to the temporary Clinical Privileges. Additionally, the Practitioner must satisfy the requirements regarding

professional liability insurance, Health Status and the Wisconsin Caregiver Background check law, as delineated in these Bylaws. The granting of temporary Privileges is appropriate: (1) to fulfill an important patient care, treatment and service need; or (2) when a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Governing Board. Such temporary Privileges may be granted for a maximum one hundred twenty (120)-day period.

- C. The applicable Service Line Medical Director may impose special requirements (e.g., supervision) on any Practitioner granted temporary Privileges. The CAO may immediately terminate temporary Privileges upon notice of any failure by the Practitioner to comply with such special requirements.
- D. The CAO may at any time, upon the recommendation of the Chief of Staff or the applicable Service Line Medical Director, terminate a Practitioner's temporary Privileges.
- E. No Practitioner is entitled to temporary Privileges as a matter of right.

### **Section 3. Special Case Privileges**

- A. Special Case Privileges will be granted in urgent cases and if no Medical Staff Member In Good Standing is qualified or available to render the necessary treatment or consultation.
- B. The CAO, or designee, shall have the approval to grant a one (1)-case temporary Privilege in the event of urgent clinical need.
- C. The National Practitioner Data Bank will be queried and Wisconsin licensure and DEA certification will be verified. The Practitioner will provide verification of acceptable professional liability insurance coverage. Verification shall be obtained from the hospital where the Practitioner has Active Staff Privileges.
- D. Practitioners who have been granted special case Privileges are not eligible to admit a patient. They shall work in conjunction with the Medical Staff Member who admitted the patient.
- E. Practitioners who have been granted special case Privileges shall not be considered to be Members of the Medical Staff, and shall not be entitled to vote or have any of the rights, such as the right to a hearing or appeal, afforded to Members of the Medical Staff.

### **Section 4. Leave of Absence**

A Leave of absence of more than ninety (90) days and less than eighteen (18) months, may be granted by the MCHS System Credentials Committee, upon



written application of the Staff Member for the following reasons: (1) educational leave; (2) medical leave; (3) military leave; and (4) personal leave. Return from any leave of absence may subject the Practitioner to the full or a partial credentialing process at the discretion of the MCHS System Credentials Committee. Failure to return from a leave of absence, or expiration of the Member's current appointment term during the leave of absence without application for reappointment, or leave of absence in excess of eighteen (18) months constitutes a resignation from the Medical Staff, and shall not entitle the Member to any right to a hearing or appellate review.

### **Section 5. Emergency and Disaster Privileges**

- A. In the case of emergency, any Practitioner, regardless of Staff status and to the degree permitted by his or her license, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultant necessary or desirable as long as an emergency situation continues to exist. For the purpose of this Article V, Section 5, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
- B. In the event the Emergency Operation Plan is activated in response to a disaster and the Hospital is unable to meet immediate patient needs, the Hospital Medical Director, CAO, Chief of Staff or their designees may grant disaster Privileges to licensed independent Practitioners consistent with applicable policies.

### **Section 6. Withdrawal of Privileges**

- A. Any Member of the Staff may voluntarily withdraw any Clinical Privilege at any time upon written notice. Such action shall not create a right of hearing under the Fair Hearing Plan.
- B. Any Clinical Privileges granted to a Member of the Medical Staff may be involuntarily reduced or withdrawn, in whole or in part, upon demonstrated lack of competence, ability, training, or experience as observed on an ongoing basis from patient care provided, a review of the records of patients treated in this or other hospitals and a review of the records of the Medical Staff which document the evaluation of the individual's participation in the delivery of medical care, or as otherwise provided in these Bylaws. Any such involuntary action shall entitle the Staff Member to the rights of review set forth in the Fair Hearing Plan.

## **Section 7. Telemedicine**

- A. Any Practitioner who provides services through a telemedicine link must have been granted Medical Staff appointment and Privileges in accordance with these Bylaws.
- B. The Medical Executive Committee shall recommend the services that will be provided by telemedicine to the Board. The Medical Staff shall, on an ongoing basis, evaluate the Hospital's ability to safely provide services to its patients in accordance with commonly accepted quality standards, including those services provided through a Telemedicine link.
- C. Each eligible individual applying for Medical Staff Membership and Privileges and intending to provide services through a telemedicine link may be credentialed and privileged: (1) in the same manner as any other applicant, or (2) through an expedited process whereby the Medical Staff and Governing Body rely on credentialing information or the credentialing and privileging decisions from a distant site that is accredited by The Joint Commission, provided that all requirements of the Hospital Telemedicine Policy are met.
- D. Practitioners providing Telemedicine services are subject to these Bylaws, the Medical Staff Policies, and all Hospital rules and policies in the same manner as any other Medical Staff Member or Allied Health Professional.
- E. In the event of any conflict between this Section and a contract for Telemedicine services, the contract shall control.

## **Section 8. History and Physical Examinations**

- A. A medical history and physical (H&P) examination must be completed and documented in the medical record for Hospital patients according to the following timeframes:
  - 1. For inpatients and patients in observation status:
    - a. Within thirty (30) days prior to admission or within twenty-four (24) hours after admission, but prior to any surgery or procedure requiring anesthesia services or other high risk procedure as defined by policy.
    - b. If the H&P examination was completed within thirty (30) days prior to inpatient admission or patients in observation status, an update documenting any changes in the patient's condition will be completed within twenty-four (24) hours after admission but prior to any surgery or procedure requiring anesthesia

services or other high risk procedure as defined by policy.

- c. If a patient is readmitted to the Hospital within thirty (30) days for the same or a related condition, an interval H&P examination reflecting subsequent history and changes in physical findings will be included in the patient's chart within twenty-four (24) hours after admission but prior to any surgery or procedure requiring anesthesia services or other high risk procedure as defined by policy. However, if the readmission is for an unrelated condition, a new H&P examination must be completed and documented within the above time frames.

2. For outpatients:

- a. Within thirty (30) days prior to a surgery or procedure for which the Medical Staff has determined that an H&P is necessary.
- b. If the H&P examination was completed within thirty (30) days prior to registration for such a procedure, an update documenting any changes in the patient's condition will be completed prior to any surgery or procedure requiring anesthesia services or other high risk procedure as defined by policy.

B. The H&P must be completed and documented by a Practitioner who is appropriately credentialed in accordance with these Bylaws and other applicable Medical Staff or Hospital requirements, except that a H&P that is performed within 30 days of admission or registration may be completed by a practitioner who is not privileged and credentialed by the Hospital so long as an update is completed and documented by a Practitioner who is appropriately privileged and credentialed under these Bylaws.

C. The H&P documentation will include, at a minimum:

1. The date and time that the examination was completed.
2. The chief complaint.
3. Relevant past medical history.
4. Current medications.
5. Drug and other allergies/sensitivities.

6. Review of systems appropriate to the clinical status of the patient with specific relevant findings on examination, including applicable laboratory or other diagnostic tests.
  7. The patient's diagnosis/diagnoses.
- D. The Medical Staff shall establish systems for monitoring the quality of H&P examinations and documentation of those examinations.
  - E. The Medical Staff shall allow Physicians to delegate the responsibility of completing or updating an H&P examination to a qualified AHP who is appropriately credentialed in accordance with these Bylaws and other applicable Medical Staff or Hospital requirements. The delegating Physician shall provide supervision or collaboration as required under state law.
  - F. In an emergency (as certified by the accountable Practitioner), where there is insufficient time to record the H&P examination prior to the surgery or procedure deemed to require an H&P, a progress or admission note with a brief summary of relevant history, physical findings and preoperative diagnosis shall be recorded in the patient's medical record prior to the surgery or procedure. Complete documentation of the H&P examination shall be included in the patient's record immediately upon the conclusion of the surgery or procedure.

## **ARTICLE VI RESIDENTS AND MEDICAL STUDENTS**

### **Section 1. Not Members Of The Medical Staff**

Residents and Medical Students are not Members of the Medical Staff. Residents and Medical Students shall function as defined in the Rules and Regulations of the Medical Staff or any educational affiliation agreement approved by the Medical Staff and Governing Board.

### **Section 2. Supervision**

Residents and Medical Students shall be under the direct supervision of a Member of the Active Medical Staff. The degree of supervision shall be determined collaboratively by the supervising Staff Member and the residency program coordinators.

### **Section 3. No Privileges**

Residents include full-time Post Graduate (PG) staff in training in an accredited program with responsibility for patient care in the Hospital, under the supervision of an Active Staff Member. Residents will not have Privileges to practice in the Hospital, as their practice is limited to functions delegated by a

Member of the Active Staff. Residents shall be credentialed through their accredited training program but shall not be credentialed through the Medical Staff process. Residents who wish to provide patient care services outside of an approved residency program must apply for Associate Medical Staff Membership and Privileges through the standard process as described in these Bylaws.

#### **Section 4. Compliance**

Residents must comply with and abide by the Medical Staff Bylaws, the Rules and Regulations, and all applicable policies and procedures, as well as with the requirements of their respective residency programs.

### **ARTICLE VII SERVICE LINES OF THE MEDICAL STAFF**

#### **Section 1. Organization of the Medical Staff – The Service Lines**

- A. The Medical Staff shall be organized into Service Lines. The Hospital Service Line designations and Service Line Medical Directors shall be the same as those of Marshfield Clinic, Inc.
- B. Assignment to Service Lines:
  - 1. Upon initial appointment to the Medical Staff, each appointee shall be assigned to a clinical Service Line. Assignment to a particular Service Line does not preclude an individual from seeking and being granted Clinical Privileges typically associated with another Service Line.
  - 2. An individual may request a change in his or her Service Line assignment to reflect a change in the individual's clinical practice.

#### **Section 2. Functions and Purpose of Service Lines**

- A. The Service Lines shall implement processes to monitor and evaluate the quality and appropriateness of the care and treatment of patients served by the Service Lines and shall monitor the practice of all those with Clinical Privileges in a given Service Line. Service Line quality review activities will be conducted in a manner consistent with the provisions of sections 146.37 and 146.38 of the Wisconsin Statutes and the federal Health Care Quality Improvement Act of 1986. The peer review protections of these statutes, including the protection of the confidentiality of Service Line records and proceedings, are intended to apply to all activities of the Service Line relating to improving the quality of health care and include activities of the individual Members of the Service Line as well as other individuals designated by the Service Line to assist in carrying out the duties and responsibilities of the Service Line. Each Service Line

shall assure continuous coverage and patient care to all patients presenting to the Hospital for treatment.

