

MEDICAL STAFF BYLAWS

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ARTICLE 1
GENERAL

1.1. DEFINITIONS

- 1.1-1 NON-PHYSICIAN PROVIDER means an individual, other than a licensed physician, who provides services under the supervision of a physician, dentist or podiatrist who has been afforded privileges to provide such care in the hospital or outpatient setting. Such NPPs shall include, without limitation, clinical psychologists; nurse practitioners; clinical nurse specialists; certified registered nurse anesthetists; certified nurse-midwives; other doctoral scientists; physician assistants, and any other health care professionals as determined by the board.
- 1.1-2 BOARD OF DIRECTORS or BOARD means the governing body of the corporation.
- 1.1-3 CHIEF EXECUTIVE OFFICER (CEO) means the individual appointed by the board to act on its behalf in the overall administrative management of the hospital.
- 1.1-4 CLINICAL PRIVILEGES or PRIVILEGES means the rights granted by the board of directors to a physician and NPP to provide those diagnostic and therapeutic services specifically delineated and includes access to those hospital resources, including equipment, facilities and personnel that are necessary to effectively provide medical or other patient care services.
- 1.1-5 DENTIST means an individual with a D.D.S. or D.M.D. degree who is licensed to practice dentistry.
- 1.1-7 EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
- 1.1-8 GOOD STANDING means the staff member has met the attendance requirements during the previous calendar year, is not in arrears in dues payment, and is not under a suspension of the appointment or admitting privileges.
- 1.1-9 HOSPITAL means Riverside Medical Center of Kankakee, Illinois.
- 1.1-10 INVESTIGATION means the process which is commenced once a formal request for remedial action has been submitted for consideration by the Medical Executive Committee of these Bylaws and the Committee moves forward with a formal investigation. All other remedial measures which are utilized prior to this request, including but not limited to monitoring, proctoring, mandatory consultations and FPPE plans are considered routine peer review activities.
- 1.1-11 MEDICAL STAFF or STAFF means the formal organization of all physicians who are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services in the hospital or outpatient setting.
- 1.1-12 MEDICAL DIRECTOR means a practitioner, engaged by the hospital either full time or part time in an administratively responsible capacity, whose activities also include clinical responsibilities.
- 1.1-13 MEDICAL EXECUTIVE COMMITTEE or MEC means the executive committee of the medical staff.
- 1.1-14 PATIENT SAFETY EVALUATION SYSTEM ("PSES") means the collection, management or analysis of information for reporting to or by a patient safety organization for patient safety activities including, but not limited to, efforts to improve patient safety and the quality of patient safety delivery, the collection and analysis of patient safety work product, the development and discrimination of information, maintenance of confidentiality and security measures and all other activities relating to improving patient safety.
- 1.1-15 PATIENT SAFETY WORK PRODUCT means any data, reports, records, memoranda, analyses, including root cause analyses, or oral or written statements which are assembled or developed by or on behalf of the Hospital for reporting to a patient safety organization or are developed by a patient safety organization for the conduct of patient safety activities and which could result in improved patient safety, healthcare quality or healthcare outcomes or which identify the fact of reporting to a patient safety organization.

- 1.1-16 PEER REVIEW refers to any and all activities and conduct which involve efforts to reduce morbidity and mortality, improve patient care or engage in professional discipline. These activities and conduct include, but are not limited to: the evaluation of medical care, the making of recommendations in credentialing and delineation of privileges for Physicians or APPs seeking or holding such Clinical Privileges at the Hospital addressing the quality of care provided to patients, the evaluation of appointment and reappointment applications and qualifications of Physicians, Licensed Independent Practitioners (LIPs) or NPPs, the evaluations of complaints, incidents and other similar communications filed against members of the Medical Staff and others granted Clinical Privileges. They also include the receipt, review, analysis, acting on and issuance of incident reports, quality and utilization review functions, and other functions and activities related thereto or referenced or described in any Peer Review policy, as may be performed by the Medical Staff or the Governing Board directly or on their behalf and by those assisting the Medical Staff and Board in its Peer Review activities and conduct including, without limitation, employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other person or organization who assist in performing Peer Review functions, conduct or activities.
- 1.1-17 PEER REVIEW COMMITTEE means a Committee, Section, Division of the Medical Staff or the Governing Board as well as the Medical Staff and the Governing Board as a whole, when participating in any Peer Review function, conduct or activity as defined in these Bylaws. Included are those serving as members of the Peer Review Committee or their employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other person or organization, whether internal or external, who assist the Peer Review Committee in performing its Peer Review functions, conduct or activities. All reports, studies, analyses, recommendations, and other similar communications which are authorized, requested or reviewed by a Peer Review Committee or persons acting on behalf of a Peer Review Committee shall be treated as strictly confidential and not subject to discovery nor admissible as evidence consistent with those protections afforded under the Medical Studies Act. If a Peer Review Committee deems appropriate, it may seek assistance from other Peer Review Committees or other committees or individual inside or outside the Medical Center. As an example, a Peer Review Committee shall include, without limitation: the MEC, all clinical divisions and service lines, the Quality Improvement Committee, the Governing Board and all other Committees when performing Peer Review functions, conduct or activities.
- 1.1-18 PHYSICIAN (for clarity in these bylaws) means an individual with a M.D., D.O., M.B.B.S., D.P.M., D.D.S., or D.M.D. degree who is licensed to practice their specialty.
- 1.1-19 PODIATRIST means an individual with a D.P.M. who is licensed to practice podiatry.
- 1.1-20 PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to the conditions and limitations imposed in these bylaws and the medical staff policies.
- 1.1-21 SPECIAL NOTICE means written notification sent by certified or registered mail, overnight delivery service providing receipt, return receipt requested.
- 1.1-22 HOSPITAL BASED PHYSICIAN means physicians whose professional activities are performed chiefly within a hospital. It includes physicians in the following specialties: Anesthesiology Emergency Medicine, Pathology, Radiology and physicians practicing as hospitalists.
- 1.1-23 AMBULATORY CARE PRACTITIONER means physicians whose professional activities are performed in an ambulatory setting.
- 1.1-24 PRESIDING OFFICER means the medical staff officer, chair, vice-chair or chief who is running or ruling over the meeting.
- 1.1-25 MEDICAL STAFF LEADER means a medical staff division chair or vice-chair, a service line chief or a committee chair.

1.1-26 MEDICAL STAFF OFFICER means the President, President-Elect, Secretary-Treasurer and Immediate Past President of the Medical Staff.

1.1-27 PROVISIONAL TRAINING PRIVILEGES means the privilege granted to a member of the medical staff or NPP to learn a new procedure under the auspices of preceptor or proctor. The privilege will not be granted for independent practice until the proctoring requirements have been met and the individual applies for and is granted the privilege by the board.

