Unified Medical Staff Bylaws

Approved:
{Date} Board of Directors

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PREAMBLE

1. To ensure that the philosophy, purpose and objectives of Ascension All Saints Hospital, Ascension Columbia St. Mary's Hospital Milwaukee, Ascension Columbia St. Mary's Hospital Ozaukee, Ascension St. Francis Hospital, Ascension Southeast Wisconsin Hospital (comprised of three 3 campuses including, Elmbrook, Franklin and St. Joseph's Campuses), and Sacred Heart Rehabilitation Institute are achieved insofar as they relate to patient services, medical education and research, the Members of the medical staffs of these six hospitals hereby organize themselves together as a Unified Medical Staff in conformity with the Bylaws hereinafter stated. The Bylaws, along with the Ascension Southeast Wisconsin Policies and Procedures set forth the organization, membership, privileges, officers, committees, meetings, hearings, procedures and practices of the Medical Staff, and a due process procedure for Members subject to certain adverse actions regarding their staff membership and clinical privileges.

2. The Medical Staff has the authority, and so upholds the Board of Directors' responsibility, to implement an effective Quality Assurance and Improvement Program, to maintain acceptable ethical and professional standards, and to guide all its activities in accordance with the Mission, Vision and Values of Ascension Wisconsin.

DEFINITIONS

For purposes of the Bylaws, the following terms are defined as noted:

1. **Administration** – Shall refer to Presidents of Hospitals and other persons appointed to assist him or her in the overall management of the Hospitals where the respective Medical Staff has elected to join these Unified Bylaws.

2. **Advanced Practice Providers** – Means those non-physician providers that are permitted by law to practice within the scope of their certification/licensure in accordance with their delineated clinical privileges as recommended by the Medical Staff and authorized by the Board of Directors, and in accordance with these Bylaws and associated Policies and Procedures. Furthermore, Advanced Practice AHPs shall practice via a collaborative practice agreement or set of supervisory guidelines with a physician

3. **Allied Health Professional** ("AHP") – Refers to health professionals other than physicians, dentists and podiatrists who are granted certain clinical privileges but are not Members of the Medical Staff. Unless otherwise specified, this broad term is intended to include Independent AHPs, Dependent AHPs, and Advanced Practice Providers.

4. **Appellate Review Body** – Means the group of clinical and administrative leaders that conducts a secondary review after a hearing as further defined in Article XXI of the Bylaws.

5. **Applicant** – Means a licensed physician, dentist or podiatrist applying for membership and privileges on the Hospital's Medical Staff who has not yet received formal approval by the Board of Directors.

6. **Board of Directors** – Means the Board of Directors of Ascension Wisconsin Southeast Wisconsin Common Hospital Board of Directors which is the governing entity that oversees Columbia St. Mary's Hospital Milwaukee, Inc., Columbia St. Mary's Hospital Ozaukee, Inc., Sacred Heart Rehabilitation Institute, Inc., Ascension SE Wisconsin Hospital, Inc., Ascension St. Francis Hospital, Inc. and Ascension All Saints Hospital, Inc.

7. **Bylaws** – Refers to this document which contains the framework by which the Medical Staff that has accepted the Bylaws shall self-govern as authorized by the Board of Directors with Board of Directors oversight and approval.

8. **Campus** - When a Hospital has multiple locations and all locations share one unique Tax ID Number, the term "Campus" shall be used to designate the specific locations of that Hospital.

9. **Caregiver Law** - For purposes herein, conviction of a "Caregiver Law" refers to any state or federal felony or misdemeanor pursuant to which the individual is banned from access to patients pursuant to applicable law including under the Wisconsin Caregiver Program found at Wis. Stats. §§ 50.065 and 146.40.

10. **Chief of Staff** – Means the highest-ranking elected leader of the MEC or in certain circumstances his or her designee. The Chief of Staff may also be referred to as the MEC Chief of Staff.

11. **Corrective Action** – Means disciplinary measures imposed, or that are considered to be imposed, upon a Practitioner due to an act or omission. This term is meant to be generic and the specific types of Corrective Action are further defined in the Bylaws.

12. **Department** – Means a clinical department of the Medical Staff.

13. **Dependent Allied Health Professional** – Means non-physician providers that are permitted by law to practice within the scope of their certification/licensure under the sponsorship/supervision of a Medical Staff member who holds current privileges at a Site subject to these Bylaws within the parameters of their respective job description which has been approved by the Medical Staff and Board of Directors and in accordance with these Bylaws and associated Policies and Procedures.

14. **Ex Officio** – Means membership by virtue of an office or position held.

15. **Hospital** – The term "Hospital" in the Bylaws refers to a licensed Hospital assigned a unique Tax ID Number.

16. **Hospital President** - Means the highest-ranking administrator of a Hospital with a unique Tax ID Number or his or her designee, if applicable.

17. **Interim Medical Executive Committee** – Means the group physicians that will guide the transition from the use of existing medical staff bylaws under historical practice to the adoption and implementation of these Bylaws.

18. **Independent Allied Health Professional** – Means those non-physician providers that are permitted by law to practice within the scope of their certification/licensure in accordance with their delineated clinical privileges as recommended by the Medical Staff and authorized by the Board of Directors, and in accordance with these Bylaws and associated Policies and Procedures.

19. **Just Culture** – Means the type of safe working environment that the Medical Staff is attempting to foster with the rules outlined in these Bylaws. The term is further defined in Article IV of the Bylaws.

20. **Local Chief of Staff -** Means the elected leader of a LMEC or in certain circumstances his or her designee. Should an LMEC be comprised of multiple Sites with their own respective Site Chiefs of Staff, the Sites shall determine a mechanism for choosing a Local Chief of Staff from the Site Chiefs of Staff. That mechanism may be delineated in Policies and Procedures applicable to the Sites.

21. **Local Department –** Means the subdivision of a Department based on location. A Local Department may serve one individual Site or a collection of Sites with particular clinical services offered.

22. **Local Medical Executive Committee** – ("LMEC") Means a subset of the Medical Staff that has organized to oversee specific or local aspects of medical practice at one or more Sites. The MEC delegates only limited authority to an LMEC, and all LMECs must report to and follow direction from the MEC and Board of Directors.

23. **Mail** – Unless otherwise modified, all mailings referred to herein may be sent by regular mail, facsimile, or electronic mail.

24. **Medical Executive Committee** – ("MEC") Means the governing body comprised of providers of the Medical Staff that works with and advises the Board of Directors. The MEC is comprised of leaders as described in the Bylaws and responsible for overseeing the actions of the Medical Staff and any LMECs.

25. **Medical Staff** – Means the organized group of all physicians, dentists and podiatrists who are given privileges to treat patients at the Hospitals that have agreed to unify under these Bylaws but may refer only to certain medical staff members at a particular Site when so indicated.

26. **Medical Staff Year** – Means the fiscal year of Ascension Wisconsin from July 1 to June 30.

27. **Member** – Means a licensed physician, dentist, or podiatrist approved by the Board of Directors for membership on the Medical Staff.

28. **Policies and Procedures** – Means the supporting administrative documentation created by the Medical Staff to be supplemental rules to the Bylaws. The Policies and Procedures are intended to be more detailed on the operations of the Medical Staff. Policies and Procedures may be created that are uniformly applicable to all member Hospitals subject to the Bylaws or individually tailored to specific Sites as determined by the MEC or applicable LMEC.

29. **Practitioner** – Means a physician, dentist, or podiatrist who is fully licensed to practice his or her profession in the State of Wisconsin.

30. **Privileges** – Means the permission granted to a Medical Staff Member or Allied Health Professional to render specific diagnostic, therapeutic, medical, oral/maxillofacial/dentist, podiatric or surgical services.

31. **Primary Site** – Means the Site at which the Applicant or Member has indicated is his or her main hospital at which he or she practices. A Member may have privileges at more than one Site, but a Member may only have one Primary Site.

32. **Officer** – Means a Member of the Medical Staff who has been elected or appointed to serve the Medical Staff in a leadership capacity based on the specific requirements of the role he or she has obtained. Officers of the MEC include the Chief of Staff and Vice Chief of Staff. Should a member Site or Sites create an LMEC, the officers of the LMEC shall include the Local Chief of Staff and may include a Local Vice Chief of Staff.

33. **Section** - Means a subgroup of a Department of the Medical Staff based on specialty within a medical practice.

34. **Local Department Chair** – Means the elected or appointed leader of a Section within a Department.

35. **Site** - The term "Site(s)" shall be used when referring to a location of care that is subject to the Bylaws. The term is intended to generically identify one or more geographic points of care

regardless of legal entity, tax identification number, or other affiliation other than being a location at which the Bylaws apply. A Site may be an individually licensed Hospital or Campus within a Hospital. The eight Sites included in the Bylaws are Ascension All Saints Hospital, Ascension Columbia St. Mary's Hospital Milwaukee, Ascension Columbia St. Mary's Hospital Ozaukee, Ascension St. Francis Hospital, Ascension Southeast Wisconsin Hospital – Elmbrook Campus, Ascension Southeast Wisconsin Hospital – Franklin Campus, Ascension Southeast Wisconsin Hospital – St. Joseph's Campus, and Sacred Heart Rehabilitation Institute.

36. **Site Chief of Staff** – Means the elected leader of a particular Site. Each of the eight Sites subject to the Bylaws shall elect a Site Chief of Staff. Each Site Chief of Staff shall be entitled to a voting membership seat on the MEC.

37. **Site Policies and Procedures** – Means supplementary rules to govern the Medical Staff that is limited in scope to an individual Site that is governed by the Bylaws.

38. **Special Notice** – Means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee.

39. **Vice President of Medical Affairs ("VPMA")** – Means the Vice President of Medical Affairs for the Hospital or Campus, as specified.

Some terms may be used in the Bylaws only in certain limited sections. In such instances, the terms shall be interpreted by the definitions located in those sections where those limitedly used terms are defined.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of Ascension Southeast Wisconsin hereinafter referred to in the Bylaws as the Medical Staff, Medical Staff, or other similar iteration.

ARTICLE II
MEDICAL STAFF ORGANIZATION

1. The Medical Staff of Ascension Southeast Wisconsin is a Medical Staff comprised of all physicians, dentists, and podiatrists who, upon the initial adoption and approval of the Bylaws are current members in good standing at Ascension All Saints Hospital, Ascension Columbia St. Mary's Hospital Milwaukee, Ascension Columbia St. Mary's Hospital Ozaukee, Ascension St. Francis Hospital, Ascension Southeast Wisconsin Hospital (comprised of 3 Campuses including Elmbrook, Franklin and St. Joseph's Campuses), and Sacred Heart Rehabilitation Institute. Thereafter, the Medical Staff shall include all physicians, dentists, and podiatrists who are appointed or re-appointed to the Medical Staff by the Board of Directors and the authority of the Bylaws. The member Hospitals and Campuses shall be governed by the Board of Directors. A Medical Executive Committee shall be established that shall oversee the quality of care, governance of the Medical Staff, draft policies relevant to the Medical Staff, and work with recommend, and report to the Board of Directors for the Sites and Members under the Bylaws.

2. The Medical Staff and supporting administrative functions are permitted to create Policies and Procedures to further detail the administrative functions of the Medical Staff and those Policies and Procedures may be made applicable to all Hospitals that are subject to the Bylaws. However, the Medical Staff and Board of Directors consider each Site's unique circumstances and possible significant differences in patient populations and services offered. To ensure that the needs and concerns of each Hospital and historical medical staff members are given due consideration and that issues localized to particular Sites are duly considered and addressed, the Medical Staff may create Policies and Procedures that are only applicable to certain Sites. Those Site Policies and Procedures shall not conflict with the Bylaws or any Policies and Procedures uniformly applicable to the member Hospitals subject to the Bylaws.

3. Upon initial approval and adoption of the Bylaws, each of the Practitioners identified above shall maintain the same membership status and clinical privileges at the same designated Hospitals and/or Campuses that he/she enjoyed just prior to the implementation of the Bylaws. Thereafter, at the time of initial appointment and with each subsequent reappointment, the Practitioner shall designate the Site(s) at which he/she intends to practice. The Practitioner shall be assigned to a category of membership at each designated Site in accordance with the criteria set forth in the Bylaws. Thereafter, the grant of membership status and clinical privileges at designated Site(s) shall be made by the Board of Directors, after review and recommendation by the Medical Staff as more specifically described in the Bylaws and associated Policies and Procedures.

4. The Practitioner's assigned category of membership at each designated Site shall determine his/her Site-specific rights and responsibilities. Each Site shall operate under the Bylaws and associated

Policies and Procedures and, under applicable Site Policies and Procedures but only to the extent that Site Policies and Procedures are not in conflict with, preempted by, or superseded by the Bylaws and associated Policies and Procedures.

5. Practitioners who enjoy Active membership status at one (1) or more Sites shall be entitled to one (1) vote on matters that call for a vote of the entire Medical Staff.

6. During the interval of time between Board approval and date of implementation of the Bylaws, the current Site-specific Chiefs of Staff, leaders of equivalent title(s), or designees shall meet as an Interim Medical Executive Committee to establish Policies and Procedures required to support the election of Officers that shall comprise the Medical Executive Committee. The Interim Medical Executive Committee shall also develop other Policies and Procedures that are required for successful implementation of the Bylaws. All policies, procedures, and other documents developed by the Interim Medical Executive Committee shall be approved prior to implementation. When all members of the Medical Executive Committee have been elected and/or appointed in accordance with the Bylaws and associated Policies and Procedures, the Interim Medical Executive Committee shall transition authority to the Medical Executive Committee.

ARTICLE III
PURPOSE AND RESPONSIBILITIES

1. The purposes of the Medical Staff are:
   - 1.1. To be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual Practitioners and the obligations of Medical Staff membership may be fulfilled;
   - 1.2. To serve as the primary means for accountability through the Medical Executive Committee to the Board of Directors for the appropriateness of the professional performance and ethical conduct of its members and affiliates and to strive toward assuring that the pattern of care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts with the resources locally available;
   - 1.3. To provide a means through which the Medical Staff may participate in the Hospitals' or Campuses' policy making and planning processes; and
   - 1.4. To cooperate with medical schools and other accrediting bodies/educational institutions in undergraduate, graduate, post-graduate and continuing education programs through appropriately crafted inter-institutional agreements.

2. The responsibilities of the Medical Staff are:
   - 2.1. To provide that all Hospital and affiliated patients, regardless of age, sex, race, religion or national origin, shall receive appropriate care consistent with the Hospitals' available resources;
   - 2.2. To provide the means whereby the Medical Staff, working with the Board of Directors and Administration, addresses medico-administrative problems;
   - 2.3. To initiate and maintain Policies and Procedures for the operation and governance of the Medical Staff in the delivery of medical care;
   - 2.4. To provide education, maintain educational standards and encourage scientific research;
   - 2.5. To assure acceptable levels of performance of the Medical Staff Members by advising the Board of Directors with respect to appointments, reappointments, staff category, Departmental and Sectional assignments, and clinical privileges;

2.6. To participate in the continuous review and evaluation of the clinical activities of the Medical Staff and to initiate and pursue Corrective Action with respect to Medical Staff Members and Allied Health Professionals where appropriate;
2.7. To monitor the quality of medical care in the Hospitals and account to the Board of Directors for the quality and efficiency of patient care rendered to patients in the Hospitals;
2.8. To assist the Board of Directors and Administration in quality improvement, utilization review and patient safety programs and initiatives;
2.9. To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to strive to meet those needs;
2.10. To exercise the authority granted by the Bylaws and the Board of Directors as necessary to adequately fulfill these responsibilities;
2.11. To aid the Hospitals in obtaining or maintaining appropriate accreditation status for the Hospitals and affiliated programs;
2.12. To conduct its affairs in a manner and atmosphere free of discrimination because of age, gender, religion, national origin, race, handicap, financial or professional affiliation status or any illegal discriminatory basis; and
2.13. To support the continued growth, development, and financial viability of the Hospitals and physicians that are a part of the Bylaws.
2.14. To promote an atmosphere of Just Culture for fair and equitable review of Practitioner performance, governance, and interaction.

ARTICLE IV
JUST CULTURE

1.1. The Medical Staff intends to foster an environment of Just Culture to create a safe working environment and culture that recognizes the humanness of decision making and behaviors. The Medical Staff desires to conduct peer review in a fair and objective manner, by focusing on the Substitution Test and Test of Intention when reviewing a specific case rather than solely on the outcome to avoid outcome bias. The Substitution Test will be used to determine whether a competent associate with an equivalent level of training and experience in the same situation could have acted in the same way as the provider subject to peer review. The Test of Intention will be used to determine the motive behind the provider's actions and whether there was a conscious violation of the standard of care. Just Culture is intended to be highlighted in the Bylaws and consistent throughout associated Policies and Procedures of the Medical Staff, specifically the Peer Review policy.
1.2. The Medical Staff recognizes six key tenets as developed by David Marx, JD, that are essential for a Just Culture:
1.2.1. Human Beings are imperfect;
1.2.2. Human Beings are prone to drift;
1.2.3. Human Reckless behavior is a rare event;
1.2.4. Only those that possess the same body of knowledge through education, training, and experience should evaluate the quality of the decision that is made;
1.2.5. Quality of a decision must be assess based on the "real time" situation; and
1.2.6. Outcome bias must be excluded from evaluation of the quality of the decisions.

ARTICLE V
MEMBERSHIP

1 Nature of Medical Staff Membership

1.1 Membership on the Medical Staff is a privilege that shall only be extended to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in the Bylaws. Membership on the Medical Staff shall confer on a Practitioner only such clinical privileges as are set forth in the notice of appointment, as well as such staff category and details as determined appropriate by the Board of Directors after review of the recommendations of the Medical Executive Committee under the Bylaws. Although a membership appointment means that the Practitioner is a member of the Medical Staff, the Practitioner is still subject to applicable Department and Site Policies and Procedures as further designated.