- B. Service Lines and/or Service Line Members will be responsible for:
1. Defining Clinical Privileges. Each Service Line shall define criteria, consistent with the policies of the Medical Staff and of the Governing Board, for the granting of Clinical Privileges by the Governing Board.
  2. Quality Improvement Activities. Each Service Line shall implement quality improvement programs for the Service Line or in concert with other organizational components of the Hospital and the Medical Staff.
  3. Each Service Line shall be responsible for conducting a primary review for quality improvement activities through the use of medical information relating to patient care. This review will contribute to the continuing education of every Practitioner and to the process of developing criteria to ensure appropriate patient care.
  4. Quality Review. Each Service Line shall review its clinical work through findings from ongoing monitoring and evaluation activities and report its findings to the Medical Executive Committee (or its designee) from the minutes of its quality improvement meetings.
  5. Policies. Each Service Line shall establish policies pertinent to the operation of the Service Line and, if necessary, the sub-sections of the Service Line, including identification of call participation requirements.
- C. At the discretion of the Service Line Medical Director, relevant sections may be established within the Service Line to improve the function and efficiency of the Service Line.

**Section 3. Service Line Medical Director**

- A. Qualifications:
1. Must be a Member of the Active Staff at a Marshfield Clinic Health System, Inc. owned or affiliated Hospital and In Good Standing. If a Marshfield Clinic Service Line Medical Director is not a current Active Staff Member at the Hospital, they may delegate an Active Staff Member to perform functions within the Hospital.

2. Each Service Line Medical Director must be certified by an appropriate specialty board or have comparable competency established through the credentialing process.
    - a. An appropriate specialty board is one which is relevant to the services provided by the Service Line and is recognized by a Member of the American Board of Medical Specialties, the American Board of Oral and Maxillofacial Surgery, the American Dental Association, American Board of Podiatric Surgery or the American Osteopathic Association.
  3. The Service Line Medical Directors will be selected by Marshfield Clinic Health System, Inc. Chief Medical Officer.
- B. Members of the Medical Staff who are dissatisfied with the performance of the Service Line Medical Director may submit their concerns to the Marshfield Clinic Health System, Inc. Chief Medical Officer.
- C. Duties:
1. The Service Line Medical Directors shall be responsible for:
    - a. Clinically-related activities of the Service Line;
    - b. Administratively-related activities of the Service Line, unless otherwise provided by the Hospital;
    - c. Continuing surveillance of the professional performance of all individuals in the Service Line who have delineated clinical privileges;
    - d. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the Service Line;
    - e. Recommending clinical privileges for each member of the Service Line;
    - f. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment and services not provided by the Service Line or the Hospital;
    - g. Integration of the Service Line or service into the primary functions of the Hospital;

- h. Coordination and integration of inter-Service Line and intra-Service Line services;
- i. Development and implementation of policies and procedures that guide and support the provision of care, treatment and services;
- j. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services;
- k. Determination of the qualifications and competence of Service Line personnel who are not licensed independent practitioners and who provide patient care, treatment and services;
- l. Continuous assessment and improvement of the quality of care, treatment and services;
- m. Maintenance of quality control programs, as appropriate;
- n. Orientation and continuing education of all persons in the Service Line; and
- o. Recommending space and other resources needed by the Service Line.
- p. Advise the Chief of Staff on matters of a patient safety, quality of care, and/or significant disciplinary concern affecting the Service Line. The Chief of Staff shall in turn inform the CAO/Hospital Medical Director of matters affecting operations and patient care.

## **ARTICLE VIII OFFICERS**

### **Section 1. The Officers of the Medical Staff shall be**

- A. The Chief of Staff
- B. The Vice Chief of Staff

### **Section 2. Qualifications of the Officers of the Medical Staff**

The officers must be Physician Members of the Active Medical Staff In Good Standing for a period of at least two (2) years at the time of their election. Officers



must remain In Good Standing and board certified during their terms of office. In case they fail to remain In Good Standing, they must immediately vacate their office. Officers may not be administrators, officers or members of the medical executive committee for a competing institution and must actively support the mission, vision and values of Marshfield Clinic Health System, Inc.

### **Section 3. Election**

- A. Chief of Staff
  - 1. Chief of Staff shall be elected by the Active Staff at the Annual Meeting of the Medical Staff. Notice, quorum and voting requirements as described in Article XI hereof shall be followed.
  - 2. Candidates for this office may be self-nominated or nominated by Members of the Medical Staff.
- B. Vice Chief of Staff. The Vice Chief of Staff shall be elected from the at large Members of the Medical Executive Committee. The Medical Executive Committee elects the Vice Chief of Staff.

### **Section 4. Term of Office and Limits**

Officers shall serve for a term of office which shall be three (3) years and shall take office upon election at the Annual Meeting of the Medical Staff. The Chief of Staff may serve only three (3) consecutive terms of office.

### **Section 5. Vacancies in Office**

In the event the Chief of Staff vacates the office for any reason, the rest of the term will be served by the Vice Chief of Staff. In the event the Vice Chief of Staff of the Medical Staff vacates his or her office, an interim Vice Chief of Staff shall be elected from among the elected at-large Members of the Medical Executive Committee.

### **Section 6. Duties of the Officers of the Medical Staff**

- A. Chief of Staff:
  - 1. The Chief of Staff shall be the principal elected officer of the Medical Staff and in that role shall work closely with the Hospital Medical Director to manage the affairs of the Medical Staff.
  - 2. The Chief of Staff shall work with the Hospital Medical Director to interpret and apply the policies of the Governing Board to

the Medical Staff and to report to the Governing Board on the performance of Staff and the quality of medical care.

3. The Chief of Staff is charged with representing the views, policies, needs and grievances of the Medical Staff to the CAO, Hospital Medical Director, and the Governing Board.
4. The Chief of Staff calls, presides and sets the agenda of all meetings of the general Medical Staff and the Medical Executive Committee.
5. The Chief of Staff shall approve such documents, policies, or papers as pertaining to the affairs of the Medical Staff.
6. The Chief of Staff shall recommend to the MEC establishment of committees and the Members of such committees.
7. The Chief of Staff may attend all Service Line meetings and committee meetings, without vote, to which he or she is not specifically assigned under these Bylaws.
8. The Chief of Staff shall, together with the Hospital Medical Director, be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions when indicated for non-compliance, and for presentation to the Medical Executive Committee when corrective action may be recommended to the Governing Board.
9. The Chief of Staff, or their designee, shall resolve Medical Staff issues among Service Lines when such issues cannot be resolved by the Service Lines themselves.
10. The Chief of Staff shall review and investigate all incidents and complaints relative to Members of the Medical Staff and take appropriate action as permitted by the Bylaws and/or the Rules and Regulations of the Medical Staff.
11. The Chief of Staff or designee shall respond to external credentialing inquiries and provide general references for Members of the Medical Staff.
12. The Chief of Staff shall be the spokesperson for the Medical Staff in its external professional and public relations or designate another person to act in that capacity.
13. The Chief of Staff shall consult directly with the Governing Board on matters related to the quality of medical care provided to patients of the Hospital. Such consultation must

occur periodically throughout the Medical Staff Year. Records of such direct consultations shall be maintained by the Governing Board and Medical Staff.

14. The Chief of Staff shall perform all duties incident to the office of Chief of Staff and other such duties as may be prescribed by the Governing Board, the Bylaws of the Governing Board, or the Bylaws of the Medical Staff.

B. Vice Chief of Staff of the Medical Staff:

1. In the absence of the Chief of Staff, or in the event of the Chief of Staff's death or inability or refusal to act, the Vice Chief of Staff shall perform the duties of the Chief of Staff.

2. The Vice Chief of Staff shall have the authority of the Chief of Staff when acting in such capacity due to the circumstances described in Article VIII, Section 6(B)(1) above.

## **Section 7. Removal of Officers**

A. Permissible basis for removal of the Chief of Staff and Vice Chief of Staff of the Medical Staff from office include:

1. Failure to remain a Member of the Medical Staff in Good Standing.

2. Failure to abide by the Bylaws and Rules and Regulations of the Medical Staff.

3. Failure to adequately perform their duties.

4. Conduct or statements damaging to the Hospital or Hospital's affiliates.

B. If there is a permissible basis for removal, an Officer may be temporarily removed by a two-thirds (2/3) vote of the entire Medical Executive Committee. The temporary removal stays in effect until it is ratified by a two-thirds (2/3) vote of the Medical Staff at which time it becomes permanent. If the vote is not ratified, the Officer will resume his or her position.

C. The Governing Board may request the Medical Staff to remove an Officer for one (1) or more of the permissible bases for removal. In the event the Medical Staff fails to take such an action, the Governing Board may send thirty (30)-day prior written notice to the Medical Executive Committee that it is considering removal of the Officer. The Governing Board will carefully consider the recommendations of

the Medical Staff and its Medical Executive Committee prior to taking any action. The Governing Board's action will be final.

## **ARTICLE IX COMMITTEES**

Hospital Committees are a major component in the organization and operations to help improve the quality of health care in the Hospital and their activities will be conducted in a manner consistent with the provisions of sections 146.37 and 146.38 of the Wisconsin Statutes and the federal Health Care Quality Improvement Act of 1986. The peer review protections of these statutes, including the protection of the confidentiality of committee records and proceedings, are intended to apply to all activities of the above committees relating to improving the quality of health care and include activities of the individual Members of the committee, as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee.

### **Section 1. Medical Executive Committee**

- A. The Medical Executive Committee shall be a standing committee empowered to act for the Medical Staff as set forth in these Bylaws. All Members of the Active Medical Staff are eligible for Membership on the MEC and a majority of voting Members of the MEC must be Physicians. The authority of the MEC is outlined in this Section, and additional functions may be delegated or removed through amendment of this Section.
- B. The structure of the Medical Executive Committee is as follows:
  - 1. The Marshfield Clinic Health System, Inc. Service Line Medical Directors.
  - 2. Five (5) at-large Members elected from among the Active Medical Staff.
  - 3. Chief of Staff.
- C. The Chief of Staff shall be the presiding officer of the Medical Executive Committee. The CAO or designee, Chief Nursing Officer or designee, Hospital Medical Director shall attend each Medical Executive Committee meeting on an ex-officio basis without vote. Others may be invited to attend the meeting on an as needed basis. The Medical Executive Committee will meet on a monthly basis or more often at the request of the Chief of Staff.
- D. Term
  - 1. The Service Line Medical Directors are appointed to the Medical Executive Committee by the CMO of Marshfield Clinic

Health System, Inc. and will serve on the Medical Executive Committee as long as they are employed in that capacity.