1.1-28 TELEMEDICINE means the exchange of medical information from one site to another via electronic communication for the purpose of providing patient care, treatment and services. The granting of telemedicine privileges will be outlined in the Credentials Policy.

1.2. PURPOSES

The medical staff shall:

- (a) Provide for its self-governance by initiating, developing and approving all medical staff bylaws, approving or disapproving any amendments to the medical staff bylaws, and selecting and removing medical staff officers;
- (b) Determine the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners within independent privileges;
- (c) Determine the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges; and
- (d) Engage in performance improvement activities

1.3. DELEGATION OF FUNCTIONS

- (a) When a function is to be carried out by a member of Hospital management, by a Medical Staff Leader, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one (1) or more designees.
- (b) When a Medical Staff Leader is unavailable or unable to perform an assigned function, a Medical Staff Officer may perform the function personally or delegate it to another appropriate individual.

1.4. MEDICAL STAFF DUES

- (a) Medical Staff dues shall be as established by the Medical Executive Committee and may vary by category.
- (b) Dues and meeting attendance fines are payable March 1st of each year unless determined otherwise by the Medical Executive Committee. Dues are nonrefundable and will not be prorated.
- (c) Unless excused by the Medical Executive Committee for good cause, failure to render payment within 60 days of the due date may result, after special notice of the delinquency, in the automatic relinquishment of Medical Staff appointment (including all prerogatives) and clinical privileges until such time as the delinquency is remedied. If dues and assessments have not been paid within 90 days of the due date, the individual shall be deemed to have voluntarily resigned his or her Medical Staff appointment.

1.5. INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, service line chiefs, division chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the Hospital's corporate bylaws.

ARTICLE 2
APPOINTMENT TO THE MEDICAL STAFF

2.1. GENERAL QUALIFICATIONS

Every physician and NPP who seeks or holds staff membership and/or clinical privileges must continuously demonstrate to the satisfaction of the medical staff and the board the following qualifications. Verification of credentials shall be in writing from the primary source whenever feasible.

2.1-1 CONDUCT AND ETHICS

Every member and NPP granted clinical privileges shall demonstrate ability

- (a) To work with and relate to other staff members, residents and students, members of other health disciplines, hospital management and employees, visitors and the community in general, in a cooperative, professional manner that is essential for maintaining a hospital environment appropriate to and as may affect the delivery of quality patient care; and
- (b) To participate equitably in the discharge of staff obligations appropriate to staff membership category; and
- (c) To adhere to generally recognized standards of professional ethics, including without limitation, prohibitions against fee-splitting, "ghost" surgery, delegating the responsibility for diagnosis or care of patients to a physician not qualified to undertake that responsibility and failing to obtain informed patient consent to treatments; and
- (d) To otherwise comply with the Riverside Code of Behavior Policy.

2.1-2 ABILITY

Each member and NPP granted clinical privileges shall document that he or she has the professional education, training, experience, clinical results and current competency to the satisfaction of the Medical Staff and Board to provide patient care at the generally recognized professional level of quality and efficiency.

- (a) **Educational and Training Criteria for Medicine/Surgery**
Each physician must demonstrate that he/she meets the following educational and training criteria: (1) completion of postgraduate training in the doctor's area of practice following the receipt of the degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Bachelor of Medicine and Bachelor of Surgery (MBBS). (2) completion of a residency program accredited by one of the following the Accreditation Council for Graduate Medical Education; the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada (each division may set more specific guidelines); and (3) current certification in the doctor's specialty by the board officially recognized by the American Osteopathic Association or the American Board of Medical Specialties or verification of board eligibility and the receipt of certification within six (6) years of date of completion of a residency specialty area in which the individual will be practicing.
- (b) **Educational and Training Criteria for Podiatry**
Each podiatrist must demonstrate that he/she meets the following educational training criteria: (1) receipt of the degree of Doctor of Podiatric Medicine in a program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association, (2) completion of at least two (2) years postgraduate residency of which one (1) year was a dedicated surgical year in a residency training program accredited by the Council on Podiatric Medical Education and accepted by the American Board Foot and Ankle Surgery, and (3) board certification by the American Board of Foot and Ankle Surgery or verification of board eligibility and the receipt of certification within six (6) years of date of completion of a residency specialty area in which the individual will be practicing.
- (c) **Educational and Training Criteria for Dentistry**
Each dentist must demonstrate that he/she meets the following educational training criteria: (1) receipt of the degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D) in a program accredited by the American Dental Association, (2) completion of at least two (2) years in postgraduate

residency of which one (1) year was a dedicated surgical year in a residency training program accredited by the American Dental Association, and (3) if relevant to the dentist's privileges, specialty boards approved by the American Dental Association; dentists with boards pending must submit an approved application to take the appropriate board examinations and document receipt of certification within six (6) years of date of completion of a residency specialty area in which the individual will be practicing.

- (d) **Educational and Training Criteria for Occupational Medicine**
Each physician must demonstrate that he/she meets the following educational and training criteria: (1) The receipt of the degree of Doctor of Medicine (MD), Doctor of Osteopathy (DO), OR Bachelor of Medicine and Bachelor of Surgery (MBBS) and completion of a residency program in Occupational Health, Emergency Medicine, Internal Medicine or Family Medicine in a program accredited by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; (3) Current certification in the doctor's specialty by the board officially recognized by the American Osteopathic Association or the American Board of Medical Specialties or verification of board eligibility and the receipt of certification within six (6) years of date of completion of a residency specialty area in which the individual will be practicing.
- (e) **Education and Training Criteria for NPPs**
Each NPP must demonstrate that he/she meets the educational and training requirements and criteria as established by the State of Illinois for their respective areas of clinical practice including, but not limited to, applicable licensure and certification requirements.
- (f) **Maintenance of Certification**
Maintenance of certification by the primary medical specialty board is considered mandatory in order to maintain Medical Staff membership and/or clinical privileges. Maintenance of certification in a non-primary specialty board certification is considered desirable, but not mandatory. This section is applicable to physicians, who obtained medical staff appointments after December 2005. Certified Non-physician Providers must maintain their certification.
- (g) **Waiver of Criteria**
Notwithstanding the foregoing, the Board of Directors may waive the aforesaid education training requirements provided that the applicant can demonstrate all of the following: (1) a minimum of ten years successful experience in the specialty for which privileges are requested; (2) superior recommendations from institutions where the applicant currently practices or has practiced in the past; and (3) ability to provide health care services to the Hospital which are not otherwise being offered.
- (h) **Written Verification of Current Competence**
Every physician and NPP granted clinical privileges must demonstrate current competence through written verification of same by peers knowledgeable about the applicant's professional performance.
- (i) **Divisional Criteria**
Every member and NPP granted clinical privileges must be a member of one (1) of the clinical divisions listed in these bylaws, and in addition to the medical staff membership qualifications required by these bylaws, must meet the standards and criteria for membership and clinical privileges in that division. Each division of the medical staff is authorized and directed to define in writing the standards and criteria for membership and clinical privileges in that division, and those standards and criteria, when approved by the Medical Executive Committee and the Board, shall become an integral part of these bylaws.

