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RULE 1  PEER REVIEW AND CORRECTIVE ACTION

1.1  PEER REVIEW AND CORRECTIVE ACTION

1.1.1  Peer Review

For purposes of these Rules, a “peer” is a Practitioner practicing in the same profession as the Practitioner under review or investigation and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a Practitioner’s performance will determine what “practicing in the same profession” means on a case-by-case basis. For example, for quality issues related to general medical care, a Physician (MD or DO) may review the care of another Physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty. Peer review includes Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation including quality and appropriateness of care, identifications of opportunities to improve care, and reviews initiated when a question arises concerning a Practitioner’s qualifications, clinical practice and/or professional conduct, including without limitation circumstances defined in the Hospital’s Quality Plan, Rule 8 (Practitioner Health Concerns) of the Credentialing and Privileging Rules, Rule 3 (Disruptive Behavior and Harassment by Practitioners) of these Rules, this Rule 1, and applicable Department or Section Rules, and Medical Staff Rules and policies, which are hereby incorporated into these Rules. All Practitioners and Hospital employees are encouraged to promptly report to Medical Staff Services or to the Section Chief, Department Chair or Vice Chair, Medical Staff President or Chief Medical Officer instances in which a Practitioner is or may be providing unsafe patient care.

1.1.2  External Peer Review

Circumstances requiring external peer review:

External peer review will take place under the following circumstances if and only if deemed appropriate based on a recommendation from a peer review body (including the MSPRC (as defined in the General Medical Staff Rules), the Credentials Committee, or an ad hoc investigation committee) and approved by the Medical Executive Committee, Medical Staff Officers, Chief Medical Officer or the Governing Body. No Practitioner can require the Hospital to obtain external peer review if it is not deemed appropriate by the Medical Executive Committee Medical Staff Officers, Chief Medical Officer or Governing Body. Circumstances, which may require external peer review include:

a. Lack of internal expertise – when no one on the Medical Staff has adequate expertise in the specialty under review; or when the only Practitioners on the Medical Staff with that expertise are partners, associates, or direct competitors of the Practitioner under review. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the Medical Executive Committee or Governing Body. Members of the Medical Staffs of the other Exempla hospitals will be considered as the initial source of external peer review whenever possible.

b. Litigation - when dealing with the potential for a lawsuit.

c. Ambiguity - when dealing with vague or conflicting recommendations from internal reviewers or Medical Staff committees and conclusions from this review will directly impact a Practitioner’s membership or Privileges.

d. New technology or Privileges – when the Medical Staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.

e. Miscellaneous issues - when the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Executive Committee or Governing Body may require external peer review in any circumstances deemed appropriate by either of these bodies.
1.1.3 Informal and Collegial Peer Review

When questions arise relating to a Practitioner’s qualifications, clinical practice and/or professional conduct, a Medical Staff Officer, and/or a Department or Section leader may initiate informal, collegial peer review efforts. Collegial intervention is encouraged, but is not mandatory. The Chief Medical Officer may assist in these efforts. If the questions concern clinical competence, at least one person conducting the collegial intervention shall be a peer of the Practitioner who is the subject of the intervention. The goal of collegial intervention is to arrive at voluntary, responsive actions by the Practitioner to the questions raised. The Medical Staff Officers and leaders are encouraged to document the collegial intervention in the Practitioner’s Credentials File, and may issue letters of warning or obtain the Practitioner’s written agreement to a proposed resolution (such as an agreement to attend additional training). If matters are documented in the Credentials File or a letter of warning is issued, the Practitioner may respond in writing. If collegial intervention does not resolve the questions, the Medical Staff Officers and leaders may proceed as set forth in these Rules. Collegial intervention shall not constitute a formal corrective action investigation, restriction of Privileges, or grounds for any formal hearing or appeal rights under the Medical Staff Bylaws or Rules. The informal and collegial intervention process described in this Rule is separate from the peer review processes set forth in Rule 8 (Practitioner Health Concerns) of the Credentialing and Privileging Rules and Rule 3 (Disruptive Behavior and Harassment by Practitioners) of these Rules.

1.1.4 Routine Peer Review

The Departments, Sections, and Medical Staff committees, including the MSPRC, are responsible for carrying out delegated peer review and quality improvement functions as requested by the Medical Executive Committee. They may be assisted by the Chief Medical Officer, Medical Staff Officers, Department and/or Section leaders. At least one Member conducting the peer review shall be a peer of the Practitioner who is the subject of the review. Routine peer review may include, without limitation, efforts to review trends, specific issues, counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures). Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner may respond in writing and may also be given an opportunity for an interview with the Department, Section or Medical Staff committee. Any letters or warning or censure, Practitioner responses, informal actions, monitoring, or counseling or education shall be documented in the Practitioner’s file. Neither Credentials Committee nor Medical Executive Committee approval is required for such actions, although the actions shall be reported to the Credentials Committee. These actions shall not constitute a formal corrective action investigation, restriction of Privileges, or grounds for any formal hearing or appeal rights under the Medical Staff Bylaws or Rules.

1.1.5 Criteria for Initiation of Formal Corrective Action Investigation

A formal corrective action investigation may be initiated whenever reliable information indicates a Practitioner may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital, that are reasonably likely to be (a) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (b) unethical; (c) contrary to Hospital or Medical Staff Bylaws, Rules or policies; (d) below applicable professional standards; (e) disruptive of Medical Staff or Hospital operations; (f) an improper use of Hospital resources; (g) in violation of accreditation standards applicable to the Hospital; or (h) in violation of laws relating to the delivery of health care services.

1.1.6 Initiation

a. Any person who believes that corrective action may be warranted may provide information to the President, any other Medical Staff Officer, any Department or Section chair, any Medical Staff committee, the chair of any Medical Staff committee, the Chief Medical Officer, the Governing Body, or the Chief Executive Officer.

b. If the President, any other Medical Staff officer, any Department or Section Chair or chief, any Medical Staff committee, the chair of any Medical Staff committee, the Chief Medical Officer, the Governing Body, or the Chief Executive Officer determines that corrective action may be
warranted under Rule 1.1.8, that person, entity, or committee may request the initiation of a formal corrective action investigation. Such requests may be conveyed to the Medical Executive Committee orally or in writing.

c. The Medical Executive Committee Chair shall notify the Chief Executive Officer and Chief Medical Officer and shall continue to keep them fully informed of all action taken. In addition, the Medical Executive Committee Chair shall immediately forward all necessary information to the Investigating Committee (as defined below), provided, however, the Medical Executive Committee may dispense with further investigation of matters deemed to have been adequately investigated by a committee or person pursuant to Rules 1.1.4 or 1.1.7, or otherwise.

1.1.7 Expedited Initial Review

a. Whenever information suggests that corrective action may be warranted, the President and/or the Chief Medical Officer, or their designee(s), may, on behalf of the Medical Executive Committee, immediately review the information and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee at its next meeting, and the Medical Executive Committee shall decide whether to initiate a formal corrective action investigation or to take or recommend corrective action.

b. In cases of reports of disruptive behavior or harassment by a Practitioner, an expedited initial review may be conducted in accordance with Rule 3 (Disruptive Behavior and Harassment by Practitioners in these Rules). The information gathered from an expedited initial review shall be referred to the Medical Executive Committee if it is determined that corrective action may be warranted against a Practitioner.