2. The at-large Members of the MEC are nominated and elected by the Active Medical Staff. Active Medical Staff may self-nominate. Elections will occur at a duly called Medical Staff meeting. The at-large Members of the MEC are elected for a three (3)-year term, except for the initial election which shall establish staggered terms of service at the discretion of the Chief of Staff. At-large Members are eligible for re-election without term limits.

E. Removal

1. The Governing Board retains the prerogative to remove an at-large Member of the MEC at any time.
2. The Active Staff Members may remove any at-large Member of the MEC, if fifteen percent (15%) of the Active Staff Members sign a petition calling for such removal of a MEC Member, and such petition is ratified by a two-thirds (2/3) majority of the quorum present at a duly called meeting of the Medical Staff.
3. A loss or restriction of Privileges based on professional competence or conduct for more than thirty (30) days shall result in an automatic removal from the MEC. A loss or restriction of Privileges for other reasons may result in removal, at the discretion of the MEC or the Governing Board.
4. Reasons for discretionary removal of a Member of the MEC include, but are not limited to:
  - a. Failure to adequately discharge or carry out with good faith the duties of the position.
  - b. Actions contrary to the philosophies, policies or mission of the Hospital.
  - c. Failure to meet the conditions of and qualifications for Membership on the Active Medical Staff.
  - d. Loss or restriction of Privileges for reasons other than professional competence or conduct.
5. A person removed as an Officer shall not be eligible for re-election to the MEC for a period of two (2) years following removal.

F. Vacancy

The MEC will recommend to the Governing Board and Medical Staff, subject to ratification of the Medical Staff, a replacement to complete the remainder of the term for any vacancy of any at-large Member.

G. Function

1. The function of the Medical Executive Committee shall be to:
  - a. Represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.
  - b. Coordinate the activities and general policies of the various Service Lines.
  - c. Receive and act upon committee reports and recommendations from Medical Staff committees, clinical departments and assigned activity groups/committees.
  - d. Approve and implement policies of the Medical Staff not otherwise the responsibility of the Service Lines.
  - e. Serve as a liaison between the Medical Staff, the CAO and the Governing Board.
  - f. Recommend action to the CAO on matters of a medical administrative nature.
  - g. Make recommendations on Hospital operational matters to the Governing Board through the CAO.
  - h. Fulfill the Medical Staff's accountability to the Governing Board through the CAO and Medical Executive Committee.
  - i. Ensure that the Medical Staff is informed of the accreditation program and the accreditation status of the Hospital.
  - j. Provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent.
  - k. Review the credentials and/or the Credentials Committee's reports of all applicants and to make recommendations directly to the Governing Board for

Staff Membership, assignments to Service Lines and delineation of Clinical Privileges.

- l. Recommend the structure of the Medical Staff.
- m. Organize the quality assessment and improvement activities of the Medical Staff, as well as the mechanism used to conduct, evaluate and revise such activities.
- n. Establish a mechanism by which Membership on the Medical Staff may be terminated.
- o. Establish a mechanism to review credentials and to delineate individual Clinical Privileges.
- p. Periodically review all information available regarding the performance and clinical competence of Staff Members and Allied Health Professional Staff with Clinical Privileges; and, as a result of such reviews, to make recommendations to the Governing Board for reappointments and renewal or changes in Clinical Privileges.
- q. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective action or review measures when warranted.
- r. Be responsible for the acquisition and maintenance of the accreditation of the Hospital as it relates to the Medical Staff. The Medical Executive Committee may require annually that The Joint Commission survey forms be used as a review method to estimate the accreditation status of the Hospital as it relates to compliance with the Medical Staff standards. The Medical Executive Committee shall identify areas of suspected non-compliance with the Medical Staff standards of The Joint Commission and shall make recommendations to the Medical Staff for appropriate action.
- s. Report activities at each Medical Staff meeting.
- t. Establish a mechanism for fair-hearing procedures.

- u. Review the Medical Staff Bylaws, Rules and Regulations at least every two (2) years and recommend revisions as deemed necessary.
- v. As generally delegated by the Medical Staff, have the authority to adopt or amend the Rules and Regulations, in accordance with Article XIV hereof.

## **ARTICLE X COMMITTEES OF THE MEDICAL STAFF**

### **Section 1. Creation of Standing Committees**

The MEC may, by resolution and without need for amendment of these Bylaws, establish committees to perform one (1) or more Staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties or composition as needed. Any function required to be performed by these Bylaws and not assigned to a standing or special committee shall be performed by the MEC. Composition, duties, meetings and reporting requirements for each standing committee are defined in Medical Staff policies or charters.

### **Section 2. Special Committees**

Special committees shall be recommended by the Chief of Staff to MEC. Such committees shall confine their activities to the purposes for which they are appointed and shall report to the MEC.

### **Section 3. Committee Structure**

The below parameters shall apply to all Medical Staff committees unless determined otherwise by that committees policy or charter.

#### **A. Chairpersons**

1. The chairperson of each committee shall be a Member of the Active Staff qualified by training, experience and demonstrated ability for the position.
2. Each chairperson shall be appointed by the MEC and shall serve for a term of two (2) years, but may be reappointed to serve additional terms without limitation.
3. Removal of a chairperson during their term of office may be initiated by a two-third (2/3) vote of MEC and ratified by the Governing Board.



B. Functions of Committee Chairperson

1. Be accountable for all professional and administrative activities of their committee.
2. Give guidance on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding patient care.
3. Monitor and evaluate the quality and appropriateness of patient care, in conjunction with the Quality Improvement Committee, and the clinical performance of all individuals with delineated Privileges.
4. Enforce the Medical Staff Bylaws, Rules and Regulations, and policies within the committee.
5. Implement within the committee actions taken by the MEC.
6. Coordinate teaching, education, and research programs in the committee's area of expertise.
7. Participate in every phase of administration of the committee through cooperation with the clinical services and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques.
8. Assist in the preparation of such annual reports pertaining to the committee as may be required by the MEC, the CAO or the Governing Board.

C. Members

1. Members of each committee shall be Members of the Active Staff and appointed every two (2) years or more frequently as determined by the MEC, unless otherwise provided in these Bylaws or policy.
2. The MEC may appoint or remove committee Members at any point as needed with the exception of a new Member of the Medical Staff or the creation of a new Medical Staff Committee.
3. The CAO and the Regional Medical Director or their respective designees, and the Chief of Staff, or designee, shall be Members, Ex Officio and without vote, of all committees.

**Section 4. Minutes**

Minutes of all committee meetings shall be prepared and include a record of attendance and the vote taken on each matter. Copies of minutes shall be approved by the attendees at the subsequent meeting and be available to the MEC.

**ARTICLE XI  
MEETINGS**

**Section 1. Annual Meeting**

- A. The Medical Staff shall hold at least one (1) meeting per Medical Staff Year. Notice may be given personally, by mail, by facsimile, or by e-mail.
- B. The President of the Governing Board, Members of the Governing Board, the CAO and others (at the discretion of the Medical Executive Committee) may be invited to attend the Annual Meeting.
- C. Attendance at Meetings:
  - 1. Members of the Active Staff are expected to attend the Annual Meeting.
  - 2. Members of other Staff categories and Residents may attend the Annual Meeting.
  - 3. Attendance records shall be kept for the meeting.
- D. The Annual Meeting of the Medical Staff may address the following:
  - 1. The Service Line and committee reports, including any significant findings identified through the Hospital's quality assurance program.
  - 2. The recommendations of the Medical Executive Committee.
  - 3. Administrative updates provided by the CAO.
  - 4. Proposed changes to the Medical Staff Bylaws.
  - 5. Election of Officers.

**Section 2. Special Meetings**

The Chief of Staff or Medical Executive Committee may call a special meeting of the Medical Staff at any time. The Medical Executive Committee shall designate the time and place of any special meeting.

### **Section 3. Meeting Minutes**

Minutes of each meeting of the Medical Staff, regular or special, shall be prepared and maintained in the Credentialing and Privileging Office.

### **Section 4. Quorum**

Except as otherwise provided herein, the presence in person or by proxy of at least one-third (1/3) of the Active Staff Members at a Medical Staff meeting shall constitute a quorum. The Active Staff Members present at a duly organized Medical Staff meeting may continue to do business until adjournment, notwithstanding the withdrawal of enough Active Staff Members to leave less than a quorum. If, at two (2) consecutive meetings, there is a failure to achieve a quorum, any action required or permitted to be taken by the Active Medical Staff which was on the published agenda for the two (2) consecutive meetings may be taken by the Governing Board.

### **Section 5. Voting**

- A. Only Members of the Active Staff shall be eligible to vote.
- B. Each voting Member shall have one (1) vote.
- C. Voting may be by voice vote, electronic vote, or secret ballot. The use of a secret ballot must be approved by two-thirds (2/3) of the voting Members present at the meeting at which such ballot is requested.
- D. Unless specifically required to the contrary by these Bylaws or Rules and Regulations, a majority of voting Members present and voting affirmatively shall carry any motion.
- E. For purposes of elections each Member of the Medical Staff is allowed one (1) proxy, for all other purposes Medical Staff Members are allowed to carry five (5) proxies.

## **ARTICLE XII IMMUNITY FROM LIABILITY**

### **Section 1. Acceptance Of Requirements**

The following statements are express conditions applicable to every applicant and to every Member of the Medical Staff. By applying for appointment, reappointment, or Clinical Privileges, the applicant expressly: (1) accepts that the provisions of these Bylaws are express conditions to the application for, or acceptance of, Medical Staff Membership and the continuation of such Membership, and/or to application for, or the exercise of, Clinical Privileges, whether or not he is granted appointment or Clinical Privileges, and (2) accepts that the hearing and appeal procedures set forth in these Bylaws shall be the sole

and exclusive remedy with respect to any professional review action taken by the Hospital and its authorized representatives. If, notwithstanding these requirements, an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital and its authorized representatives named in the action for all costs incurred in defending such legal action, including reasonable attorney fees. The acceptance of these provisions applies during the application process (regardless of whether or not they are granted Membership and Privileges), as well as during the time of any appointment or reappointment and thereafter.