2 Basic Qualifications for Staff Membership

2.1 Only physicians, dentists, and podiatrists who can document their background, experience, training, and demonstrated competence, the cost-effective nature of their respective hospital practices, their adherence to the ethics of their profession and to the appropriate utilization and consumption of the resources of the Hospitals and/or nursing homes and any other affiliated locations at which they have clinical privileges, their good reputation, and their ability to work with others, with sufficient adequacy to assure the Medical Staff and the Board of Directors that all patients treated by them at the Hospitals will be given a high quality of medical care and that the operations of the Hospitals continue in a smooth and orderly fashion, shall be qualified for membership on the Medical Staff. While professional competence is the primary qualification for Medical Staff appointment, the needs of the Hospitals for additional Practitioners in a given area of practice or specialty, the ability of the Hospitals to support with personnel, supplies, and equipment, as well as the growth and development of the Medical Staff may be considered in granting or denying appointment or reappointment.

2.2 In addition, to be eligible to be and remain on the Medical Staff, a Practitioner shall have the burden of demonstrating that he/she possesses the following minimum requirements:

2.2.1 Be a graduate of an accredited medical, osteopathic, dental or podiatric school and be a qualified Practitioner of medicine, osteopathy, dentistry or podiatry;

2.2.2 Possess an unlimited license to practice medicine and surgery, podiatry or dentistry in the State of Wisconsin, including full compliance with all continuing education requirements of licensure;

2.2.3 Be and remain certified by a specialty board recognized by the American Board of Medical Specialties, American Osteopathic Association, American Dental Association or The American Board of Podiatric Surgery or be qualified to take, and, within five (5) years of initial eligibility, pass the examination. This requirement applies only to Practitioners who join the Medical Staff after July 1, 2020. Effective July 1, 2020, Practitioners who were current Medical Staff members just prior to the approval and implementation of the Bylaws will remain so regardless of Board Certification status. Those already meeting Board Certification requirements shall remain Board Certified following approval of the Bylaws. When a practitioner's Board Certification status or eligibility has lapsed at the time of re-appointment, the practitioner may be granted the opportunity, at the approval of the Board of Directors, to have a certain amount of time to regain Board Certification or

eligibility, but under no circumstance shall that period extend beyond the next re-appointment.

2.2.4 Have a record that is free from any state or federal felony conviction or any Caregiver Law conviction, except as is otherwise permitted in the Bylaws;

2.2.5 Be qualified legally, professionally, and ethically for the position to which the Applicant may be appointed;

2.2.6 Be free from physical or mental conditions that would impair his/her ability to exercise clinical privileges requested or to care for patients in the Hospitals and provide ongoing documentation of his/her compliance with all personal health requirements applicable to those who provide patient care in the Hospitals. Failure to provide proof of compliance with Hospital or Ascension Wisconsin's health policies including without limitation its Influenza Immunization policy (in the absence of an approved exemption on medical or religious grounds), within thirty (30) days after receiving written notice of delinquency describing the failure to comply, shall be deemed an automatic termination of medical staff membership and privileges. Such termination shall be deemed a voluntary resignation. There will be no review, fair hearing, or appeal of the termination based on failure to comply with such policies;

2.2.7 Possess the ability to work effectively with members of the Medical Staff, Administration, other Practitioners, and employees of the Hospitals;

2.2.8 Possess current valid professional liability insurance coverage in such form and in amounts satisfactory to the Hospitals;

2.2.9 Comply with all requirements regarding caregiver background checks as may be required by Wis. Stat. § 50.065 or any successor statute;

2.2.10 Reside and, when applicable, maintain primary office location within the proximity of the Hospitals that have opted into the Bylaws to ensure timely patient care as determined by local Hospital or Campus policy; and

2.2.11 Be eligible to participate in the Medicare and Medicaid programs.

2.3 The Board of Directors may, in its sole discretion, waive any of the minimum requirements upon the concurrence of the Medical Executive Committee to address special circumstances of individual Practitioners.

3. Basic Responsibilities of Staff Membership

3.1. The following requirements shall be applicable to every Medical Staff Applicant and Medical Staff Member and shall be conditions for consideration of applications for appointment and reappointment and for continued Medical Staff appointments. Each Member of the Medical Staff shall:

3.1.1. Provide patients with continuous quality care;

3.1.2. Abide by state and federal law and the Bylaws and all other lawful standards, policies, and rules of the Medical Staff and Hospitals, including but not limited to the Ascension Wisconsin Mission, Vision and Values;

3.1.3. Execute such Medical Staff, Department, Section, committee, and Hospital functions for which he or she is responsible;

3.1.4. Prepare and complete in a timely manner, as defined elsewhere by the Medical Executive Committee, the medical and other required records for all patients treated in the Hospitals or other affiliated locations as applicable;

3.1.5. Abide by ethical principles of his or her profession and the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the National Conference of Catholic Bishops;

3.1.6. Refrain from illegal fee splitting and other illegal inducements relating to patient referral;

3.1.7. Maintain continuous care and supervision of any patient admitted to a member Hospital. All members of the Medical Staff must furnish the Hospital with a current name of at least one alternate on the Medical Staff and shall explicitly delineate cross-coverage arrangements at the time of all periods of unavailability. Failure to provide patient coverage may be considered a serious breach of the Bylaws and may be grounds for Corrective Action;

3.1.8. Maintain eligibility to participate in the Medicare and Medicaid programs;

3.1.9. For any of the following situations, the practitioner must promptly notify the Hospital President, Chief of Staff, VPMA, Department Chair, or Medical Staff Office of his/her Primary Site, as soon as practicable but no later than five (5) business days and provide such additional information as may be requested regarding each of the following:

3.1.9.1. Revocation, limitation, or suspension of his/her professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal government agency relating to his/her professional license, or the imposition of terms of probation or other practice limitation by any government agency;

3.1.9.2. Cancellation or change of professional liability insurance coverage or participation in the Wisconsin Injured Patients' and Families Compensation Fund;

3.1.9.3. Receipt of a quality letter, an initial sanction notice, notice of proposed sanction, or of the commencement of a formal investigation or the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Human Services, the Wisconsin Department of Health Services, the Wisconsin Medical Examining Board or Dental Examining Board or Podiatric Examining Board, any law enforcement agency, or any health regulatory agency of the United States or the State of Wisconsin;

3.1.9.4. Receipt of notice of the filing of any suit against the Practitioner alleging professional liability in connection with the treatment of any patient and any settlement, judgment, dismissal, or other resolution of any such suit;

3.1.9.5. If the Practitioner becomes aware that he or she is the subject of any active investigation, involving his or her violation of any federal or state felony or violation of any Caregiver Law;

3.1.9.6. Being charged with any violation of any state or federal felony or any Caregiver Law.

3.1.9.7. Being convicted of any state or federal felony or any Caregiver Law; or

3.1.9.8. Termination, suspension, or restriction of staff membership or privileges, whether temporary or permanent, at any hospital or other health care facility, including without limitation any Ascension Hospital.

3.1.10. Failure to timely make notifications within the permitted five (5) business days of any of the items (3.1.9.1) through (3.1.9.8) above of this Section shall constitute an automatic withdrawal of an Applicant's pending application. Notwithstanding any

other term or conditions set forth in the Bylaws, any such automatic withdrawal shall be administrative and not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and Applicants whose applications are deemed to be automatically withdrawn pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

3.1.11. For Current Members of the Medical Staff, failure to timely make the notifications of the items specified in (3.1.9) of this Section may result in automatic suspension hereunder. If suspended, the suspension shall be reviewed by the Medical Executive Committee within thirty (30) days and the Medical Executive Committee can maintain or lift the suspension or terminate privileges and membership. Notwithstanding any other term or conditions set forth in the Bylaws, any such automatic suspension and/or termination under this notification section shall be administrative and not constitute an adverse action otherwise giving rise to any appeal or fair hearing rights and Members whose applications are deemed to be automatically suspended and/or terminated pursuant to this Section are not entitled to any rights to a fair hearing or appellate review.

3.1.12. At the request of the Medical Executive Committee or Board of Directors, agree to undergo a health examination by a physician acceptable to the Medical Executive Committee or Board of Directors or to submit other reasonable evidence of current health status that may be requested by the Medical Executive Committee or the Board of Directors. The presence of a physical or mental condition that would impair the Practitioner's ability to care for patients will not constitute a bar to the granting or exercise of clinical privileges if, with reasonable accommodation, the Practitioner can safely care for patients.

3.1.13. Participate and cooperate with the Hospital's Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with the applicable policies (and ensure that the Medical Staff has sufficient information about the Member to conduct such activities even if that necessitates providing information on care conducted at facilities outside of Ascension);

3.1.14. Pay such application fees, dues, or assessments as may be established by the Medical Staff from time to time; and

3.1.15. Participate in a program of continuing education designed to keep the Member informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care and to refresh him/her in various aspects of basic medical education. The method and scope of such program shall be determined by Medical Staff needs and patient care evaluation activities and may be satisfied by satisfying the continuing education requirements of the Wisconsin Medical Examining Board.

4. Conditions and Duration of Appointment

4.1. Appointments will be made by the Board of Directors upon recommendations of the Central Credentials Committee and Medical Executive Committee.

4.2. The Board of Directors will not take action on any application or refuse to renew an appointment or cancel an appointment previously made without prior conference and consultation with the Central Credentials Committee and the Medical Executive Committee, unless after request from the Board of Directors, both the Central Credentials Committee and the Medical Executive Committee decline to provide a recommendation within a sixty (60) day period.

4.3. Appointment to membership on the Medical Staff shall be for a period of up to two (2) years and assigned to a category of membership at each relevant practice Site based upon the criteria identified in the Bylaws and associated Policies and Procedures. Upon the expiration of the initial two (2) year appointment, unless there is reason not to do so, the term shall be extended as necessary so that the reappointment is handled in accordance with the standard reappointment procedures of the Medical Staff as more specifically described in Policies and Procedures.

4.4. Appointment to the Medical Staff shall confer on the appointee only such responsibilities and clinical privileges as have been granted by the Board of Directors in accordance with the Bylaws.

4.5. If the applicant does not meet the Board's membership or privileging criteria as identified in the Bylaws and the Policies and Procedures, his/her application will not be processed, and he or she will not be entitled to a fair hearing or any rights of due process provided under the Bylaws.

4.6. The method of review of Practitioners shall be determined by the Department of the Practitioner's Primary Site, subject to the approval of the MEC It shall include, at a minimum, participation in quality assurance studies and may include a random review of the charts and/or reports of patients receiving care or consultation from the Practitioner.

4.7. Practitioner shall comply with the Medical Staff duty requirements of the staff category the Practitioner is seeking, including meeting, education, and other staff services.

4.8. Medical Staff applications and applications for clinical privileges shall not be denied on the basis of race, color, religion, gender or national origin or on any illegal discriminatory basis.

5. Leave of Absence

5.1. A Practitioner seeking a leave of absence must submit the request to the Department Chair or, in the alternative, the Chief of Staff of the Practitioner's Primary Site. The applicable Department Chair or Chief of Staff that received the request will then review and present the request to the Central Credentials Committee. If approval is recommended, the request shall be escalated to the MEC. The Board of Directors may ultimately grant the request for leave of absence. The leave must be for a specific reason and specified length of time not to extend beyond one (1) year. Failure of a Practitioner to return or to make application for extension of leave shall be considered automatic resignation from the Medical Staff. Upon return from leave of absence, the Practitioner will be required to submit a request in writing to the Chairperson of the Department of the Practitioner's Primary Site who will review the request and make recommendation to the Central Credentials Committee, Medical Executive Committee, and the Board of Directors regarding reinstatement to the Medical Staff. If the current period of appointment has expired during the leave of absence, reapplication is required.

5.2. The Practitioner on leave of absence is to be notified of the reappointment process in the same manner as other members of the Medical Staff so that he or she may apply for reappointment and, if necessary, request extension of the leave of absence. Medical Staff members on leave of absence shall pay dues throughout their leave.

6. Contract and Medico-Administrative Practitioners

6.1. For a Practitioner whose clinical practice and Medical Staff privileges are covered fully or partially by means of an agreement between an outside physician group and a member Hospital, should such contract be terminated in accord with the terms and provisions of the contract, then such shall result in a resignation of the privileges covered by such contract. The Medical Staff membership of the Practitioner shall automatically terminate concurrently with the termination of the applicable agreement unless the Practitioner requests and is granted other clinical privileges. Unless provided to the contrary in the Practitioner's contract, such resignation shall not give rise to a hearing or further review in accord with the Bylaws.

6.2. If a Practitioner has an administrative contract with a Hospital or Site, removal from office shall be in accordance with that administrative contract unless the contract otherwise conflicts with the terms in the Bylaws or as otherwise determined by the Board of Directors.

7. Resignations. If a Member wishes to resign from the Medical Staff, the Member shall give such notice in writing to the President of his/her Primary Site and the Central Credentials Committee.

ARTICLE VI
CATEGORIES OF THE MEDICAL STAFF

1. The Categories of Membership of the Medical Staff shall include the following:
   1.1. Active
   1.2. Courtesy
   1.3. Member Only
   1.4. Voluntary
   1.5. Honorary

2. At the time of initial Appointment and with each subsequent Reappointment, each Practitioner shall designate the Site(s) at which he/she intends to practice, including his/her Primary Site. At the time of initial appointment and with each subsequent reappointment, the Department Chair of the Applicant's Primary Site shall recommend the Practitioner's category of membership at each designated Site based upon the Practitioner's level of commitment and activity at that Site. The Department Chair of the Applicant's Primary Site may also recommend a change in the Practitioner's membership category at one (1) or more Sites at any time during the Practitioner's appointment cycle when a sustained change is noted in the Practitioner's level of commitment and activity. All recommendations regarding category of membership shall reflect the criteria set forth in the Bylaws and shall require MEC and Board approval.

3. At the time of initial Appointment and with each subsequent Reappointment, the Department Chair of the Applicant's Primary Site shall recommend the Practitioner's category of membership at each designated Site based upon the Practitioner's level of commitment and activity at that Site. The Department Chair of the Applicant's Primary Site may also recommend a change in the Practitioner's membership category at one (1) or more Sites at any time during the Practitioner's appointment cycle when a sustained change is noted in the Practitioner's level of commitment and activity. All

recommendations regarding category of membership shall reflect the criteria set forth in the Bylaws and shall require Medical Executive Committee and Board approval.

4. All Medical Staff who maintain clinical privileges must participate and cooperate with the Hospital's Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with the applicable Policies and Procedures. This shall include the ability to demonstrate sufficient clinical activity to conduct OPPE and FPPE unless so waived by the Medical Executive Committee and Board. In those instances when clinical activity requirements have been waived by the Medical Executive Committee and Board, the Practitioner must, upon request, provide OPPE and/or FPPE information from his/her primary external hospital or as many other external facilities as necessary to satisfy the Medical Executive Committee and Board to ensure that the Medical Staff has sufficient information to conduct OPPE and FPPE. When the Practitioner demonstrates a sustained pattern of clinical inactivity and/or does not provide sufficient OPPE and/or FPPE information from his/her primary external hospital, the Medical Executive Committee may recommend reassignment of the Practitioner to the Membership Only Category pending Board approval.

5. Active Staff

5.1. Description and Responsibilities

5.1.1. The Active Staff shall consist of Practitioners who are professionally qualified, willing and able to devote their time to the interest of the Hospital or Campus, or regularly admit, attend, or consult on patients at the Hospital, Campus, or any provider-based ambulatory facility owned and/or operated by the Hospital or Campus. "Regularly admit, attend or consult" refers to ten (10) or greater patient encounters per year;

5.1.2. The Active Staff at a Hospital or Campus shall be responsible for fulfilling membership duties of the Active Staff, including but not necessarily limited to:

5.1.2.1. Emergency consultation and care;
5.1.2.2. Participation at designated meetings of the Hospital or Medical Staff;
5.1.2.3. Timely completion of mandatory training as assigned;
5.1.2.4. Active participation in the Hospital's continuing medical education program and/or post graduate medical education activities;
5.1.2.5. Active participation in patient care quality improvement programs, including Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE); and
5.1.2.6. Payment of dues and assessments as determined by Policies and Procedures.

5.1.3. In addition to the above, Active members at Sacred Heart Rehabilitation Institute must also attain acceptable qualifications in physiatry according to current national standards, or otherwise be qualified by virtue of training and experience to provide rehabilitation and medical management, and support charity care as assigned by the Medical Director.

5.2. Rights of the Active Staff

5.2.1. Members assigned Active Staff Status at one (1) or more Site(s) shall:

5.2.1.1. Admit or treat patients consistent with their clinical privileges and subject to the Bylaws and applicable Policies and Procedures;
5.2.1.2. Be entitled to one (1) vote on matters that call for a vote of the Medical Staff;
5.2.1.3. Be eligible to hold Officer positions;
5.2.1.4. Be eligible to hold a Department Chair position;
5.2.1.5. Be eligible to serve on Committees and to hold Committee Chair positions;
5.2.1.6. Be eligible to vote on Medical Staff matters presented at a specific Site when assigned Active status at that Site;
5.2.1.7. Be eligible to hold Site-specific Officer positions when assigned Active status at that Site;
5.2.1.8. Be eligible to serve as Local Department and/or Local Department Chair when assigned Active status at that Site;
5.2.1.9. Be eligible to participate at Local Department or Section meetings and vote on matters presented at Local Department or Section meetings;
5.2.1.10. Be eligible to hold Site-specific Committee Chair positions when assigned Active status at that Site;
5.2.1.11. Be eligible to serve on Site-specific Committees and vote on matters presented at Site-specific Committees; and
5.2.1.12. Conduct other business that may arise.

5.2.2. Service on the Emergency Department call roster shall be determined by the Local Department Chair as further defined in Policies and Procedures which may vary between Departments and Sites based on the type of services provided and available providers.

5.2.3. Active Staff members shall attend service, charity, or unassigned patients as assigned by the applicable Department Chair in accord with approved Department Policies and Procedures.