1.1.8 Formal Corrective Action Investigation

a. If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may investigate the matter itself or assign the task to a subcommittee, an appropriate Medical Staff Officer, the Credentials Committee, a standing or ad hoc committee, and/or one or more persons who are not members of the Medical Staff (collectively, the “Investigating Committee”). The Investigating Committee shall include at least one peer of the Practitioner who is the subject of the investigation. The Investigating Committee shall not include any relative of the Practitioner or any other person the Medical Executive Committee determines has a conflict of interest, which may make it difficult for the person to exercise his or her independent judgment in the best interest of the Medical Staff and the Hospital in accordance with the purposes of these Rules. The Investigating Committee shall proceed with the investigation in a prompt manner and shall make reasonable efforts to forward a written report of the investigation to the Medical Executive Committee within sixty (60) days from the assignment, provided an outside review is not necessary. If an outside review is necessary, the Investigating Committee shall make reasonable efforts to forward the written report within sixty (60) days of receipt of the outside review. The time frames in this Rule 1 are intended to serve as guidelines, and shall not create any right for the Practitioner to have an investigation completed within such time periods. If the Medical Executive Committee concludes that action is indicated but no further investigation is necessary, it may proceed to make its recommendation or take action.

b. The Investigating Committee shall allow the Practitioner the opportunity for an interview. During this interview (but not, as a matter of right, before the interview), the Practitioner shall be informed of the general nature of the information supporting the matters being investigated and shall be invited to discuss, explain or refute such matters. Any interview with the Practitioner shall not constitute a “hearing” as that term is used in the Medical Staff Bylaws and Rules, nor shall the hearings or appeals rules or other procedural rights apply. The Investigating Committee shall include a summary of the interview in the report to the Medical Executive Committee.
c. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including precautionary suspension.

1.1.9 Medical Executive Committee Action

Prior to any adverse action being recommended or approved, the Medical Executive Committee shall assure that the Practitioner was given an opportunity for an interview to provide information as part of the review and investigation process. In making its deliberations, the Medical Executive Committee may consider, as appropriate, relevant literature and clinical practice guidelines, all opinions and views expressed throughout the review and investigation processes, any reports of outside consultants, and any information or explanations provided by the Practitioner who is the subject of the investigation. The Medical Executive Committee shall make reasonable efforts to make its recommendations within forty-five (45) days of receipt of the report or other information. Such recommended action may include, without limitation:

a. Determining no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the Practitioner’s file;

b. Deferring action for a reasonable time;

c. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Medical Staff Officers or leaders from issuing informal written or oral warnings outside of the mechanism for formal corrective action. In the event such letters are issued, the affected Practitioner may make a written response which shall be placed in the Practitioner’s file;

d. Recommending the imposition of terms of limitation upon continued Medical Staff membership or exercise of Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

e. Recommending reduction, modification, suspension, or revocation of Privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;

f. Recommending reductions of membership status or limitation of any prerogatives directly related to the Practitioner’s delivery of patient care;

g. Recommending suspension or revocation of Medical Staff membership. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;

h. Determine that the investigation should be closed;

i. Taking other actions deemed appropriate under the circumstances,

j. Recommending a probationary period based the practitioner’s competence. If probation is recommended, the terms and duration of the probation and the conditions for terminating the probationary period shall be stated. (Physicians are required to report probationary periods to the Board of Medical Examiners), and

k. Recommending further review, in the form of an intensive review or a focused professional practice evaluation.

1.1.10 Procedural Rights
a. If the Medical Executive Committee determines that either no corrective action is required or that
the corrective action required does not constitute grounds for a hearing under Rule 2.2 (such as
proctoring or issuing a letter of warning, admonition, reprimand, or censure), the decision shall be
forwarded to the Governing Body. The decision shall become final if the Governing Body affirms
it or takes no action on it within 70 days after receiving the Notice of decision.

b. If the Medical Executive Committee recommends an action that is a ground for a hearing under
the Rules, the President shall give the Practitioner Special Notice of the adverse recommendation
and of the right to request a hearing. The Governing Body may be informed of the
recommendation, but shall take no action until the Practitioner has either waived his or her right to
a hearing or completed the hearing.

1.1.11 Initiation by Governing Body

If the Medical Executive Committee fails to authorize an investigation or take corrective action, the
Governing Body may direct the Medical Executive Committee to authorize an investigation or take
corrective action, after consulting with the Medical Executive Committee. If the Medical Executive
Committee fails to act in response to that Governing Body direction, the Governing Body may authorize an
investigation or initiate corrective action, but must comply with applicable hearing and appeal provisions of
these Rules. The Governing Body shall inform the Medical Executive Committee in writing of the action
taken.

1.2 PRECAUTIONARY SUSPENSION

1.2.1 Criteria for Initiation

a. The President, the Medical Executive Committee, the chair of the Department in which the
Member holds Privileges, the Chief Executive Officer, the Chief Medical Officer, the Governing
Body Chair, or the Governing Body shall each have the authority to suspend as a precaution the
Medical Staff membership or all or any portion of the Privileges of a Practitioner whenever the
failure to take such action may result in imminent danger to the health and/or safety of any
individual or the safe and/or effective operation of the Hospital. When consistent with safety, the
person or body authorized to impose a precautionary suspension may make reasonable efforts to
interview the Practitioner before or at the time the precautionary suspension is being imposed.
Such person or body shall document the interview in the Practitioner’s file.

b. Unless otherwise indicated by the terms of the precautionary suspension, such precautionary
suspension shall become effective immediately upon imposition and the person or body
responsible shall promptly give Special Notice to the Practitioner and written Notice to the
Governing Body, the Medical Executive Committee, and the Chief Executive Officer. The
Special Notice shall generally describe the reasons for the precautionary suspension.

c. Unless otherwise indicated by the terms of the precautionary suspension, the Practitioner’s
patients at the Hospital shall be promptly assigned to another Member by the Department chair or
by the President considering, where feasible, the wishes of the patient and the affected Practitioner
in the choice of a substitute Member.

d. The Notice of the precautionary suspension given to the Medical Executive Committee shall
constitute a request to initiate formal corrective action investigation and the procedures set forth in
Rule 1.1 shall be followed; provided, however, the Investigating Committee shall make reasonable
efforts to forward a written report of the investigation within thirty (30) days of the precautionary
suspension. The President or Chief Medical Officer, on behalf of the Medical Executive
Committee, may conduct an expedited initial review in accordance with Rule 1.1.7 before the
Medical Executive Committee acts on the request for a formal corrective action investigation.

1.2.2 Medical Executive Committee Action
a. The affected Practitioner may request an interview with the Medical Executive Committee. The interview shall be convened as soon as reasonably possible under all circumstances and shall not constitute a hearing, as that term is used in the Medical Staff Bylaws and these Rules. The Medical Executive Committee may thereafter continue, modify, or terminate the terms of the precautionary suspension, or recommend or take any other action in accordance with these Rules.

b. Unless it expires by its terms or is earlier terminated by the Medical Executive Committee, the precautionary suspension shall not exceed thirty (30) days during the pendency of the expedited review and formal corrective action investigation process and of any hearing and appellate review process.

c. At any time during the precautionary suspension or at the end of the thirty (30) day precautionary suspension period, the Medical Executive Committee may recommend or take any other action in accordance with these Rules, including further formal investigation and/or a summary suspension as set forth in Rule 1.2.3 below. The Medical Executive Committee shall give the Practitioner Special Notice of its decision, which shall include the information specified in Rule 2.3.1 if the Medical Executive Committee determines at that time to take or recommend any adverse action, which entitles the Practitioner to the procedural rights afforded by the Medical Staff Bylaws and Rules.

d. Precautionary suspension under this Rule shall be deemed an interim precautionary step in the professional review process, including the investigation process and potential corrective action, which may be taken against the Practitioner. A precautionary suspension is not an adverse professional review action and shall not imply any finding of lack of qualifications, quality care or professional conduct. A precautionary suspension under this Rule shall not constitute an adverse action, which entitles the Practitioner to the procedural rights afforded by the Medical Staff Bylaws and Rules.