## **Section 2. Immunity**

To the fullest extent permitted by law, the applicant or Member extends absolute immunity to, agrees not to sue, and releases from liability, this Hospital, and its authorized representatives and any third party, with respect to any civil liability which might arise from any act, communication, report, recommendation or disclosure involving any applicant or Member and performed, made, requested or received by this Hospital and its authorized representatives, to, from, or by any third party, concerning any activity relating to, but not limited to, the following:

- A. An application for appointment, reappointment or for Clinical Privileges including, but not limited to, temporary Privileges, emergency Privileges and disaster Privileges.
- B. A periodic reappraisal undertaken for reappointment or for increase or decrease in Clinical Privileges.
- C. A proceeding for revocation, reduction, restriction or suspension of Clinical Privileges or Medical Staff Membership, or any other disciplinary sanction.
- D. Summary suspension.
- E. Hearing and appellate review.
- F. Collegial intervention or corrective action.
- G. Medical care evaluation.
- H. Utilization and quality assurance review.
- I. Peer review activities.
- J. Soliciting, receiving, providing, or acting upon information bearing on the individual's professional ability, qualifications, character, mental or emotional stability, physical condition, ethics or behavior.
- K. Other activities relating to the quality of patient care or the professional conduct of an applicant or Member of the Medical Staff including, but not limited to, an applicant's or Member's professional

qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior.

- L. Any other matter that might directly or indirectly have an effect on the individual's competence, on patient care or on the orderly operation of this or any other hospital or health care facility.

### **Section 3. Authorization to Obtain Information**

By applying for appointment, reappointment, or Privileges, or by exercising Clinical Privileges or providing specified patient care services within this Hospital, the individual specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, physical or mental Health Status, ethics, behavior or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff or for Clinical Privileges. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such issues. The individual also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request. The Practitioner agrees to execute consent form(s) to facilitate the release of privileged or confidential records and to perform criminal background checks (including a Wisconsin criminal background check, such as the Caregiver Background Check, and any out-of-state, military, federal, or international criminal background checks).

### **Section 4. Authorization to Release Information**

Similarly, the individual specifically authorizes the Hospital and its authorized representatives to release such information to other hospitals, health care facilities, managed care organizations, government authorities, licensure bodies, and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or Clinical Privileges, or for any licensure or regulatory matter.

### **Section 5. Confidentiality**

Information with respect to any individual submitted, collected, prepared or disclosed by the Hospital and its authorized representatives or any other health care facility, medical staff, or other third party for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research shall, to the fullest extent permitted and required by law, be confidential and privileged. Investigations, evaluations and assessments of the individual's care or behavior undertaken pursuant to these Bylaws or otherwise shall, to the fullest extent permitted and required by law, be confidential and privileged.

## **Section 6. Definitions**

- A. As used in this Article XII, the term “Hospital and its authorized representatives” includes, but is not limited to, the Hospital corporation and its affiliates; the Governing Board; employees, volunteers, or other workforce members; administrators; the CEO of MCHS Hospitals, Inc., the CAO of Hospital; Medical Staff Officers; Chief of Staff; Service Line Medical Directors; Medical Staff Members and other Practitioners with Clinical Privileges; certain contracted consultants to the Hospital; the Hospital's attorneys; and any other person or entity that, on behalf of or for the benefit of the Hospital, obtains, evaluates, or acts upon the individual's credentials, application, or conduct, or who provides or is asked to provide information, statements, reports, or testimony for any of the activities to which this Article XII applies.
- B. As used in this Article XII, the term “third parties” means all individuals or government agencies, organizations, associations, partnerships and corporations, regardless of whether they are health care facilities, from whom information has been requested by the Hospital and its authorized representatives or that has requested such information from the Hospital and its authorized representatives.

## **Section 7. Cumulative Effect**

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof, and in the event of conflict, the applicable law shall be controlling.

## **ARTICLE XIII MEMBER RIGHTS**

In the event the Medical Staff as a whole or the Medical Executive Committee have concerns regarding the Bylaws, Rules and Regulations, associated policies, or any other conflict that cannot be resolved or otherwise appropriately managed through existing processes, three (3) representatives of the Active Medical Staff and/or the Medical Executive Committee may request an opportunity to meet with each other, or with the Governing Board. Any request for such a meeting by the Medical Staff must be accompanied by a petition of twenty-five percent (25%) of the Active Staff.

In addition to the amendment processes for the Bylaws, Rules and Regulations and associated policies described herein, the Medical Staff, upon a petition of two-thirds (2/3) of the Active Staff, may recommend amendments to the Bylaws, Rules and Regulations or policies for adoption directly to the Governing

Board, provided that the recommendation is first communicated to the Medical Executive Committee.

#### **ARTICLE XIV**

### **RULES AND REGULATIONS AND ASSOCIATED MEDICAL STAFF POLICIES**

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Board. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed upon the recommendation of the Chief of Staff to the Medical Executive Committee, and approval of such recommendation by the Medical Executive Committee. Notice of such amendment or repeal will be provided to the Medical Staff, and Medical Staff Members shall have a reasonable opportunity for comment. Members of the Active Staff may also propose amendments to the Rules and Regulations, and associated Medical Staff policies, directly to the Medical Executive Committee upon a petition of twenty-five percent (25%) of the Active Staff.

In the event that urgent amendment of the Rules and Regulations is required in order to comply with law, regulation or accreditation requirements, Chief of Staff shall have the authority to alter the Rules and Regulations without prior notification of the Medical Staff. In such cases, the Chief of Staff shall notify the Medical Executive Committee shall notify the Medical Staff of the provisional amendment and provide an opportunity for review and comment of the amendment.

The Medical Executive Committee shall have the authority to amend or adopt policies as may be necessary to carry out the functions of the Medical Staff. Notice of any such policy so adopted shall be provided to the Medical Staff. All changes shall become effective when approved by the Governing Board. Except as provided herein, Rules and Regulations governing activities within Service Lines will be approved by the Service Line, the Medical Executive Committee, and the Governing Board, and are subject to the provisions above.

#### **ARTICLE XV**

### **GENERAL PROVISIONS**

Technical or insignificant deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken. Any time limits set forth in these Bylaws may be extended or accelerated by the Medical Executive Committee, Governing Board or CAO. The time periods specified in these Bylaws for action by the Medical Executive Committee, Governing Board or CAO and any other committees are to guide those bodies in accomplishing their tasks and shall

not be deemed to create any right for reversal of any action taken by those bodies if such action is not completed in the time periods specified.

**ARTICLE XVI  
AMENDMENTS**

Subject to the provisions herein, these Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. To be adopted, an amendment shall require a simple majority vote of the Active Medical Staff when a quorum is present.

Amendments so made shall be effective when approved by the Governing Board. The Bylaws may not be amended or adopted by unilateral action of the Medical Staff or Governing Board.

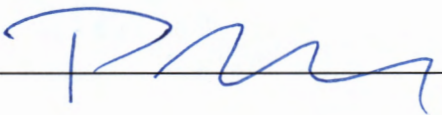
**ARTICLE XVII  
ADOPTION**

These Bylaws together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Governing Board of the Hospital. These Bylaws together with the appended Rules and Regulations, shall be reviewed at least every two (2) years.

**ARTICLE XVIII  
REPEALING**

These Bylaws, together with the appended Rules and Regulations or any part of such, may be repealed at any regular or special meeting of the Active Medical Staff. The repealing of the Bylaws and/or the Rules and Regulations shall require a two-thirds (2/3) vote of the Active Medical Staff present. Repeals or revisions shall be effective when approved by the Governing Board.

ADOPTED by the Active Medical Staff on February 24, 2020.

 \_\_\_\_\_, Chief of the Medical Staff

APPROVED by the Governing Board on February 27, 2020.

 \_\_\_\_\_, Chairman of the Governing Board



**EXHIBIT 1**

**CORRECTIVE ACTION AND FAIR HEARING PLAN**  
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# **CORRECTIVE ACTION AND FAIR HEARING PLAN ADDENDUM To the Bylaws of the Medical Staff**

## **ARTICLE I CORRECTIVE ACTION**

### **Section 1. Collegial Intervention**

It is the policy of the Hospital and its Medical Staff to encourage the use of progressive steps by Hospital and Medical Staff leadership, beginning with collegial and educational efforts, to address concerns regarding a Medical Staff member's clinical practice or professional conduct. The goal of collegial intervention is to arrive at voluntary, responsive actions by the Practitioner to resolve questions that have been raised. Collegial efforts may include, without limitation, counseling, sharing of comparative data, monitoring, and additional training or education. Collegial intervention efforts are encouraged, but are not mandatory, and their use is within the discretion of Medical Staff leadership. The Chief of Staff, in conjunction with the CAO, shall determine whether a matter shall be handled in accordance with this Section 1 or another applicable Hospital or Medical Staff policy.

### **Section 2. Request for Investigation of Corrective Action**

All requests for corrective action shall be in writing, shall be made to the Chief of Staff, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. A written request for investigation of corrective action may be submitted by an officer of the Medical Staff, the Chief of any Service Line, the Chairperson of any committee of the Medical Staff, the CAO, or the Governing Board. A request for investigation of corrective action or any investigation that may be commenced as a result thereof shall not preclude the invocation of summary suspension. A written request for corrective action with respect to a given Practitioner shall may be based on competence or professional conduct including but not be limited to:

- A. Conduct by a Practitioner considered below the standards or aims of the Medical Staff or to adversely reflect upon the reputation of the Medical Staff or Hospital in the community or which is disruptive to the operations of the Hospital.
- B. Conduct below the standards of ethics and morality expected within the Hospital.
- C. Conduct indicating a failure to meet expected clinical standards, clinical incompetence or conduct that could cause harm to a patient or patients.
- D. Material misstatement in or omission from any application for membership or Privileges or any misrepresentation in presenting the Practitioner's credentials.

- E. Harassment, abuse, mistreatment, or other intentional negative or disrespectful conduct toward a patient, employee or contractor of the Hospital, any Practitioner, or member of the Governing Board.
- F. Known or suspected violation(s) of the Bylaws, the Medical Staff Rules and Regulations, any Hospital or Medical Staff policy, or applicable ethical, legal or licensing standards; or conduct that is considered lower than the standards of or disruptive to the orderly operation of the Hospital or Medical Staff, including the inability to work harmoniously with others.

