CORRECTIVE ACTION/FAIR HEARING PLAN

FOR

HENDRICKS REGIONAL HEALTH

DANVILLE, INDIANA

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PREAMBLE AND PURPOSE

The governing body, Medical Staff and any committees thereof, in order to conduct professional peer review activities, hereby constitute themselves as peer review and professional review committees as defined by the Indiana Peer Review Act and the Health Care Quality Improvement Act of 1986. Such committees hereby claim all privileges and immunities afforded to them by said federal and state statutes. The purpose of this Corrective Action/Fair Hearing plan ("Plan") is to provide a mechanism through which a fair hearing and appeal might be provided to all professional health care providers having privileges or applying for privileges at the Hospital. This Plan is intended to comply with the Health Care Quality Improvement Act of 1986 and the Indiana Peer Review Act. As such, any action taken pursuant to this Plan shall be in the reasonable belief that such was in the furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care in the Hospital), only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any professional health care provider involved, and only in the reasonable belief that the action was warranted by the facts known after a reasonable effort has been made to obtain the facts.

DEFINITIONS

1. **"Adversely Affecting" or "Adverse Action"** shall mean any action reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership on the Medical Staff of the Hospital. Such actions are specifically set forth in Section 1.2 of the Fair Hearing Plan. Letters of reprimand or warning, requirements of proctoring or consultations, Investigative Suspensions not in excess of fourteen (14) calendar days, requirements of further continuing medical education or training, and imposition of terms of probation which do not prevent a practitioner from exercising any privileges which have been granted to him or her shall not constitute "Adverse Action" and shall not give rise to any rights to a hearing or appeal. Further, automatic suspensions, as set forth in the Corrective Action Section III, shall not be deemed "Adverse Actions".

2. **"Clinical Privileges"** includes privileges, membership on the Medical Staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care in the Hospital. "Clinical Privileges" does not include assignment to departments or committees, participating in Medical Staff functions by allied care providers or requirements to complete required hours of continuing medical education, completion of medical records or maintenance of required professional liability insurance and qualifications as a health care provider under the Indiana Medical Malpractice Act.

3. **"Days"** as included in this Plan with respect to time allowed for delivery or receipt of any Notice, shall be defined to mean calendar days (i.e., including Saturdays, Sundays, and legal holidays) unless the due date for such Notice or receipt falls on a Saturday, Sunday, or legal holiday, in which case the due date shall be the first date immediately following which is not a Saturday, Sunday, or legal holiday.

4. **"Direct Economic Competition"** shall mean any individual who would with reasonable probability have a financial interest in the outcome of any Adverse Action taken against a provider pursuant to this Plan.

5. **"Governing Body"** shall mean the Board of Trustees of the Hospital or any committee thereof acting as a hearing body. When the Governing Body is considering appointments or reappointments to, delineation of privileges, and/or proposed corrective action for any practitioner within the Hospital, it shall be acting s a Professional Review Body as defined by the Health Care Quality Improvement Act of 1986 and as a Peer Review Committee as defined by the Indiana Peer Review Act, I.C. 34-4-12.6-1.

6. **"Hearing Committee" or "Hearing Body"** means the Committee appointed under this Plan to conduct an evidentiary hearing properly filed and pursued by an affected practitioner.

7. **"Investigative Suspensions"** are suspensions of all or any portion of a Practitioner's privileges for a period not to exceed fourteen (14) days during which an investigation is being conducted to see if any corrective action is necessary. Investigative Suspensions are instituted in the same manner and are reviewable in the same manner as a summary suspension. Investigative Suspensions may be imposed to protect either patient safety and/or the orderly operation of the Hospital in a non-disruptive manner. If an Investigative Suspension is lifted or terminates in fourteen (14) days or less without further corrective action, no right to a hearing or appeal shall arise unless an Investigative Suspension has been imposed on the same Practitioner more than twice in any six (6) month period of time.

8. **"Notice"** means notification sent by certified or registered mail, return receipt requested, and/or personally delivered by hand or by courier service designed for overnight or same day delivery.