1.2.3 Summary Suspension

a. Effective at the end of a thirty (30) day precautionary suspension or sooner in the discretion of the Medical Executive Committee, after considering the results of the formal corrective action investigation to date, the Medical Executive Committee may summarily suspend the Medical Staff membership or all or any portion of the Privileges of the Practitioner if the failure to take such action may result in imminent danger to the health of any individual.

b. Unless otherwise indicated by the terms of the summary suspension, such summary suspension shall become effective immediately upon imposition, and the Medical Executive Committee shall promptly give Special Notice to the Practitioner, which shall include the information specified in Rule 2.3.1, and written Notice to the Governing Body and the Chief Executive Officer.

c. If the affected Practitioner has not had an interview with the Medical Executive Committee in accordance with Rule 1.2.2, the Practitioner may request such an interview. The interview shall be convened as soon as reasonably possible under all circumstances and shall not constitute a hearing, as that term is used in the Medical Staff Bylaws and these Rules. The Medical Executive Committee may thereafter continue, modify, or terminate the terms of the summary suspension, or recommend or take any other action in accordance with these Rules, including further formal investigation. The Medical Executive Committee shall give the Practitioner Special Notice of its decision, which shall include the information specified in Rule 2.3.1 if the Medical Executive Committee determines at that time to take or recommend any adverse action in addition to the summary suspension, which entitles the Practitioner to the procedural rights afforded by the Medical Staff Bylaws and Rules.

d. A summary suspension under this Rule shall constitute an adverse action, which entitles the Practitioner to the procedural rights under these Rules, provided however, the hearing for the summary suspension shall be consolidated with the hearing for any other corrective action.
e. Unless otherwise indicated by the terms of the summary suspension or unless already addressed through the precautionary suspension, the Practitioner’s patients at the Hospital shall be promptly assigned to another Member by the Department chair or by the President considering, where feasible, the wishes of the patient and the affected Practitioner in the choice of a substitute Member.

f. Unless it expires by its terms or is earlier terminated by the Medical Executive Committee, the summary suspension shall continue during the pendency and completion of the formal corrective action investigation process and of any hearing and appellate review process.

1.3 INTERVIEW

Interviews shall neither constitute nor be deemed a “hearing” as described in the Medical Staff Bylaws and Rules, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the Practitioner’s request, to grant an interview only when so specified in this Rule. When an interview is granted, the Practitioner shall be informed of the general nature of the reasons for the recommendation and may present information relevant thereto. The Practitioner may not be represented by an attorney at the interview. A record of the matters discussed and the findings resulting from an interview shall be made.

1.4 CONFIDENTIALITY

To maintain confidentiality, participants in the peer review, corrective action, Focused Professional Practice Evaluation, and Ongoing Professional Practice Evaluation processes shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws and these Rules for peer review matters. Nothing in these Rules shall restrict the Hospital’s reporting obligations under applicable state or federal laws, accreditation requirements, or contracts, or the Medical Staff’s or any Practitioner’s reporting obligations under applicable state or federal laws.

1.5 SYSTEMWIDE PEER REVIEW AND CORRECTIVE ACTION

1.5.1 Notice of Actions- Practitioners with Privileges

a. The President, the Chief Executive Officer, Credentials Committee and Medical Executive Committee are authorized to inform their counterpart officer or Committee at any other System Member where a Practitioner is known to hold Privileges or to have an application pending for Privileges whenever any of the Hospitals:

1. Deny initial appointment or any requested Privileges (other than for lack of sufficient activity).

2. Initiate a corrective action investigation.

3. Conduct other peer review activities in accordance with Rule 1.

b. The Hospital and the other System Members may determine whether to pool their peer review activities relating to the Practitioner. The effect of any corrective action or adverse action on the involved Practitioner’s Privileges at another System Member shall be determined by the Medical Staff Bylaws or other applicable Rules or policies of that other System Member; or if there are no applicable bylaws or policies, the information shall be deemed transmitted for the receiving System Member’s independent review and action.

c. The President, Chief Executive Officer, Credentials Committee and Medical Executive Committee are authorized to disclose to another System Member’s peer review body (or an authorized representative of that body) information from the Hospital and Medical Staff records regarding such a Practitioner for purposes of considering or conducting combined or pooled peer review.

1.5.2 Notice of Action-Practitioners Seeking Privileges
a. In addition to the discretionary reporting and combined investigation provisions set forth at Rule 1.5.1, the President, the Chief Executive Officer, Credentials Committee and Medical Executive Committee are authorized to inform their counterpart officer or Committee at any other System Member where a Practitioner is known to hold Privileges or to have an application pending for Privileges whenever any of the following actions has been taken:

1. Suspension of Privileges should be reported promptly to other System Members upon imposition (other than automatic suspension for failure to complete medical records or pay dues).

2. Denial of initial appointment or reappointment or any requested Privileges (other than for lack of sufficient activity).

3. Other corrective actions may be reported at any time the President or Chief Executive Officer determines such a report to be appropriate, and should be reported promptly upon final action by the Board.

b. The Hospital and the other System Members shall determine whether to pool their peer review activities relating to the Practitioner. The effect of any corrective action or adverse action on the involved Practitioner’s Privileges at another System Member shall be determined by the Medical Staff Bylaws or other applicable rules or policies of that other System Member; or if there are no applicable bylaws or policies, the information shall be deemed transmitted for the receiving System Member’s independent review and action.

c. The President, Chief Executive Officer, Credentials Committee and Medical Executive Committee are authorized to disclose to another System Member’s peer review body (or an authorized representative of that body) information from the Hospital and Medical Staff records regarding such a Practitioner for purposes of considering or conducting combined or pooled peer review.

1.5.3 Effect of Actions Taken by Other System Members

Except as provided in Rule 1.5.1, whenever the President or Medical Executive Committee receives information about an action taken at another System Member and involving a Practitioner holding Privileges at the Hospital, the President or Medical Executive Committee shall, consistent with the exigencies of patient safety, independently assess the facts and circumstances to ascertain whether to take comparable action. However, when the Practitioner was suspended at the other System Member, any person or body authorized under Rule 1.2.1 to impose a precautionary suspension is authorized to immediately impose a comparable suspension at this Hospital, subject to review in accordance with the provisions of Rule 1.2.

1.6 ONGOING MONITORING OF PEER REVIEW

When applicable, any recommendations or actions that are the result of a review, Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation, corrective action investigation, or hearing or appeal shall be monitored by the Medical Staff, through appropriate Medical Staff Officers, leaders and/or committees as part of the peer review and quality improvement processes. Although Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation are mandatory and protected peer review, they are not an investigation.
RULE 2  HEARINGS AND APPELLATE REVIEWS

2.1  GENERAL PROVISIONS

2.1.1 Philosophy

These hearing and appellate review procedures are intended to provide a fair review of decisions that adversely affect practitioners (as defined below) while immunizing the peer review participants from liability to the full extent permitted by law. These flexible procedures are also intended to avoid burdens that might discourage the Medical Staff and Governing Body from performing peer review activities.