6. Courtesy Staff

6.1. Description and Responsibilities

6.1.1. The Courtesy Staff shall consist of Practitioners who are not willing or able to devote their time to the interest of the Hospital or Campus, but occasionally admit, attend, or consult on patients at the Hospital, Campus, or any provider-based ambulatory facility owned and/or operated either wholly or partially by the Hospital or Campus. "Occasionally admit, attend, or consult" refers to nine (9) or fewer patient encounters per year.

6.1.2. The Courtesy Staff shall pay dues and assessments as determined by Policies and Procedures.

6.2. Rights of the Courtesy Staff

6.2.1. Members assigned Courtesy Staff Status at one (1) or more Site(s) shall:

6.2.1.1. Admit or treat patients consistent with their clinical privileges;
6.2.1.2. Be eligible to participate at Local Department or Section meetings and vote on matters presented at Local Department or Section meetings;
6.2.1.3. Be eligible to serve on Site-specific Committees and vote on matters presented at Site-specific Committees;
6.2.1.4. Conduct other business that may arise, excluding those rights reserved for Active Staff.

6.2.2. Members assigned Courtesy Staff Status at one (1) or more Sites shall **NOT**:

6.2.2.1. Be entitled to one (1) vote on matters that call for a vote of the Medical Staff;
6.2.2.2. Be eligible to hold Officer positions;
6.2.2.3. Be eligible to hold a Department Chair position;
6.2.2.4. Be eligible to serve on Committees and to hold Committee Chair positions;
6.2.2.5. Be eligible to vote on Medical Staff matters presented at a specific Site;
6.2.2.6. Be eligible to hold Site-specific Officer positions;
6.2.2.7. Be eligible to serve as Local Department and/or Local Department Chair; and
6.2.2.8. Be eligible to serve as Site-specific Committee Chair.

6.2.3. Service on the Emergency Department call roster shall be determined by the Local Department Chair as further defined in Policies and Procedures which may vary between Departments and Sites based on the type of services provided and available providers.

7. Member Only Staff

7.1. Description and Responsibilities

7.1.1. The Member Only Staff may include the following:

7.1.1.1. Practitioners who require Medical Staff membership only to participate in insurance plans; and
7.1.1.2. Practitioners who demonstrate no clinical activity and no OPPE or FPPE data at a member Hospital or Campus for a sustained period of time.

7.1.2. Practitioners assigned to Member Only status may not be assigned another category of membership at another Site at same time.

7.1.3. Practitioners who are assigned to Member Only status shall not be assigned a Primary Practice Site or Department. When a Practitioner is assigned Member Only status, the Central Credentials Committee Chair shall review pertinent credentials information and make recommendations to the Medical Executive Committee and Board.

7.1.4. The Member Only Staff shall pay dues and assessments as determined by Policies and Procedures.

7.2. Rights of the Member Only Staff

7.2.1. Members assigned Member Only Staff Status shall **NOT**:

7.2.1.1. Admit or treat patients;
7.2.1.2. Exercise clinical privileges;
7.2.1.3. Be entitled to one (1) vote on matters that call for a vote of the Medical Staff;
7.2.1.4. Be eligible to hold Officer positions;
7.2.1.5. Be eligible to hold a Department Chair position;
7.2.1.6. Be eligible to serve on Committees and to hold Committee Chair positions;
7.2.1.7. Be eligible to vote on Medical Staff matters presented at a specific Site;
7.2.1.8. Be eligible to hold Site-specific Officer positions;
7.2.1.9. Be eligible to serve as Local Department and/or Local Department Chair;
7.2.1.10. Be eligible to serve as Site-specific Committee Chair.
7.2.1.11. Be eligible to participate at Local Department or Section meetings and vote on matters presented at Local Department or Section meetings;
7.2.1.12. Be eligible to serve on Site-specific Committees and vote on matters presented at Site-specific Committees; and
7.2.1.13. Conduct other business that may arise.

8. Voluntary Staff

8.1. Description and Responsibilities

8.1.1. Volunteer Staff shall consist of Practitioners who require Medical Staff membership and privileges to volunteer their services at Hospital-sponsored free clinics.

8.1.2. Appointees to the Volunteer Staff may exercise such clinical privileges as are granted by the Board of Directors upon recommendation of the Medical Executive Committee. These privileges are to be exercised only at the designated Hospital-sponsored free clinic(s).

8.2. Rights of the Voluntary Staff

8.2.1. Members assigned Voluntary Staff Status at one (1) or more Site(s) shall:

8.2.1.1. Exercise such clinical privileges as are granted by the Board of Directors upon recommendation of the Medical Executive Committee. These privileges are to be exercised only at the designated Hospital-sponsored free clinic(s); and

8.2.1.2. Conduct other business that may arise, excluding those rights reserved for Active and Courtesy Staff.

8.2.2. Members assigned Voluntary Staff Status shall not be required to:

8.2.2.1. Serve on the Emergency Department call roster.

8.2.3. Members assigned Voluntary Staff Status at one (1) or more Site(s) shall **NOT**:

8.2.3.1. Be entitled to one (1) vote on matters that call for a vote of the Medical Staff;
8.2.3.2. Be eligible to hold Officer positions;
8.2.3.3. Be eligible to hold a Department Chair position;
8.2.3.4. Be eligible to serve on Committees and to hold Committee Chair positions;
8.2.3.5. Be eligible to vote on Medical Staff matters presented at a specific Site;
8.2.3.6. Be eligible to hold Site-specific Officer positions;
8.2.3.7. Be eligible to serve as Local Department and/or Local Department Chair;
8.2.3.8. Be eligible to serve as Site-specific Committee Chair.
8.2.3.9. Be eligible to participate at Local Department or Section meetings and vote on matters presented at Local Department or Section meetings;
8.2.3.10. Be eligible to serve on Site-specific Committees and vote on matters presented at Site-specific Committees unless so waived by the Local Medical Executive Committee and approved by the Board of Directors.

9. Honorary Staff

9.1. Description and Responsibilities

9.1.1. The Honorary Staff shall consist of Practitioners who are no longer Active Staff members at a member Hospital or Campus but are honored by the Medical Staff for their outstanding professional reputation and exceptional service.

9.2. Rights of the Honorary Staff

9.2.1. The Honorary Staff shall be eligible to:

9.2.1.1. Serve on Committees (excluding Medical Executive Committees) and vote on matters presented at the Committees; and
9.2.1.2. Serve as Committee Chair (excluding Medical Executive Committees).

9.2.2. The Honorary Staff shall not be required to:

9.2.2.1. Pay dues or assessments;
9.2.2.2. Serve on the Emergency Department call roster;
9.2.2.3. Attend Medical Staff or other committee meetings unless an Office holder.

9.2.3. The Honorary Staff shall **NOT**:

9.2.3.1. Admit or treat patients;
9.2.3.2. Exercise clinical privileges;
9.2.3.3. Be entitled to one (1) vote on matters that call for a vote of the Medical Staff;
9.2.3.4. Be eligible to hold Officer positions;
9.2.3.5. Be eligible to hold a Department Chair position;
9.2.3.6. Be eligible to vote on Medical Staff matters presented at a specific Site;
9.2.3.7. Be eligible to hold Site-specific Officer positions;

9.2.3.8. Be eligible to serve as Local Department and/or Local Department Chair;
9.2.3.9. Be eligible to serve as Site-specific Committee Chair; and
9.2.3.10. Be eligible to participate at Local Department or Section meetings and vote on matters presented at Local Department or Section meetings.

ARTICLE VII
ALLIED HEALTH PROFESSIONALS

1. Allied Health Professionals (AHPs) are not members of the Medical Staff; however, their patient care activities are overseen by the MEC with approval from the Board of Directors. In accordance with the Bylaws and Policies and Procedures, the Medical Staff shall review the credentials, qualifications, and competency of Allied Health Professionals and forward recommendations to the Board of Directors for final approval. AHPs shall be further addressed and governed by associated Policies and Procedures.

2. A recommendation by the Medical Executive Committee and decision by the Board of Directors not to grant the requested privileges or scope of practice to an AHP or to suspend, terminate, discontinue privileges, or limit scope of practice shall entitle the affected individual to the procedural rights as described in the Policies and Procedures as applicable.

ARTICLE VIII
DEPARTMENTS AND SECTIONS

The Medical Staff shall be organized into Departments that shall promote uniformity in best practices among those medical specialties and/or subspecialties that provide care, treatment and/or services to similar patient populations. The designation and assignment of medical specialties and/or subspecialties to Departments shall be further described in associated Policies and Procedures. Departments shall meet regularly and at least once per year. Departments may be further subdivided by geographic location, such as by Site, for Members practicing a specialty of medicine. The Departments may be further subdivided, such as by Site(s), or based on subspecialty. Each Department as described in the Policies and Procedures shall meet on a regular basis consistent with those Policies and Procedures. Local Departments of subspecialty Sections may meet on an as needed basis or as called by a Local Department or Section Chair as consistent with Policies and Procedure.

ARTICLE IX
OFFICERS AND DEPARTMENT CHAIRS

1. General. In addition to what is contained in the Bylaws, the specific duties of Officers, Officer positions, and nominating or election procedures may be further outlined in Policies and Procedures. The Board of Directors reserves the right to waive or modify any qualifications of an Officer at any level of governance in extenuating circumstances.

2. MEC Officers. The Officers of the Medical Staff shall include the Chief of Staff and the Vice Chief of Staff. The Officers shall be elected to serve on the Medical Executive Committee. As discussed below, the MEC delegates authority to Members of the Medical Staff at specific Sites to create LMECs by which they are allowed to govern themselves on issues relating to local matters subject to Board of Directors approval and MEC oversight.

3. Qualifications. All Officers of the Medical Staff must:

3.1.1. Be an Active member of the Medical Staff at time of nomination and must remain Active and in good standing throughout his/her term in office.
3.1.2. Demonstrate competence in his/her field of practice and demonstrated experience and ability to direct the medico-administrative aspects of Medical Staff activities. Nominees may be required to provide a position statement or background information for their candidacy.
3.1.3. Have no pending or adverse recommendations related to their Medical Staff status or clinical privileges.
3.1.4. Actively participate in Medical Staff affairs, foster a community of Just Culture, and demonstrate an interest in quality care.

4. Chief of Staff and Vice Chief of Staff nomination and election procedure.

4.1. Nomination Procedure. As soon as possible following elections of Local and/or Site Chiefs of Staff, the Site Chiefs of Staff or their designees shall meet as the Nominating Committee to prepare a slate of two (2) to three (3) qualified candidates for the office of Chief of Staff. Each candidate must be granted the opportunity to accept his/her nomination and the final slate of candidates must be identified at least ten (10) days in advance of the election. The elected Chief of Staff is permitted to hold more than one position such as a Site Chief of Staff or Department Chair.
4.2. Election Procedure. Once the candidates for Chief of Staff are chosen and have accepted the possibility of obtaining the office of Chief of Staff, the MEC shall elect the Chief of Staff. Once elected, the Chief of Staff is to appoint the Vice Chief of Staff. The Chief of Staff is encouraged to choose one of the other nominees from the Chief of Staff election as the Vice Chief of Staff. Because the Site Chiefs of Staff are elected directly by the Sites they serve, they are entrusted to nominate and elect the Chief of Staff as opposed to a direct election of the Chief of Staff by all Members.

5. Term of Office. Officers shall be elected in accordance with the Bylaws and shall serve a two (2) year term beginning on July 1 (or the day after Board approval if the Board has not approved the Officer's election prior to July 1). Elected Officers are restricted to two (2) full consecutive terms in the same office, unless recommended by the Medical Executive Committee and approved by the Board of Directors. Length of a Term may be extended in special circumstances if recommended by the members of the Medical Executive Committee and approved by the Board of Directors.

6. Vacancies. In the event of a temporary absence, incapacitation, or resignation of the elected Chief of Staff, the Vice Chief of Staff shall immediately serve the remainder of the term. If neither the Chief of Staff nor Vice Chief of Staff are available to a resolve an issue, then the MEC shall recommend an interim replacement to the Board of Directors for approval.

7. Removal from Office. An Officer may be removed from office with or without cause by the Board of Directors upon receipt of a recommendation of a two-thirds majority of the Medical Executive Committee, excluding the Chief of Staff as a voting member. Or by petition of ten percent (10%) of the Active members of the Medical Staff and a subsequent two-thirds (2/3) affirmative vote by ballot of the Active Medical Staff members for MEC officer positions or two thirds (2/3) affirmative vote by the Site Active Medical Staff members for Site Officer positions. Permissible bases for removal from office include, without limitation, failure to meet the qualifications for office, and failure to perform the duties of the office.

8. Officer Duties.

8.1. The Chief of Staff shall:

8.1.1. Serve as the Medical Staff's advocate and representative to the Board of Directors and Administration;
8.1.2. Evaluate the effectiveness of the hospital's credentialing, privileging, and quality processes and report results to the Board of Directors, Medical Executive Committee, and Administration;
8.1.3. Act in coordination and cooperation with the Site-specific Officers and the Administration or designee(s) regarding matters of mutual concern that impact the Medical Staff;
8.1.4. Serve as a member of all Medical Executive Committees that serve the Medical Staff;
8.1.5. Be responsible for the enforcement of Bylaws and associated Policies and Procedures for implementation of sanctions where they are indicated, and for compliance with the procedural requirements under the Bylaws when Corrective Action is requested against a Medical Staff member;
8.1.6. Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff as a whole;
8.1.7. Call, preside at, and be responsible for the agenda of all meetings of the Medical Executive Committee;
8.1.8. Appoint Medical Staff members to serve as Chair of Medical Executive Committees when such committees serve the Medical Staff as a whole;
8.1.9. Act as a spokesperson for the Medical Staff as a whole in its external professional and public relations;
8.1.10. Act in coordination and cooperation with the Board and member Hospital administrators in all matters of mutual concern within a member Hospital;
8.1.11. Be responsible for the educational activities of the Medical Staff; and
8.1.12. Be the spokesperson for the Medical Staff in its external professional and public relations.

8.2. The Vice Chief of Staff shall support the Chief of Staff and accept above duties of the Chief of Staff as delegated by the Chief of Staff and immediately fulfill the Office of Chief of Staff in the event of the vacancy by the Chief of Staff.

9. Local and Site Officer Nomination and Election Procedure.

9.1. Nomination and Notice Procedure. During the latter half of the odd numbered Medical Staff Years, notice shall be sent to the Active Medical Staff of an LMEC informing them of an upcoming election for Site Chiefs of Staff and, as applicable, Site Vice Chiefs of Staff. Active Members shall be invited to nominate candidates that meet the qualifications of this Article for the Site or Local Chief of Staff position(s). Any questions regarding a Practitioner's qualifications shall be reviewed by the LMEC with oversight from the MEC and final approval from the Board of Directors, if necessary.
9.2. Elections are intended to be held through an electronic voting process and should be completed prior to the end of the odd Medical Staff Year. A Member may request the medical staff office for the ballot in a different format, but such request shall not be granted additional time to review and cast votes. Members eligible to vote in an Officer election shall be the Active Staff Members at the Site where the Officer shall serve. Members eligible to vote will be notified of the electronic balloting process during the last half of the applicable year for the election they are requested to participate. Officers shall be elected from the nominees by a simple majority vote of those eligible voters who submitted their ballot prior to close of elections. In the event of a tie, the current Site or Local Chief of Staff will select three (3) members of the LMEC to determine the elected Officer through a process of discernment and final consensus.

10. LMEC Officers. Should a Site or multiple Sites choose to form an LMEC as permitted under the Bylaws given the delegated authority by the MEC, then the LMEC must have at least one Officer which will be known as the Local Chief of Staff. The Local Chief of Staff shall be appointed by the LMEC after the Site Chief of Staff elections as contemplated in section 9 of this Article. Members at the Site or collection of Sites subject to the LMEC. The LMEC may choose to appoint or elect a Local Vice Chief of Staff. The qualifications and procedures relating to Officers of the MEC as described in this Article shall apply to LMEC Officers unless otherwise waived by the Board of Directors upon recommendation from the MEC. Duties that apply to MEC Officers relating to the Medical Staff as a whole shall be applied appropriately to LMEC Officers in proportion to the Site(s) that have elected the Officers into the positions in which they serve (e.g. whereas the Chief of Staff has the duty to call MEC meetings, the LMEC Chief of Staff has the duty to call LMEC meetings. Similarly, petitions to remove an LMEC Officer would be based on the proportion of the Members of the Medical Staff at Sites that are a part of the LMEC). When a LMEC exists, the procedures as outlined in this Article only relate to the Active Members and Officers that are a part of the LMEC (i.e. eligible voters are only those Practitioners that are Active Medical Staff members at the Site(s) subject to the LMEC). The Local Chief of Staff shall preside over the LMEC and have the same duties as the Chief of Staff as applicable to his or her positions as the Local Chief of Staff and the Site(s) that are members of the LMEC.

11. Site Officers. Each of the member Sites shall have a Site Chief of Staff who shall be elected in accordance with this Article with the necessary qualifications as other Officers. The Site Chief of Staff may appoint a Site Vice Chief of Staff unless Site Policies and Procedures specify the need to elect a Vice Chief of Staff. The Site Chief of Staff shall have the duties of the Chief of Staff of the MEC as applicable to the specific Site of his or her position.

12. Department Chair and Department Vice Chair. The Medical Staff shall determine Departments, as described in Policies and Procedures, by which to organize the members of the Medical Staff. Each Department shall have a Department Chair and Vice Chair. Each Department Chair shall serve as a member of the MEC. The Department Chair and Vice Chair shall be nominated and elected in accordance to the provisions in this Article.

    12.1. Nominations and Elections of Department Chairs.

        12.1.1. Nominations for Department Chairs shall occur as soon as possible following elections of Local Department Chairs. The Local Department Chairs or their designees shall meet as the Nominating Committee to prepare a slate of one (1) to three (3) qualified candidates for the office of Chief of Staff. Each candidate must be granted the opportunity to accept his/her nomination and the final slate of candidates must be identified at least ten (10) days in advance of the election,

        12.1.2. Elections for Department Chairs Procedure. Once the candidates for Department Chairs are chosen and have accepted the possibility of obtaining the role of Department Chair, the then sitting MEC shall elect the Department Chairs. Once elected, the Department Chair is to appoint the Department Vice-Chair unless there are no other qualified candidates for Vice-Chair as determined by the Nominating Committee with oversight from the MEC. The Department Chair is encouraged to choose one of the other nominees from the Department Chair election as the Department Vice-Chair. Because the Local Department Chairs are elected directly by the Sites they serve, they are entrusted to nominate the Department Chair as opposed to a direct election of the Department Chair by all Department Members.