9. **"Peer Review Committee" or Professional Review Body"** - shall mean the governing body of the Hospital, the Medical Staff, the, Physician Relations Committee, Quality Assurance Committee and other committees of the Medical Staff or Governing Body which evaluates, recommends, or takes actions based on the competence or professional conduct of an individual practitioner and which affects or may affect the clinical privileges or membership on the Medical Staff of any practitioner, including any recommendation or decision whether the practitioner may have clinical privileges with respect to or membership on the Medical Staff of the Hospital, the scope or conditions of such privileges or membership, or any changes or modifications in such privileges or membership. "Peer Review Committees" shall further include any committee of the Medical Staff or Board having responsibility of evaluation of qualifications of professional healthcare providers which includes the performance of patient care and related duties in a manner that is not disruptive to the delivery of quality medical care in the hospital setting and evaluation of patient care which includes the accuracy of diagnosis, propriety, appropriateness or necessity of care rendered by a professional healthcare provider, and the reasonableness of the utilization of services, procedures, and facilities in the treatment of individual patients and such other matters as are within the scope of the Indiana Peer Review Act.

10. **"Personnel of a Peer Review Committee"** means not only members of the committee, but also all of the committee's employees, representatives, agents, attorneys, investigators, assistants, clerks, staff, and any other person or organization who serves a peer review committee in any capacity, including any person acting as a member or staff to the committee, any person under a contract or other formal agreement with the committee, and any person who participates with or assists the committee with respect to the action. Individuals involved in Peer Review activities shall be impartial peers and shall not have an economic interest in and/or a conflict of interest with the subject of the Peer Review activity. Impartial peer would also exclude individuals with blood relationships, spousal relationships, employer/employee relationships, or other potential conflicts that might prevent the individuals from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of Peer Review.

11. **"Practitioner"** shall mean the applicant to the Medical Staff or Medical Staff member against whom an adverse action has been recommended or taken.

12. **"Professional Review Action"** means an action or recommendation of a peer review committee which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual practitioner (which conduct affects or could affect adversely the health or welfare of a patient or patients or is disruptive or not conducive to the orderly operation of the Hospital), and which affects (or may affect) adversely the clinical privileges of the practitioner. Such term includes a formal decision of a professional review body not to take an action or make a recommendation and also includes professional review activities relating to a professional review action and shall further mean any activity of the hospital with respect to an individual practitioner to determine whether the practitioner may or may not have clinical privileges with respect to, or membership in, the hospital, to determine the scope or condition of such privileges or membership, or to change or modify such privileges or membership.

13. **“Federal Health Program”** means Medicare, Medicaid or any other federal or state program providing health care benefits, which is funded directly or indirectly by the United States Government.

14. **“Criminal Convictions”** shall include conviction, or a plea of guilty or nolo contendere for any

felony, or for any misdemeanor related to the practice of a health care profession, Federal Health Program fraud, or abuse (including but not limited to any finding of liability under the False Claims Act), third party reimbursement, or controlled substances.

CORRECTIVE ACTION

SECTIONS I: PROCEDURES FOR INITIATING CORRECTIVE ACTION.

1.1 Standard of Professional Conduct

Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff, or Hospital, or to be disruptive to the delivery of quality medical care in the hospital, or to make inefficient use of the Hospital's resources, or determined to violate federal or state laws or regulations as determined by standards established by the Medical Staff, by the Hospital's Chief Executive Officer, or by any member of the Governing Body. All such requests for corrective action shall be in writing and directed to the Chief of Staff. Such request shall be supported by reference to the specific activities or conduct, which constitute the grounds for the request.

1.2 Grounds for Requesting Corrective Action

In particular, the following are intended to be representative of grounds which could precipitate a request for corrective action:

1.2.1 The clinical competence of a practitioner;

1.2.2 The care of a particular patient or patients by a practitioner;

1.2.3 The violation of the Bylaws of the Medical Staff, Governing Body, or other policies and rules and regulations of the Hospital;

1.2.4 A violation of ethics as outlined by the American Medical Association, American Osteopathic Association, American Dental Association, or the American Podiatric Association.

1.2.5 The mental, emotional, or physical competency of any practitioner; or

1.2.6 Conduct disruptive to the delivery of quality medical care or detrimental to the operation of the hospital and/or patient care; or

1.2.7 Unauthorized release of peer review information.

1.2.8 Violations of Standards of Conduct established by the Hospital’s Corporate Compliance Program.

1.2.9 Failure to comply with the Health Insurance Portability & Accountability Act (HIPAA) or other governmental regulatory requirement.