These review procedures give the Medical Staff and Governing Body discretion to create hearing processes that provide for a low level of formality while assuring a fair review under a variety of circumstances. The Medical Staff, the Governing Body, and their officers, committees, and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986, the Colorado Professional Review Act, and the Hospital Licensing Statute Quality Management Provisions, as such are amended from time to time, and claim all privileges and immunities afforded by applicable federal and state laws.

2.1.2 Exhaustion of Remedies

If an adverse action as described in Rule 2.2 is taken or recommended, the Practitioner must exhaust the remedies afforded by these Rules before commencing any judicial proceeding in any administrative, state or federal court.

2.1.3 Limitations on Remedies

The hearing and appeal rights established in the Rules are “judicial” and not “legislative” in structure and function. The hearing committee and Appeal Board (as defined below) have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of the Medical Staff Bylaws, Rules or policies.

2.1.4 Joint Hearings and Appeals

The Medical Staff and Governing Body are authorized to participate in joint hearings and appeals with other System Members in accordance with Rule 2.10.

2.1.5 Definitions

Except as otherwise provided in these Rules, the following definitions shall apply under this Rule:

a. “Body whose decision prompted the hearing” means the Medical Executive Committee in all cases when the Medical Executive Committee or authorized Medical Staff officers, Members, or committees took the action or rendered the decision, which resulted in a hearing being requested. It refers to the Governing Body in all cases when the Governing Body or its authorized officers, directors, or committees took the action or rendered the decision, which resulted in a hearing being requested.

b. “Practitioner,” as used in this Rule, means the Practitioner who is entitled to request a hearing pursuant to Rule 2.3.2.

2.1.6 Substantial Compliance

Technical, insignificant, immaterial, or non-prejudicial deviations from the procedures set forth in these Rules shall not be grounds for invalidating the action taken or immunities available.
2.2 **Grounds for Hearing**

Except as otherwise specified in these Rules, a Practitioner may request a hearing when an “adverse action” is taken or recommended against the Practitioner, including those adverse actions based on findings made after an investigation indicating that the Practitioner lacks qualifications, has provided substandard or inappropriate care, or has exhibited inappropriate professional conduct. “Adverse actions” are limited to the following:

2.2.1 Denial of initial appointment to the Medical Staff.

2.2.2 Denial of reappointment to the Medical Staff.

2.2.3 Denial of requested Privileges.

2.2.4 Revocation, restriction or reduction of Privileges.

2.2.5 Involuntary imposition of mandatory concurrent consultation requirements that restrict the Practitioner’s Privileges (i.e., the consultant must approve a course of treatment recommended by the Practitioner in advance).

2.2.6 Summary suspension (but not precautionary suspension) of Medical Staff membership and/or Privileges.

2.2.7 Any other adverse action recommended or taken that must by law be reported by the Hospital to the National Practitioner Data Bank, regardless of whether the Practitioner or any other individual or entity may have a separate reporting obligation.

No other findings, actions or recommendations shall entitle a Practitioner to request a hearing. A Practitioner is not entitled to request a hearing where the Practitioner fails to demonstrate the basic qualifications for Medical Staff membership under Article 2 of the Medical Staff Bylaws or the basic qualifications or criteria for Privileges, or for other matters specified in Rule 2.9 (Exceptions to Hearing Rights).

2.3 **Requests for Hearing**

2.3.1 Special Notice of Adverse Action or Recommended Adverse Action

In all cases in which adverse action has been taken or a recommendation made as set forth in Rule 2.2, the Chief Executive Officer shall promptly give the Practitioner Special Notice of the adverse action that includes:

a. A statement of the adverse action recommended or taken;

b. A general statement of the reasons for the adverse action recommended or taken;

c. A statement that the Practitioner has the right to request a hearing;

d. A statement that a request for a hearing must be sent within 30 days of receipt of the Special Notice; and

e. A statement of the hearing rights described in the Peer Review, Fair Hearing and Appeal Rules. (This requirement may be satisfied by enclosing a copy of this Rule 2.)

2.3.2 Request for Hearing

a. The Practitioner shall have 30 days following the date of receipt of a Special Notice of adverse action to request a hearing. The request shall be in writing addressed to the President with a copy to the Chief Executive Officer. The request shall include the name, address and telephone number of any attorney or other representative retained by the Practitioner as of the date of the Practitioner’s request for a hearing. In the event the Practitioner has not engaged an attorney or
other representative by the date of his or her request for a hearing, the Practitioner may identify his or her attorney or other representative in accordance with Rule 2.4.5.

b. If the Practitioner does not request a hearing within the time and in the manner described above, the Practitioner shall be deemed to have waived any right to a hearing or appeal and accepted the adverse action recommended or taken. Such final recommendation or action shall be considered by the Governing Body within 70 days and shall be given great weight by the Governing Body, although it is not binding on the Governing Body.

2.4 Hearing Procedure

2.4.1 Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the chair of the Governing Body shall fulfill the functions assigned in this Rule to the President.

2.4.2 Special Notice of Hearing Time, Place, Witnesses and Reasons for Adverse Action

Upon receipt of a timely request for hearing, the President shall promptly schedule a hearing and a pre-hearing conference. The President shall give Special Notice to the Practitioner of the time, place, and date of the hearing and the pre-hearing conference. The date the hearing commences shall not be less than 30 days from the date of Practitioner’s receipt of the Special Notice of the hearing. The Special Notice of the hearing shall also include a statement of the reasons for the adverse action taken or recommended, including the alleged acts or omissions by the Practitioner and a list of the patient charts in question (when applicable) and the witnesses (if any) expected to testify at the hearing. Supplemental Notices may be provided to the Practitioner at any time, but not less than three business days before the pre-hearing conference, except for good cause.

2.4.3 Hearing Committee

a. When a hearing is requested, the President shall appoint a Hearing Committee which shall be composed of not less than 3 Members who are not in economic competition with the Practitioner, and who have not acted as accuser, investigator, witness, fact finder, initial decision maker, or other active participant in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the active Medical Staff, the President may appoint Members from other Medical Staff categories or Practitioners who are not Medical Staff Members. Such appointment shall include designation of a chair. The Hearing Committee shall include at least 1 member who is a peer. The President may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.

b. The Hearing Committee shall have such powers as are necessary to discharge its responsibilities.

c. The Practitioner shall be notified of the identity of the members of the Hearing Committee in advance of the pre-hearing conference.

2.4.4 The Hearing Officer

The President shall appoint an impartial and unbiased Hearing Officer to preside at the hearing. The Hearing Officer shall be an attorney at law. The Hearing Officer may not act as a witness, prosecutor or advocate. The Hearing Officer shall maintain order and decorum in the proceedings and assure that all parties have a reasonable opportunity to be heard and present relevant evidence. The Hearing Officer shall apply these Rules and determine the order of the presentation of evidence and argument during the hearing. The Hearing Officer shall have the authority to make all rulings on disputes involving the application of these Rules, including challenges to the qualifications of members of the Hearing Committee. The Hearing
Officer shall insure that the hearing proceeds efficiently and expeditiously. The Hearing Officer may participate in the deliberations of the Hearing Committee, but shall not be entitled to vote.

2.4.5 Representation

The Practitioner shall have the right, at his or her expense, to representation by an attorney or by another person who is a Practitioner licensed to practice in the State of Colorado. If the Practitioner elects to have attorney representation, the body whose decision prompted the hearing may also have attorney representation. Conversely, if the Practitioner elects not to be represented by an attorney in the hearing, then the body whose decision prompted the hearing shall not be represented by an attorney in the hearing. When attorneys are not allowed, the Practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a Practitioner licensed to practice in the State of Colorado who is not also an attorney. The Practitioner shall provide written notice to the President of the name, address and telephone number of the Practitioner’s attorney or other representative no later than 5 days before the pre-hearing conference.