2.1-3 DISABILITY

Providers must be free of or have under adequate control any significant physical or behavioral impairment that interferes with, or presents a substantial probability of interfering with, the qualifications required by these Bylaws, such that patient care is or is likely to be adversely affected. If at any time, a member of the Medical Staff or an NPP granted clinical privileges has a reasonable suspicion that a practitioner is not able to exercise any or all of his/her clinical privileges based on a physical and/or behavioral health issue, this concern must be communicated to the Division Chair and/or the President of the Medical Staff who shall determine whether the practitioner shall

be required to submit to an evaluation of his/her physical and/or behavioral health status by a physician or physicians acceptable to them to be reviewed by the Practitioner Health Committee. This evaluation may be a prerequisite to any of the following: (1) application for appointment/reappointment; or (2) the exercise of previously granted privileges or a request for new privileges; or (3) maintenance of staff appointment. Any refusal to submit to such an evaluation may subject the practitioner to remedial action.

2.1-4 HOSPITAL AND COMMUNITY NEED, AND ABILITY TO ACCOMMODATE

In acting on new applications for staff membership and clinical privileges, and on applications for changes in clinical privileges, in staff membership status, or in clinical unit affiliation, consideration must be given to the hospital's current and projected patient care, teaching and research needs and the hospital's ability to provide facilities, beds, and support services that will be required if the application is acted upon favorably. In making these required need/ability determinations, consideration will be given to utilization patterns, present and projected patient mix, actual and planned allocations of physical, financial and human resources to general and specialized clinical support services, and the hospital's and medical staff's general and specific goals and objectives as reflected in the hospital's short- and long-range plans.

2.1-5 EFFECT OF OTHER AFFILIATIONS

No physician is automatically entitled to membership on the medical staff or to the exercise of particular clinical privileges merely because he or she is licensed to practice in this or in any other state, or because he or she is a member of the faculty of a medical school, or because he or she had, or presently has, staff membership or privileges at another health care facility or in another practice setting, or because he or she participates or does not participate in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party payer which contracts with this hospital.

2.1-6 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of age, gender, sexual, race, creed, color, disability, or national origin or on the basis of any other legally protected status unrelated to the delivery of quality patient care in the hospital, to professional qualifications, to the hospital's purposes, needs and capabilities, or to the community need.

2.2. BASIC OBLIGATIONS OF INDIVIDUAL STAFF MEMBERSHIP

Each member of the medical staff, regardless of assigned staff category, exercising privileges under these bylaws, shall:

- (a) Provide his or her patients with continuous care at the generally recognized professional level of quality and efficiency;
- (b) Abide by the medical staff bylaws and by all other lawful standards and policies of the medical staff and of the hospital which have been approved by the medical staff;
- (c) Discharge such staff, committee, division and hospital functions for which he or she is responsible by staff category assignment, appointment, and election or otherwise;
- (d) Prepare and complete in timely fashion the medical and other required records for all patients he or she admits or in any way provides care to in the hospital;
- (e) Abide by generally recognized standards of professional ethics;
- (f) Take call in accordance with medical staff policies; and
- (g) Satisfy the continuing education requirements established by the medical staff and by the clinical division of which he or she is a member and also participate in the educational programs conducted by the hospital.

- (h) Histories and physicals are expected to be completed no more than thirty (30) days prior to an elective inpatient admission or outpatient procedures or within 24 hours after inpatient admission or on observed patients and prior to operative or other procedures and/or the administration of moderate or deep sedation or anesthesia by a physician or other licensed professional permitted under Illinois law. If an H&P is completed within 30 days prior to registration or inpatient admission, the patient will be examined and an update documenting any changes in the patient's condition is completed within 24 hours after inpatient admission but prior to surgery or a procedure requiring anesthesia. A nursing assessment is completed within 24 hours of inpatient admission. Nutritional screenings and/or functional status screenings, in each case, when warranted by the patient's conditions or needs, are completed within 24 hours of inpatient admission.

When such history and physical examinations are not recorded before the time stated for operation or sedation procedure, the operation or sedation procedure shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

For any obstetric patient, a legible durable copy of the prenatal record may be substituted for a history and physical for a normal, uncomplicated vaginal delivery. If an H&P is completed within 30 days prior to registration or inpatient admission, the patient will be examined and an update documenting any changes in the patient's condition is completed within 24 hours after inpatient admission but prior to surgery or a procedure requiring anesthesia.

2.3. MEMBERSHIP TERM

Medical staff memberships are for a period of three (3) years except that the medical executive committee may set a more frequent reappraisal period for the exercise of particular privileges in general or by staff members who have identified health disabilities, or disruptive and unacceptable behavior, as determined by the medical executive committee. Initial Medical Staff membership will be for a period of three (3) years, with re-evaluation through the FPPE process.

2.4. VOLUNTARY RESIGNATION

A member of the Medical staff who relocates his/her practice of medicine beyond the hospital's service area and relocates his/her residence beyond the response time requirements as outlined in medical staff policy without providing formal notice and is unreachable for ninety (90) days is considered to have voluntarily relinquished membership and clinical privileges. An exception to this would include an approved leave of absence granted to the member prior to his/her relocation. All voluntary resignations of medical staff membership or medical staff privileges shall be submitted to the Medical Executive Committee for evaluation and recommendation to the board. Privilege resignations that could adversely affect patient care may not be accepted on the timeline requested.

2.5. LEAVE OF ABSENCE

2.5-1 INITIATION

Individuals must request a leave of absence in writing to the Division Chair anytime they are unable to satisfy their patient care responsibilities for longer than 30 days. The request must state the beginning and ending dates of the leave, the reasons for the leave, and the arrangement that has been made for patient coverage. Leaves of absence are limited to one (1) year.

- (a) The Division Chair will determine whether a request for a leave of absence will be granted. The Division Chair may consult with the President of the Medical Staff. If the reason for the absence is related to their physical or mental the President of the Medical Staff, may trigger an automatic medical leave of absence.
- (b) In the case of military leave, the President of the Medical Staff shall have the authority to approve a leave of absence immediately.
- (c) Leaves of absence are matters of courtesy, not right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

- (d) Any question or concern about a member's failure to request a leave of absence in accordance with this Section shall be referred to the Medical Executive Committee for review.
- (e) All leave of absence requests will be forwarded to the Medical Executive Committee and the Board for ratification.