1.3 MEC Investigation

If, in the opinion of the Chief of Staff (or the Vice Chief of Staff, if the Chief of Staff is unavailable or unable to make such a determination), the result of such corrective action could potentially adversely affect the clinical privileges of a practitioner, the Chief of Staff (or Vice Chief of Staff, if appropriate) of the Staff shall promptly request the Medical Executive Committee to investigate the matter.

This investigation must be carried out by the Medical Executive Committee itself or by an Ad Hoc Investigating Committee appointed by the Medical Executive Committee.

1.4 MEC Report

The Medical Executive Committee shall, within thirty (30) days after receipt of the request, make a report of its investigation to the Chief of Staff, the Chief Executive Officer, and the affected Practitioner. Prior to making any such report, the Practitioner against whom corrective action has been requested shall have the opportunity for an interview with the Medical Executive Committee or Ad Hoc Investigating Committee at which time the Practitioner shall be informed of the general nature of the questions directed to him/her and shall be invited to discuss, explain, or refute said questions. This interview shall not constitute a hearing, shall be preliminary and investigatory in nature, and the procedural rules provided herein with respect to hearings shall not apply. A record of such interview and the deliberations of the Medical Executive or Ad Hoc Investigating Committee shall be made.

1.5 MEC Authority

The Medical Executive Committee, in its report, shall have the authority to make the following recommendations:

1.5.1 To reject or modify the request for corrective action;

1.5.2 To issue a warning, letter of admonition, or letter of reprimand;

1.5.3 To impose terms of probationer a requirement for consultation;

1.5.4 To recommend to the Governing Body reduction, suspension, or revocation of clinical privileges;

1.5.5 To recommend to the Governing Body that an already imposed summary suspension of clinical privileges be terminated, modified, or extended; or

1.5.6 To recommend to the Governing Body that the practitioner's staff clinical privileges be suspended or revoked; or

1.5.7 Such other recommendation that is reasonable under the circumstances.

1.6 Rights of Affected Practitioner

Any proposed recommendation to be made by the Medical Executive Committee to the Governing Body that would adversely affect the clinical privileges of a member or an applicant to the Medical Staff shall entitle the affected practitioner to the hearing and appeal rights as provided in this plan.

Notwithstanding any other provision or recommendation to the contrary, the Governing Body retains the right to unilaterally constitute a Hearing Committee (as provided for hereinafter), in order to evaluate the need for corrective action on the part of any practitioner who is an applicant to or a member of the Medical Staff.

1.7 Reports of Actions

The Chief of Staff and the Chief Executive Officer shall continue to keep each other fully informed of all actions taken in connection herewith, and shall advise and provide copies to each other of any communications made between the Medical Executive Committee and the affected practitioner.

SECTION II: SUMMARY SUSPENSION.

2.1 Imposition of Summary Suspension

Any two (2) of the following acting together as a Peer Review Committee: The Chief of Staff (or in his/her absence, the Vice Chief of Staff), the Chairman of the Physician Relations Committee, the Chairman of any hospital duly constituted Quality Assurance Committee, or the hospital's Chief Executive Officer, shall have the authority, whenever action must be taken immediately in the best interest of patient care in the hospital and/or the orderly functioning of the hospital, to suspend summarily all or any portion of the clinical privileges of a practitioner including any lesser measures of summary probation or required consultation, and such summary suspension shall become effective immediately upon imposition. The reasons for the suspension shall promptly thereafter be stated in writing and given to the practitioner in the same manner as other notices as provided herein. When such two individuals summarily suspend a practitioner under this Section, they shall be acting as a Peer Review Committee of the Governing Body and shall be entitled to the rights, privileges, and immunities of the Indiana Peer Review Act and the Health Care Quality Improvement Act of 1986.