2.4.6 Failure to Appear or Proceed

Failure without good cause of the Practitioner to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary forfeiture of the right to a hearing and acceptance of the recommendations or actions involved.

2.4.7 Postponements and Extensions

After a request for hearing has been made, the Hearing Officer may, for good cause and with notice to all parties, grant extensions of deadlines imposed by these Rules.

2.4.8 Pre-Hearing Conference

Unless otherwise agreed by all parties, the Hearing Officer shall schedule a pre-hearing conference at least 5 days before the hearing. The Hearing Officer shall make all rulings and enter orders necessary for the efficient and fair presentation of evidence at the hearing. The Hearing Officer shall hear and decide all objections to exhibits or witnesses, challenges to the qualifications of the Hearing Committee members, challenges to the qualifications of the Hearing Officer, and all other disputes arising under these Rules or otherwise that can reasonably be anticipated in advance of the hearing. The failure of a party to object or move for relief at the pre-hearing conference shall constitute, absent good cause shown, grounds for denying the party’s objection or motion at the hearing.

2.4.9 Pre-Hearing Discovery

a. Rights of Inspection and Copying

The Practitioner may inspect and copy (at his or her expense) any documentary information relevant to the reasons for the adverse action recommended or taken that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to this matter that the Practitioner has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least 5 days before the pre-hearing conference shall be good cause for a continuance of the hearing or such other discretionary action as may be warranted by the circumstances. All confidential documentary information disclosed shall be kept confidential and shall not be disclosed or used by the receiving party for any purpose not related to the hearing and appeal, unless otherwise required by law. The disclosure of documentary information under these Rules is not intended to waive any Privilege under applicable law.
b. Limits on Discovery

The Hearing Officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied based on relevancy. Discovery may also be denied or limited if the request is unreasonable or unduly burdensome or expensive or when necessary to protect any applicable Privilege or based on patient privacy. Further, the right to inspect and copy by either party does not extend to confidential peer review information concerning specifically identified or identifiable AHPs or Practitioners other than the Practitioner under review. The right to inspect and copy does not create or imply any obligation to modify or create documents.

c. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment, or Privilege application review or during corrective action after requested by or on behalf of the Medical Staff, any committee or peer review body. The Hearing Officer shall not admit such evidence unless the Practitioner demonstrates good cause for failing to comply with the earlier request.

2.4.10 Pre-Hearing Exhibit Exchange

The parties must exchange all exhibits that might be offered into evidence at least 5 days before the pre-hearing conference. Failure to comply with this Rule shall be good cause for the Hearing Officer to grant a continuance or to limit the introduction of any exhibits not provided to the other side in a timely manner. Objections to exhibits shall be submitted in writing to the Hearing Officer at or before the pre-hearing conference. All confidential exhibits exchanged shall be maintained as confidential and shall not be disclosed or used by the receiving party for any purpose not related to the hearing and appeal, unless otherwise required by law. The exchange of exhibits under these Rules is not intended to waive any Privilege under applicable law.

2.4.11 Pre-Hearing Witness Lists

At least 5 days before the pre-hearing conference, each party shall furnish to the other a written list of the names and addresses of persons, in addition to those witnesses identified in the Special Notice of the hearing under Rule 2.4.2, who can reasonably be anticipated to give testimony or evidence in support of that party at the hearing. Testimony of additional witnesses may be presented for purposes of rebuttal or other good cause shown. Failure to provide the name of a witness at least 5 days before the pre-hearing conference date shall constitute good cause for the Hearing Officer to continue the hearing, exclude the witness’s testimony, or take other action warranted by the circumstances. The Practitioner, his or her attorney or other representative or any other person acting on behalf of the Practitioner shall not contact Hospital employees concerning the subject matter of the hearing without prior approval of the Chief Executive Officer or his or her designee.

2.4.12 Pre-Hearing Disputes

a. The parties shall promptly notify the Hearing Officer of any disputes involving discovery, procedure, or other matters that might be resolved before the hearing. Objections to any pre-hearing rulings of the Hearing Officer may be made at the hearing.

b. The parties may present any motions necessary to exercise rights created by these Rules. Except for good cause shown, motions shall be in writing, shall be submitted no later than 10 days before the hearing, and shall concisely state the relief requested, relevant facts, and any supporting authority. The moving party shall provide copies by hand delivery (or by such other reliable method of delivery approved by the Hearing Officer) to the Hearing Officer and the opposing party. The opposing party may serve a response within 5 days. The Hearing Officer may hold a hearing by telephone or otherwise before ruling. Rulings on written motions shall be in writing and promptly provided to the parties. The Hearing Officer shall make all motions, responses, and rulings thereon part of the record of the proceedings.
2.4.13 Record of the Hearing

A court reporter shall record the hearing proceedings and retain all exhibits. Unless requested by a party, the pre-hearing conference need not be recorded. The cost of attendance of the court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the requesting party. The Hearing Officer may require oral evidence be taken under oath.

2.4.14 Rights of the Parties

a. At the hearing, both sides shall have the following rights, subject to reasonable limits determined by the Hearing Officer:
   1. to call and examine witnesses, to the extent they are available and willing to testify,
   2. to offer exhibits,
   3. to cross-examine or impeach any witness on any matter relevant to the issues,
   4. to be represented by counsel, who may examine witnesses and present statements and arguments, and
   5. to submit a written statement within 5 business days after the close of the hearing.

b. The Practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination.

c. The Hearing Committee may question witnesses or call additional witnesses as the Hearing Committee, in its discretion, deems necessary.

2.4.15 Rules of Evidence

Judicial rules of evidence and judicial rules of procedure shall not apply to a hearing conducted under this Rule. All relevant evidence shall be considered by the Hearing Committee, without regard to admissibility of such evidence in a court of law.

2.4.16 Computation of Time

Calendar days shall be used in all computations of time made under the provisions of this Rule; provided that if the last day for any Special Notice or Notice is a Saturday, Sunday, or legal holiday, the period is extended to include the next day which is not a Saturday, Sunday or legal holiday.

2.4.17 Burdens of Presenting Evidence and Proof

a. At the hearing, the body whose decision prompted the hearing shall have the initial burden of presenting evidence warranting its action or recommendation.

b. If the body whose decision prompted the hearing presents evidence warranting its action or recommendation, the Practitioner shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence that the action or recommendation of the body whose decision prompted the hearing is unreasonable or not warranted by the evidence.

c. If the Practitioner meets his or her burden of persuasion, the Hearing Committee shall reverse or modify the action or recommendation of the body whose decision prompted the hearing; provided, however, that the Hearing Committee may not recommend an adverse action that is more restrictive than the adverse action recommended or taken by the body whose decision prompted the hearing.
d. If the Practitioner fails to meet his or her burden, the Hearing Committee may affirm entirely or affirm and modify the recommendation and action of the body whose decision prompted the hearing; provided, however, that the Hearing Committee may not recommend an adverse action that is more restrictive than the adverse action recommended or taken by the body whose decision prompted the hearing.

2.4.18 Recess and Close of Hearing

The Hearing Officer may, for good cause, recess and reconvene the hearing without Special Notice. The hearing shall be closed when the Hearing Officer declares that all evidence has been received.

2.4.19 Basis for Decision

The Hearing Committee’s decision shall be based on the evidence introduced at the hearing, including written statements, testimony and opinions, relevant literature, clinical practice guidelines, reports of any outside consultants, and any other relevant information or explanations provided by the Practitioner, and all logical and reasonable inferences that may be drawn from the evidence.