2.5-2 DUTIES OF MEMBER ON LEAVE

During the leave of absence, the individual will not exercise any clinical privileges and will be excused from all Medical Staff duties (e.g., meeting attendance, committee service, and emergency service call obligations), but will maintain current, valid professional liability insurance coverage or tail coverage during the leave. All medical records must be completed as noted in the medical record completion policy. Dues must be kept current during the leave.

2.5-3 REINSTATEMENT

- (a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital not less than ten (10) days prior to the date on which he or she desires to return. Requests for reinstatement will then be reviewed by the respective division chair and President of the Medical Staff.

If the requested leave of absence was based on medical reasons, other than maternity leaves, a request for reinstatement must confirm the need for the medical leave and the practitioner's current condition or status. The request must be accompanied by a note from the practitioner's treating physician as to whether the practitioner can safely exercise all or some of his/her existing clinical privileges with or without a reasonable accommodation.

The Division Chair shall review this information and shall determine whether additional information is needed before determining whether the practitioner can return to the Medical Staff. The Division Chair may consult with the President of the Medical Staff on the decision to approve a reinstatement. The practitioner bears the burden of providing any and all information requested under this provision. The failure to submit this information in a timely manner shall result in the voluntary resignation of the practitioner's medical staff membership and clinical privileges without any hearing rights.

- (b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. This determination will then be forwarded to the Medical Executive Committee and the Board for ratification. If, however, the Medical Executive Committee or Board has any questions, those questions will be directed to the individual for response.
- (c) With the exception of military leaves of absence, an individual who fails to return from a one (1) year leave of absence shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the President of the Medical Staff, in consultation with the relevant division chair and the Medical Executive Committee.
- (d) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, unless the individual submits a reapplication for processing during the individual's assigned reappointment cycle and the reapplication is approved by the board.

2.5-4. FPPE AFTER ONE (1) YEAR OR LONGER LEAVE OF ABSENCE

Medical staff members returning from an extended leave of absence of one (1) year without practicing medicine during this time must complete a minimum of three (3) months FPPE in accordance with the current sponsorship policy. The medical staff division may set more stringent guidelines if they choose to do so.

ARTICLE 3
CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained herein and in the Credentials Policy are eligible to apply for appointment to one (1) of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as Appendix A to these bylaws.

3.1. ACTIVE HOSPITAL STAFF

3.1-1 QUALIFICATIONS

The Active Hospital Staff shall consist of Physicians who:

- (a) Demonstrate a commitment to the Medical Staff through service on Medical Staff or Hospital committees or active participation in performance/quality improvement functions.
- (b) Certified by a board officially recognized by the American Osteopathic Board, the American Board of Podiatric Surgery, the American Board of Medical Specialties or the American Board of General Dentistry.

3.1-2. PREROGATIVES AND RESPONSIBILITIES

Active Hospital Staff:

- (a) Shall admit patients without limitation, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;
- (b) Shall vote in all general and special meetings of the Medical Staff and applicable division, service line, and committee meetings;
- (c) May hold office, serve as a division chair, service line chief, or medical director, serve on Medical Staff committees, and serve as a chair of a committee, and
- (d) May serve on committees, as requested;
- (e) Shall exercise such clinical privileges as are granted to them;
- (f) Shall participate in the evaluation of new members of the Medical Staff;
- (g) Shall participate in the professional practice evaluation and performance improvement process (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);
- (h) Shall accept inpatient consultations, when requested; and
- (i) Eligible to serve as a member at large on the Joint Conference Committee; and
- (j) Must pay application fees, dues, and assessments.

3.2. ACTIVE COMMUNITY STAFF

3.2-1. QUALIFICATIONS

The Active Community Staff consists of those Physicians who:

- (a) Are certified by a board officially recognized by the American Osteopathic Board, the American Board of Podiatric Surgery, the American Board of Medical Specialties or the American Board of General Dentistry.
- (b) Desire to be associated with, but who do not intend to establish an inpatient clinical practice at, this Hospital;
- (c) Have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Active Community Staff; and

- (d) May wish to request only limited outpatient-related therapies for the care and treatment of their patients at the Hospital.

Guidelines:

The primary purpose of the Active Community Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Hospital Staff members for admission and care.

3.2-2. PREROGATIVES AND RESPONSIBILITIES

Active Community Staff members:

- (a) Shall attend meetings of the Medical Staff and applicable divisions or service lines;
- (b) Shall vote in all general and special meetings of the Medical Staff and applicable division, service line and committee meetings;
- (c) May hold office
- (d) May serve as a division chair, service line chief, medical director or committee chair;
- (e) Shall generally have no staff committee responsibilities, but may be invited to serve on a committee (with vote);
- (f) Shall exercise such clinical privileges as are granted to them;
- (g) Shall participate in the evaluation of new members of the Medical Staff;
- (h) Shall participate in the professional practice evaluation and performance improvement process (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);
- (i) May attend educational activities sponsored by the Medical Staff and the Hospital;
- (j) May refer patients to members of the Active Hospital Staff for admission and/or care;
- (k) Are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;
- (l) Are also encouraged to communicate directly with Active Hospital Staff members about the care of any patients referred, as well as to visit any such patients, and record a courtesy progress note in the medical record containing relevant information from the patients' outpatient care;
- (m) May review the medical records and test results (via paper or electronic access) for any patients who are referred; may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records; may refer patients to the Hospital's diagnostic facilities and order such tests; and
- (n) Eligible to serve as a member at large on the Joint Conference Committee; and
- (o) Must pay application fees, dues and assessments.

3.3. CONSULTING STAFF

3.3-1. QUALIFICATIONS

The Consulting Staff shall consist of Physicians who:

- (a) Are certified by a board officially recognized by the American Osteopathic Board, the American Board of Podiatric Surgery, the American Board of Medical Specialties or the American Board of General Dentistry.

- (b) Do not otherwise qualify for appointment to the Active Hospital Staff.

3.3-2. PREROGATIVES AND RESPONSIBILITIES

Consulting Staff:

- (a) May attend and participate in general and special meetings of the Medical Staff (without vote) and may attend applicable division and service line meetings (with vote) and applicable committee meetings (with vote);
- (b) May not hold office;
- (c) Shall participate in the professional practice evaluation and performance improvement process (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);
- (e) Shall exercise such clinical privileges as are granted to them;
- (e) Eligible to serve as a member at large on the Joint Conference Committee;
- (f) Must pay application fees, dues and assessments;
- (g) Must have an Active Hospital staff status surgeon (fully credentialed in the field or subspecialty of the consulting staff surgeon) on the case, scrubbed in any surgical case, who will be fully responsible for and perform the preoperative and post-operative care of the patient, and participate in the intraoperative care of the patient.