2.2 Hearing on Summary Suspension

A practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Medical Executive Committee hold a meeting on the suspension within a reasonable time period (but not more than fourteen (14) days) thereafter in order that the affected practitioner might respond to the action and make any requests the practitioner deems appropriate under the circumstances. At such meeting, the Medical Executive committee shall consider any comments or evidence presented by the affected practitioner and may thereafter recommend modification, continuance, or termination of the terms of the summary suspension. Unless the Medical Executive Committee determines to exonerate the practitioner at this meeting or to lift the suspension and impose any warnings, probation, or other measures not constituting adverse action, the matter shall thereafter be treated as a request for corrective action, and the procedures thereunder shall be followed. Should the Governing Body disagree with the decision of the Medical Executive Committee to exonerate the physician or to modify the terms of suspension, it shall have the right to unilaterally constitute a Hearing Committee, as provided for hereinafter, to evaluate and review the evidence pursuant to this Plan and take final action on any recommendation arising from such hearing procedures. The Chief Executive Officer shall respond to the affected practitioner with notice of a hearing within 7 days of notification from the Medical Executive Committee.

2.3 Medical Coverage for Affected Practitioner's Patients

Immediately after the imposition of a summary suspension, the Chief of Staff or his/her designee shall have the authority to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of such suspension. The wishes of the patient shall be considered and followed, if possible, in the selection of any alternative practitioner.

SECTION III: AUTOMATIC SUSPENSION.

3.1 Delinquent Medical Records

A practitioner's patient's chart shall be deemed delinquent if not completed by the 15th day following discharge of the patient. The hospital Health Information Management Department shall issue an-appropriate warning to each practitioner who has delinquent charts as defined in the Medical Record Completion Policy. Failure of the practitioner to complete medical records as outlined in section E of the Policy will result in suspension of the practitioner's clinical privileges until all delinquent charts of that practitioner's patients are completed. The Chief of Staff or Designee will be informed of the impending suspension.

A practitioner whose privileges are suspended pursuant to this provision may not admit patients under the name of another practitioner but may continue to care for patients already admitted prior to the effective date of the suspension.

A practitioner whose privileges are suspended pursuant to this provision three (3) times during a twelve (12) month period shall be terminated from membership on the medical staff and such physician shall be required to reapply for membership pursuant to the hospital's application process. Such a termination shall give rise to the hearing and appeal rights as provided for in this plan.

Automatic suspension for delinquent medical records is imposed by written notice to the practitioner, Chief Executive Officer, Chief of Staff, Department Heads, and Admitting Office by the Director of Medical Records.

Practitioners may request in advance a waiver of these requirements for planned vacations or professional absence. Such a request for a waiver shall be directed to the hospital's Chief Executive Officer who shall, after consultation with the Chief of Staff, approve or disapprove such a request. The hospital's Chief Executive Officer shall not unreasonably withhold approval of such a request. However, the practitioner shall be required to complete any such delinquent charts within fifteen (15) days after the practitioner's return, or face the automatic suspension provisions of this Section.

3.2 Suspension of License to Practice/DEA

Any suspension of the practitioner's license to practice his or her profession by his or her licensing board and any suspension of a practitioner's license to prescribe narcotic drugs shall automatically suspend the practitioner's hospital privileges for the same period of time. Any such suspension shall be submitted to the Medical Executive Committee and shall not be lifted until the Medical Executive Committee votes on whether or not to initiate its own corrective action.

3.3 Exclusion from participation in any Federal Health Program

Any notification or query indicating the practitioner has been excluded from participation in any Federal Health Program shall automatically suspend the practitioner's privileges.

3.4 Criminal Convictions

Any notification indicating the practitioner has been convicted of a felony, or for any misdemeanor related to the practice of a health care profession, Federal Health Program fraud, or abuse (including but not limited to a finding of liability under the False Claims Act), third party reimbursement, or controlled substances**.**

3.5 Medical Malpractice Insurance

Any notification of cancellation or failure to renew professional liability insurance, and of the failure to carry sufficient insurance (or self-insurance) and to pay the surcharge necessary to qualify the practitioner as a provider under the Indiana Medical Malpractice Act, shall automatically suspend any practitioner's privileges in the hospital until such coverage is re-established.

3.6 Continuing Medical Education Requirements

Automatic suspension may also be imposed for failure to complete any required number of hours of continuing medical education or for failure to attend required meetings of the Medical Staff and committees as the Medical Staff may provide in its Rules and Regulations.

3.7 Rights of Affected Practitioner

Automatic suspensions do not give rise to a hearing or appeal. They are imposed by notice to the affected practitioner by the Health Information Management Department, Medical Executive Committee or Chief Executive Officer as appropriate, and are terminated by the practitioner fulfilling or correcting the appropriate requirement. An automatic termination of privileges and the requirement to reapply for staff membership, which is imposed pursuant to Section 3.1, shall give rise to the hearing and appeal rights as provided for in this plan.