2.4.20 Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

2.4.21 Decision of the Hearing Committee

The Hearing Committee shall render a written decision within 30 days of the close of the hearing. If the Practitioner’s Privileges have been suspended, the time for the decision shall be rendered within 15 days after the close of the hearing. The Hearing Officer may extend the time for the Hearing Committee’s report not to exceed 30 days, unless the Practitioner’s Privileges have been suspended, in which case, the extension may not exceed 10 days. A copy of the decision shall be forwarded to the Chief Executive Officer, the Medical Executive Committee, the Governing Body, and to the Practitioner. The report shall contain the Hearing Committee’s findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. The Practitioner shall be provided a copy of this Rule 2 explaining the procedure for appealing an adverse decision. The decision of the Hearing Committee shall be final, subject only to such rights of appeal or Governing Body review as described in these Rules. If the Hearing Committee fails to render a written decision within the time allowed under this Rule, the action or recommendation of the body whose decision prompted the hearing shall be deemed affirmed. If the Practitioner requests an appeal in accordance with Rule 2.5.1, the Hearing Committee shall submit a written report describing the matters decided by the Hearing Committee, if any, and the matters unresolved by the Hearing Committee, including a description of the views of the Hearing Committee members.

2.5 Appeal

2.5.1 Time for Appeal

Within 40 days of receiving the decision of the Hearing Committee, the Practitioner may request an appellate review. A written request for such review shall be delivered to the President, the Chief Executive Officer, and the body whose decision prompted the hearing. If appellate review is not requested within this period, the Practitioner shall have waived any right of appeal. If there is no appeal, the recommendation of the Hearing Committee shall be the final recommendation and action of the Medical Staff, and shall be forwarded to the Governing Body for final action. The Governing Body shall adopt or reject the Hearing Committee’s recommendation within 70 days.
2.5.2 Appeal Board

The Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board, which shall be composed of not less than 3 members of the Governing Body or independent third parties designated by the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board. No member of the Appeal Board may be in direct economic competition with the Practitioner or have acted as accuser, investigator, witness, fact finder, initial decision maker, member of the Hearing Committee, or active participant in the consideration of the matter that is the subject of the appeal. The Appeal Board may select an attorney to act as an appellate Hearing Officer and have all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Rule 2. The Hearing Officer shall not have a vote. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

2.5.3 Time, Place, and Notice

If an appellate review is requested in a timely manner, the Appeal Board shall, within 30 days after receiving a Notice of appeal, schedule a review date and cause each side to be given Notice (with Special Notice to the Practitioner) of the time, place, and date of the appellate review. The appellate review shall commence within 60 days from the date the transcript of the hearing is available or the date of the Notice, which ever is later, provided, however, when a request for appellate review concerns a Member who is under suspension which is then in effect, the appellate review should commence within 45 days from the date the request for appellate review was received. The time for appellate review may be extended by the Hearing Officer or Appeal Board for good cause.

2.5.4 Appeal Procedure

Each party shall have the right to be represented by an attorney or other representative designated by that party in connection with the appeal. The proceeding by the Appeal Board shall be an appellate hearing based upon the record of the hearing before the Hearing Committee, the memoranda submitted by the parties, and the oral arguments of the parties. The appellate Hearing Officer may establish reasonable deadlines for the appealing party to provide a written memorandum and for the responding party to respond. Each party shall have the right to present a written memorandum in support of his, her, or its position on appeal, with specific reference to the hearing transcript. Each party has the right to personally appear and make oral argument, not to exceed such time limits as may be established by the Hearing Officer. The appeal shall be deemed submitted when oral arguments are complete. The Appeal Board may, at a time convenient to itself, deliberate outside the presence of the parties.

The Appeal Board may consider evidence not available at the hearing, subject to a showing that such evidence could not have been made available in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing Committee for the taking of further evidence and for a decision.

2.5.5 Decision

a. The Appeal Board shall consider whether the decision of the Hearing Committee is reasonable and warranted by the evidence. The Appeal Board may affirm, modify, reverse, or remand the matter for further review by the Hearing Committee or any other body designated by the Appeal Board; provided, however, that the Appeal Board may not take adverse action that is more restrictive than the action recommended or taken by the body whose decision prompted the hearing.

b. Within 45 days after the appeal is submitted, the Appeal Board shall prepare a written decision that specifies the reasons for the decision and the findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the decision reached, if such findings and conclusions differ from those of the Hearing Committee.

c. A copy of the Appeal Board decision shall be forwarded to the Chief Executive Officer, the Medical Executive Committee, the Governing Body, and to the Practitioner. The Appeal Board
decision shall become final action of the Governing Body at the time of the Governing Body’s next meeting, unless the Governing Body rejects, modifies or returns the matter for further action.

d. The Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the Governing Body for review. If the matter is remanded for further review and recommendation, the further review shall be completed within 30 days unless the parties agree otherwise or for good cause as determined by the Appeal Board.

e. The Hearing Officer may extend the time for the Appeal Board’s decision not to exceed 30 days. If the Appeal Board fails to render a written decision within the time allowed under this Rule, the matter shall be referred to the Governing Body for final decision, and the Appeal Board shall submit a written report describing evidence considered, the matters decided by the Appeal Board, if any, and the matters unresolved by the Appeal Board, including a description of the views of the Appeal Board members. The Governing Body shall make a final decision in accordance with this Rule 2.5 within 45 days of receipt of the Appeal Board’s written report.

2.5.6 Right to One Hearing

Unless otherwise ordered by the Appeal Board, no Practitioner shall be entitled to more than 1 evidentiary hearing and 1 Appellate Review on any matter, which shall have been the subject of adverse action or recommendation.

2.6 CONFIDENTIALITY

To maintain confidentiality in the performance of peer review, disciplinary, and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws or Rules. Nothing in these Rules shall restrict the Hospital’s reporting obligations under applicable state or federal laws, accreditation requirements, or contracts, or the Medical Staff’s or any Practitioner’s reporting obligations under applicable state or federal laws.

2.7 RELEASE

By requesting a hearing or appellate review under these Rules, a Practitioner agrees to be bound by the provisions in the Medical Staff Bylaws and Rules relating to immunity from liability for the participants in the hearing and Appellate Review processes.

2.8 GOVERNING BODY COMMITTEES

In the event the Governing Body should delegate some or all of its responsibilities described in this Rule 2 to its committees, the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify, or return for further action or hearing the recommendations or decisions of its committee.

2.9 EXCEPTIONS TO HEARING RIGHTS

2.9.1 Exclusive Use Departments, Hospital Contract Practitioners

a. Exclusive Use Departments

The hearing and appellate rights of this Rule 2 do not apply to a Practitioner whose application for appointment or reappointment for Medical Staff membership and Privileges was denied or who could not exercise Privileges during any appointment period on the basis the Privileges he or she seeks are granted or may be exercised only pursuant to an exclusive contract.

b. Hospital Contract Practitioners

The hearing rights of this Rule 2 do not apply to Practitioners who have contracted or subcontracted with the Hospital to provide exclusive clinical services when the contract is
terminated, the Practitioner is removed from office, and/or the Practitioner is prevented from exercising Privileges in accordance with any exclusive contract. Such matters shall instead be governed by the terms of the contract with the Hospital. Notwithstanding the foregoing, the hearing and appellate rights of this Rule 2 shall apply if an adverse action is recommended or taken that must by law be reported by the Hospital to the National Practitioner Data Bank, regardless of whether the Practitioner or any other individual or entity may have a separate reporting obligation under applicable law.