### **Section 3. Procedure Following Receipt of the Request**

Following receipt of a request for corrective action, the Chief of Staff shall bring the matter to the Medical Executive Committee as soon after receiving the request as practicable, but in no event longer than two (2) days from the receipt thereof. If time or circumstances require prompt action, the Medical Executive Committee shall be called into a special meeting to consider the matter. The Chief of Staff shall promptly notify the CAO of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the CAO fully informed of all action taken. The Medical Executive Committee shall meet as soon after receiving the request as practicable and make a decision as follows:

- A. The Medical Executive Committee may decide, in its sole discretion, to handle the matter by collegial intervention; to direct the matter be handled in accordance with another hospital or Medical Staff policy; or to proceed in another manner;
- B. If the request for investigation contains information sufficient to warrant a recommendation for corrective action, the Medical Executive Committee, in its sole discretion, shall make such recommendation following a personal interview with the Practitioner, if the Practitioner chooses to attend such interview; or
- C. If the request for investigation does not contain information sufficient to warrant a recommendation for corrective action, the Medical Executive Committee shall initiate investigation of the matter by directing that the Chief of Staff investigate the matter, conducting the investigation itself, or by appointing an ad hoc investigative committee comprised of at least three (3) physicians to investigate the matter. Members of the ad hoc investigative committee should be members of the Medical Staff if possible, although need not be. Absent extraordinary circumstances, the individuals performing the investigation shall not include partners of, associates of, relatives of, or individuals in direct economic competition with the affected Practitioner, nor any other person with a perceived bias in favor of or against the Practitioner.

#### **Section 4. Procedure for Investigation**

- A. The investigation should include opportunity for an interview with the Practitioner involved. The Practitioner should be informed (by the Chief of Staff or designee) of the general nature of the allegations that have been made and that such allegations, if substantiated, may result in corrective action in accordance with the Bylaws. The Practitioner shall be permitted to discuss and explain the conduct at issue. 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. The investigating committee shall make a record of the interview.
- B. Due to the informal nature of the interview, Practitioner's legal counsel will be excluded from attending the interview except in unusual circumstances, in which case the Chief of Staff or designee may in his or her discretion allow the Practitioner's legal counsel to attend.
- C. The investigating committee shall have available the full resources of the Medical Staff and the Hospital to aid in its work, as well as authority to use outside consultants as necessary. The committee also may require a physical or mental examination of the Practitioner by a physician (or more than one) satisfactory to the committee or individual performing the investigation and shall require the Practitioner to sign any authorization necessary to ensure that the results are made available to the committee or individual performing the investigation, the Medical Executive Committee, and the Governing Board.
- D. The investigation, if performed by anyone other than the Chief of Staff or the Medical Executive Committee, shall not be considered complete until a report of the investigation is received by the Medical Executive Committee.

#### **Section 5. Report of Investigation**

Reasonable efforts shall be made to complete the investigation and issue the report of the investigation within thirty (30) days of the commencement of the investigation. This timeframe is intended to serve as a guideline, and as such, shall not be deemed to create any right for a Practitioner to have an investigation completed within this time period.

#### **Section 6. Medical Executive Committee Action**

The Medical Executive Committee shall take action within thirty (30) days of receipt of the investigation report unless an extension of time is necessary. Such action may include, without limitation, of any one (1) or more of the following recommendations:

- A. Rejection or modification of the request for investigation of corrective action;
- B. A verbal warning, a letter of admonition, or a letter of reprimand;
- C. Performance monitoring or proctoring, with specific criteria, duration and resources;
- D. Terms of probation or a requirement of consultation;
- E. Medical and/or behavioral health treatment;
- F. Reduction, restriction, suspension or revocation of Clinical Privileges;
- G. Reduction of staff category or limitation of any staff prerogatives;
- H. Suspension or revocation of staff appointment; or
- I. Such other recommendation as it deems appropriate.

**Section 7. Effect of Medical Executive Committee Action**

- A. A recommendation by the Medical Executive Committee that would entitle the Practitioner to a hearing under Article 1, Section 8 of this Plan shall be forwarded to the CAO, who shall notify the Practitioner in accordance with Article II of this Plan. The CAO shall then hold the recommendation until after the Practitioner has exercised or waived the right to a hearing. If the Practitioner waives the right to a hearing, the CAO shall forward the recommendation of the Medical Executive Committee to the Governing Board, along with supporting documentation.
- B. If the action of the Medical Executive Committee does not entitle the Practitioner to a hearing, the action shall immediately take effect and a report of the action taken and the reasons therefor shall be made to the Governing Board, and the action shall stand unless modified by the Governing Board. If the Governing Board subsequently considers a modification of the Medical Executive Committee action that would, if taken by the Medical Executive Committee, entitle the individual to a hearing in accordance with Article 1, Section 8 of this Plan, the Governing Board shall so notify the affected Practitioner through the CAO, and shall take no final actions thereon until the Practitioner has exercised or waived the procedural rights provided.

**Section 8. Medical Executive Committee Actions or Recommendations Entitling Practitioner to a Hearing**

The following recommendations or actions of the Medical Executive Committee shall, if based on the professional competence or professional conduct of the

Practitioner and if deemed adverse pursuant to Section 9 below, entitle the affected Practitioner to a hearing upon timely and proper request, provided that the Practitioner is an appointee to the Medical Staff, holds Privileges at the Hospital, and/or is an applicant with a completed application. Unless the Practitioner's Privileges are otherwise summarily suspended, the Practitioner's Privileges shall remain intact until final action by the Governing Board.

- A. Denial of initial staff appointment.
- B. Denial of reappointment.
- C. Revocation of staff appointment.
- D. Denial of requested advancement in staff category.
- E. Involuntary reduction in staff category.
- F. Denial of some or all requested Clinical Privileges.
- G. Limitation, reduction, restriction, or suspension of Clinical Privileges for more than fourteen (14) days.
- H. Revocation of some or all Clinical Privileges for more than fourteen (14) days, except as a result of an exclusive contract to provide certain services.
- I. Terms of probation that constitute a restriction of staff appointment or Clinical Privileges.
- J. Individual imposition or application of mandatory consultation requirement, if the consultant must approve the course of treatment in advance.
- K. Denial of reinstatement from a leave of absence if the reason for denial relates to professional competence or professional conduct.

### **Section 9. When Deemed Adverse**

An action or recommendation of the Medical Executive Committee listed in Section 8 above shall be deemed adverse only when it has been:

- A. Recommended or undertaken by the Medical Executive Committee;
- B. Taken by the Governing Board contrary to a favorable recommendation by the Medical Executive Committee; or
- C. Taken by the Governing Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

## **Section 10. Medical Executive Committee Actions or Recommendations that Do Not Entitle Practitioner to a Hearing**

Notwithstanding any other provision of the Medical Staff Bylaws, the following recommendations or actions, without limitation, do not entitle a Practitioner to any of the hearing or appeal rights set forth in this Fair Hearing Plan, and the action shall take effect immediately without action of the Governing Board and without the right of appeal to the Governing Board:

- A. Decision that no action is warranted;
- B. Issuance of a verbal warning, reprimand, or other collegial intervention;
- C. Issuance of a letter of reprimand, warning, guidance, or counsel;
- D. Denial, limitation, expiration, or termination of temporary Clinical Privileges;
- E. Denial, limitation, expiration, or termination of emergency or disaster Clinical Privileges;
- F. Automatic suspension or relinquishment of appointment or Clinical Privileges;
- G. Suspension or limitation of staff appointment or Clinical Privileges for fewer than fifteen (15) calendar days;
- H. Any action listed in Article I, Section 8 above that is voluntary or accepted by the Practitioner (or applicant) or is not based on the Practitioner's professional competence or professional conduct;
- I. Determination that an application is incomplete or that it cannot be processed for any reason, including, but not limited to, a misstatement or omission;
- J. Determination of ineligibility based on failure to meet threshold eligibility criteria;
- K. Denial of appointment/reappointment/Privileges based on the lack of Hospital need or resources or because of an exclusive contract;
- L. Imposition of focused professional practice evaluation such as monitoring or general consultation where the Practitioner does not require prior approval of the consultant/monitor prior to initiating a course of treatment;
- M. Denial of a request for leave of absence or denial for an extension of a leave of absence;



- N. Imposition of a requirement for additional training or continuing education or denial of requested training or education;
- O. Routine assignment of a proctor to a Practitioner recently appointed to the Medical Staff or to a Practitioner with new Privileges;
- P. Denial of reinstatement after leave for reasons unrelated to professional competence or professional conduct;
- Q. Probation that does not limit Clinical Privileges;
- R. Requirement of a physical or mental examination and report by a physician or psychologist chosen or acceptable to the Medical Executive Committee and compliance with any recommendations issued as a result of such examination, provided that those recommendations do not constitute a limitation of Clinical Privileges. The Practitioner shall execute a release allowing anyone involved in the corrective action process, as well as Hospital legal counsel, to receive documentation of the results of the examination and to discuss with the health care professional the examination and results; and/or
- S. Any other action that is not based on Practitioner's professional competence or conduct.

### **Section 11. Temporary Suspension Of Admitting Privileges - Medical Records**

In the event that a Practitioner is determined to be delinquent in completion of medical records, the Chief of Staff or designee shall give the Practitioner a written warning to complete the outstanding records by a date certain. If the Practitioner fails to do so, the Practitioner's admitting Privileges (if any) shall automatically be suspended. This suspension shall not affect the Practitioner's ability to care for patients already in the Hospital nor the Practitioner's ability to care for outpatients. The suspension shall lift automatically upon satisfactory completion of the records. Any temporary suspension imposed pursuant to this Section 11 shall not entitle a Practitioner to any of the hearing and appeal rights set forth in this Fair Hearing Plan.

### **Section 12. Automatic Suspension**

- A. Action by the applicable licensing board or by a court of competent jurisdiction revoking or suspending a Practitioner's license, or imposing probation or limitation of practice, shall have the following automatic consequences:
  - 1. Revocation: Action by a licensing authority revoking a Practitioner's professional license or loss or lapse of the professional license for any reason (except a lapse due to a temporary failure to renew)

shall result in immediate and automatic revocation of the Practitioner Medical Staff membership and Clinical Privileges.

2. **Restriction/Limitation/Suspension:** Whenever a Practitioner's professional license is limited, restricted, or suspended by the applicable licensing authority, the Practitioner's Clinical Privileges and Medical Staff membership shall be immediately and automatically limited, restricted, or suspended in a similar manner. Upon reinstatement of the Practitioner's license without such restriction, limitation, or suspension, the Practitioner's Medical Staff membership and Clinical Privileges shall be automatically reinstated, unless such reinstatement conflicts with the corrective action process or other process that would prevent the exercise of Clinical Privileges.
3. **Lapsed:** A temporary lapse of a Practitioner's professional license due to a failure to renew shall result in an automatic suspension of such Practitioner's Medical Staff membership and Clinical Privileges until such time as the license is reinstated, at which time the Practitioner's Medical Staff membership and Clinical Privileges shall be reinstated.
4. **Probation:** Whenever a Practitioner is placed on probation by the applicable state licensing authority, his or her Medical Staff membership and Clinical Privileges shall be automatically limited in the same manner, effective upon and for at least the term of the probation.