FAIR HEARING PROCESS

SECTION I: INTRODUCTION.

1.1 Intent of Plan

When any practitioner who is either a member of the medical staff or an applicant to the medical staff receives notice of a proposed recommendation of the Medical Executive Committee, the Governing Body, (or any committee of either) that could adversely affect the practitioner's appointment to, application for, or status as a member of the Medical Staff or the practitioner's right to exercise clinical privileges as a member of the Medical Staff, the practitioner shall be entitled to a hearing and an appellate review as hereinafter set forth. The intent of this plan is to ensure that the applicable immunities, acts, and protections of the Indiana Peer Review Act of 1986 and the Health Care Quality Improvement Act are afforded to the participants in any such hearing and/or appellate review.

1.2 Grounds for Hearing

Except as otherwise specified in this plan or in the Medical Staff Bylaws, any one or more of the following actions or recommended actions shall be deemed an actual or potential adverse action and constitute grounds for hearing:

1.2.1 Denial of medical staff membership.

1.2.2 Denial of requested advancement in staff membership status or category.

1.2.3 Denial of medical staff reappointment.

1.2.4 Involuntary change of medical staff category.

1.2.5 Suspension of membership status.

1.2.6 Revocation of medical staff membership.

1.2.7 Denial of requested clinical privileges, excluding temporary privileges

1.2.8 Involuntary reduction of current clinical privileges.

1.2.9 Suspension of clinical privileges for a period of longer than fourteen (14) days.

1.2.10 Termination of all clinical privileges for a period of longer than thirty (30)

1.2.11 Involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional staff status).

SECTION II: NOTICE OF PROPOSED ADVERSE ACTION.

2.1 Notice of Adverse Action

In any potential adverse action, the hospital's Chief Executive Officer shall be responsible for giving prompt written notice to the affected practitioner of the proposed adverse action and of the practitioner's rights to a hearing by registered or certified mail, return receipt requested, or by hand delivery or delivery by courier service designed for overnight or same day delivery. Such notice shall contain, at a minimum, the following information:

2.1.1. That a professional review action has been proposed which could adversely affect the clinical privileges of the practitioner;

2.1.2 The reasons for the proposed action;

2.1.3 Any time limit (but not less than thirty (30) days from the date of the notice) with which the practitioner must request a hearing; and

2.1.4 A summary of the practitioner's rights in the hearing as hereinafter set forth in Section 3.5.

2.2 Notice of Hearing

If a hearing is requested by the affected practitioner on a timely basis as set forth in Section 2.1.3, the Chief Executive Officer will provide to the affected practitioner a notice of hearing via registered mail, return receipt requested. The following information will be provided:

2.2.1 The time, place, and date of the hearing, which date shall not be less than thirty (30) days after the date of notice of hearing; and

2.2.2 A list of witnesses known at the time of the notice which are expected to testify at the hearing on behalf of the committee bringing the proposed adverse action.

2.2.3 The rights as spelled out in Section 3.5, Rights of Participants.

2.3 Failure to Request a Hearing

The failure of an affected practitioner to request a hearing on a timely basis shall be deemed a waiver of the affected practitioner's right to a hearing and to any appellate review to which the affected practitioner might otherwise have been entitled on the matter.

SECTION III: CONDUCT OF HEARING AND NOTICE

3.1 Conduct of Hearing

If a hearing is requested on a timely basis pursuant to Section 2.1.3, the hearing shall be held before an impartial panel of three (3) practitioners appointed by the hospital acting through the Chief of Staff.

If the Chief of Staff is the subject of the hearing, then the Vice Chief of Staff shall appoint the hearing panel. Any individual selected for such a Hearing Committee shall not be in direct economic competition with the affected practitioner unless the affected practitioner approves in writing of such an individual. Hearing Committee members may include persons who are not on the Medical Staff of the hospital as long as they hold a valid license in the profession of the committee. No member of the Hearing Committee should have actively participated in prior consideration of the matter. For example, if the MEC makes the adverse recommendation, no one on the Hearing Committee should be from the MEC.