    12.2. Removal of Department Chair. A vote regarding removal of a Department Officer must follow procedure found in this Article except that the voting Members must be from the applicable Department. A Department Chair vacancy shall be filled by the Department Vice Chair.

12.3. Duties. The roles and responsibilities of the Department Chair shall include:

12.3.1. Oversight of clinically related activities of the Department;
12.3.2. Oversight of administratively related activities of the Department, unless otherwise provided by the Hospital(s) or Campus(es);
12.3.3. Continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges;
12.3.4. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Department;
12.3.5. Recommending clinical privileges for each member of the Department;
12.3.6. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Department or organization;
12.3.7. Integration of the Department or service into the primary functions of the organization;
12.3.8. Coordination and integration of interdepartmental and intradepartmental services;
12.3.9. Development and implementation of Policies and Procedures that guide and support the provision of care, treatment, and services;
12.3.10. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
12.3.11. Determination of the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
12.3.12. Continuous assessment and improvement of the quality of care, treatment, and services;
12.3.13. Maintenance of quality control programs, as appropriate;
12.3.14. Orientation and continuing education of all persons in the Department or service; and
12.3.15. Recommending space and other resources needed by the Department or service.
12.3.16. The Department Vice Chair shall assist the Department Chair in fulfillment of his or her duties as delegated and immediately fulfill the Office of Department Chair in the event of the vacancy of the position of Department Chair.

13. Local Department formation. Sites are permitted to organize into smaller Local Departments to conduct the duties of Departments on a Site or combined-Site level. A Local Department may be created to address the clinical issues of one particular Site or a group of Sites with similar clinical practices. In the event multiple Sites wish to participate under one Local Department, there will only be one Local Department Chair that will oversee all participating Sites with clinical services offered by the Local Department. Local Departments shall meet regularly and at least quarterly.

14. Local Department Chairs and Vice Chairs. In the event a Local Department is formed within a Department, there shall be a Local Department Chair. Local Department Chairs may assist the Department Chair with the duties outlined in this Article and shall report to the Department Chair for oversight. The directly elected Local Department Chair may appoint a Local Department Vice Chair of his or her choosing.

15. Local Department Chair Nomination and Election Procedure.

15.1. Nomination and Notice Procedure. During the latter half of the even numbered Medical Staff Years, notice shall be sent to the Active Medical Staff Members of a Department informing them of an upcoming election for Local Department Chairs. Active Staff Department Members shall be invited to nominate candidates that meet the qualifications of this Article for the Local Department Chair position. Any questions regarding a

Practitioner's qualifications shall be reviewed by the corresponding LMEC, if applicable, with oversight from the MEC and final approval from the Board of Directors, if necessary.

15.2. Elections are intended to be held through an electronic voting process and should be completed prior to the end of the even Medical Staff Year. A Member may request the medical staff office for the ballot in a different format, but such request shall not be granted additional time to review and cast votes. Members eligible to vote in a Local Department Chair election shall be the Active Staff Members of the Department at the Site(s) where the position will be held. Members eligible to vote will be notified of the electronic balloting process during the last half of the applicable year for the election they are requested to participate. Officers shall be elected from the nominees by a simple majority vote of those eligible voters who submitted their ballot prior to close of elections. In the event of a tie, the current applicable Site or Local Chief of Staff will select three (3) members of the LMEC to determine the elected Officer through a process of discernment and final consensus.

16. Subspecialty Sections. Departments and Local Departments may also be further subdivided into Sections based on specialty or subspecialty. Each subdivision by specialty will be known as a Section. Each Section shall have a Section Chair. Each Section Chair shall be appointed by the Department Chair or designee (such as a Local Department Chair) in consultation with the applicable Chief(s) of Staff. Sections and Section Chairs shall be responsible for the duties delegated to them by the Department and Department Chairs with oversight by the Department, MEC, and Board of Directors. Certain additional requirements may be further delineated in Policies and Procedures.

17. Academic and Administrative Chairs. The Board of Directors may determine, after receipt of recommendations from the Medical Executive Committee, that certain Departments, pursuant to affiliation agreements with teaching institutions or otherwise, may have a position of Academic Chairperson as well as an Administrative Chairperson. The Board of Directors may appoint the Academic Chairperson and/or the Administrative Chairperson. The Bylaws shall not preclude the Academic Chair and Administrative Chair being the same person. The job description for each such Academic Chairperson, method of selection and levels of accountability shall be approved by the Board of Directors, upon recommendations of the Medical Executive Committee and the relevant Hospital President.

18. Disclosure of Conflicts. It is the sole responsibility of Medical Staff officers and Medical Executive Committee members to disclose in writing to the Medical Staff, prior to the date of election or appointment, any personal, professional, or financial affiliations or relationship which could foreseeably result in a conflict of interest with their activities on behalf of or responsibilities of the Medical Staff. Disclosure procedure shall be further outlined in applicable Policies and Procedures depending on the scope of office for the Officer.

ARTICLE X
CREDENTIALING AND PRIVILEGES

1. Credentialing and Privileges

1.1. As further defined in Policies and Procedures, a Central Credentials Committee shall be established to review applications for all Sites under the Bylaws. The Medical Staff's credentialing and privileging process shall involve a series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to

membership on the Medical Staff and recommendations to grant or deny initial and renewed privileges.

1.2. The Central Credentials Committee shall oversee all credentialing of applications to Sites under the Bylaws. Any Site or group of Sites may choose to create a Local Credential Committee for further review of applications as delegated by the Central Credentials Committee. The functions and procedures of the Local Credentials Committee(s) may be further delineated in Policies and Procedures.

1.3. Initial appointments and re-appointments to the Medical Staff, including medical staff membership, membership category, and the determination whether to grant, deny, continue, revise, discontinue, limit or revoke specified privileges, shall be made by the Board of Directors after review and recommendation by the MEC and, in accordance with the Bylaws and associated Policies and Procedures. In those instances where the MEC has failed to make a recommendation six (6) calendar months after receipt of a complete application, the Board of Directors may act independently after reviewing reliable evidence with respect to the applicant's professional and ethical qualifications.

1.4. All requests for applications for appointment to the medical staff and requests for clinical privileges will be forwarded to the Central Credentials Committee. Upon receipt of the request, the Central Credentials Committee, Medical Staff Office, or designee will provide the applicant with an application package, which will include a complete set or overview of the Medical Staff Bylaws or a reference to an electronic source for this information. This package will enumerate the eligibility requirements for medical staff membership, privileges, and performance expectations for individuals granted medical staff privileges and/or membership.

1.5. Each application for appointment to the Medical Staff shall be signed by the applicant and shall contain a specific acknowledgement of the obligation to:

1.5.1. Provide continuous appropriate care to patients;
1.5.2. Pledge that he/she will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services;
1.5.3. Abide by the Bylaws and the Policies and Procedures of the Medical Staff and associated Hospitals;
1.5.4. Abide by the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops;
1.5.5. Release the associated Hospitals and their agents and employees from any and all liability arising from actions taken in good faith in connection with the investigation and evaluation of the applicant's credentials;
1.5.6. Release all third parties who provide information in good faith to the associated Hospitals, their employees and agents in connection with such investigation and evaluation from any liability;
1.5.7. Consent to and direct the sharing of health care services review information among the Hospitals and their related and affiliated institutions; and
1.5.8. Comply with the Standards of Conduct established under Ascension's Corporate Compliance Program.

1.6. If an applicant does not meet the Board's membership criteria as identified in the Bylaws and associated Policies and Procedures, his/her application will not be processed and he or she will not be entitled to a fair hearing or any rights or due process provided under the Bylaws.

1.7. The Central Credentials Committee will forward a completed application packet to the Local Department Chair, Local Department Chair designee, or Local Credentials Committee of the applicant's Primary Site (as further outlined in Policies and Procedures) for review and recommendation of medical staff membership, membership category, and the determination whether to grant, deny, continue, revise, discontinue, limit or revoke specified privileges. At any time during the review process, the Local Department Chair, or designee, may request further information from the applicant, request interviews, and confer with the Department Chair, other Local Department Chairs, Section Chairs, or other interested parties. The Central Credentials Committee shall recommend decisions to the MEC who shall in turn recommend approval or denial of applications to the Board of Directors. Applications for Medical Staff Membership may be obtained from the Medical Staff Office.

1.8. Each applicant accepted to membership on the Medical Staff shall be appointed for a period of up to two (2) years and assigned to a category of membership at each designated Site based upon the criteria identified in the Bylaws and associated Policies and Procedures. Upon the expiration of the initial two (2) year appointment, unless there is reason not to do so, the term shall be extended as necessary so that the reappointment is handled in accordance with the standard reappointment procedures of the Medical Staff as more specifically described in the associated Policies and Procedures.

1.9. Credentialing shall involve the collection, verification, and assessment of information regarding three critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s).

1.9.1. The license verification process shall be conducted prior to the granting of initial privileges, re-privileging, and at the time of each practitioner's professional license expiration, as outlined in associated Policies and Procedures.

1.9.2. The verification of an applicant's education and relevant training shall be obtained from the original source, whenever feasible, as outlined in associated Policies and Procedures. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source.

1.9.3. Experience, ability, and current competence in performing the requested privilege(s) shall be verified by peers knowledgeable about the applicant's professional performance. This process shall include an assessment for proficiency in the following six (6) areas: patient care; medical/clinical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice, as outlined in associated Policies and Procedures.

1.10. The Medical Staff shall establish and maintain a privileging process as outlined in associated Policies and Procedures.

1.10.1. Before a requested privilege is granted, it shall be determined whether sufficient space, equipment, staffing and financial resources are in place or are available to support the requested privilege.

1.10.2. The criteria for granting a new privilege(s) to a Practitioner with a record of competent professional performance at an associated Hospital or Campus subject to the Bylaws shall include information from the Practitioner's ongoing professional practice evaluation data at that Hospital or Campus.

1.10.3. When the practitioner does not have a record of competent professional performance at an associate that Hospital or Campus, current data shall be collected during a time-

limited period of privilege-specific professional performance monitoring conducted at that Hospital or Campus.

1.10.4. The exercise of privileges within each Department shall be subject to the rules of that Department. Decisions and actions taken within a Department involving a Practitioner at one Site shall be transmitted to all other affected Department Chairpersons.

1.10.5. All licensed independent practitioners who are responsible for a patient's care, treatment, and services via a telemedicine link at any Hospital or Campus subject to the Bylaws must be credentialed and privileged to do so at the Hospital or Campus through the relevant Medical Staff credentialing process.

2. Temporary Privileges

2.1.1. When the request for temporary privilege(s) applies to only one (1) Hospital or Campus, the President of that Hospital or Campus, acting on behalf of the Board of Directors and based upon the recommendation of the Chief of Staff or designee of that Hospital or Campus, may grant temporary clinical privileges to a qualified Practitioner who fulfills the criteria set forth below. When the request for temporary privilege(s) applies to two (2) or more Hospitals or Campuses, the President of the Practitioner's Primary Site, acting on behalf of the Board of Directors and based upon the recommendation of the Chief of Staff or designee of the Practitioner's Primary Site may grant temporary privileges to a qualified Practitioner who fulfills the criteria set forth below. On weekends and evenings, privileges may be granted verbally by the Administrator-on-call based upon subsequent receipt of documentation by the Central Credentials Committee.

2.2. The circumstances for which the granting of temporary privileges is acceptable include the following:

2.2.1. To fulfill an important patient care, treatment, and/or services need.

2.2.2. When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and Board of Directors.

2.3. Temporary privileges may be granted to the following:

2.3.1. Qualified Physicians, Dentists, Podiatrists, and Independent Allied Health Professionals who request temporary privileges to render care to a single patient or to render care to patients while awaiting a formal appointment decision from the Medical Executive Committee and the Board of Directors. For Physicians, this includes the privilege to admit patients in accordance with the directives set forth in the associated Bylaws and Policies and Procedures;

2.3.2. Dependent Allied Health Professionals who request temporary privileges to assist their sponsoring Physician(s) in rendering care to a single patient or to render care to patients while awaiting a formal appointment decision from the Medical Executive Committee and the Board of Directors; and

2.3.3. Advanced Practice Practitioners may request temporary privileges if the requesters also follow other requirements of these Bylaws and Policies and Procedures regarding collaboration agreements.

2.4. Temporary Privileges to fulfill an important patient care, treatment, and/or services need.

2.4.1. Temporary privileges may only be granted on a case by case basis when there is an important patient need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved.

2.4.2. On weekends and evenings, privileges may be granted verbally by the Administrator-on-call based upon subsequent receipt of documentation by the Central Credentials Committee.

2.4.3. When temporary privileges are granted to meet an important patient care need, current licensure and current competence will be verified by the Central Credentials Committee. Temporary clinical privileges for the visiting practitioner will be granted on a per case basis, not to exceed four (4) cases/episodes in a one-year period.

2.5. Temporary Privileges for an applicant whose file is pending review/approval of the Medical Executive Committee and Board of Directors.

2.5.1. Temporary privileges may be granted to a new applicant with a complete application that raises no concerns and is awaiting review and approval of the Medical Executive Committee and Board of Directors.

2.5.2. Temporary privileges may be granted only if the applicant:

2.5.2.1. Has no current or previously successful challenge to licensure or registration;

2.5.2.2. Has not been subject to involuntary termination of medical staff membership at another organization;

2.5.2.3. Has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges; and

2.5.2.4. Temporary privileges for the "practitioner with application pending" will be granted for ninety (90) days or until such time that the Hospital Board formally acts upon the request for clinical privileges, not to exceed one hundred twenty (120) days.

2.6. General Conditions for Temporary Privileges.

2.6.1. If granted temporary privileges, the Practitioner shall act under the supervision of the applicable Department Chairperson to which the Practitioner has been assigned and shall ensure that the Chairperson, or the Chairperson's designee, is kept closely informed as to his/her activities within the applicable Hospital or Campus.

2.6.2. Temporary privileges may be terminated at any time by the Hospital President or designee or the Chief of Staff or designee. Alternatively, the Chief of Staff or designee shall assign a member of the Medical Staff to assume the responsibility for the care of such practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff Member. A practitioner currently holding temporary privileges or one whose temporary privileges have been terminated shall not be entitled to the procedural rights in accordance with the Bylaws.

3. Emergency Privileges. In case of an emergency, any Medical Staff member or Allied Health Professional, to the degree permitted by his/her license, regardless of his/her Medical Staff Status or lack thereof, shall be permitted to do everything possible to care for the patient, using every facility in the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Medical Staff member or Allied Health Professional must

request the privileges necessary to continue to treat the patient. Should the Medical Staff member or Allied Health Professional not desire to request such privileges, the patient shall be assigned to an appropriate Medical Staff member. For purposes of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of the patient is in immediate danger, and in which any delay in administering treatment would increase that danger.

4. Disaster Privileges

4.1. Disaster privileges may be granted when the emergency management plan for a Hospital has been activated and the Hospital is unable to handle the immediate patient needs. The Ministry Market Executive, Hospital or Campus President or applicable Chief of Staff (or their designees) may grant Disaster privileges in response to a disaster, to providers of known competence, qualifications and quality, who hold medical staff membership and clinical privileges at another facility accredited by The Joint Commission or at a Medicare certified hospital. These credentials will be verified as soon as possible utilizing the Wisconsin Credentialing Asset Management System ("WICAMS") website or contacting the Emergency Operations Center ("EOC"), both of which are operated under the auspices of the Wisconsin Hospital Emergency Preparedness Plan ("WHEPP").

4.2. If the disaster is such that communication with the WICAMS website or EOC is not possible, the Ministry Market Executive or designee, Hospital or Campus President or applicable Chief of Staff (or their designees) may grant disaster privileges upon presentation of any of the following:

4.2.1. A valid, government-issued photo ID issued by a state or federal agency (e.g., driver's license or passport); and

4.2.2. At least one (1) of the following:

4.2.2.1. A current hospital photo ID card that clearly identifies professional designation;

4.2.2.2. A current license to practice (primary source verified);

4.2.2.3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team;

4.2.2.4. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

4.2.2.5. Identification by current hospital or medical staff members(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during the disaster.

4.3. Primary source verification of licensure begins as soon as the immediate situation is under control and shall be completed within 72 hours from the time that the volunteer practitioner presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible; there then must be documentation of the following:

4.3.1. Why primary source verification could not be performed in the required time frame;

4.3.2. Evidence of a demonstrated ability to continue to provide adequate care, treatment and services; and

4.3.3. An attempt to rectify the situation as soon as possible.

4.4. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

4.5. Those granted disaster privileges must practice under the direction of an existing member of the medical staff. Disaster privileges will terminate once the disaster situation subsides.

4.6. The grant of disaster privileges will be communicated to key departments via the process outlined in the Medical Staff policy. Credentialing files containing copies of verifications and other supporting documentation will be maintained for all providers who are granted disaster privileges.

4.7. Any individual identified in the Hospital or Campus' disaster plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

ARTICLE XI
PROFESSIONAL PRACTICE EVALUATION

1. Peer Review

1.1. The Medical Staff shall develop and maintain systematic peer review processes to ensure that Members provide safe, quality patient care. Peer review, as further described in associated Policies and Procedures, may include a variety of processes including at minimum, case review, ongoing professional practice evaluation, and focused professional practice evaluation.

1.2. All peer review activities shall be confidential and entitled to protection under applicable state and federal laws including, without limitation, the Healthcare Quality Improvement Act of 1986 and Wisconsin State Statute Sections 146.37 and 146.38. All reports and records shall be marked confidential and maintained by Medical Staff Services and/or designated Quality and Clinical Data Management Departments.