3.4. HONORARY STAFF

3.4-1. QUALIFICATIONS

The Honorary Staff will consist of Physicians who:

- (a) Have a record of previous long-standing service to the Hospital and have retired from the active practice of medicine; or
- (b) Are recognized for outstanding or noteworthy contributions to the medical sciences.

None of the specific qualifications for appointment are applicable to members of the Honorary Staff.

3.4-2. PREROGATIVES AND RESPONSIBILITIES

Honorary Staff members:

- (a) May not admit, attend, or consult on patients;
- (b) May attend Medical Staff and division meetings when invited to do so (without vote);
- (c) May be invited to serve on committees (with vote);
- (d) Are entitled to attend educational programs of the Medical Staff and the Hospital;
- (e) May not hold office or serve as a division chair, service line chief, or committee chair; and
- (f) Are not required to pay application fees, dues or assessments.

3.5. NON-PHYSICIAN PROVIDERS

3.5-1 QUALIFICATIONS

The Non-Physician Providers include licensed independent practitioners and advanced dependent practitioners who are authorized by law and by the Hospital to provide patient care services within the Hospital. The Non-

Physician Provider Staff is not a category of the Medical Staff, but is included in this Article of the Bylaws for convenient reference.

3.5-2. PREROGATIVES AND RESPONSIBILITIES

The Non-Physician Providers:

- (a) May function in the Hospital under the oversight of a Supervising/Collaborating Physician, where applicable, and as permitted by their license and clinical privileges or scope of practice;
- (b) May attend applicable division meetings (without vote);
- (c) May attend service line or committee meetings (without vote), if assigned by the President of the Medical Staff;
- (d) Must actively participate in the professional practice evaluation and performance improvement processes; and
- (e) Must pay application fees.

ARTICLE 4 OFFICERS

4.1. DESIGNATION

The officers of the Medical Staff shall be the President of the Medical Staff, the President-Elect of the Medical Staff, the Secretary-Treasurer, and the Immediate Past President of the Medical Staff.

4.2. ELIGIBILITY CRITERIA

Only those members of the Medical Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the Medical Executive Committee and approved by the Board. They must:

- (a) Have served on the Active Hospital Staff or Active Community Staff for at least three (3) years;
- (b) Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
- (c) Be willing to faithfully discharge the duties and responsibilities of the position;
- (d) Have experience in a leadership position, or other involvement in performance improvement functions;
- (e) Participate in Medical Staff leadership training, as determined by the Medical Executive Committee;
- (f) Have demonstrated an ability to work well with others; and
- (g) Disclose if they (i.) are serving as a Medical Staff Officer, Board member, or division chair at any other hospital, or (ii) have any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within an individual's office and billed under the same provider number used by the individual.

Any disclosures under paragraph seven (7) of this Section shall be reviewed by the Nominating Committee, the Medical Executive Committee, and the Board, to determine whether the relationship is such that it renders an individual ineligible for the position for which he or she is being considered.

4.3. DUTIES

4.3-1. PRESIDENT OF THE MEDICAL STAFF

The President of the Medical Staff shall:

- (a) Act in coordination and cooperation with the President & Chief Executive Officer in matters of mutual concern involving the care of patients in the Hospital;
- (b) Represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the President & Chief Executive Officer and the Board;
- (c) Call, preside at, and be responsible for the agenda of all meetings of the Full Staff;

- (d) Serve as chair of the Medical Executive Committee (with a vote);
- (e) Serve as a member of the Board, in accordance with the Hospital corporate bylaws;
- (f) Promote adherence to the Bylaws and policies of the Medical Staff and to the policies and procedures of the Hospital;
- (g) Be the spokesperson for the Medical Staff in its external professional and public relations;
- (h) Promote the educational activities of the Medical Staff;
- (i) Perform all functions authorized in these Bylaws, and other applicable policies, including collegial intervention in the Credentials Policy;
- (j) Assume other such duties as are assigned by the Board;
- (k) Serves as an ex-officio member of all divisions and committees (with a vote);
- (l) Must actively participate in the professional practice evaluation and performance improvement processes; and
- (m) Must pay application fees, dues and assessments.

4.3-2. PRESIDENT-ELECT OF THE MEDICAL STAFF

The President-Elect of the Medical Staff shall:

- (a) Assume all duties of the President of the Medical Staff and act with full authority as President in his or her absence;
- (b) Serve on the Medical Executive Committee;
- (c) Automatically succeed the President of the Medical Staff at the completion of his/her term or in the event of a vacancy during his/her term; and
- (d) Assume other such duties as are assigned by the President of the Medical Staff or the Board.

4.3-3. SECRETARY-TREASURER

The Secretary-Treasurer shall:

- (a) Assume all duties of the President of the Medical Staff and act with full authority as President in the absence of the President and President-Elect;
- (b) Serve on the Medical Executive Committee;
- (c) Cause to be kept accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings.
- (d) Be responsible for the collection of, accounting for, and disbursements of all Medical Staff funds, dues, etc., and make disbursements authorized by the Medical Executive Committee;
- (e) Automatically succeed the President-Elect at the completion of his/her term or in the event of a vacancy during his/her term; and
- (f) Perform such other duties as are assigned by the President of the Medical Staff.

4.3-4. IMMEDIATE PAST PRESIDENT OF THE MEDICAL STAFF:

The Immediate Past President of the Medical Staff shall:

- (a) Serve on the Medical Executive Committee;
- (b) Serve as an advisor to other Medical Staff Leaders; and
- (c) Assume all duties assigned by the President of the Medical Staff, the Medical Executive Committee, or the Board.

4.4. NOMINATIONS

The Nominating Committee shall consist of the current Medical Staff officers. The Immediate Past President shall serve as chair of the committee.

- (a) The Nominating Committee shall convene at three (3) months prior to an election and shall submit to the Medical Executive Committee the names of one (1) or more qualified nominees for each forthcoming vacancy in office. Each nominee must meet the eligibility criteria in Section 4.2 and agree to serve, if elected. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.
- (b) Nominations may also be submitted in writing by petition signed by at least 10% of the voting members of the Medical Staff no later than 15 days before the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 4.2 of these Bylaws, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

4.5. ELECTION

- (a) The election shall be held at the September meeting of the Medical Staff by voice vote. Those candidates who receive a majority of the votes cast shall be elected, subject to Board confirmation. If no candidate receives a simple majority vote on the first voice vote, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes.
- (b) In the alternative, at the discretion of the Medical Executive Committee, the election may be held by written ballot returned to Physician Services. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in Physician Services by the day of the election. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation.

4.6. TERM OF OFFICE

Officers shall assume office on January 1st and shall serve for a term of two (2) years.