3.2 Failure of Practitioner to Appear

The right to any hearing pursuant to this provision will be forfeited if the affected practitioner fails, without good cause in the opinion of the Hearing Committee, to appear at the place, time, and date of the scheduled hearing.

3.3 Exchange of Witness List and Exhibits

The presiding member of the Hearing Committee shall appoint a date, time, and place for the exchange of exhibits and witness list, which date shall not be less than five (5) days prior to the scheduled date of the hearing. Any witnesses not then listed and any exhibits provided may, in the discretion of the Hearing Committee, be excluded from the hearing.

3.4 Access of Affected Practitioner to File

All material contained in a practitioner's credentials and/or personal file shall be part of the hearing record and the practitioner shall have the right to have a copy of all such material in advance of the hearing.

3.5 Rights of Participants

In the hearing, the affected practitioner and the Medical Staff or Governing Body committee bringing the charges, each will have the following rights:

3.5.1 To representation by an attorney or any other person of the party's choice;

3.5.2 To have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof;

3.5.3 To call, examine, and cross-examine witnesses;

3.5.4 To present any evidence determined to be relevant by the Hearing Committee, regardless of its admissibility or inadmissibility in a court of law;

3.5.5 To submit a written statement at the close of the hearing; and

3.5.6 Upon the completion of the hearing, the affected practitioner shall have the right to receive the written recommendation of the committee, including a statement of the basis for the recommendation.

3.6 Record of Hearing

An accurate record of the hearing must be kept. The mechanism shall be established by the Hearing Committee and may be accomplished by the use of a court reporter (preferred method), electronic recording unit, or detailed transcription.

3.7 Postponement or Recess

The Hearing Committee shall have the right to postpone the hearing or to recess the hearing if, in its judgment, such action will be in the best interest of obtaining the facts at issue.

3.8 Hearing Committee Chairman

The Hearing Committee, prior to formal hearing, shall meet and elect a Chairman who shall preside over the hearing and make determinations and decisions as called for in Section 3.5 above and shall further determine the order of procedure in the hearing. The Chairman shall assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. If a Hearing Committee is acting in concur with a Hearing Officer, the role of the Hearing Officer, if any, in arriving at the final findings and recommendation of the hearing will be determined in advance.

3.9 Report of Committee

Within ten (10) days after the end of the formal hearing and any succeeding deliberations by the Hearing Committee thereafter, the Hearing Committee shall issue its written report and recommendation to the Governing Body. This time period may be extended if the Hearing Committee has not received a copy of the transcript or other materials in sufficient time to allow the Committee adequate ability to thoroughly review the facts and testimony in the hearing. The Committee's written report shall be provided to the affected practitioner along with a statement of the Committee regarding the basis for any recommendation made. Such decision shall be mailed by certified mail, return receipt requested, to the affected practitioner and copies shall be delivered to the Chief Executive Officer of the Hospital and the Chief of Staff.

If the report and/or recommendation of the Hearing Committee is still adverse to the affected Practitioner, the affected Practitioner shall have the right to appeal such recommendation pursuant to the provisions of Section IV of this Plan. If the report/recommendation is adverse to the Medical Staff or Board Committee bringing the initial action, it shall also have the right to appeal in the same manner as the affected Practitioner under Section IV.

3.10 Burden of Proof

When a hearing concerns charges that a Practitioner is not providing acceptable medical care or is impaired by physical, mental, or emotional defect, the Practitioner shall be required to show that his/her care is appropriate and that he/she continues to be competent to exercise privileges on the Medical Staff. When the charges concern disruptive or unethical behavior, the party bringing such charges shall be required to present evidence in support thereof. Thereafter, the practitioner must demonstrate that the action or facts upon which it is based is either arbitrary, unreasonable or capricious.

3.11 Presence of Hearing Committee Members

A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the hearing of evidence, he/she may not participate in the deliberations or the decision unless such committee member shall be able to hear a recording or read the transcript of the deliberations that were missed or with the consent of both parties.

SECTION IV: APPEAL TO THE GOVERNING BODY.