1.3. As further described in Policies and Procedures, Practitioners may be required to provide information from outside entities. In such event, the Medical Staff Office will follow procedures and attempt to cooperate with the physician to obtain the necessary materials in a reasonable fashion. However, ultimately the responsibility lies with the Practitioner to provide the necessary review information. The relevant reviewing body shall determine, within a reasonable standard, the amount of information necessary for thorough review that is consistent with policy.

2. Focused Professional Practice Evaluation

2.1. A period of Focused Professional Practice Evaluation (FPPE) shall be implemented when privileges are initially granted, when new privileges are granted to any currently privileged practitioner, and in response to concerns regarding the provision of safe, high quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend. FPPE is a routine step of peer review; it is not Corrective Action, as described in the Bylaws. FPPE shall be implemented in accordance with the Bylaws and associated Policies and Procedures.

2.2. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the Practitioner's current clinical competence, practice behavior and ability to perform the requested privilege.

2.3. Information for FPPE includes, as appropriate, chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient, as further outlined in associated Policies and Procedures.

3. Ongoing Professional Practice Evaluation

3.1. Ongoing Professional Practice Evaluation (OPPE) is the routine ongoing monitoring and evaluation of current competency for those members of the Medical Staff who currently hold clinical privileges. OPPE data may be obtained from a variety of sources including, for example, individual case review, aggregate performance measures such as rate, rule, or review indicators, as well as referrals for adverse events. OPPE is a routine step of peer review – it is not Corrective Action, as described in the Bylaws. OPPE shall be implemented in accordance with the Bylaws and associated Policies and Procedures.

3.2. Relevant information obtained from the OPPE process shall be integrated into Medical Staff performance improvement activities. Such information shall help determine whether existing privileges should be maintained, revised, or revoked.

3.3. The Department Chair at the Practitioner's Primary Site may recommend revision of membership category at any time during the Practitioner's appointment cycle when a sustained change is noted in the Practitioner's clinical activity and Hospital or Campus commitment. Such recommendation requires Medical Executive Committee and Board approval.

ARTICLE XII
HISTORY AND PHYSICAL

1. A complete medical history and physical examination ("H&P") shall be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with federal law[1], state law, administrative code[2], and Medical Staff or Hospital or Campus Policy prior to surgery.

2. The H&P must be completed no more than thirty (30) days before or twenty-four (24) hours after admission for each patient but prior to surgery or a procedure requiring anesthesia services. For a medical history and physical examination that was completed within thirty (30) days prior to admission, an updated H&P regarding the patient's condition must be completed within twenty-four (24) hours after admission but prior to surgery or a procedure requiring anesthesia services, whichever comes first. The H&P conducted or updated upon admission must be completed or authenticated by a licensed practitioner who is credentialed and privileged by the Medical Staff. The Hospital or Campus shall record each patient's medical history and physical examination, including updates, in the medical record within twenty-four (24) hours after admission but prior to surgery or a procedure requiring anesthesia. The minimum required content of an H&P is delineated in the Policies and Procedures.

ARTICLE XIII
MEDICAL STAFF DUES

Annual Medical Staff dues shall be governed by the most recent action taken by the MEC as more specifically described in the Policies and Procedures. Invoices for dues will be distributed to Medical Staff members and Allied Health Professionals in accordance with Policies and Procedures. Failure to abide by

timeline payment deadlines as outlined in Policies and Procedures shall constitute a resignation from the Medical Staff and shall not be subject to any procedural rights set forth in the Bylaws.

ARTICLE XIV
COMMITTEES

1. Appointments and Functions.

    1.1. There shall be such standing and special committees of the Medical Staff as are necessary to perform the functions required by the Bylaws.

    1.2. The Board of Directors delegates each committee to create internal records regarding attendance and participation which are subject to MEC and Board approval to ensure quality and effective performance by the committees.

    1.3. The Chair or otherwise highest-ranking officer, or his or her designee, may appoint ad hoc members to any committee. The ad hoc member shall be limited in scope and time to specific issues requiring additional assistance. Examples of ad hoc committee appointments include an additional member containing particular expertise in a field of medicine in conducting technical peer review of cases in which substantive knowledge of the medical field is needed.

2. Standing Committees.

    2.1. Medical Executive Committee ("MEC").[1]

        2.1.1. Composition. The voting membership of the MEC shall consist of the Site Chiefs of Staff and the Department Chairs.

        2.1.2. Officers. The Chief of Staff and Vice Chief of Staff shall serve as Officers of the MEC.

        2.1.3. Administrative Members. The Hospital and Campus Presidents, Vice President(s) of Medical Affairs, and Chief Nurse Officers, or their designee, shall each be ex-officio members of the MEC without power to vote. Other administrative members of Hospitals, Campuses, or other Ascension entities may be invited to participate on an ad hoc basis.

        2.1.4. Duties.

            2.1.4.1. Represent and act on behalf of the Medical Staff between meetings of the Medical Staff, subject to such limitations as may be imposed by the Bylaws. The authority delegated to the MEC may be limited or removed by the Medical Staff by amending the Bylaws;

            2.1.4.2. Oversee the quality, ethical standards, and behavior of the Medical Staff. The MEC may delegate LMECs to initiate policies and new procedures to institute best practices for patients served by the Medical Staff. The MEC may also delegate to LMECs initiation of investigations into Medical Staff Member behavior and possible Corrective Action, if any. However, no official policies may be implemented or Corrective Action taken without approval from the MEC;

[1] Wis. Admin. Code § DHS 124.12(8)(b)

2.1.4.3. Receive, review, and resolve significant discrepancies or disputes related to membership, credentialing, and privileging.;
2.1.4.4. Oversee the process for Corrective Action and Fair Hearing/Appellate Review in accordance with the procedures set forth in the Bylaws.
2.1.4.5. Oversee the process for summary suspension when served in accordance with the procedures set forth in the Bylaws;
2.1.4.6. To coordinate the activities and general policies of the Local Medical Executive Committees to ensure consistent practice with broader system and Policies and Procedures;
2.1.4.7. To receive and act upon committee reports;
2.1.4.8. To implement policies of the Medical Staff;
2.1.4.9. To provide liaison between the Medical Staff, the Hospital Presidents, and the Board of Directors;
2.1.4.10. To recommend action to the Hospital Presidents and the Board on matters involving the Medical Staff;
2.1.4.11. To make recommendations to the Board of Directors on matters including, but not limited to, the Medical Staff's structure, and the process used to review credentials and delineate privileges, and the MEC's review of and actions on reports of Medical Executive Committees, Departments and other groups;
2.1.4.12. To recommend applicants for Medical Staff membership, and to submit such recommendations to the Board of Directors.
2.1.4.13. To request evaluations of practitioners privileged through the Medical Staff process when there is a doubt about an Applicant's ability to perform the privileges requested;
2.1.4.14. To review periodically all information available regarding the performance and clinical competence of Practitioners with clinical privileges, and as a result of such reviews, to make recommendations for reappointments and renewal or changes in clinical privileges to the Board of Directors;
2.1.4.15. To have a mechanism to recommend Medical Staff membership termination;
2.1.4.16. To coordinate Medical Staff activities regarding the evaluation and improvement of medical care provided in the Hospitals including, but not limited to, assuring representation and active participation by the Medical Staff in quality initiatives;
2.1.4.17. To report at each Medical Staff meeting;
2.1.4.18. To review, at least biennially the Bylaws and recommend changes to such Bylaws for Medical Staff approval; and
2.1.4.19. The MEC may delegate any of these tasks to an LMEC but shall maintain oversight and review of recommendations made by the LMEC before a final recommendation is presented to the Board.
2.1.4.20. To perform any other responsibilities as may be required of a medical executive committee by accrediting or regulatory bodies, or as may reasonably be requested by the Board of Directors.

2.1.5. Meetings. The MEC shall meet at least four (4) times per year, in advance of the Board of Directors meeting, and shall maintain a permanent record of its proceedings and actions. The MEC Chief of Staff shall make a regular report to the Board of Directors on the activities of the Committee.

2.1.6. Quorum. A quorum shall consist of a majority of voting members of the Committee.

2.2. Local Medical Executive Committees ("LMEC"). The MEC delegates authority to Members of the Medical Staff at specific Sites to create LMECs by which they are allowed to govern themselves on issues relating to local matters.

2.2.1. Composition. LMEC Officers. As outlined in Article IX of the Bylaws, any formed LMEC shall have a Chief of Staff. The Chief of Staff may appoint a Vice Chief of Staff if necessary with the approval of the MEC.

2.2.1.1. If applicable, the LMEC shall be comprised of the Local Chief of Staff and any other Site Chiefs of Staff of Sites that may have opted together under the LMEC. The LMEC shall determine which Site Chief of Staff also serves as the LMEC when more than one Site Chief of Staff is a member of the LMEC. Other Officers may include a Local Vice Chief of Staff and other applicable Department Officers. All Officers must meet the qualifications as outlined in Article IX of the Bylaws.

2.2.1.2. The Hospital and Campus Presidents, Vice President(s) of Medical Affairs, and Chief Nurse Officers, or their designee, shall each be ex-officio members of the LMEC without power to vote. Other administrative members of Hospitals, Campuses, or other Ascension entities may be invited to participate on an ad hoc basis by the LMEC.

2.2.2. Duties. The MEC delegates its duties as outlined in Section 1.2.1 of this Article to the LMEC. The LMEC must receive approval from the RMEC before recommending any final action or policies to the Board.

2.2.3. Meetings. The LMEC shall meet at least four (4) times per year, in advance of the Board of Directors meeting, and shall maintain a permanent record of its proceedings and actions. The Local Chief of Staff, acting as Chair of the Medical Executive Committee, shall make a regular report to the Board of Directors on the activities of the Committee.

2.2.4. Quorum. A quorum shall consist of a majority of voting members of the Committee.

2.3. Central Credentials Committee.[2]

2.3.1. Composition. The Central Credentials Committee shall consist of at least six (6) representatives. Representatives shall be appointed by the Medical Executive Committee who should attempt to nominate representatives from multiple Sites and from multiple specialties. The Central Credentials Committee shall be allowed to appoint ad hoc members if certain expertise or additional input is needed. In addition to the below, the duties and responsibilities of the Central Credentials Committee shall be further outlined in Policies and Procedures regarding the credentialing and privileging process for Practitioners. The Central Credentials Committee may fulfill the below duties themselves or may delegate duties to Site specific Credentials Committees in accordance with Policies and Procedures.

2.3.2. Duties. The duties of the Credentials Committee shall be:

2.3.2.1. To investigate and verify the credentials of all Applicants for membership and delineation of clinical privileges in compliance with the Bylaws, and conduct such interviews as may be required;

2.3.2.2. To report to the Medical Executive Committee and make recommendations on each Applicant for Medical Staff membership and clinical privileges, as well as those

[2] Wis. Admin. Code § DHS 124.12(4)(b)

persons other than Practitioners seeking clinical privileges. Such report shall include specific consideration of the recommendations from the Department in which such Applicant requests privileges and from other committees as needed;

2.3.2.3. To review biennially all information available regarding the status and privileges of Medical Staff Members then scheduled for periodic review and as a result of such review to make recommendations for the granting of privileges, staff category, reappointments, and the aligning of Practitioners to the various departments or services;

2.3.2.4. To investigate any breach of ethics that is reported to it;

2.3.2.5. To review and evaluate criteria developed by the Departments with regard to privileges, and report on same to the Medical Executive Committee;

2.3.2.6. To review and evaluate the certification and credentials of Allied Health Professionals, including specific consideration of the recommendation from the Department in which such Applicant requests privileges and from the Medical Executive Committee and report to the Medical Executive Committee with a recommendation;

2.3.2.7. To coordinate its activities with the Medical Staff Professional Review Committee by means of ongoing committee interaction as needed.

2.3.2.8. To oversee any Hospital or Site-Specific Credential Committees that may be created consistent with specific credentialing Policies and Procedures to be developed and approved by the Medical Executive Committees.

2.3.3. Meetings. The Credentials Committee shall meet at least two (2) times per year, and more often if necessary, to review applications and shall maintain a permanent record of its proceedings and actions

2.4. Local Credentials Committees. The Central Credentials Committee delegates authority to Members at specific Sites to create Local Credentials Committees to assist in review and processing of applications. Local Credentials Committees must abide by the duties and Policies and Procedures of the Central Credentials Committee. If formed, the Local Credentials Committee must meet at least four (4) times per year.

2.5. The Medical Executive Committee shall establish interdisciplinary Professional Review Committees for the purpose of conducting professional review. If needed, the Medical Executive Committee may establish more than one professional review committee based on Site, Department, Specialty, or for any other reason or permit LMECs to create additional Professional Review Committees which shall by overseen by the Medical Executive Committee.

2.5.1. Composition. The membership of Professional Review Committee will be interdisciplinary and include standing physician members of the particular Department(s), standing physician members from other appropriate specialties and ad hoc physician members from additional specialties as indicated. In addition, the Committees will be supported by appropriate Hospital leadership representative(s) and Quality Improvement personnel assigned to the Committee. Resident physicians may participate at the discretion of the Committee Chair. The Medical Executive Committee may appoint the Professional Review Committee Chair.

2.5.2. Duties. The Professional Review Committee is responsible to conduct concurrent and retrospective review of the members of the applicable Department(s). The Professional Review Committee shall:

2.5.2.1. Monitor Medical Staff performance through the use of prospective quality indicators;
2.5.2.2. Review all cases that vary from screening indicators;
2.5.2.3. Determine compliance with established standards of care;
2.5.2.4. Make recommendations for Corrective Action to the Department Chair or Site Chief of Staff (as appropriate) when standards of care are not met;
2.5.2.5. Report the results of aggregated and profiled quality review findings to the Medical Staff Professional Review Committee, the Department Chair and the Medical Staff Office a minimum of annually, and more frequently as indicated or requested;
2.5.2.6. Provide specific feedback to a referring Professional Review Committee for each referred situation, that addresses the issues raised;
2.5.2.7. Provide acknowledgement to referring entities other than a Professional Review Committee or Department Chair, indicating only that the referral was received, will be reviewed and appropriately acted upon; and
2.5.2.8. Provide reports on quality improvement activities to the Medical Staff Professional Review Committee as requested.

2.5.3. Meetings. Professional Review Committees will meet regularly according to the needs of the review activity, but no less than quarterly.

The Medical Executive Committee may establish other standing committees as deemed necessary and implement corresponding Policies and Procedures regarding the composition, duties, and meeting frequency of those committees.

ARTICLE XV
MEETINGS OF THE MEDICAL STAFF

1. Regular meetings of the Medical Staff as a whole shall be held as needed but not less than at least one (1) meeting per calendar yea. The Chief of Staff shall preside at these meetings and report on matters on behalf of the Medical Executive Committee. Each Site-specific Chief of Staff shall report on matters on behalf of his/her respective Medical Staff Division.
2. Regular meetings of a Hospital or Campus Medical Staff as a whole shall be held as needed. The applicable Chief of Staff shall preside at these meetings and report on matters on behalf of the applicable Local Medical Executive Committee.
3. The Chief of Staff, Site Chief of Staff, or a majority of the applicable Medical Executive Committee, may call a special meeting of the Medical Staff at any time. The relevant Chief of Staff shall call a special meeting of the Medical Staff within thirty (30) days after receipt of a written request signed by not fewer than twenty-five (25) members of the Active Medical Staff stating the purpose for such meeting. The Chief of Staff shall designate the time and place of any special meeting. No business shall be transacted at any special meeting except as stated in the notice calling that meeting.
4. Electronic notice stating the location, date and time of any regular or special meeting of the Medical Staff shall be communicated to the Medical Staff not less than ten (10) calendar days before the date of such meeting. No amendment to the Bylaws or other material change in Medical Staff governance shall be acted upon at any regular or special meeting unless the notice calling the meeting so stipulated.

5. The Active Medical Staff members present at any duly noticed regular or special meeting of the Medical Staff shall constitute a quorum for purposes of amendments of the Bylaws and for all other actions. The action of a majority of the members present at a meeting shall be the action of the Medical Staff. Only Medical Staff members who are assigned to an Active category of membership may vote on matters presented at such meetings as further described in the Bylaws, but all members of the Medical Staff and ex officio members may have a voice in the deliberations.
6. Minutes of each regular or special meeting of the Medical Staff shall be documented, and shall include a record of attendance of members, and the action taken on each item of business.

ARTICLE XVI
IMMUNITY FROM LIABILITY

The following shall be express conditions to any individual Practitioner or Allied Health Professional's application or reapplication for, or exercise of, clinical privileges as a Member of the Medical Staff.

1. No person acting in good faith who participates in the review or evaluation of the services of health care providers or facilities or the charge for such services conducted in connection with any program organized and operated to help improve the quality of health care, to avoid improper utilization of the services of health care providers of facilities or to determine the reasonable charges for such services, or who participates in the obtaining of health care information is liable for any civil damages as a result of any act or omission by such person in the course of such review or evaluation. Acts and omission to which this immunity applies include, but are not limited to, acts or omission by peer review committees or hospital governing bodies in censuring, reprimanding, limiting or revoking hospital staff privileges or notifying the medical examining board or podiatry affiliated credentialing board or taking any other disciplinary action against a health care provider or facility and acts or omissions by a medical director in reviewing the performance of emergency medical services practitioners or ambulance service providers. The good faith of any person shall be presumed.[3]

2. Any act, communication, report, recommendation, or disclosure, with respect to any such Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility or organization, for the purpose of achieving or maintaining quality and efficient patient care in this or any other health care facility or organization shall be privileged to the fullest extent permitted by law.