4.7. REMOVAL

Removal of an elected officer or member of the Medical Executive Committee may be effectuated by a two-thirds vote of the Medical Executive Committee, or by a two-thirds vote of all members of the Active Hospital Staff, or by the Board. Grounds for removal shall be:

- (a) Failure to comply with applicable policies or Bylaws;
- (b) Failure to continue to satisfy any of the criteria in section 4.2. of these Bylaws;
- (c) Failure to perform the duties of the position held;
- (d) Conduct detrimental to the interests of the Hospital and/or its Medical Staff;
- (e) An infirmity that renders the individual incapable of fulfilling the duties of that office; or
- (f) Failure to attend 50% of Medical Executive Committee meetings annually.

At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to address the Medical Executive Committee. No removal shall be effective until approved by the Board.

4.8. VACANCIES

The President-Elect, who shall serve until the end of the President's unexpired term, shall fill a vacancy in the office of President of the Medical Staff. A vacancy in the office of President-Elect shall be filled by the Secretary-Treasurer, who shall serve until the end of the President-Elect's unexpired term. In the event there is a vacancy in the Secretary-Treasurer office, the Medical Executive Committee shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, in the discretion of the Medical Executive Committee.

Upon such succession, the President-Elect and/or Secretary-Treasurer shall have the discretion to assume his or her own two (2) -year term as President or President-Elect, subject to confirmation by the Medical Executive Committee.

ARTICLE 5
DIVISIONS AND SERVICE LINES

5.1. ORGANIZATION

The Medical Staff shall be organized into divisions and service lines as listed in the Medical Staff Organization Manual. Subject to the approval of the Board, the Medical Executive Committee may create or eliminate divisions or service lines or otherwise reorganize the Medical Staff structure.

5.2. COLLEGIAL FUNCTIONS

- (a) Each division will serve as the most immediate peer group for providing clinical and emotional support among and between peers, for teaching, continuing education, research and sharing of new knowledge and providing consultation within the division and throughout the hospital in its specialty area.
- (b) The orientation and continuing education of all persons in the division or service line;
- (c) Recommend space and other resources needed by the division or service line; and
- (d) Submit written reports to the division chair for use in performance review including findings of division monitoring and evaluation activities.

5.3. DIVISIONS

5.3-1. ASSIGNMENT TO DIVISIONS

- (a) Upon initial appointment to the Medical Staff, each member shall be assigned to a division.
- (b) An individual may request a change in division assignment to reflect a change in the individual's clinical practice. Requests for a change in division assignment must be submitted in writing to both divisions requesting recommendations to the Medical Executive Committee for consideration. The Medical Executive Committee shall review the request and make a recommendation to the Board regarding whether to grant the individual's request.

5.3-2. FUNCTIONS OF DIVISIONS

- (a) Divisions are established to lead the Medical Staff's transition to a patient-centric structure, by enhancing the delivery of care, clinical outcomes, and operational performance.
- (b) Each division should assure that the care of the patient is the highest priority, with a focus on maximizing quality, safety, service and value.
- (c) Divisions are responsible for establishing credentialing and privileging criteria, applying it to all applicants and recommending the granting of clinical privileges.

5.3-3. SELECTION AND REMOVAL OF DIVISION CHAIRS

- (a) Each division shall be led by one (1) chair and three (3) vice chairs who must satisfy the eligibility criteria below:
 - 1. Have served on the Active Hospital Staff or Active Community Staff for at least two (2) years;
 - 2. Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges.

3. Be willing to faithfully discharge the duties and responsibilities of the position;
 4. Have experience in a leadership position, or other involvement in performance improvement functions
 5. Participate in Medical Staff leadership Training, as determined by the Medical Executive Committee;
 6. Have demonstrated an ability to work well with others; and
 7. Disclose if they (1) are serving as a Medical Staff Officer, Board member, or division chair at any other hospital, or (2) have any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within an individual's office and billed under the same provider number used by the individual.
 8. Any disclosures under paragraph seven (7) of this Section shall be reviewed by the Nominating Committee, the Medical Executive Committee, and the Board, to determine whether the relationship is such that it renders an individual ineligible for the position for which he or she is being considered.
- (b) Division chairs and vice chairs shall be elected for a term of two (2) years. The terms of the division vice chairs shall be staggered to ensure continuity.
- (e) Division chairs and vice chairs may be removed by a two-thirds vote of the division members or by the Board. Grounds for removal shall be:
1. Failure to comply with applicable policies or Bylaws;
 2. Failure to continue to satisfy any of the criteria in this section.

5.3-4. NOMINATIONS and DUTIES OF DIVISION CHAIRS

NOMINATIONS

Nominations for the election of Division Chair or Vice-Chair shall be put forward by the Division Leadership. Notice of the nomination will be sent to all members of the Division to allow the members an opportunity to nominate additional candidate(s) who meet the qualifications and have agreed in writing to accept the nomination. At the next Division meeting, an election will be held to fill the open position.

DUTIES

Division chairs are responsible for the following, either individually or in collaboration with Hospital personnel:

- (a) Review and report on applications for initial appointment and clinical privileges;
- (b) Review and report on applications for reappointment and renewal of clinical privileges;
- (c) Coordinate all clinically-related activities of the division;
- (d) Coordinate all administratively-related activities of the division, unless otherwise provided for by the Hospital;
- (e) Continually review the professional performance of all individuals in the division who have delineated clinical privileges, including performance ongoing and focused professional practice evaluations (OPPE and FPPE);
- (f) Recommend criteria for clinical privileges that are relevant to the care provided in the division;

- (g) Evaluate requests for clinical privileges for each member of the division;
- (h) Assess and recommend the off-site sources for needed patient care, treatment and services not provided by the division or the Hospital;
- (i) Integrate the division into the primary functions of the Hospital;
- (j) Coordinate and integrate services within the division and between divisions;
- (k) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services in the service line;
- (l) Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- (m) Determine the qualifications and competence of credentialed division personnel who are not licensed independent practitioners (such as nurses and dental hygienists) and who provide patient care, treatment, and services;
- (n) Continuously assess and improve the quality of care, treatment, and services provided within the division, which may include a random audit of medical records in the division to determine whether chart notations were accurate, complete and acceptable in content and quality;
- (o) Maintain quality monitoring programs, as appropriate;
- (p) Provide for the orientation and continuing education of all persons in the division, and being responsible for teaching and research activities; making recommendations for space and other resources needed by the division;
- (q) Be accountable to the Medical Executive Committee for all professional, quality and administrative activities related to the medical services of the division;
- (r) Implement division related actions taken by the Medical Executive Committee;
- (s) Participate in Medical Staff leadership training, as determined by the Medical Executive Committee; and
- (t) Perform all functions authorized in the Credentials Policy, including collegial intervention efforts.

Divisions shall meet bi-monthly.