4.1 Practitioner's Right to Appeal

If the written recommendation of the Hearing Committee is adverse to the Practitioner, the Practitioner shall be entitled to an appeal to the Governing Body. Within ten (10) Days after the Practitioner receipt of the Hearing Committee's recommendation, the affected Practitioner may, by written Notice to the Governing Body delivered through the Chief Executive Officer by certified or registered mail, return receipt requested, by hand delivery, or by courier designed for overnight or same day delivery, request an appellate review by the Governing Body. Such appellate review may be held only on the record on which the adverse recommendation or decision has been based, which record shall include any supporting documents that were admitted by the Hearing Committee during the course of review by the Governing Body. Such appellate review may be held only on the record on which the adverse recommendation or decision has been based, which record shall include any supporting documents that were admitted by the Hearing Committee during the course of the hearing. At the discretion of the Governing Body, oral argument may be permitted.

4.2 Waiver of Right to Appellate Review

If such appellate review is not requested within ten (10) days, the affected practitioner shall be deemed to have waived his or her right to the same and to have accepted such adverse recommendation or decision, and the same shall be submitted to the Governing Body for final action.

4.3 Date for Appellate Review

If the practitioner provides timely notice to the Governing Body of the practitioner's request for an appellate review, within fifteen (15) days after receipt of such notice, the Governing Body shall schedule a date for such review, including a time and place for oral argument if such has been requested and approved by the Governing Body and shall, through the Chief Executive Officer, by written notice sent by certified mail, return receipt requested, notify the affected practitioner of the same. The date of the appellate review shall not be less than twenty (20) days nor more than sixty (60) days from the date of the receipt of notice of the request for appellate review, except that when the affected practitioner requesting the review is under a suspension, which is then in effect, such review shall be scheduled as soon as the arrangements for it may reasonably be made, but not more than thirty (30) days from the date of receipt of such notice from the affected practitioner.

4.4 Conduct of Appellate Review

The appellate review may be conducted by the Governing Body as a whole, or, if approved by the Governing Body, by an appellate review committee of the Governing Body appointed by the Chairman of the Board. Such an appellate review committee shall not have less than three (3) members.

4.5 Practitioner's Access to Records

The affected practitioner shall have access to the report, record, exhibits and transcript, if any, of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision. The affected practitioner shall have the right to submit a written statement in his or her own behalf, in which those factual and procedural matters with which the practitioner disagrees, and his or her reasons for such disagreement, shall be specified. This written statement may cover any matters raised in any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. Such written statement shall be submitted to the Governing body through the Chief Executive Officer by certified mail, return receipt requested, at least five (5) days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Medical Staff or Governing body committee bringing the initial adverse recommendation.

4.6 Determination of Appellate Review Body

The Governing Body, or its appointed review committee, shall act as an appellate body. It shall review the record created in the proceedings and shall consider the written statement(s) submitted pursuant to this Section for the purpose of determine-in whether the adverse recommendation or decision against the affected Practitioner was supported by the evidence and whether the practitioner was granted a hearing pursuant to the Plan. If oral argument is requested and approved as a part of the appellate review procedure, the affected practitioner may be present at such appellate review, shall be permitted to speak against the adverse recommendation or decision, and shall answer questions put to him or her by any member of the appellate review body. The Medical Staff or Governing Body committee which presented the original charges at the Hearing Committee shall also be represented by an individual, if desired, who shall be permitted to speak in support of the adverse recommendation or decision, and who shall answer questions put to him or her by any member of the appellate review body. Both parties may be represented by counsel if they so choose.

4.7 Scope of Appellate Review

New or additional matters not raised during the original hearing or in the Hearing Report, not otherwise reflected in the record, shall only be introduced at the appellate review if the appellate body decides that the practitioner has carried the burden of showing the materiality of the new information and the burden of showing that in the exercise of due diligence the practitioner could not have discovered the information during the pendency of hearing. The appellate body shall, in its sole discretion, determine whether such new matter may be accepted.

4.8 Decision of the Governing Body

If the appellate review is conducted by the Governing Body, it may affirm, modify, or reverse the recommendation, or in its discretion, refer the matter back to the Hearing Committee/Officer for further review and recommendation. Such review

and recommendation to be provided to the Governing body within fourteen (14) days. Such referral may include a request that the Hearing Committee/Officer arrange for a further hearing to resolve specified disputed issues.