3. The privileges and immunities established in this Article shall extend to the Hospital and any of the following individuals who have any responsibility for obtaining or evaluating the Applicant's or appointee's credentials, or for acting upon that individual's application and conduct at the Hospital: Members of the Medical Staff; the Board of Directors and its representatives; the Hospital President, and his/her designated representatives; other Hospital employees; consultants to the Hospital; and the Hospital's attorneys. The privileges and immunities in this Article shall also extend to third parties who supply information to any of the foregoing authorized to receive, release or act upon the information. For the purpose of this Article, the phrase "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board of Directors, the Medical Staff or Administration. There shall, to the fullest extent permitted by law,

[3] Wisconsin State Statute Section 146.37

be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or other disclosure and shall not be deemed to be a waiver of any privilege of confidentiality.

4. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

   4.1. Application for appointment or clinical privileges;
   4.2. Monitoring of any Practitioner;
   4.3. Periodic reappraisals for reappointment of clinical privileges;
   4.4. Corrective Action including suspension;
   4.5. Hearings and appellate reviews;
   4.6. Medical care evaluations;
   4.7. Utilization reviews; and
   4.8. Other Hospital or Campus, departmental, service, or committee activities related to quality and efficient patient care, professional conduct, the Applicant or Member's competence, character, ethics or behavior, or the orderly operation of the Medical Staff at any applicable Site.

5. The acts, communications, reports, recommendations and disclosures referred to in this Article may relate to an individual's professional qualifications, clinical competency, character, judgment, physical or emotional health, ethics, or any other matter that might directly or indirectly have an effect on patient care at member Sites or any other health care facility or organization.

6. As a condition of membership on the Medical Staff and exercise of clinical privileges at the Sites subject to these Bylaws, each individual hereby authorizes the Sites, the Medical Staff and its officers, and Department Chairs or designees to request and/or receive confidential peer review information related to the quality of care and/or professional competence or conduct of the individual from any other institution at which the individual holds medical staff membership or clinical privileges. In furtherance of the foregoing, each individual shall upon request from the MEC or Administration from a member Site execute releases to permit such records to be released to the Central Credentials Committee or other applicable committee. Execution of such releases is not a prerequisite to the effectiveness of this Article.

7. The consents, authorizations, releases, rights, privileges and immunities provided for the protection of the member Sites, Practitioners, Allied Health Professionals, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointments, shall also be fully applicable to the activities and procedures covered by this Article. All provisions in the Bylaws and in other forms used in the credentials process relating to authorizations, confidentiality of information and immunity from liability are in addition to the immunities provided by law and not in limitation thereof.

ARTICLE XVII
CONFIDENTIALITY

1. The Medical Staff recognizes that it is vital to maintain the confidentiality of certain information, for reasons of both law and policy. Practitioners participate in credentialing, peer review, and quality improvement activities, and others contribute to these activities, in reliance upon the preservation of confidentiality. The confidentiality of these activities, and of all Medical Staff records, is to be

preserved and these communications, information and records will be disclosed only in the furtherance of credentialing, peer review, and quality improvement activities, and only as specifically permitted under the conditions described in the Bylaws and Medical Staff policy. This requirement of confidentiality extends to the records and minutes of all Medical Executive Committees, to the records of all Medical Staff credentialing, peer review and quality improvement activities, to the credentials and peer review files concerning individual Practitioners, and to the discussions and deliberations which take place within the confines or under the aegis of Medical Executive Committees.[4]

2. Each Medical Staff member and credentialed Allied Health Professional with privileges, by acceptance of appointment or reappointment, therefore pledges to: (1) maintain all such information and any and all discussions and deliberations regarding the same in strict confidence; (2) agree to make no disclosures of such confidential information outside of appropriate meetings, except when: (a) the disclosures are to another authorized member of the Medical or Allied Health Professional Staff or authorized employee of Hospital and are for the purposes of conducting legitimate Medical Staff affairs; (b) the disclosures have been authorized, in writing, by the CEO or designee and the Chief of Staff; or (c) as otherwise permitted by the Medical Staff Policy. Any such disclosures shall be made only in a private setting for the specified purpose regarding the disclosure.

ARTICLE XVIII
AMENDMENT, ADOPTION, AND OPT OUT OF THE BYLAWS

1. Medical Staff Responsibility and Authority. The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and directly propose recommendations to the Board of Directors regarding Bylaws and Amendments thereto, which shall be effective when approved by the Board of Directors. Such responsibility and authority shall be executed in good faith and in a reasonable, timely, and responsible manner, so as to have Bylaws of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review. The Bylaws shall be reviewed as needed by the Medical Executive Committee to determine if any amendments are necessary. Approval of amendments to the Bylaws may not be delegated to the Medical Executive Committee unless otherwise described in this Article.

2. Methodology. The following mechanisms apply to amendments and adoption of the Bylaws.

   2.1. The Bylaws may be revised or amended by a majority of votes cast by the Active Staff Members eligible to vote who are present at any Medical Staff meeting called for such purposes, or by a majority of the votes cast by the Active Staff Members eligible to vote in a mail ballot, provided that fourteen (14) days prior written notice accompanied by the proposed alterations has been given to the voting Members of the Medical Staff by the Medical Executive Committee. Once approved by the Active Members eligible to vote, the amendments shall be forwarded to the Board of Directors for approval. A mail balloted vote may be conducted via paper mail ballots or electronic mail. Electronic ballots are presumed to be preferred. Physicians eligible to vote may request a ballot in a different format; such request shall be honored as quickly as possible, but it will not automatically increase the amount of time in order to review and cast the ballot.

   2.2. Amendments may be proposed by written petition to the Medical Executive Committee Chief of Staff if submitted by ten percent (10%) of the eligible voting Active Staff Members, by a Medical

[4] Wisconsin State Statute Section 146.38

Executive Committee member, or by any standing committee. The Medical Executive Committee Chief of Staff shall present the petition for discussion to the Medical Executive Committee within sixty (60) days. Following its review and comment, the Medical Executive Committee shall present the proposed amendment in writing to the Active Staff Members eligible to vote as herein required.

2.3. The Medical Executive Committee has the power to adopt such amendments to the Bylaws as are, in the Committee's judgment, technical or administrative modifications or clarifications; reorganization, rebranding, or renumbering; or amendments necessary because of spelling, punctuation, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Board of Directors within ninety (90) days of adoption by the Medical Executive Committee. The action to amend, in such circumstances, may be taken by motion acted upon in the same manner as any other motion before the Medical Executive Committee.

2.4. Amendments to the Bylaws are accomplished through a cooperative process involving both the Medical Staff and the Board of Directors and are effective upon approval by the Board of Directors. The Board of Directors gives full consideration to the recommendations and views of the Medical Staff before taking final action.

2.5. All Medical Staff Members shall be advised in writing of Bylaws changes that are implemented pursuant to the procedures described above, and they will be provided with revised texts or copies of the revised affected pages, as appropriate.

2.6. Should the Bylaws ever require urgent amendment if necessary to comply with law or regulation, the MEC may provisionally adopt the amendment and the Board of Directors may provisionally approve of the amendment until such time as the normal amendment procedures of the Bylaws may be followed.

3. Adoption. The Bylaws, together with the Policies and Procedures, shall be effective when adopted by a majority vote of the Active Staff voting and have been approved by the Board of Directors and shall replace any previous Bylaws, Policies and Procedures unless the effective or implementation date is otherwise indicated at the time of voting. All members of the Medical Staff shall receive written notification of any amendments to the Bylaws once approved. The amended Bylaws shall be equally binding to the Board of Directors and the Medical Staff.

4. Medical Staff and Opt-Out. The Active Medical Staff at a Hospital that has elected to be governed by the Bylaws has the option to opt out of the Medical Staff. A majority of Active Medical Staff members who hold privileges at the Hospital (the "Eligible Members"), voting in the affirmative as described below is required to opt out of the Medical Staff created by the Bylaws. To hold a vote to opt out, a petition, signed by forty-five (45) percent of the Eligible Members must first be presented to the Medical Executive Committee ("MEC") and Board of Directors. Within sixty (60) days following the Board of Director's receipt of the written petition and its verification that the requisite number of bona fide signatures are present, the Board of Directors shall direct the MEC to hold an opt out vote at an in-person meeting held for that purpose. The MEC shall provide thirty (30) days' advance written notice to each of the Eligible Members of the Hospital subject to the petition, and the opt out vote shall occur by written ballot of those Eligible members present at the meeting. If the Eligible Members present at the in-person meeting represent a majority of the Eligible Members at the petitioning Hospital, and those Eligible Members present vote in the affirmative to opt out of the Medical Staff, then the Board of Directors will establish a separate medical staff at the Hospital under Bylaws substantially in the form as set forth in the Bylaws but for the provisions that created the Medical Staff and other governmental and organizational provisions. Should a vote be held by a Hospital Medical Staff's Eligible Members be held and not pass, another vote to opt-out shall not occur until two (2) years after the date of the previous opt out vote.

5. In the event that any hospital opt out of the Bylaws and later wants to opt back into the Medical Staff under the Bylaws or a new hospital not originally contemplated in the Bylaws wishes to join the Medical Staff, that hospital may do so according to the hospital's then applicable Bylaws. Should the interested hospital vote to join the Medical Staff, the MEC shall review and recommend to the Board of Directors whether to allow the hospital to join the Medical Staff. The Board of Directors shall review the recommendation and provide final determination regarding whether the hospital shall be admitted as a member of the Medical Staff.

ARTICLE XIX
COLLEGIAL EFFORTS TO CORRECT BEHAVIORS AND ADMINISTRATIVE TIME OUT

1. Terminology. In this Article, use of the term Chief of Staff is intended to refer to the applicable Chief of Staff of an LMEC where the potential Corrective Action issue is investigated or originated. Similarly, Administration, Hospital President, and VPMA, shall refer to the relevant administrative leader at the particular site where the Member or Practitioner has privileges or is being investigated.
2. Collegial Efforts to Correct Behaviors

2.1. The Hospital President or designee and Chief of Staff or designee will strive to use progressive steps, beginning with collegial and education efforts, to address questions relating to a Member's clinical practice and/or professional conduct. The goal of these progressive steps is to help the Member voluntarily respond and resolve questions that have been raised. All collegial intervention efforts by the Hospital President or designee and Chief of Staff or designee shall be considered confidential and part of the Hospital's performance improvement and professional peer review activities as defined by applicable state and federal law, and as addressed in the Articles relating to Immunities from Liability and Confidentiality.

2.2. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the Chief of Staff or designee and Hospital President or designee. Collegial intervention efforts may include but are not limited to the following:

2.2.1. Educating and advising Members of all applicable bylaws, policies, procedures, rules and/or regulations including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
2.2.2. Following up on any questions or concerns raised about the clinical practice and/or conduct and recommending such steps as proctoring, monitoring, consultation, or letters of guidance;
2.2.3. Sharing summary comparative quality, utilization, and other relevant information to assist Members to conform their practices to appropriate norms.

2.3. Following collegial intervention efforts, if it appears that the Member's performance does not improve, or in cases where it appears that collegial intervention is inappropriate, the Hospital President or designee and Chief of Staff or designee may request that the Local Medical Executive Committee authorize an investigation into the matter. If the Hospital

President or designee and Chief of Staff disagree whether an investigation is needed, the Local Medical Executive Committee will make the determination. If questions involve a member of the Local Medical Executive Committee, that member will recluse him/herself from such deliberations.

3. Administrative Time Out

3.1. As a part of its progressive approach to Member conduct and performance issues, the Local Medical Executive Committee may, with approval of the Hospital President or designee, give a Member one or more Administrative Time Outs, not to exceed five (5) total days of Administrative Time Out in a calendar year. The Administrative Time Out is intended, in good faith, to serve as a last resort by the Local Medical Executive Committee prior to making a recommendation to suspend or terminate membership or privileges for a significant period or permanently. During an Administrative Time Out, the Member must continue to fulfill his/her emergency patient call obligations, if any, but may not exercise any other clinical privileges except in an emergency situation or to address an imminent delivery. An Administrative Time Out may be instituted only under the following circumstances:

3.1.1. When the action that has given rise to the time out relates to an administrative policy of the Hospital or Medical Staff such as: completion of medical records, practitioner behavior or requirements for emergency department coverage; and

3.1.2. When the action(s) have been reviewed by the Local Medical Executive Committee and the Local Medical Executive Committee has determined that one or more of the above policies have been violated; and

3.1.3. When the Member has received prior notice regarding the conduct in question; and

3.1.4. When the affected Member has been offered an opportunity to meet with the Local Medical Executive Committee prior to the imposition of the Administrative Time Out. Failure on the part of the Member to comply with the Local Medical Executive Committee's request for a meeting will constitute a violation of the Bylaws and will not prevent the Local Medical Executive Committee from issuing the Administrative Time Out.

3.2. An Administrative Time Out will take effect after the Member has been given an opportunity to either arrange for his/her patients currently at the Hospital to be cared for by another qualified Member or until he/she has had an opportunity to provide needed care prior to discharge, but in no event later than forty-eight (48) hours after written notice from the MEC of the imposition of the Administrative Time Out. During this period, the Member will not be permitted to schedule any elective admissions, surgeries, or procedures. The Chief of Staff or designee will determine details of the extent to which the Member may continue to be involved with hospitalized patients prior to the effective date of the Administrative Time Out.

3.3. Issuance of an Administrative Time Out does not trigger hearing or appeal rights.

ARTICLE XX
DISCIPLINARY MEASURES

1. Terminology. In this Article, use of the term Chief of Staff is intended to refer to the applicable Chief of Staff of an LMEC where the potential Corrective Action issue is investigated or originated. Similarly, Administration, Hospital President, and VPMA, shall refer to the relevant administrative leader at the Site where the Member or Practitioner has privileges or is being investigated. All references to decisions made by LMECs are not final and are merely recommendations to the MEC based on the authority delegated to the LMEC by the MEC. The MEC shall review all recommendations from the LMEC and make a recommendation to the Board of Directors for final decision authority.

2. Corrective Action.

    2.1. Request for Corrective Action. As detailed elsewhere in the Bylaws, the MEC delegates to the LMECs the authority to initiate investigation into Corrective Action, but it reserves the right to approve all disciplinary decisions prior to final implementation and Board of Directors approval. Peer Review may be initiated by an LMEC. An LMEC is encouraged to seek expertise from Practitioners at other Sites, when appropriate, to further pursue a Just Culture in reviewing Practitioners. The MEC retains the right to review recommendations made by an investigating LMEC. The MEC shall recommend decisions regarding Peer Review to the Board of Directors for ultimate approval.

    Whenever the activities or professional conduct of any Practitioner are considered to be lower than the standards or aims of the Medical Staff for the quality of medical care and professional conduct, or to reflect poorly upon the reputation of the Medical Staff as a whole in the community, or to be disruptive to the operations of the Hospital, where the Practitioner fails to abide by the Bylaws or Policies and Procedures, or where the health of the Practitioner is believed to be potentially placing patients, other Practitioners, and/or Hospital staff at risk, Corrective Action against the Practitioner may be requested by any of the following:

    Whenever the activities or professional conduct of any Practitioner are considered to be lower than the standards or aims of the Medical Staff for the quality of medical care and professional conduct, or to reflect poorly upon the reputation of the Medical Staff as a whole in the community, or to be disruptive to the operations of the Hospital, where the Practitioner fails to abide by the Bylaws or Policies and Procedures, or where the health of the Practitioner is believed to be potentially placing patients, other Practitioners, and/or Hospital staff at risk, Corrective Action against the Practitioner may be requested by any of the following:

        1.1.1.1. Any Officer of the MEC or LMEC;

        1.1.1.2. The Chair of any Department;

        1.1.1.3. The Chair of any Local Department;

1.1.1.4. The Chair of any Standing Committee of the Medical Staff;

1.1.1.5. The Vice President of Medical Affairs;

1.1.1.6. The Hospital President; or

1.1.1.7. The Board of Directors.

All requests for Corrective Action shall be in writing, shall be made to the applicable Chief of Staff where the investigation initiated, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. The commencement of Corrective Action shall not preclude the summary suspension of all or any portion of clinical privileges. The imposition of a summary suspension shall not require or necessarily be a prerequisite to Corrective Action.

2.2. Precautionary Suspension. At any time during an investigation, the applicable Local Medical Executive Committee, with the approval of the Chief of Staff and the Hospital President, may suspend all or any part of the clinical privileges of the individual being investigated. This suspension will be deemed to be administrative in nature for the protection of Hospital patients. It shall remain in effect during investigation only, shall not indicate the validity of the charges, and shall remain in effect without appeal, during the course of the investigation. If such suspension is placed in effect, the investigation must be completed within fourteen (14) days of the suspension. In the event of such a precautionary suspension, the appropriate Department Chair, or if unavailable, the Chief of Staff or Vice President of Medical Affairs, shall immediately assign to another Medical Staff Member with appropriate clinical privileges responsibility for the care of patients of the suspended appointee until the suspension has been lifted or such patients are discharged from the Hospital, giving consideration wherever possible, to the wishes of the patient.

2.3. Investigation of Corrective Action Requests.

2.3.1. Investigation completed. A request for Corrective Action that originated as the result of an investigation conducted by a Professional Review Committee or other Medical Staff Standing or ad hoc Committee will be handled as follows:

2.3.1.1. A written opinion to affirm or amend the Corrective Action request will be obtained from the applicable Department, or Local Department Chair within ten (10) days after the Department or Local Department Chair's receipt of the request for Corrective Action.

2.3.1.2. The applicable Chair will forward the request for Corrective Action and Department or Local Department Chair opinion to the applicable Site Chief of Staff for review by the Local Medical Executive Committee. The Site Chief of Staff may forward the request for Corrective Action and Department or Local Department Chair opinion directly to the Medical Executive Committee for review under the following circumstances:

2.3.1.2.1. The Practitioner is on the Active Staff at more than one Site.

2.3.1.2.2. The request involves a Site Chief of Staff, Department or Local Chair, or any Officer under the Bylaws.

2.3.2. Investigation not completed. A request for Corrective Action that has not originated as the result of an investigation conducted by a Professional Review Committee or other Medical Staff Standing or ad hoc Committee will be handled as follows:

2.3.2.1. The MEC Chief of Staff shall forward such request to the applicable Local Chief of Staff and Department or Local Department Chair wherein the Practitioner has such privileges. Upon receipt of such request, the Department Local Department Chair, if applicable, shall investigate the matter personally, request review by an applicable Professional Review Committee or, if appropriate, appoint a designee or an ad hoc committee from within the Department or Section to investigate the matter. Such matter need not be referred to the Local Department Chair if the Chief of Staff determines that time or such other circumstance requires a prompt or alternate review, such as a request for Corrective Action involving a Local Department Chair. While requests for Corrective Action shall principally be reviewed within Departments, the Chief of Staff or Local Medical Executive Committee may instead determine to conduct such review or appoint a special ad hoc committee to review and supply a recommendation to the Medical Executive Committee.