2.9.2 Allied Health Practitioners

Allied Health Practitioners (AHPs), except as provided in the AHP Rules for independent AHPs, are not entitled to the hearing rights set forth in this Rule. (See the AHP Rules for a description of AHP procedural rights.)

2.9.3 Denial of Applications for Failure to Meet the Minimum Qualifications and Standards

Practitioners shall not be entitled to any hearing or appellate review if their Medical Staff membership or Privileges are denied or their applications or requests are not accepted for the review process because of the Practitioner’s failure to meet any of the basic standards specified in the Medical Staff Bylaws, to meet the basic qualifications or criteria for Privileges, to file a complete and timely application, or to provide all information deemed relevant for consideration of an application for appointment or reappointment or a request for Privileges.

2.9.4 Automatic Suspension, Limitation or Termination of Privileges

Practitioners whose Medical Staff membership or Privileges are automatically suspended, terminated, restricted or placed on probation in accordance with the Medical Staff Bylaws, the Credentialing and Privileging Rules or the General Medical Staff Rules because the Practitioner fails to make a Special Appearance; because the Practitioner’s license or credential to practice has been revoked, suspended, restricted or placed on probation; because the Practitioner’s DEA certificate is revoked, suspended, expires or is placed on probation; because the Practitioner failed to complete medical records; because the Practitioner failed to maintain professional liability insurance; because the Practitioner failed to pay dues or fees; for exclusion or because the Practitioner failed to comply with government or third party payor requirements; because the Practitioner violated the call panel rules, or because the Practitioner failed to verify criteria for Privileges are not entitled under Rule 2 to any hearing or appellate review rights, unless such automatic action is required by law to be reported to the National Practitioner Data Bank.

2.9.5 Precautionary Suspension

No hearing or appellate review shall be available when a Practitioner’s Medical Staff membership or Privileges are suspended as a precaution in accordance with Rule 1.2.

2.10 JOINT HEARINGS AND APPEALS FOR SYSTEM MEMBERS

2.10.1 Joint Hearings

a. When a Practitioner is entitled to a hearing because a combined or pooled credentialing, corrective action or other peer review action has been taken or recommended, a single joint hearing may be conducted in accordance with hearing procedures that have been jointly adopted by the involved System Members, provided such procedures are substantially comparable to those set forth in Rule 2 and further provided at least 1 member of the Hearing Committee is a Member of this Hospital’s Medical Staff.

b. In the event there is such a joint hearing, the recommendation of the Hearing Committee shall be reported to this Hospital’s Governing Body for final action.

2.10.2 Joint Appeals
The procedures may also call for joint appeals by System Members, provided such procedures are substantially comparable to those set forth in this Rule 2 and, further, provided that at least 1 member of the Appeal Board is a representative of this Hospital’s Governing Body.

2.10.3 Effect of Joint Hearings/Appeals

A joint hearing and/or appeal in accordance with the foregoing shall be deemed to satisfy procedural rights afforded to the Practitioner pursuant to federal and state law, and the participants shall be entitled to all immunities available under applicable laws.

2.10.4 Provision for Separate Hearing

Notwithstanding the foregoing, if a Practitioner can demonstrate to the Medical Executive Committee (in the case of a hearing based on a recommendation of the Medical Executive Committee) or the Governing Body (in the case of a hearing based on a recommendation of the Governing Body or in the case of an appeal) before the initiation of a joint hearing and/or appeal that the benefits of quasi-judicial economy and efficiency are outweighed by particular burdens or unfairness unique to the individual Practitioner’s circumstances, the Medical Executive Committee or Governing Body may, in its sole discretion, order that a separate hearing and/or appeal be conducted solely with respect to Privileges at this Hospital, in accordance with this Rule 2. (Examples of such unique burdens or unfairness would include unavailability of witnesses or documents to the joint proceeding; but the mere fact that the outcome would affect Privileges at more than 1 facility would not ordinarily be deemed sufficient to preclude a joint hearing.)

RULE 3 DISRUPTIVE BEHAVIOR AND HARASSMENT BY PRACTITIONERS

3.1 INTRODUCTION

It is the policy of the Hospital and the Medical Staff that all individuals within its facilities be treated with courtesy, respect and dignity. Disruptive behavior and harassment by Practitioners seriously undermine these goals and can interfere with Hospital operations and the provision of quality patient care. Practitioners are therefore expected to conduct themselves in a professional and cooperative manner while in the Hospital or involved in Medical Staff or Hospital business and to strictly refrain from harassment of Hospital employees.

All persons are encouraged to report potential disruptive behavior or harassment by Practitioners. The Hospital and the Medical Staff encourage the informal resolution of disruptive behavior and harassment by Practitioners in accordance with this Rule 3 and the Behavior Policies (as defined below) when informal resolution is possible and likely to be effective. However, nothing in this Rule 3 precludes precautionary suspension, summary suspension, formal corrective action investigation or other corrective action, if appropriate.

3.2 ASSOCIATED BEHAVIOR POLICIES AND RULES

If a Practitioner engages in potential disruptive behavior or harassment, the matter may be subject to review and resolution without formal corrective action in accordance with the peer review processes set forth in this Rule 3, as further detailed in the Policy on Disruptive Practitioner Behavior and the Policy on Practitioner Harassment of Employees, which are incorporated herein by reference, as such Policies are amended from time to time (collectively referred to as the “Behavior Policies”).

Practitioner health concerns identified through the review process may be addressed in accordance with Rule 8 (Practitioner Health Concerns) of the Credentialing and Privileging Rules. Precautionary suspension, summary suspension, formal corrective action investigation and other corrective action, if appropriate, may be addressed in accordance with Rule 1 (Peer Review and Corrective Action) of these Rules. If a Hospital employee engages in disruptive behavior or harassment, the matter should be promptly reported to the Hospital’s Human Resources department and addressed in accordance with the Hospital’s Human Resources policies.

3.3 DEFINITIONS

“Disruptive behavior” includes, without limitation:
1. Attacks (verbal or physical) leveled at other persons, including other Practitioners, Hospital employees, AHPs, patients, or families of patients, which are personal, irrelevant, or go beyond the bounds of fair professional conduct.

2. Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, which may impugn the quality of care or other matters within the Hospital, or criticize particular Practitioners, nurses or other Hospital employees, AHPs, or the Medical Staff Bylaws, Rules or Policies or Hospital policies.

3. Non-constructive criticism addressed to or concerning its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

4. Refusal to accept Medical Staff assignments, or participation in committee, departmental, or section affairs, or refusal to so participate except on the Practitioner's own terms, or participation in a disruptive manner.

5. Assault, fraudulent acts, stealing, and throwing equipment or records.

6. Negative or inappropriate comments to patients, their families, or others associated with the patients about the Hospital, other Practitioners, AHPs or Hospital employees concerning their treatment in the Hospital.

7. Harassment of persons other than Hospital employees, including harassment of other Practitioners and Medical Staff members.

Constructive criticism of the System, the Hospital, other Practitioners, AHPs or Hospital employees which is limited to appropriate channels, such as through the quality improvement or peer review processes, should not be categorized as “disruptive behavior.”

“Harassment” of Hospital employees, as used in this Rule 3 includes, without limitation:

1. Conduct relating to an individual’s race, age, religion, color, sex, sexual orientation, national origin, marital status, veteran status, or disability, which has the purpose or effect of creating a hostile, intimidating or offensive work environment, or of unreasonably interfering with an individual’s work performance.