4.9 Report of Appellate Review Committee

If the appellate review is conducted by a committee of the Governing Body, such committee shall, within fourteen (14) days after the scheduled or adjourned date, whichever is later, of the appellate review, either make a written report recommending that the Governing Body affirm, modify, or reverse the prior decision, or refer the matter back to the Hearing Committee for further review and recommendation. Such referral may include a request that the Hearing Committee/Officer arrange for a further hearing to resolve disputed issues. Within fourteen (14) days after receipt of such recommendation after referral, the committee shall make its recommendation to the Governing Board as above provided.

4.10 Conclusion of Proceedings

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section have been completed or waived. Where permitted by law and/or the Hospital Bylaws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to act.

SECTION V.: FINAL DECISION BY THE GOVERNING BODY

5.1 Notice of Final Decision of Governing Body

Within thirty (30) days after the conclusion of the appellate review, the Governing Body shall make its final decision in the matter and shall send written notice thereof to the Chief of Staff, the Chief Executive Officer, and the affected practitioner, by certified mail, return receipt requested. In such notice, the affected practitioner shall be provided with the decision of the governing body and the basis upon which it was made.

5.2 Affected Practitioner's Rights

Notwithstanding any other provision herein, no practitioner shall be entitled, as a right, to more than one hearing and one appellate review on any matter which shall have been the subject of an action by the Medical Executive Committee or by the governing body, or by a duly authorized committee of the governing body, or both.

5.3 Compulsory Reporting of Adverse Actions

In compliance with the Health Care Quality Improvement Act of 1986 and I.C. 16-10-1-6.5(b), the hospital's Chief Executive Officer shall report to the Indiana Medical Licensing Board and to the designated federal agency any final, substantive, and adverse disciplinary action taken by the governing body. Such report shall also be made if the practitioner voluntarily resigns while under investigation by the hospital relating to possible incompetence or professional conduct.

Any adverse action, with the exception of a summary suspension meeting the criteria for reporting as set forth in the Health Care Quality Improvement Act,

shall not be deemed to be a "professional review action", as defined in the Act, until all procedures and appeals in the Medical Staff Bylaws have been completed or waived and there has been a final action taken by the hospital board.

SECTION VI: OTHER PROCEDURAL CONSIDERATIONS.

6.1 Additional Evidence Discovered

6.1.1 After Waiver - If an affected practitioner discovers facts which the practitioner was not aware of or with the exercise of due diligence would not have been made aware of after the practitioner had either waived his/her right to a hearing and/or to appellate review, the practitioner may petition the governing body to allow withdrawal of the waiver. The affected practitioner shall be required to prove that the additional information could reasonably be expected to be material in any corrective action which might be taken against the practitioner and that he/she was not aware of the information at the time the practitioner waived his/her rights and would not have become aware of it in the course of due diligence. The Governing Body may grant the affected practitioner a hearing which he/she had otherwise waived, remand the matter to a special Hearing Committee for an additional hearing, or rule that the affected practitioner has not carried his burden of proof on materiality or due diligence.

6.1.2 After Hearing But Before Final Action - If a practitioner discovers additional facts after a hearing has concluded of which he/she was not aware during the hearing and could not have reasonably have discovered with the exercise of due diligence, he/she may petition the Governing body to have the matter remanded to the Hearing Committee to hear additional evidence on the new information. The affected practitioner shall have the burden of proving both that the new information is material and that due diligence would not have discovered it prior to the conclusion of the hearing. The Governing Body may grant the petition and remand or find that the practitioner failed to carry his/her burden of proof as to materiality or due diligence.

SECTION VII: AMENDMENT.

7.1 Amendments to Plan

This plan may be amended or repealed, in whole or in part, by one of the following mechanisms:

7.1.1 A resolution passed by a majority of the Medical Staff recommending such action to the Governing Body, and such resolution is ultimately accepted and adopted by the Governing Body; or

7.1.2 A resolution of the Governing Body, taken on its own initiative after a request to the Medical Staff has been made by the Governing Body to initiate an amendment which, in the opinion of the Governing Body, is necessary and appropriate and the Medical Staff thereafter has refused or failed to act on such a request for amendment.

SECTION VIII: ADOPTION.

8.1 Medical Staff

This Plan was adopted and recommended to the Governing Body by the Medical Staff in accordance with and subject to the Medical Staff Bylaws.

8.2 Governing Body

This Plan was approved and adopted by resolution of the Governing Body after considering the Medical Staff's recommendations and in accordance with and subject to the Hospital Bylaws.