5.4. SERVICE LINES

5.4-1. FUNCTIONS OF SERVICE LINES

Service Lines may perform any of the following activities:

- (a) Plan continuing education activities;
- (b) Discuss policies;
- (c) Discuss equipment needs;
- (d) Develop recommendations to a division chair or the Medical Executive Committee;
- (e) Conduct Utilization Review;
- (f) Perform Quality Improvement;

- (g) Participate in the development of criteria for clinical privileges (when requested by a division chair); and
- (h) Discuss a specific issue at the request of a division chair or the Medical Executive Committee

Service lines shall meet as often as determined by each service line.

5.4-2. SELECTION AND REMOVAL OF SERVICE LINE CHIEFS

- (a) Each Service Line shall be led by one (1) chief and one (1) vice-chief who must satisfy the eligibility criteria below:
 - 1. Have served on the Active Hospital Staff or Active Community Staff for at least two (2) years;
 - 2. Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges
 - 3. Be willing to faithfully discharge the duties and responsibilities of the position
 - 4. Have experience in a leadership position, or other involvement in performance improvement functions;
 - 5. Participate in Medical Staff leadership training, as determined by the Medical Executive Committee;
 - 6. Have demonstrated an ability to work well with others; and
 - 7. Disclose if they (1) are serving as a Medical Staff Officer, Board member, or division chair at any other hospital, or (2) have any financial relationship (i.e. an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within an individual's office and billed under the same provider number used by the individual.
 - 8. Any disclosures under paragraph seven (7) of this Section shall be reviewed by the Nominating Committee, the Medical Executive Committee, and the Board, to determine whether the relationship is such that it renders an individual ineligible for the position for which he or she is being considered.
- (b) Service line chiefs and vice-chiefs shall be elected for a term of two (2) years. Service line chiefs and vice-chiefs may be removed at the discretion of the Medical Executive Committee after receiving input from service line members.
- (c) Medical Staff member may only be a service line chief or vice-chief of one service line at a time.

5.4-3. NOMINATIONS

- (a) Nominations for the election of Service Line Chief and Vice-Chief shall be put forward by the Service Line membership. Notice of the nomination will be sent to all members of the Service Line to allow the members an opportunity to nominate additional candidate(s) who meet the qualifications and have agreed in writing to accept the nomination. At the next Service Line meeting, an election will be held to fill the open position.

5.4-4. DUTIES OF SERVICE LINE CHIEFS

The service line chief shall carry out those functions delegated by the division chair, which include the following:

- (a) Evaluate individuals during the focused professional practice evaluation process to confirm competence for all initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment;
- (b) Participate in the development of criteria for clinical privileges within the service line; and

- (c) Review and report regarding the professional performance of individuals practicing in the service line.
- (d) Develop and implement policies and procedures that guide and support the provision of care, treatment, and services in the service line;
- (e) Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- (f) Maintain quality monitoring programs, as appropriate;
- (g) Implement division related actions taken by the Medical Executive Committee; and
- (h) Participate in Medical Staff leadership training, as determined by the Medical Executive Committee.
- (i) Serve on the Medical Executive Committee

5.4-5 SERVICE LINE MEMBERS

Service line members shall be appointed by the President of the Medical Staff and approved by the Medical Executive Committee.

ARTICLE 6
MEDICAL STAFF COMMITTEES AND PERFORMANCE IMPROVEMENT FUNCTIONS

6.1. MEDICAL STAFF COMMITTEES

6.1-1. GENERAL

This article and the Medical Staff Organization Manual outline the Medical Staff Committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board.

6.1-2. APPOINTMENT OF COMMITTEE MEMBERS AND CHAIRS

- (a) Unless otherwise indicated, all committee chairs and members shall be appointed by the President of the Medical Staff who shall serve as ex officio (with vote) on all committees. Committee chairs shall be selected based on the criteria set forth in Section 4.2. of these Bylaws.
- (b) Unless otherwise provided, committee chairs and members shall be appointed for a term of two years and may be reappointed for additional two (2) -year terms. All appointed chairs and members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.
- (c) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the President & Chief Executive Officer. All such representatives shall serve on the committees, without vote.
- (d) Unless otherwise indicated, the President & Chief Executive Officer (or their respective designees) shall be members, ex officio, without vote, on all committees.

6.1-3. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws or in the Medical Staff Organization Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the Medical Executive Committee and to other committees and individuals as may be indicated.

6.2. MEDICAL EXECUTIVE COMMITTEE

6.2-1. COMPOSITION

- (a) The Medical Executive Committee shall consist of the President of the Medical Staff, the President-Elect, the Secretary-Treasurer, the Immediate Past President of the Medical Staff, the division chairs, the division vice chairs, the service line chairs and such other medical practitioners as are appropriate from time to time, as appointed by the President of the Medical Staff. At all times, the Medical Executive Committee shall include at least two (2) members who are ambulatory care practitioners and at least one (1) member who is a hospital-based physician.
- (b) The President of the Medical Staff shall chair the Medical Executive Committee.
- (c) The President & Chief Executive Officer shall be an ex officio member of the Medical Executive Committee, without vote.
- (d) The President of the Medical Staff may invite other individuals to attend and participate at meetings of the Medical Executive Committee (without vote).

6.2-2. DUTIES

The Medical Executive Committee is delegated the primary authority over activities related to the functions of the Medical Staff and performance improvement. This authority may be removed or modified by amending these Bylaws and related policies. The Medical Executive Committee is responsible for the following:

- (a) Act on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between Medical Executive Committee meetings);
- (b) Recommend directly to the Board on at least the following:
 - 1) The Medical Staff's structure;
 - 2) The mechanism used to review and to delineate individual clinical privileges;
 - 3) Applicants for Medical Staff appointment and reappointment;
 - 4) Termination, restriction, and suspension of appointment, reappointment and/or clinical privileges;
 - 5) Delineation of clinical privileges for each eligible individual;
 - 6) Participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;
 - 7) The mechanism by which Medical Staff appointment maybe terminated;
 - 8) Hearing procedures; and
 - 9) Reports and recommendations from Medical Staff committees, divisions, and other groups, as appropriate.
- (c) Consult with administration on quality-related aspects of contracts for patient care services;
- (d) Review quality indicators to ensure uniformity regarding patient care services;
- (e) Provide leadership in activities related to patient safety;
- (f) Provide oversight in the process of analyzing and improving patient satisfactions;
- (g) Ensure that, at least every three (3) years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;
- (h) Provide and promote effective liaison among the Medical Staff, Administration, and the Board; and
- (i) Perform such other functions as are assigned to it by the Board or as authorized in these Bylaws, the Credentials Policy, or other applicable policies.

6.2-3. MEETINGS

- (a) The Medical Executive Committee shall meet at least ten times a year, and the President of the Medical Staff may otherwise electronically transmit matters to the membership for their consideration as an alternative to a formal meeting.
- (b) The Medical Executive Committee shall maintain a permanent record of its proceedings and actions.