**B. Drug Enforcement Administration (DEA) Number:**

1. **Revocation/Voluntary Surrender:** Whenever a Practitioner's DEA number is revoked or voluntarily surrendered, his or her Privileges to prescribe medications controlled by such registration number shall be immediately and automatically revoked.
2. **Suspension:** Whenever a Practitioner's DEA number is suspended, he or she shall be divested, at least, of his or her right to prescribe medications controlled by such registration number at the Hospital, effective upon and for at least the term of the suspension.
3. **Reduction:** If a Practitioner has a DEA number which has a reduced or limited schedule of drugs, the Privileges granted to prescribe medications controlled by such registration number shall automatically reflect that reduced or limited schedule.

**C. Malpractice Insurance:** If at any time a Practitioner's professional liability insurance coverage lapses, falls below the minimum required by the

Governing Board, is terminated, or otherwise ceases to be in effect (in whole or in part), or is otherwise materially limited, the Practitioner's Medical Staff Membership and Clinical Privileges shall be automatically suspended, as of the date the coverage becomes insufficient and until sufficient coverage is restored. If the automatic suspension lasts longer than three (3) months, the Practitioner's Medical Staff Membership and/or Clinical Privileges shall be considered to have been automatically and voluntarily resigned.

- D. Health Screening: The Clinical Privileges of a Practitioner who fails, without cause, to comply with health screening requirements imposed by the Hospital, Medical Staff policy, or applicable law shall immediately and automatically be suspended. Such suspension shall be lifted only after the Practitioner provides evidence that he or she has complied with all such screening requirements.
- E. Sanction by or Exclusion from Federal Health Care Programs: Whenever a Practitioner is sanctioned by or excluded, terminated, or otherwise precluded from participation in a federal health care program, including but not limited to the Medicare or Medicaid programs, the Practitioner's Medical Staff membership and Clinical Privileges shall be automatically terminated as of the date such action becomes effective.
- F. Criminal Activity: A Practitioner's Medical Staff membership and Clinical Privileges shall be automatically terminated upon conviction, indictment, or plea of guilty, no contest, or nolo contendere pertaining to:
  - 1. Any felony;
  - 2. Any misdemeanor substantially related to health care; or
  - 3. Any misdemeanors involving: (a) controlled substances; (b) illegal drugs; (c) Medicare, Medicaid, or insurance or other health care fraud or abuse; or (d) violence against another; or (e) any other felony or misdemeanor substantially related to health care.
- G. The Chief of Staff or CAO may, with approval from the Medical Executive Committee, prevent, lift or modify any automatic suspension.
- H. An automatic suspension shall occur upon a Practitioner's failure without good cause to supply information or documentation requested by any of the following: the CAO or his or her designee, the Medical Executive Committee, or the Governing Board. A suspension shall be imposed only if: (1) the request for information or documentation was in writing, (2) the request was related to the evaluation of the Practitioner's current qualifications for Medical Staff membership or Clinical Privileges, (3) the Practitioner failed to either comply with the request or to satisfactorily

explain his/her inability to comply, and (4) the Practitioner was notified in writing that failure to supply the requested information or documentation within fifteen (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 Clinical Privileges and shall remain in effect until the Practitioner supplies the information or documentation sought or satisfactorily explains his/her failure to supply it.

- I. An automatic suspension of all Privileges may be imposed upon a Practitioner's failure to notify the CAO within five (5) days of receipt by the Practitioner of an initial sanction notice of any action on the Practitioner's license or other certification or registration essential to his or her practice, or of the commencement of any formal investigation or the filing of charges with any court of record or any state or federal agency or with any accrediting organization or any Quality Improvement Organization or by law enforcement. The Medical Executive Committee shall promptly review the matter and submit a recommendation to the Governing Board regarding the continued Medical Staff membership and Clinical Privileges of the Practitioner.
- J. Each Practitioner shall have the duty to notify the CAO of any action which may constitute a cause for automatic suspension. Failure to report such action may result in suspension.
- K. Automatic suspension activated pursuant to this Section 12 shall not give rise to any right of hearing or appellate review.
- L. It shall be the duty of the Chief of Staff and the CAO to enforce all automatic suspensions and it shall be within the discretion of either the Chief of Staff or the CAO to lift or otherwise manage any automatic suspension.

### **Section 13. Summary Suspension**

- A. Any one of the following—the Chief of Staff, the CAO, the Medical Executive Committee, or the Governing Board—shall have the authority to suspend or restrict all or any portion of a Practitioner's Clinical Privileges, whenever, in that person's sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital. A summary suspension meeting the preceding criteria may be imposed at any time, including, without limitation, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the Practitioner to request a hearing.

- B. Such summary suspension shall become effective immediately upon imposition, shall be reported in writing to the CAO and the Medical Executive Committee, and shall remain in effect unless or until modified or lifted by the Chief of Staff, the CAO, the Medical Executive Committee, or the Governing Board.
- C. Notice of summary suspension shall be delivered by certified mail, return receipt requested, to the Practitioner's last known residential or office address; electronic mail, read or delivery receipt requested; or personal delivery to the Practitioner. The notice shall state the reasons for imposition of the summary suspension.
- D. As soon as reasonably possible after the summary suspension is imposed, but in no event more than fourteen (14) days after imposition of such suspension, the Medical Executive Committee shall meet to review and consider the suspension. The Medical Executive Committee shall, absent extraordinary circumstances, invite the Practitioner to discuss the matter at this meeting, although the meeting shall not constitute a formal hearing, the Practitioner shall not be entitled to have an attorney present at the meeting, and the individual shall be dismissed prior to deliberations. The Medical Executive Committee may allow the Practitioner to submit (within specified time parameters) a written statement in lieu of or in addition to appearing at the meeting. The Medical Executive Committee may recommend modification, continuance, or termination of the terms of the summary suspension. Any procedural rights the Practitioner may have in connection with the summary suspension shall be governed by the Fair Hearing Plan.
- E. Immediately upon the imposition of a summary suspension, the Chief of Staff shall have authority to provide for alternative medical coverage for the patients of the suspended Practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner. Any Medical Staff member suspended pursuant to this Article shall remain available for consultation to the alternative medical practitioner.

#### **Section 14. 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 the Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified herein. 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 AND PREHEARING PROCEDURES**

**Section 1. Notice to Practitioner of Adverse Recommendation or Action**

Where an adverse recommendation or adverse action has been made or an action has been taken pursuant to Article 1, Section 9 of this Plan, the CAO shall promptly give notice to the Practitioner. The notice shall:

- A. Advise the Practitioner of the recommendation or proposed action and the basis for the recommendation or proposed action;
- B. Advise the Practitioner of his/her right to request a hearing pursuant to the provisions of this Fair Hearing Plan;
- C. Enclose a copy of this Plan;
- D. Specify that the Practitioner has thirty (30) days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Article II, Section 2 hereof;
- E. State that failure to request a hearing within the specified time period, or to personally appear at the scheduled hearing on any day during which proceedings are to occur, shall constitute a waiver of the Practitioner's right to a hearing;
- F. State that the hearing shall be held (as determined by the Hospital):
  - 1. Before a Hearing Officer who is appointed by the hospital in accordance with Article II, Section 8 of this Plan and who is not in direct economic competition with the Practitioner involved; and/ or
  - 2. Before a Hearing Committee constituted of individuals who are appointed by the Hospital in accordance with Article II, Section 6 of this Plan and not in direct economic competition with the Practitioner involved;
  - 3. If no Hearing Officer is appointed, the Chair of the Hearing Committee shall serve in that role, in which case it will be referred to as the "Presiding Officer."
- G. State that upon receipt of the Practitioner's hearing request, the CAO will notify the Practitioner of the date, time and place of the hearing;
- H. State that in the hearing, the Practitioner involved has the right to:
  - 1. Representation by an attorney or any other person of the Practitioner's choice;

2. Have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof;
  3. Call, examine, and cross-examine witnesses;
  4. Present evidence determined to be relevant by the Hearing Officer or Presiding Officer (as delineated elsewhere in this Plan), regardless of its admissibility in a court of law; and
  5. Submit a written statement at the close of the hearing; and
- I. State that upon completion of the hearing, the Practitioner involved has the right to:
    1. Receive the written recommendation of the Hearing Officer or Presiding Officer, including a statement of the basis for the recommendation; and
    2. Receive a written decision of the Governing Board subsequent to the Hearing Officer or Hearing Committee's recommendation, including a statement of the basis for the decision.

## **Section 2. Request for Hearing**

A Practitioner shall have thirty (30) days following the receipt of a notice pursuant to Article II, Section 1 above within which to file a written request for a hearing. Such request shall be delivered to the CAO either in person or by certified or registered mail so that he or she receives it within the time limit. Receipt by the CAO of a request for hearing shall toll the effective date of the action and maintain the status quo of the Practitioner unless the Practitioner is otherwise suspended pursuant to the Bylaws or this Plan, or unless the Medical Executive Committee or the Governing Board imposes limitations on the Privileges or membership of the Practitioner pending completion of the hearing and review process.

## **Section 3. Effect of Waiver by Failure to Request a Hearing**

A Practitioner who fails to request a hearing within the time period and in the manner specified in Section 2 above waives any right to such hearing and to any appellate review to which the Practitioner might otherwise have been entitled. In the event that the Practitioner waives the right to hearing and appellate review, all of the following shall be true:

- A. An adverse action taken by the Governing Board shall become effective as the final decision of the Governing Board.

- B. An adverse action or recommendation by the Medical Staff shall be submitted to the Governing Board. At the Governing Board's next regular or special meeting following waiver, it shall consider the Medical Staff's recommendation, review all the information and material considered by the Medical Staff, and consider all other relevant information received from any source.
  - 1. If the Governing Board's action on the matter is in accord with the Medical Staff's recommendation, such action shall constitute the final decision of the Governing Board.
  - 2. If the Governing Board's action has the effect of changing the Medical Staff's recommendation, the matter shall be submitted to a joint conference as provided in Article VII. The Governing Board's action on the matter following receipt of the Joint Conference Committee's recommendation shall constitute its final decision.
- C. The CAO shall promptly send the Practitioner notice informing him or her of each action taken pursuant to this Section 3 and shall notify the Chief of Staff and the Medical Executive Committee of each such action.