2. Physical or verbal abuse of such significant character and nature that no person of reasonable sensitivities should be expected to tolerate it in the workplace. Harassment encompasses a broad range of behavior, including a single incident or a pattern of behavior that includes, but is not limited to (a) physical or mental abuse, (b) racial insults or insults relating to age or sex, (c) derogatory ethnic jokes, (d) religious slurs, (e) taunting, intended to provoke an individual, (f) ostracizing an individual or (g) imposing special work burdens.

3. Sexual harassment which includes an unwanted sexual advance, requests for sexual favors and other verbal or physical conduct of a sexual nature where (a) submission to such conduct is made a term of employment, (b) submission to such conduct is used as the basis for employment decisions affecting the individual, or (c) the conduct has the purpose of unreasonably interfering with an individual’s work performance or creating an intimidating, hostile, or offensive work environment. Sexual harassment, like other forms of harassment, covers a broad range of conduct ranging from subtle forms of psychological pressure to actual physical abuse.

While it is the intent of the Hospital and the Medical Staff to discourage rude or impolite behavior directed against any Hospital employee, these incidents are not considered harassment under this Rule.

“Reviewers,” for purposes of this Rule 3 includes one or more of the following persons:
1. The President, the Department Chair, and/or the Section Chief (and/or other persons designated by the President); or

2. a committee appointed by the Medical Executive Committee from time to time to address disruptive behavior and/or harassment by Practitioners.

3.4 REPORTING

Reporting and documenting each instance of potential disruptive behavior or harassment by a Practitioner is essential to the Hospital’s and the Medical Staff’s efforts to identify and eradicate such conduct at the Hospital. Practitioners, AHPs, nurses and other Hospital employees are strongly encouraged to report potential disruptive behavior or harassment by Practitioners and to report any potential retaliation for prior reports.

A report of potential disruptive behavior or harassment shall be in writing or electronic transmission and forwarded to Medical Staff Services. Such reports should include all of the following information:

1. The Practitioner’s name.

2. The date, time and place of the Practitioner’s questionable behavior.

3. A statement of whether such behavior involved a Hospital patient, and if so, the name of the patient.

4. The circumstances surrounding the situation.

5. A factual description of the behavior, including the names of witnesses to the behavior.

6. The consequences and potential consequences of the behavior, if any, to the orderly and efficient operation of the Hospital or the ability to provide quality patient care.

7. A description of the action, if any, taken in response to the behavior and the name of the person(s) taking such action.

8. Any other information requested in Behavior Policies.

Medical Staff Services shall promptly forward a copy of the report to the Department Chair and/or Section Chief, with an additional copy to the President and Chief Medical Officer. If a person makes a verbal complaint, he or she shall be encouraged to document the report as set forth in this Rule, but failing this, the person receiving a verbal report may make a written report based on the verbal complaint. Medical Staff Services shall forward a copy of any report of Practitioner harassment against a Hospital employee to the Hospital’s Human Resources department for purposes of evaluating the allegations on behalf of the Hospital and conducting interviews with the Hospital employee and witnesses. If the Practitioner is an employee of the Hospital, the Chief Medical Officer or his/her designee should participate in the review and informal resolution, and attend interviews with the employed Practitioner.

3.5 REVIEW OF POSSIBLE DISRUPTIVE BEHAVIOR OR HARASSMENT

3.5.1 Reports of potential disruptive behavior or harassment by Practitioners shall be reviewed on an expedited basis by the Department Chair and/or Section Chief to determine whether to proceed with further review and attempted informal resolution under this Rule 3 and the Behavior Policies, or to promptly refer this matter for a formal corrective action investigation and/or to proceed with precautionary suspension in accordance with Rule 1. The President and/or Chief Medical Officer may participate in the expedited review of alleged disruptive behavior or harassment.

3.5.2 Unless the Practitioner is suspended as a precautionary measure under Rule 1 or the matter has been referred to the Medical Executive Committee, the initial peer review of disruptive Practitioner behavior or harassment may be conducted by the Reviewers. The Director of Human Resources or his/her designee and the Chief Medical Officer may conduct or participate in interviews and informal resolution of disruptive
Practitioner behavior or Practitioner harassment affecting Hospital employees (See Behavior Policies). Notwithstanding any confidentiality provision in the Medical Staff Bylaws or these Rules, information concerning alleged Practitioner harassment of a Hospital employee may need to be disclosed, such as in the context of the Hospital’s defense of Equal Employment Opportunity Commission (“EEOC”) charges or litigation against the Hospital arising from a Practitioner’s alleged harassment.

3.5.3 The Reviewers shall review the alleged disruptive behavior or harassment as deemed appropriate, including an interview with the Practitioner, interviews with any witnesses, interviews with the Practitioner’s peers, review of patient records, or other relevant review. The Director of Human Resources or his/her designee or the Chief Medical Officer may participate in this process if the disruptive behavior or harassment affects or is directed at Hospital employees. (See Behavior Policies). Unfounded or unsubstantiated reports of disruptive behavior or harassment may be dismissed by the Reviewers, with a memo to the Practitioner’s file.

3.6 INFORMAL RESOLUTION

The Hospital and the Medical Staff encourage the informal resolution of disruptive behavior and harassment by Practitioners without formal corrective action when possible and likely to be effective. Informal resolution may not be appropriate if there is a single egregious act (a flagrant violation, conspicuously bad or offensive behavior) or a pattern of disruptive behavior or harassment. The components of informal resolution should include the following, as further detailed in the Behavior Policies:

a. Allow the Practitioner an opportunity for an interview.
b. Inform the Practitioner of the general nature of the disruptive behavior and/or harassment concerns reported.
c. Inform the Practitioner that disruptive behavior and/or harassment cannot be tolerated.
d. Promote confidentiality of the peer review process.
e. Solicit the Practitioner’s cooperation in the resolution of the behavior and/or harassment concerns.
f. Issue a letter of warning to the Practitioner if appropriate.
g. Allow the Practitioner the opportunity to respond in writing to the matters addressed in the interview or to any letter of warning.

The CEO and/or a member of the Governing Body may be asked to assist in the informal resolution process, including participation in the interview with the Practitioner. The Director of Human Resources and/or the Chief Medical Officer may participate in the Practitioner interviews if the harassment or disruptive behavior affects Hospital employees. The information gathered by the Reviewers shall be forwarded to the Medical Executive Committee if it is determined that formal corrective action may be warranted against a Practitioner. The Medical Executive Committee may appoint the Reviewers to conduct a formal corrective action investigation under Rule 1, if appropriate.

3.7 NO RETALIATION

No Practitioner shall retaliate against any person who reports potential disruptive behavior or harassment, or any witnesses or other persons who participate in the review, investigation or resolution of such matters. Retaliation is a very serious matter, and may be treated as a single egregious act (a flagrant violation, conspicuously bad or offensive behavior) or a recurrence of disruptive behavior or harassment by the Practitioner, regardless of the merits of the initial report. Retaliation may be addressed in accordance with Rule 1, including precautionary suspension, if appropriate.
3.8 EDUCATION

The Medical Staff shall educate Practitioners, AHPs, and Hospital employees about the policy of the Hospital concerning disruptive behavior and harassment reflected in this Rule 3 and associated Policies, which along with the Medical Staff Expectations and Bylaws and Rules constitute a code of conduct for Medical Staff Members.
Approved by:

Medical Executive Committee on

Signed: ______________________________________

Medical Staff

Exempla Board of Directors on

Signed: ______________________________________

Board of Directors