2.3.2.2. Within thirty (30) days after the Department or Local Department Chair's receipt of the request for Corrective Action (or sooner as may be required by Section 8.1.2 above), the Department or Local Department Chair shall make a report of his or her investigation to the applicable LMEC. Prior to the making of such report, the Practitioner shall have an opportunity for an interview with the Department or Chair (or designee) or the ad hoc investigating committee, if so appointed. At such interview, the Practitioner shall be informed of the general nature of the charge(s), and shall be invited to discuss, explain or refute it/them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in the Bylaws with respect to a hearing shall apply thereto. A record of such interview shall be made by the Department or Local Department Chair (or his or her designee) or the Chair of the ad hoc investigating committee, as applicable.

2.3.3. Action by the Local Medical Executive Committee. Within thirty (30) days following the receipt of the report on an investigation of a request for Corrective Action, the applicable Local Medical Executive Committee shall take action upon the request. If the Corrective Action could involve a reduction or suspension of clinical privileges or a suspension or expulsion from the Medical Staff, the Practitioner shall be permitted to make an appearance before the Local Medical Executive Committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the

procedural rules provided in the Bylaws with respect to a hearing shall apply. A record of such appearance shall be made by the Local Medical Executive Committee. If the Local Medical Executive Committee requires a medical examination and report as part of the investigation, within thirty (30) days following receipt of the physician's report, the Local Medical Executive Committee shall take action on the report in the same manner as specified in this Section. The action of the Local Medical Executive Committee on a request for Corrective Action may be to recommend to the Medical Executive Committee that it reject, modify or dismiss the request for Corrective Action, to issue a warning, a letter of admonition, or a letter of reprimand, to impose terms of probation or a requirement for consultation, to recommend reduction, suspension or revocation of clinical privileges, to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained, or to recommend that the Practitioner's staff membership be suspended or revoked. (This list is not exhaustive by reason of enumeration.) The Local Medical Executive Committee will forward its recommendation to the Medical Executive Committee within thirty (30) days of receipt of the Department's report of its investigation. The recommendation of the Local Medical Executive Committee is a preliminary recommendation and does not entitle the Practitioner to any fair hearing or appellate rights under the Bylaws.

2.3.4. Action by the Medical Executive Committee. Within thirty (30) days of its receipt of the recommendation from the Local Medical Executive Committee, the Medical Executive Committee shall take action on the request for Corrective Action. Such action may be to accept, reject or modify the recommendation of the Local Medical Executive Committee. If the action of the Medical Executive Committee is to reject the recommendation, the matter shall be referred back to the Local Medical Executive Committee for further review consistent with the recommendations of the Medical Executive Committee.

2.3.5. Procedural Rights. Any recommendation by the Medical Executive Committee for reduction, suspension of more than fourteen (14) days or revocation of clinical privileges or for suspension of more than fourteen (14) days or revocation of Medical Staff membership, shall entitle the Practitioner to the procedural rights provided elsewhere in the Bylaws. A requirement of consultation, monitoring or similar action shall not be a professional review action generating a right to hearing unless such action also includes an actual limitation or reduction of the Practitioner's clinical privileges. Neither the issuance of a warning, a letter of admonition, nor a letter of reprimand, nor the requirement of a medical examination or any other actions except those specified elsewhere in this Article shall be a professional review action that shall give rise to any right to a hearing or an Appellate Review.

2.3.6. Notice of Recommended Action. The Chief of Staff shall promptly notify the Hospital President and the Vice President of Medical Affairs, in writing, of all requests for Corrective Action received by the LMEC or Medical Executive Committee and shall continue to keep the Hospital President fully informed of all actions taken in connection therewith.

3. Summary Suspension of Privileges.

3.1. Imposition of Summary Suspension. The MEC or Local Medical Executive Committee, the Chief of Staff, a Local Chief of Staff, a Site Chief of Staff, the Department Chair, or the Chair of a Section in which the Practitioner has privileges, the Vice President of Medical Affairs, the Hospital President, the Executive Committee of the Board of Directors and the Board of Directors shall each have the authority whenever action must be taken in the best interest of patient care in the Hospital, to summarily suspend all or any portion of the clinical privileges of a Practitioner, and such suspension shall become effective immediately upon imposition. A written report of such suspension shall be made to the applicable LMEC, or if not applicable the Medical Executive Committee, by the suspending agent within twenty-four (24) hours. The report shall state the reason(s) for the suspension. A copy of the report shall be given to the Practitioner.

3.2. Action by the Local Medical Executive Committee. The Local Medical Executive Committee may, upon the Practitioner's request, afford the Practitioner an opportunity to meet with the Local Medical Executive Committee in special session to informally discuss the suspension. The Local Medical Executive Committee, with the concurrence of the applicable Hospital President, shall be authorized to lift, maintain or modify the summary suspension unless imposed by the Executive Committee of the Board of Directors or the Board of Directors, in which case the concurrence of the Chairman of the Board of Directors is also necessary. The informal discussion shall not constitute a hearing.

3.3. Hearing Rights. A Practitioner whose summary suspension pursuant to this section is for more than fourteen (14) days shall be entitled to request either a hearing pursuant to the procedures set forth in Article XXI or a hearing on the matter in such reasonable time period as a hearing committee may be convened in accordance with the Bylaws after receipt by the Hospital President of a request for expedited hearing. Such expedited hearing shall be held in general accord with the procedures set forth in Article XXI. Due to the expedited nature of a hearing under this subsection, the procedural requirements set forth in Article XXI may be adjusted as needed to facilitate expedited review while still affording due process to the Practitioner. The availability of an expedited review is to minimize the period of summary suspension before fair hearing, should a Practitioner so request. If an expedited hearing is held at the Practitioner's request, it shall be in lieu of and not in addition to, any right to hearing otherwise available to the Practitioner under Article XXI.

3.4. Continuation of Suspension. If the Practitioner whose suspension is for more than fourteen (14) days requests a hearing under Article XXI instead of an expedited hearing, and if the hearing request also requests a removal of the suspension, the Local Medical Executive Committee shall be promptly convened. The written position of the Member and the Local Medical Executive Committee on the singular issue of maintenance of the suspension pending hearing and appellate review shall be considered by the Local Medical Executive Committee, as well as the recommendation of the applicable Hospital President, the President and the Chair of the Practitioner's Department and/or Local Department Chair. The Local Medical Executive Committee shall be authorized to maintain, modify or lift the summary suspension and shall reduce its determination to a written finding.

3.5. Local Medical Executive Committee Action. After expedited hearing held pursuant to Section 1.3.3 above, the Local Medical Executive Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as

a result of such hearing, the Local Medical Executive Committee does not recommend immediate termination of the summary suspension, the Practitioner shall, in accordance with Article XXI, be entitled to request an appellate review by the Medical Executive Committee and Board of Directors. If the action was taken directly by the MEC, then the Board of Directors shall be the only appellate review organization. The terms of the suspension as sustained or as modified by the Local Medical Executive Committee shall remain in effect pending a review by the Medical Executive Committee and a final decision thereon by the Board of Directors.

3.6. Care of Patients. Immediately upon the imposition of a suspension, the Local or Site Chief of Staff, Vice President of Medical Affairs or responsible Department Chair or Local Department Chair shall provide for alternative medical coverage for the patient(s) of the suspended Practitioner who are still in the Hospital at the time of such suspension. The wishes of the patient(s) shall be considered in the selection of such alternate Practitioner(s). The suspended Practitioner shall confer with the alternate Practitioner to the extent necessary to safeguard the patient(s).

4. Automatic Suspension and Automatic Termination.

4.1. Automatic Termination. The following shall result in automatic termination of a Medical Staff Member's membership and clinical privileges.

4.1.1. Conviction. of the Practitioner of any state or federal felony related to the provision of health care or conviction of any Caregiver Law. There will be no review, fair hearing, or appeal of the termination based on such conviction.

4.1.2. The Practitioner's medical staff membership at any other Hospital subject to the Bylaws has been terminated (other than voluntary resignation by the Practitioner unrelated to any investigation). There will be no review, fair hearing, or appeal of the termination based on the foregoing.

4.1.3. Upon the happening of any misrepresentation, misstatement or omission in the Medical Staff application or any supporting documentation, whether intentional or not. There will be no review, fair hearing, or appeal of the termination based on the foregoing.

4.1.4. In the event that a Practitioner has been decertified, debarred or excluded from participation in the Medicare or Medicaid program. There will be no review, fair hearing, or appeal of the termination based on the foregoing.

Immediately upon the imposition of an automatic termination, the Practitioner shall provide for alternative medical coverage for the patient(s) who are still in the Hospital at the time of such termination. The wishes of the patient(s) shall be considered in the selection of such alternate Practitioner(s). The terminated Practitioner shall confer with the alternate Practitioner to the extent necessary to safeguard the patient(s). If the Practitioner is unable or unwilling to coordinate alternative medical coverage for the patient(s) in the Hospital, the applicable Chief of Staff, Vice President of Medical Affairs or responsible Department Chair shall have the authority to provide for alternative medical coverage for patients of the terminated Practitioner.

Notwithstanding any other term or condition of the Bylaws, automatic termination for the reasons set forth in this Section shall not be deemed an adverse action nor shall it be deemed a professional review action and thus does not give rise to any right of hearing or appellate review.

4.2. Automatic Suspension. The following shall result in automatic suspension of a Medical Staff member's membership and clinical privileges.

4.2.1. Action by the Wisconsin Medical Examining Board or any other State's medical examining or licensing board revoking or suspending a Practitioner's license, or imposing probation or limitation of practice, shall automatically suspend all of the Practitioner's Hospital privileges. Such shall occur whether the action of the Medical Examiners Board is unilateral or agreed to by the Practitioner. In such an event, the Medical Executive Committee shall promptly review the matter and submit a recommendation to the Board of Directors regarding the Practitioner's Medical Staff status and clinical privileges. The MEC may delegate the investigation to an applicable LMEC with review to be conducted by the MEC. The Medical Executive Committee shall, if concurred by the Hospital President be authorized to lift or modify any such automatic suspension pending final determination by the Board of Directors. In the event that such limitation imposes only a requirement to obtain additional continuing medical education and no other restrictions or practice limitations, the President of the Medical Staff may, if concurred by the Hospital President, lift such automatic suspension pending review by the Medical Executive Committee.

4.2.2. Conviction of the Practitioner of any state or federal felony unrelated to the provision of health care. The suspension shall be reviewed by the Board of Directors and the Board of Directors can maintain or lift the suspension or terminate privileges and membership. There will be no review, fair hearing, or appeal of the suspension and/or termination based on such conviction.

4.2.3. An automatic suspension shall be imposed, after a warning of delinquency, upon a Practitioner for failure to complete medical records in accordance with the time limits set forth in the current Policies and Procedures, except as otherwise set forth in the Policies and Procedures. Such suspension shall take the form of withdrawal of the Practitioner's admitting privileges and shall be effective until requirements for medical record completion, as stated in the Policies and Procedures are met. Such suspension of privileges shall not affect the status or privileges of the Practitioner as regards patients who are at the time of the automatic suspension in the Hospital under the care of the Practitioner.

4.2.4. A Practitioner whose DEA number is revoked or restricted or voluntarily surrendered shall automatically be divested of the right to prescribe medications controlled by such number.

4.2.5. An automatic suspension of all privileges shall be imposed by the Hospital President, after discussion with the applicable Local or Site Chief of Staff, for misconduct that does not directly involve clinical issues but is in violation of Hospital policy. Such misconduct can consist of but is not limited to: sexual

harassment or abuse of others; drug, alcohol or other addiction; criminal, fraudulent or other improper conduct.

4.2.6. An automatic suspension shall be imposed upon a Practitioner's failure without good cause to supply information or documentation requested by any of the following: the Hospital President or his or her designee, the Central Credentials Committee, a Local Medical Executive Committee, the Medical Executive Committee or the Board. Such suspension shall be imposed only if: (1) the request was in writing, (2) the request was related to evaluation of the Practitioner's current qualifications for membership or clinical privileges, (3) the Practitioner failed to either comply with such request or to satisfactorily explain his or her inability to comply, and (4) the Practitioner was notified in writing that failure to supply the request information within 15 days from receipt of such notice would result in automatic suspension. Any automatic suspension imposed pursuant to this paragraph may be a suspension of any portion or all of the Practitioner's privileges and shall remain in effect until the Practitioner supplies the information or documentation sought or satisfactorily explains his or her failure to supply it.

4.2.7. An automatic suspension shall be imposed in accordance with the medical staff policy governing delinquency in or failure to complete medical records.

4.2.8. An automatic suspension shall be imposed upon a Practitioner's failure to maintain professional liability insurance coverage in accordance with limits established by the Medical Staff.

Immediately upon the imposition of an automatic suspension, the Practitioner shall provide for alternative medical coverage for the patient(s) who are still in the Hospital at the time of such suspension. The wishes of the patient(s) shall be considered in the selection of such alternate Practitioner(s). The suspended Practitioner shall confer with the alternate Practitioner to the extent necessary to safeguard the patient(s). If the Practitioner is unable or unwilling to coordinate alternative medical coverage for the patient(s) in the Hospital, the applicable Chief of Staff, Vice President of Medical Affairs or responsible Department Chair shall have the authority to provide for alternative medical coverage for patients of the suspended Practitioner.

Notwithstanding any other term or condition of the Bylaws, automatic suspension for the reasons set forth in this Section shall not be deemed an adverse action nor shall it be deemed a professional review action and thus does not give rise to any right of hearing or appellate review.

5. 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 in the Bylaws. 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 XXI
FAIR HEARING AND APPELLATE REVIEW PROCEDURE[5]

1.1. Initiation of a Hearing.

1.1.1. Except as otherwise provided in the Bylaws, the following recommendations or actions shall, if deemed a professional review action as defined below, entitle the Practitioner affected thereby to a hearing.

1.1.1.1. Denial of initial Medical Staff appointment, reappointment or requested privileges;

1.1.1.2. Revocation of Medical Staff membership;

1.1.1.3. Suspension of Medical Staff membership for more than fourteen (14) days;

1.1.1.4. Revocation of clinical privileges;

1.1.1.5. Reduction or suspension of clinical privileges for more than fourteen (14) days;

1.1.1.6. Limitation of admitting prerogatives;

1.1.1.7. Terms of probation which limits clinical privileges;

1.1.1.8. Requirement of consultation which limits clinical privileges;

1.1.1.9. Reduction in Medical Staff category;

1.1.1.10. Denial of a requested advancement in Medical Staff category;

1.1.1.11. Denial of requested Department affiliation; or

1.1.1.12. Denial of a request for a leave of absence.

1.1.2. A recommendation or action listed in Section 1.1.1 above shall be deemed a professional review action only when it has been:

1.1.2.1. Recommended by the Local Medical Executive Committee or Medical Executive Committee; or

1.1.2.2. Is a suspension of more than fourteen (14) days which is continued in effect after review provided in Article XX; or

[5] Wis. Admin. Code § DHS 124.05(2)(e)7

1.1.2.3. Is taken by the Board of Directors contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no right to a hearing existed; or

1.1.2.4. Taken by the Board of Directors on its own initiative without benefit of a prior recommendation by the Medical Executive Committee. The forgoing shall constitute professional review actions for the purpose of the Bylaws in that only this professional review action shall have a potential for being adverse regarding the Practitioner's status. Only such action shall entitle a Practitioner to the hearing and appellate review required herein. In formulating such action or recommendation, the acting body should conclude that:

1.1.2.4.1. There is a reasonable belief that the action is in furtherance of quality health care;

1.1.2.4.2. Reasonable efforts are taken to obtain the pertinent facts; and

1.1.2.4.3. A reasonable belief exists that the action is warranted by the facts.

1.1.3. A Practitioner against whom professional review action has been taken pursuant to Section 1.1.2 shall within ten (10) days be given Special Notice of such action by the Hospital President, Chief of Staff, or designee of either leader. The notice to the Practitioner shall state:

1.1.3.1. That a professional review action has been taken or is proposed to be taken against the Practitioner;

1.1.3.2. The reasons for the professional review action;

1.1.3.3. That the Practitioner has a right of hearing pursuant to the Bylaws and has no less than thirty (30) nor more than sixty (60) days from the date of furnishing the notice to request a hearing; and

1.1.3.4. A summary of the hearing procedures and rights of the Practitioner. This summary can be accomplished by furnishing the Practitioner a copy of the Bylaws with the notice.

1.1.4. A Practitioner shall have no less than thirty (30) nor more than sixty (60) days following the receipt of a notice pursuant to Section 1.1.3 to file a written request for a hearing. Such request shall be delivered to the Hospital President either in person or by registered mail. Any time limits set forth in the Bylaws may be extended or accelerated by mutual agreement of the Practitioner and the Hospital President or the Hospital President's designee.

1.1.5. A Practitioner who fails to request a hearing within the time and manner specified in Section 1.1.4 waives any right to such hearing and to any appellate review to which the

Practitioner might otherwise have been entitled. Such waiver to right of hearing shall result in the following:

1.1.5.1. A professional review action of the Local or Medical Executive Committee shall remain in effect pending the final decision of the Board of Directors.

1.1.5.1.1. The Board of Directors shall consider the Local or Medical Executive Committee's recommendation at its next regular meeting following waiver. In its deliberations, the Board of Directors shall review all the information and material considered by the Local or Medical Executive Committee and may consider all other relevant information received from any source.