#### **Section 4. Notice of Time and Place for Hearing**

- A. Upon timely receipt of a written request for hearing, the CAO shall deliver such request to the Chief of Staff or to the Chairperson of the Governing Board, depending on whose recommendation or action prompted the request for hearing.
- B. The Chief of Staff, or the Chairperson of the Governing Board, shall schedule a date and arrange for a hearing.
- C. The hearing date shall be not less than (thirty) 30 days from the date of the CAO's receipt of the request for hearing.
- D. The CAO shall send the Practitioner notice of the time, place, and date of the hearing. Unless otherwise agreed to by the Practitioner and CAO in writing, the hearing date shall not be less than thirty (30) days from the date of the notice of such hearing.

#### **Section 5. Statement of Issues and Events**

The notice of hearing shall be accompanied by a concise statement of the Practitioner's alleged acts or omissions, a list of the specific or representative patient records in question (if applicable), a list of preliminary 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 a list of those individuals from whom the Hearing Committee shall be selected.

#### **Section 6. Appointment of Hearing Committee**

- A. The Chief of Staff shall select a Hearing Committee composed of at least three (3) but no more than five (5) members of the Active Medical Staff. The Chief of Staff shall designate one of the members so appointed as chair ("Presiding Officer") unless a Hearing Officer is appointed in accord with Article II, Section 8. 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 Fair Hearing Plan, direct economic competition shall be defined to mean those Practitioners actively engaged 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 whether or not they are members of the Medical Staff.
- B. Prior to final selection of the Hearing Committee, the affected Practitioner shall be given a list of seven (7) individuals from which the Hearing Committee will be appointed. The Practitioner may strike two (2) persons from the list. The Practitioner must inform the CAO in writing of the names to be stricken within five (5) 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 7. Service on the Hearing Committee**

A member of the Active Staff or of the Governing Board shall not be disqualified from serving on a Hearing Committee because the member has heard of the case or has knowledge of the facts, or supposed facts involved, or participated in the review or investigation of the matter at issue. No member of the Medical Staff or Governing Board who requests corrective action pursuant to Article I shall serve as a voting member of the Hearing Committee. However, such individuals may appear before the Hearing Committee if requested by either party. In any event, all members of a Hearing Committee must consider and decide the case with good faith objectivity.

#### **Section 8. Appointment of Hearing Officer**

The use of a Hearing Officer to preside at a hearing held in accord with this Fair Hearing Plan is optional. The use and appointment of Hearing Officer shall be determined by the Chair of the Governing Board or the Chief of Staff, depending on whether the Governing Board or the Medical Executive Committee occasioned the hearing. A Hearing Officer may or may not be an attorney. Such Hearing Officer shall

act in an impartial manner as the presiding officer of the hearing. If there is a Hearing Committee, the Hearing Officer may participate in its deliberations and act as its advisor, but shall not be entitled to vote. If there are not sufficient Active Staff members who are not in direct economic competition with the Practitioner to form a Hearing Committee, the Hearing Committee may be composed of other physicians (whether or not Medical Staff members) or by the Hearing Officer, in which case the Hearing Officer will act in place of the Hearing Committee.

### **Section 9. Role of Hearing Officer Or Presiding Officer**

The Hearing Officer or Presiding Officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Hearing Officer shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

- A. The Hearing Officer or 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, or 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.
- B. The Hearing Officer or Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

## **Section 10. Representation**

- A. By a Member of the Medical Staff:
  - 1. The Practitioner who requested the hearing shall be entitled to be accompanied by and represented at the hearing by a member of the Active Staff in good standing.
  - 2. Such Medical Staff representative shall not include members of the Medical Executive Committee or any committee which formally considered and acted upon the underlying action leading to the hearing.
- B. By Legal Counsel:
  - 1. If the Practitioner desires to be represented by an attorney at any hearing or appellate review appearance pursuant to this Plan, the request for a hearing or appellate review must so state. The request must also include the name, address and phone number of the attorney. Any Practitioner who incurs legal fees shall be solely responsible for their payment.
  - 2. The Medical Executive Committee and the Governing Board may also be allowed representation by counsel, whether or not the Practitioner opts to do so. Absent a divergence of interests between the Medical Executive Committee and the Governing Board, the same attorney may represent both. Such attorney may or may not be ongoing counsel to the Hospital. All standard conflict of interest rules relevant to counsel shall be observed.

## **Section 11. Discovery**

- A. The hearing is not a court trial. The right to discovery is limited as specified herein and no other discovery rights exist outside of this Plan. The Practitioner requesting the hearing shall, if applicable and upon specific written request, be entitled 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 Medical Executive Committee or the Governing Board;
  - 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 Medical Executive Committee or the Governing Board, which may be redacted to protect the Hospital's interests in a manner that does not impede the Practitioner's ability to defend himself or herself, at the discretion of the Hearing Officer, Presiding Officer or Hearing Committee.
- B. At least ten (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 each party intends to call as witnesses at the hearing and the name of any Medical Staff member chosen as a representative under Article II, Section 10. Each party shall update its witness list if and when additional witnesses are identified prior to hearing.
  - C. Prior to the hearing, on dates set by the Hearing Officer or Presiding Officer or agreed upon by representatives 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.
  - D. Prior to the hearing, on dates set by the Hearing Officer or Presiding Officer, the Practitioner requesting the hearing shall, upon specific request, provide the Medical Executive Committee and/or the Governing Board copies of any expert report or other documents relied upon by the Practitioner.
  - E. If the Presiding Officer or Hearing Officer requires the parties to submit written statements of the case, notice to that effect shall be provided to each party at least ten (10) business days prior to the hearing. The written statements of the case shall be supplied both to the Hearing Committee or Hearing Officer and to the other party at least two (2) business days prior to the commencement of the hearing.
  - F. There shall be no discovery regarding individual Practitioners other than the Practitioner subject to the hearing.
  - G. Neither the Practitioner, his or her attorney, nor any other person representing the Practitioner shall contact any Hospital employee appearing on the Hospital's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

## **Section 12. Pre-Hearing Conference**

- A. The Hearing Officer or Presiding Officer shall require counsel for the Practitioner and the Medical Executive Committee (or the Governing Board) 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 Practitioner may state any objection (and the grounds therefor) to any person named to serve on the Hearing Committee or as the Hearing Officer. The Hearing Officer or Presiding Officer shall have the sole authority to rule on the objections; counsel for either party may preserve any objections on the record.
  
- B. The Hearing Officer or 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 Hearing Officer or 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 Committee members and the basis for those objections be made at the pre-hearing conference; the Hearing Officer or the Presiding Officer may recommend to the CAO that a Hearing Committee 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 Hearing Officer or Presiding Officer, in advance; and/or
  - 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 the parties.

## **ARTICLE III HEARING PROCEDURE**

### **Section 1. Personal Appearance Required**

Failure without good cause of the Practitioner to appear in person and proceed at a hearing shall constitute voluntary waiver of the right to hearing, at which point the adverse action or recommendation involved shall become final and effective immediately upon approval by the Governing Board.

### **Section 2. Rights of Parties**

- A. "Parties" for the purpose of this Plan shall be the affected Practitioner and the Medical Executive Committee or Governing Board, depending on whose action prompted the request for hearing. During a hearing, each of the parties shall have the right to:
1. Call, examine and cross-examine witnesses, including expert witnesses;
  2. Introduce exhibits and present relevant evidence, as determined by the Hearing Officer or Presiding Officer;
  3. Rebut any relevant evidence;
  4. Submit a written statement at the close of the hearing; and
  5. Record the hearing by use of a court reporter or other mutually acceptable means of recording.
- B. If the Practitioner who requested the hearing does not testify on his or her own behalf, the Practitioner may be called by the Hearing Committee, Hearing Officer or the other party and examined as if under cross-examination.

### **Section 3. 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 person or persons that may later be called upon to review the record and render a recommendation or decision in the matter. The Presiding Officer or Hearing Officer may select the method to be used for making the record, such as a court reporter, electronic recording unit, detailed transcription, or any combination thereof. If an electronic recording unit is used, each person speaking should endeavor to identify himself or herself each time he or she speaks. A Practitioner electing an alternate method shall bear the cost thereof.

#### **Section 4. Postponement**

Requests for postponement of a hearing shall be granted by the Presiding Officer or Hearing Officer only upon a showing of good cause and only if the request is prompt. A hearing shall be postponed no more than two (2) times by the Practitioner.

#### **Section 5. Participation**

Where there is a Hearing Committee, a majority of the Hearing Committee must be present throughout the hearing and deliberations. If a Hearing 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.

#### **Section 6. Presentation of 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 Hearing Officer or Presiding Officer, it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, which memoranda shall become a part of the hearing record. The Hearing Officer or Presiding Officer may, but is not required to, order that oral evidence be taken only on oath or affirmation.
- B. The Hearing Committee or Hearing Officer 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 or Hearing Officer shall be entitled to conduct independent reviews, research, and interviews, but may utilize the products of such 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 Presiding Officer or Hearing Officer may require that the parties submit written, detailed statements of the case to the Hearing Committee or the Hearing Officer 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 the Practitioner is required by the Hearing Committee or Hearing Officer to supply a detailed statement of the case and fails to do so, the Hearing Committee or

Hearing Officer may conclude that such failure constitutes a waiver of the Practitioner'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 or Hearing Officer and the parties in advance of or at the hearing. These 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.

### **Section 7. Official Notice**

In reaching a decision, the Hearing Committee or Hearing Officer 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 on the matters to be noticed and those matters shall be noted in the hearing record. Any party shall be given opportunity, on timely request, to request 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 Presiding Officer or Hearing Officer.

### **Section 8. Burden of Proof**

The body whose adverse action or recommendation occasioned the hearing shall have the initial obligation to present evidence in support of its actions. The Practitioner shall then be responsible for presenting clear and convincing evidence that the adverse action or recommendation lacks any factual basis or that conclusions drawn from the facts are either arbitrary, unreasonable or capricious. The body whose adverse action or recommendation occasioned the hearing shall then have the opportunity for rebuttal.

### **Section 9. Recesses and Adjournments**

The Hearing Officer, 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, provided such adjournment shall not extend the time within which any action is required to be taken under this Plan, without the express consent of the parties. 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 within the time frame previously set forth in this Plan, conduct its subsequent deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.



**ARTICLE IV  
HEARING COMMITTEE REPORT AND FURTHER ACTION**

**Section 1. Hearing Committee Report**

Within thirty (30) days after final adjournment of the hearing, the Hearing Committee or Hearing Officer shall make a written report of the findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered, to the CAO. The CAO shall promptly send a copy of the report to the Practitioner, the Chief of Staff, the Medical Executive Committee and the Governing Board.

**Section 2. Effect of Favorable Result**

Where the Hearing Committee or Hearing Officer has recommended a resolution favorable to the Practitioner, within thirty (30) days of receipt of the Hearing Committee or Hearing Officer report, the Governing Board shall issue a written report adopting, modifying, or rejecting the Hearing Committee or Hearing Officer's recommendation. If the Governing Board's decision is also favorable to the Practitioner, it becomes the final decision.

**Section 3. Effect of Adverse Result**

Where the Hearing Committee or Hearing Officer has recommended a resolution adverse to the Practitioner, the CAO shall provide the Practitioner special notice of the right to request an appellate review as provided in Article V of this Plan. This special notice shall be sent together with the copy of the Hearing Committee or Hearing Officer report.

**Section 4. Special Notice of Result**

- A. The CAO shall promptly send a copy of the Hearing Committee or Hearing Officer's report to the Practitioner by special notice. The special notice shall also include the written decision or recommendation of the Governing Board.
- B. If the result sent to the Practitioner is or continues to be adverse to the Practitioner, 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 Board of the adverse decision;
  - 2. That the Practitioner has fifteen (15) days, following mailing the special notice required by this Section 4, 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 may be accomplished by furnishing the Practitioner a copy of the Fair Hearing Plan with the special notice.

## **ARTICLE V APPELLATE REVIEW**

### **Section 1. Request for Appellate Review**

- A. The grounds for appellate review shall be limited to one or more of the following:
  1. There was a substantial and material failure to comply with this Plan or the Bylaws during or prior to the hearing such that the Practitioner was denied a fair hearing;
  2. The recommendations of the Hearing Committee or Hearing Officer were made arbitrarily or capriciously; and/or
  3. The recommendations of the Hearing Committee or Hearing Officer were not supported by any substantial evidence.
- B. A Practitioner shall have fifteen (15) days following the mailing of the special notice within which to file a written request for appellate review. Such request shall be delivered to the CAO within the time specified either in person or by certified or registered mail and may include a request for a copy of this record of the Hearing Committee or Hearing Officer and all other material that was considered in making the adverse action or result, if not previously forwarded.

### **Section 2. Waiver by Failure to Request Appellate Review**

A Practitioner who fails to request an appellate review within fifteen (15) days following the mailing of the special notice or who fails to submit a written statement required by Article V, Section 6, waives any right to such review. Such waiver shall have the same force and effect as that provided in Article II, Section 3.

### **Section 3. Notice of Time, Place and Date**

Upon receipt of a timely request for appellate review, the CAO shall deliver such request to the Chairperson of the Governing Board. Within ten (10) business days after receipt of such request, the Chairperson of the Governing Board shall schedule and arrange for an appellate review which shall be conducted not more than thirty-five (35) days from the date the CAO received the appellate review request. At least twenty (20) days prior to the appellate review, the CAO shall send the Practitioner notice of the time, place and 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 twenty (20) days from the date the CAO received the request for review. In such case, the Practitioner shall be afforded notice of the time, date and place of review as soon as practicable. The time for the appellate review may be extended by the Governing Board or, if applicable, the Appellate Review Committee for good cause. The appellate review can occur at a regular meeting of the Governing Board.

#### **Section 4. Appellate Review Committee**

The Governing Board shall determine whether the appellate review shall be conducted by the Governing Board as a whole or by an Appellate Review Committee composed of three (3) to five (5) members of the Governing Board appointed by the Chairperson of the Governing Board. If an Appellate Review Committee is appointed, the Chairperson of the Governing Board shall designate one (1) of its members as chairperson. References to the Appellate Review Committee below shall apply equally to the Governing Board in the event the Governing Board elects to conduct the appellate review as a whole.

#### **Section 5. 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 or Hearing Officer, that Hearing Committee's or Hearing Officer's report, and all subsequent results and actions thereon. The Appellate Review Committee shall also consider the written statements submitted pursuant to Article V, Section 6 and such other materials as may be presented and accepted under Article V, Section 9.

#### **Section 6. 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 or she disagrees, and the reasons for such disagreement. The statement shall be submitted to the Appellate Review Committee through the CAO at least ten (10) business days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Medical Staff or by the Governing Board, as the case may be; and if submitted, the CAO shall provide a copy to the Practitioner at least five (5) business days prior to the scheduled date of the appellate review. The Practitioner's failure to submit a written statement by the deadline shall constitute a waiver of the right to appellate review and the appellate review shall be cancelled.

#### **Section 7. Presiding Officer For Appellate Review**

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

## **Section 8. 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 asked by any member of the Appellate Review Committee.

## **Section 9. 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 10. 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 11. Participation**

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

## **Section 12. 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 convene to deliberate outside the presence of the parties. Upon conclusion of those deliberations, the Appellate Review Committee shall adjourn.

## **Section 13. Action Taken**

- A. Within ten (10) business days following adjournment or as soon thereafter as practicable, the Appellate Review Committee shall submit a written report of its findings and recommendations in the matter to the Governing Board. If appellate review is conducted by the Governing Board as a whole, its conclusions shall be the Governing Board's final action unless otherwise provided in this Plan.

- B. The Appellate Review Committee may recommend that the Governing Board affirm, modify or reverse the adverse result or action previously taken by the Governing Board. In its discretion, the Appellate Review Committee may refer the matter back to the Hearing Committee or Hearing Officer for further review and require a recommendation to be returned to the Appellate Review Committee within twenty (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 ten (10) business days after receipt of such recommendation after referral, the Appellate Review Committee shall make its recommendations to the Governing Board to affirm, modify or reverse the adverse action of the body who occasioned the review.

#### **Section 14. Conclusion**

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

### **ARTICLE VI FINAL DECISION OF THE GOVERNING BOARD**

#### **Section 1. Governing Board Action**

- A. Within ten (10) business days after receipt of the recommendation of the Appellate Review Committee or at the adjournment if the Appellate Review Committee is the Governing Board itself, the Governing Board shall render its final decision in the matter in writing and shall send a copy of the final decision to the Practitioner by special notice and to the, CAO, Chief of Staff and the Medical Executive Committee.
- B. If the Governing Board's decision is to affirm its previous adverse recommendation in the matter, if any, such decision shall be immediately effective and final.
- C. If the Governing Board's decision is to affirm the Medical Executive Committee's previous adverse recommendation in the matter, if any, such decision shall be immediately effective and final.
- D. If the Governing Board's action has the effect of changing the Medical Executive Committee's previous adverse recommendation, if any, the Governing Board shall refer the matter to the Joint Conference Committee, as provided in Article VII. The Governing Board's action on the matter following receipt of Joint Conference's recommendation shall be immediately effective and final.

**ARTICLE VII  
JOINT CONFERENCE COMMITTEE REVIEW FOR  
PURPOSES OF FAIR HEARING PLAN**

**Section 1. Membership and Time Limits**

- A. Within thirty (30) days following receipt of a matter referred to it by the Governing Board pursuant to the provisions of this Fair Hearing Plan, a Joint Conference Committee of equal numbers of members of the Medical Executive Committee and the Governing Board shall convene to consider the matter.
- B. Within seven (7) days following the conclusion of its considerations, the Joint Conference Committee shall submit its recommendation to the Governing Board.
- C. The Governing Board may affirm, modify, or reverse a recommendation of the Joint Conference Committee. The Governing Board's action on the matter following receipt of the Joint Conference Committee's recommendation shall be immediately effective and final.

**ARTICLE VIII  
GENERAL PROVISIONS**

**Section 1. Number of Hearings and Reviews**

Notwithstanding any other provision of the Bylaws or of this Plan, no Practitioner shall be entitled as a right to more than one (1) evidentiary hearing and one (1) appellate review with respect to a an adverse recommendation or action.

**Section 2. Waiver**

A Practitioner's failure to make a required request or appearance or otherwise comply with this Plan at any time after receipt of special notice of an adverse recommendation, action, or result, consents to such adverse recommendation or result and voluntarily waives all rights to which such Practitioner might otherwise have been entitled under the Bylaws then in effect or under this Plan with respect to the matter involved.

**Section 3. 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 Medical Executive Committee, the Chief of Staff, the CAO, the Hospital's legal counsel or the Governing Board to receive the information. This shall not preclude the Chief of Staff or the CAO 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 Bylaws or as authorized, in writing, by the CAO or by legal counsel for the Hospital. Any breach of confidentiality by an individual or committee member may result in corrective action but shall not entitle the Practitioner to any additional rights under this Plan.

#### **Section 4. Release**

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 matters relating thereto including but not limited to the immunity and release provisions.

#### **Section 5. 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 CAO or the Medical Executive Committee. The time periods specified in this Plan for action by the Medical Staff, the Governing Board 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 adverse action if the process or corrective action procedures are not completed within the time periods specified. Technical or insignificant deviations from the procedures set forth in the Plan are not grounds for invalidation of any of the actions taken under the Plan.

### **ARTICLE IX AMENDMENT**


#### **Section 1. Amendment**

This Plan may be amended or repealed, in whole or in part, in accordance with the process for amending the Medical Staff Bylaws as set forth in Article XVI of the Medical Staff Bylaws, subject always to consistency with the Medical Staff Bylaws and corporate Bylaws of the Governing Board.

**ARTICLE X  
ADOPTION**


**Section 1. Medical Staff**

The foregoing Fair Hearing Plan was adopted and recommended to the Governing Board by the Medical Staff with, and subject to, the Medical Staff Bylaws, Rules and Regulations on 2/24/2020.

  
\_\_\_\_\_  
Chief of Staff  
2/27/20  
\_\_\_\_\_  
Date

**Section 2. Governing Board**

The foregoing Fair Hearing Plan was approved and adopted by resolution of the Governing Board after considering the Medical Staff's recommendations, and in accordance with, and subject to, the Medical Staff Bylaws on 2/27/2020.

  
\_\_\_\_\_  
Chairperson, Governing Board  
2/27/2020  
\_\_\_\_\_  
Date