1.1.5.1.2. The Board of Directors' action on the matter shall constitute the final action of the Board of Directors.

1.1.5.2. A professional review action taken by the Board of Directors shall thereupon become effective as the final decision of the Board of Directors.

1.1.6. The Hospital President shall promptly send the Practitioner Special Notice informing the Practitioner of each action taken pursuant to Section 1.1.5 and shall notify the Chief of Staff of each such action.

1.2. Hearing Prerequisites.

1.2.1. Upon receipt of a timely request for hearing, the Hospital President shall deliver such request to the Local Chief of Staff, MEC Chief of Staff or the Chair of the Board of Directors, depending upon whose recommendation or action prompted the request for hearing.

1.2.2. Within thirty (30) days after receipt of such request, the MEC Chief of Staff or the Chair of the Board of Directors, as appropriate, shall schedule and arrange for a hearing. The Hospital President shall send the Practitioner notice of the time, place and date of the hearing. Unless otherwise agreed to by the Practitioner and Hospital President, the hearing date shall be not less than thirty (30) nor more than sixty (60) days from the date of receipt of the notice of hearing. The notice of hearing required by this Section shall be accompanied by a concise statement of the basis for the professional review action; a list by number of the specific or representative patient records in question; a preliminary list of witnesses, if any, who may be requested to testify on behalf of the body whose action prompted the request for hearing; and the other reasons or subject matter, if any, forming the basis for the professional review action that is the subject of the hearing.

1.2.3. For a Practitioner who is under suspension that has been continued in effect for more than fourteen (14) days, at the Practitioner's specific request, a hearing shall be held as soon as all arrangements for it may reasonably be made. Such hearing shall be held no more than fourteen (14) days from the date of receipt of the request for hearing. In such event, the thirty (30) day notice requirement is deemed waived.

1.2.4. At least ten (10) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals that party intends to call as witnesses at the hearing. Each party shall update such witness list if and when additional witnesses are identified prior to hearing, and neither party shall call witnesses not so named in advance except in rebuttal.

1.2.5. Failure without good cause of the Practitioner to appear and proceed at such hearing shall constitute voluntary abandonment of the appeal and the professional review action involved shall become final and effective immediately when approved by the Board of Directors. Postponement of a hearing may be effected for good cause if mutually acceptable to the parties concerned.

1.2.6. Appointment of a Hearing Committee.

1.2.6.1. By Medical Staff. A hearing occasioned by a Local or Medical Executive Committee recommendation or action pursuant to Section 1.1.2(a)-(b) above shall be conducted by a hearing committee appointed by the Chief of Staff and composed of five (5) members of the respective Active Staff, either Local or from the Medical Staff as a whole depending on which level the hearing is conducted. The applicable Chief of Staff shall submit seven (7) names to the Practitioner involved, who shall then strike two (2) names to arrive at a hearing committee of five (5) members. Notwithstanding the foregoing, the parties may stipulate that the hearing may proceed with less than five (5) members. One of the members so appointed shall be designated as the Chair. If a Hearing Officer is appointed in accord with Section 1.8.1 below, the Hearing Officer shall preside as Committee Chair. Members of the Hearing Committee shall not be in direct economic competition with the Practitioner. For purposes of the Bylaws, "direct economic competition" shall be defined to mean those Practitioners actively engaged in practice in the primary medical community of the Hospital, and who practice in the same medical specialty or section. The Hearing Committee may utilize, on a consulting basis, members of the same medical specialty or section.

1.2.6.2. By Board of Directors. A hearing occasioned by a professional review action of the Board of Directors Section 1.1.2(c)-(d) above shall be conducted by a Hearing Committee appointed by the Chair of the Board of Directors and composed of five (5) persons. At least two (2) Medical Staff members shall be included on this Committee, and Medical Staff appointees shall not be in direct economic competition with the Practitioner. One of the appointees to the Committee shall be designated as the Chair. Such role may be filled by a Hearing Officer appointed pursuant to Section 1.8.1 below.

1.2.6.3. Service on the Hearing Committee. Members of the Medical Staff or the Board of Directors shall not be disqualified from serving on a Hearing Committee because they have heard of the case or have knowledge of the facts involved or what they suppose the facts to be. No member of the Medical Staff or Board of Directors who requests Corrective Action or serves on a committee reviewing such request shall serve as a member of the Hearing Committee. Any member of the

Medical Staff or Board of Directors may appear before the Committee if requested by either of the parties concerned. In any event, all members of a Hearing Committee shall be required to consider and decide the case with good faith objectivity.

1.2.7. If there are not sufficient members of the Active Staff who are not in direct economic competition with the Practitioner to form a committee, the committee may be composed of other physicians (whether or not Medical Staff Members) or an administrative hearing officer as may be designated by the Hospital President. The Board of Directors or the Local or Medical Executive Committee with the Board of Directors' approval, and with the written consent of the affected Practitioner, may elect to contract with an independent consultant to perform the functions of the Hearing Committee as set forth in the Bylaws. In such event, the composition of the Hearing Committee shall be determined by the Board of Directors in its arrangements with the independent consultant. The Board of Directors may require the affected Practitioner to pay a share of the independent consultant's fees, up to one-half of the total charges.

1.3. Hearing Procedure.

1.3.1. No member of the Hearing Committee may vote by proxy.

1.3.2. The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived review rights in the same manner and with the same consequence as provided in Section 1.1.5 above.

1.3.3. The Chair of the Hearing Committee shall be the presiding officer at the hearing. The Chair 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 Chair 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. Unless the Chairman is a Hearing Officer appointed pursuant to Section 1.8.1, the Chair shall also vote on any final recommendations as well as on any other matters giving rise to a vote of the Hearing Committee.

1.3.4. The Practitioner for whom the hearing has been scheduled shall be entitled to be accompanied by and/or represented at the hearing by a Member in good standing of the Active Staff. The Local or Medical Executive Committee, when its recommendation has prompted the hearing, shall appoint at least one (1) of its members, some other Medical Staff Member or a person of its choosing to represent it at the hearing to present the facts in support of its professional review action and to examine witnesses. When recommendation or action of the Board of Directors has prompted the hearing, the Board of Directors shall appoint at least one (1) of its members or another person of its choosing to represent it at the hearing.

1.3.5. If the affected Practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance, his/her request for such hearing or appellate review

must so state. Such notice must also include the name, address and phone number of the attorney. Failure to notify the Hearing Committee in accord with this Section shall permit the Committee to preclude the participation by legal counsel or to adjourn the hearing for a period not to exceed twenty (20) days. The Local or Medical Executive Committee or the Board of Directors may also be allowed representation by an attorney. While legal counsel may attend and assist the respective parties in proceedings provided herein, it is intended that the proceedings will not be judicial in form but a forum for professional evaluation and discussion. Accordingly, the Hearing Committee and/or Appellate Review Body retains the right to limit the role of counsel's active participation in the hearing process. Any Practitioner who incurs legal fees in his/her behalf shall be solely responsible for payment thereof.

1.3.6. During a hearing, each of the parties shall have the right to:

1.3.6.1. Call and examine witnesses;

1.3.6.2. Introduce exhibits and present relevant evidence;

1.3.6.3. Question any witness on any matter relevant to the issue;

1.3.6.4. Impeach any witness;

1.3.6.5. Rebut any evidence;

1.3.6.6. Submit a written statement at the close of a hearing; and

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

"Parties" for the purpose of these Article shall be the affected Practitioner and the Body taking or recommending the professional review action. If the Practitioner who requested the hearing does not testify in his or her own behalf, the Practitioner may be called by the Committee or the other party and examined as if under cross-examination.

1.3.7. 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 Chair or Hearing Officer, it is the sort of evidence on which responsible persons are accustomed to rely upon in the conduct of serious affairs. The Practitioner shall be entitled to submit, prior to or during the hearing, memoranda concerning any issue of law or fact.

1.3.7.1. The Chair or Hearing Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation.

1.3.7.2. The Chair or Hearing Officer may adjourn the hearing and reconvene the same for the convenience of the participants in the hearing, without special notice, provided such adjournment shall not extend the time within which any action is required to be taken under the Bylaws, without the express consent of the parties.

Upon conclusion of the presentation of evidence, the hearing shall be closed. The Committee may, at a time convenient to itself within the time frame previously set forth in the Bylaws, conduct its subsequent deliberations outside the presence of the parties.

1.3.7.3. The Committee shall be entitled to consider any pertinent material contained on file in the Hospital and all other information that can be considered, pursuant to the Bylaws, in connection with applications for appointment or reappointment to the Medical Staff for clinical privileges. The Hearing Committee shall be entitled to conduct independent review, research and interviews, but may utilize the products of such in its decision only if the parties are aware of such and have the opportunity to rebut any information so gathered.

1.3.7.4. The Hearing Committee may meet without the presence of the parties to deliberate and/or establish procedures. The Hearing Committee may require that the parties submit written, detailed statements of the case to the Committee and to each other. Such statements of the case may be in a form which constitutes all the facts of the case. If so done, the hearing can consist of clarification and explanation of the written statements of the case. If a party is ordered by the Hearing Committee to supply a detailed statement of the case and fails to do so, the Hearing Committee can conclude that such failure constitutes a waiver of the parties' case.

1.3.7.5. If the Hearing Committee determines to require the parties to submit written statements of the case, notice to that effect shall be provided to both parties at least ten (10) days prior to any scheduled hearing. The written statements of the case shall be supplied both to the Committee and to the other party at least forty-eight (48) hours prior to the commencement of the hearing.

1.3.7.6. Statements from Members of the Medical Staff or others may be distributed to the Hearing Committee and the parties in advance of or at the hearing. Such 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.

1.3.8. The body whose professional review action occasioned hearing shall have the initial obligation to present evidence in support thereof. The Practitioner shall thereafter be responsible for supporting a challenge to the professional review action by clear and convincing evidence that the grounds therefore lack any factual basis or that such basis or the conclusion drawn there from are either arbitrary, unreasonable or capricious.

1.3.9. A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Hearing Committee may select the method to be used for making the record such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. A

Practitioner requesting an alternate method of recording the hearing shall bear the cost thereof.

1.3.10. Requests for postponement of a hearing shall be granted by the Hearing Committee only upon a showing of good cause. A hearing shall be postponed no more than two (2) times at the request of the Practitioner.

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

1.4. Hearing Committee Report and Further Action.

1.4.1. Within thirty (30) days after the final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendations in the matter and shall forward the same, together with the hearing record and all other documentation considered by it, to the body (either the Local Medical Executive Committee, Medical Executive Committee, or the Board of Directors) whose professional review action occasioned the hearing. All findings and recommendations by the Hearing Committee shall be supported by reference to the hearing record and the other documentation considered by it.

1.4.2. Within thirty (30) days after receipt of the report of the Hearing Committee, the Local or Medical Executive Committee or the Board of Directors, as the case may be, shall consider the same and affirm, modify, or reverse its recommendation or action in the matter. It shall transmit the result, together with the hearing record, the report of the Hearing Committee, and all other documentation considered to the Hospital President.

1.4.2.1. Notice of Result. The Hospital President shall promptly send a copy of the result to the Practitioner, to the MEC Chief of Staff and to the Board of Directors. The Practitioner shall be furnished a copy of the Hearing Committee report with such notice, as well as the written recommendation of the body furnishing the final recommendation.

1.4.2.2. Effect of Favorable Result.

1.4.2.2.1. Adopted by the Board of Directors: If the Board of Directors result pursuant to this Section is favorable to the Practitioner, such result shall become the final decision of the Board of Directors and the matter shall be considered finally closed.

1.4.2.2.2. Adopted by the Local or Medical Executive Committee: If the Local or Medical Executive Committee's result pursuant to this Section is favorable to the Practitioner, the Hospital President shall promptly

forward it, together with all supporting documentation, to the Board of Directors for action. The Board of Directors shall adopt or reject the Local or Medical Executive Committee's result in whole or in part or refer the matter back to the Local or Medical Executive Committee for reconsideration. Any such referral shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board of Directors must be made, and may include a directive that an additional hearing be conducted to clarify the issues that are in doubt. After receipt of such subsequent recommendation, and any new evidence in the matter, the Board of Directors shall take final action. The Hospital President shall promptly send the Practitioner Special Notice informing him/her of each action taken pursuant to this paragraph. Favorable action shall become the final decision of the Board of Directors, and the matter shall be considered finally closed.

1.4.2.3. Effect of Adverse Result. If the result of the Local or Medical Executive Committee or of the Board of Directors continues to be adverse to the Practitioner in any of the respects listed in Section 1.1.2 above, the Special Notice required by Section 1.1.3 shall inform the Practitioner of a right to request an appellate review by the Board of Directors as provided in Section 1.5.1 below.

1.5. Initiation and Prerequisites of Appellate Review.

1.5.1. A Practitioner shall have fifteen (15) days following receipt of a notice pursuant to Section 1.4.2(c) to file a written request for appellate review. Such request shall be delivered to the Hospital President either in person or by certified or registered mail and may include a request for a copy of the record of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse action or result.

1.5.2. A Practitioner who fails to request an appellate review within the time and in the manner specified in Section 1.5.1 waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 1.1.5 of this Article.

1.5.3. Upon receipt of a timely request for appellate review, the Hospital President shall deliver such request to the Chairman of the Board of Directors. Within fifteen (15) days after receipt of such request, the Chairman of the Board of Directors shall schedule and arrange for an appellate review which shall be conducted not more than sixty (60) days from the date of receipt of the appellate review request. Provided, however, that an appellate review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but not later than fourteen (14) days from the date of receipt of the request for review. The Hospital President shall send the Practitioner special notice of the time, place and date of the review. The time for the appellate review may be extended by the Appellate Review Body for good cause. The appellate review can occur at a regular meeting of the Board of Directors.

1.5.4. The Chair of the Board of Directors shall determine whether the appellate review shall be conducted by the Board of Directors as a whole or by an Appellate Review Body which shall be composed of three (3) members of the Board of Directors appointed by the Chair. If a Committee is appointed, one of its members shall be designated as Chair.

1.6. Appellate Review Procedure.

1.6.1. The proceedings by the review body shall not be a new or additional hearing but shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, that Committee's report, and all subsequent results and actions thereon. The Appellate Review Body shall also consider the written statements submitted pursuant to Section 1.6.2 and such other materials as may be presented and accepted under Sections 1.6.4 and 1.6.5 below.

1.6.2. The Practitioner seeking the review shall submit a written statement detailing the findings of fact, conclusions, and procedural matters with which the Practitioner disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Appellate Review Body through the Hospital President at least twenty (20) days prior to any scheduled appellate review date. A written statement in reply may be submitted by the Local or Medical Executive Committee or by the Board of Directors, as appropriate; and if submitted, the Hospital President shall provide a copy thereof to the Practitioner at least five (5) days prior to the scheduled date of the appellate review. These advance filing dates will not apply to expedited review under Section 1.5.3.

1.6.3. The Chair of the Appellate Review Body shall be the presiding officer. The Chair shall determine the order of procedure during the review, make all required rulings, and maintain decorum. The Chair may, in his or her discretion, impose reasonable time limits upon the parties.

1.6.4. The Appellate Review Body may in its sole discretion allow the parties to personally appear and make oral statements in favor of their positions. Any party so appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

1.6.5. 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 may be introduced to the Appellate Review Body which, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

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

1.6.7. The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The Appellate Review Body

shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

1.6.8. The Appellate Review Body may recommend that the Board of Directors affirm, modify, or reverse the adverse result or action taken by the Local or Medical Executive Committee or by the Board of Directors pursuant to Section 1.4.2. If appellate review is conducted by the entire Board of Directors, its conclusions shall be the final action unless otherwise provided herein. In its discretion, it may refer the matter back to the Hearing Committee or Local or Medical Executive Committee for further review and require a recommendation to be returned to it within thirty (30) days and in accordance with its instructions. Any written report following referral shall be shared with the Practitioner. Within ten (10) days after receipt of such report, the Appellate Review Body shall make its recommendation to the Board of Directors.

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

1.6.10. The Practitioner requesting the appellate review shall establish by clear and convincing evidence that the Board of Directors or Local or Medical Executive Committee result, following the hearing, lacks sufficient factual basis or that the basis or conclusions drawn there from are arbitrary, unreasonable or capricious.

1.7. Final Decision by Board of Directors. Within thirty (30) days after the conclusion of the appellate review, the Board of Directors shall render its final decision in the matter in writing and shall send notice thereof to the Practitioner by Special Notice and by regular notice to the Hospital President, Chief of Staff, and to the Local or Medical Executive Committee. This decision shall be immediately effective and final.

1.8. General Provisions.

1.8.1. The use of a hearing officer to preside at a hearing held in accord with the Bylaws is optional. The use and appointment of such officer shall be determined by the Chairman of the Board of Directors with concurrence of the Chief of Staff. A hearing officer should be experienced in conducting hearings. Such hearing officer shall act in an impartial manner as the presiding officer of the hearing. If requested by the hearing committee, the hearing officer may participate in its deliberations and act as its advisor but shall not be entitled to vote.

1.8.2. If at any time after receipt of Special Notice of an adverse recommendation, action or result, a Practitioner fails to make a required request or appearance or otherwise fails to comply with provisions of Article XXI, he/she shall be deemed to have consented to such professional review action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the Bylaws.

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

and the Board of Directors need not conduct additional hearings or reviews upon reapplication or request for reconsideration by the Practitioner, absent a clear and convincing indication of new or additional information.

1.8.4. By requesting a hearing or appellate review under the Bylaws, a Practitioner agrees to be bound by the provisions of the Bylaws in all matters relating thereto.

1.8.5. Any time limits set forth in the Bylaws may be extended or accelerated by mutual agreement between the Practitioner and the Hospital President or the Local or Medical Executive Committee. The time periods specified in the Bylaws for action by the Medical Staff, the Board of Directors and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of the professional review action if the hearing process is not completed within the time periods specified.

1.8.6. Technical or insignificant deviations from the hearing procedures set forth in the Bylaws shall not be grounds for invalidating the action taken.