6.3. PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

- (a) Patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;
 - 1) The Hospital's and individual practitioners' performance on DNV and Centers for Medicare & Medicaid Services ("CMS") core measures;

- 2) Medical assessment and treatment of patients;
 - 3) Medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;
 - 4) The utilization of blood and blood components, including review of significant transfusion reactions;
 - 5) Operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;
 - 6) Appropriateness of clinical practice patterns;
 - 7) Significant departures from established patterns of clinical practice;
 - 8) Use of information about adverse privileging determinations regarding any practitioner;
 - 9) The use of developed criteria for autopsies;
 - 10) Sentinel events, including root cause analyses and responses to unanticipated adverse events;
 - 11) Health care-associated infections and the potential for infection;
 - 12) Unnecessary procedures or treatment;
 - 13) Appropriate resource utilization;
 - 14) Education of patients and families;
 - 15) Coordination of care, treatment, and services with other practitioners and Hospital personnel;
 - 16) Accurate, timely, and legible completion of medical records;
 - 17) The required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in the Medical Staff policy on History and Physicals;
 - 18) Review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and
 - 19) Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.
- (b) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

6.4. CREATION OF STANDING COMMITTEES AND SPECIAL TASK FORCES

- (a) The Medical Executive Committee may, by resolution, and without amendment to these Bylaws, establish additional standing committees to perform one (1) or more staff functions, including professional practice evaluation activities.
- (b) The Medical Executive Committee may dissolve or rearrange the structure, duties, or composition of the Medical Staff committees as needed to better accomplish Medical Staff functions.

- (c) Any function required to be performed by these Bylaws, which is not assigned to an individual, or a standing committee shall be performed by the Medical Executive Committee.
- (d) Special task forces may also be created and their members and chairs shall be appointed by the President of the Medical Staff and/or the Medical Executive Committee. Such special task forces shall confine their activities to the purpose for which they were appointed and shall report to the Medical Executive Committee.

ARTICLE 7
MEETINGS

7.1. GENERAL MEDICAL STAFF MEETINGS

The Medical Staff shall meet at least twice during the Medical Staff year, with regularly scheduled meetings during the months of March and September.

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the Medical Executive Committee, the President & Chief Executive Officer, or the Board or by a petition signed by at least 10% of the Active Hospital Staff.

7.2. DIVISION, SERVICE LINE, AND COMMITTEE MEETINGS

7.2-1. REGULAR MEETINGS

Except as otherwise provided in these Bylaws or in the Organizational Manual, each division, service line, and committee shall meet as often as necessary to accomplish their functions, at times set by the Presiding Officer.

7.2-2. SPECIAL MEETINGS

A special meetings of any division, service line, or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, the Medical Executive Committee, or the President & Chief Executive Officer, or by a petition signed by at least 10% of the voting members of the division, service line, or committee, but not by fewer than two (2) members.

7.3. PROVISIONS COMMON TO ALL MEETINGS

7.3-1. PREROGATIVES OF THE PRESIDING OFFICER

- (a) The Presiding Officer of each meeting is responsible for setting the agenda for any regular or special meeting of the Medical Staff, division, service line, or committee.
- (b) The Presiding Officer has the discretion to conduct any meeting by telephone conference or videoconference.
- (c) The Medical Executive Committee shall maintain a permanent record of its proceedings and actions.

7.3-2. NOTICE OF MEETINGS

- (a) **Regular Meetings**
Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of divisions, service lines, and committees at least 14 days in advance of meetings. Notice may also be provided by posting in a designated location at least 14 days prior to the meetings. All notices shall state the date, time, and place of the meetings.
- (b) **Special Meetings**
When a special meeting of the Medical Staff, a division, a service line, and/or a committee is called, notice must be given at least 48 hours prior to the special meeting. In addition, posting may not be the sole mechanism used for providing notice of any special meeting.
- (c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

7.3-3. QUORUM AND VOTING

- (a) For any regular meeting of the Medical Staff, division, service line, or committee, those voting members present (but not fewer than two (2)) shall constitute a quorum. Exceptions to this rule are as follows:
 - (b) For any amendments to these Medical Staff Bylaws, at least 10% of the voting Active Hospital Staff shall constitute a quorum.
 - a. Early/Absentee Voting

- i. Eligible voters may cast a ballot in person the day of the bi-annual meeting of the medical staff. Ballots will be available in Physician Services during their normal hours of operation. As an alternative, voters can request that an electronic ballot be sent to him/her via email. All votes must be cast before the meeting.
- b. Conference Call Attendee Voting
 - i. Eligible voters who participate via conference call in the bi-annual meeting of the medical staff will be sent an electronic ballot via email. The vote must be cast by adjournment of the meeting.
- (c) Recommendations and actions of the Medical Staff, divisions, service lines, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority of the votes cast by the voting staff at the meeting.
- (d) As an alternative to a formal meeting, and at the discretion of the Presiding Officer, the voting members of the Medical Staff, a division, service line, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, telephone, or other technology approved by the President of the Medical Staff, and their votes returned to the Presiding Officer by the method designated in the notice.

7.3-4. MINUTES, REPORTS AND RECOMMENDATIONS

- (a) Minutes of all meetings of the Medical Staff, divisions, and committees (and applicable service lines meetings) shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The Presiding Officer shall authenticate the minutes.
- (b) Minutes of all recommendations and actions of the Medical Staff, divisions, service lines, and committees shall be transmitted to the Medical Executive Committee. The Board shall be kept apprised of the recommendations of the Medical Staff and its division, service lines, and committees.
- (c) A summary of Medical Executive Committee minutes shall be presented to the Full Staff meetings.
- (d) A permanent file of the minutes of all meetings shall be maintained by the Hospital.
- (e) Minutes of all division, committee and staff meetings and reports used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality or for the improvement of patient care, shall be privileged, strictly confidential and shall be returned to the secretary of the meeting at or before the conclusion of the meeting.
- (f) Meetings of the staff, divisions, service lines, and committees will be conducted according to the then current edition of Robert's Rules of Order. In the event of conflict between said Rules and any provisions of the medical staff bylaws, the bylaws take precedence.

7.3-5. CONFIDENTIALITY

All Medical Staff business conducted by committees, divisions, or service lines is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review process, except authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

7.3-6. ATTENDANCE REQUIREMENTS

- (a) Attendance at meetings of the Medical Executive Committee is required. All members are required to attend at least 50% of all regular and special meetings of the Medical Executive Committee for two (2)

years or for the term of appointment. Failure to attend the required number of meetings may result in voluntary relinquishment of the office.

- (b) Each Active Hospital Staff member and Active Community Staff member is expected to attend and participate in Medical Staff meetings and applicable division meetings each year. Failure to attend 50% of division and General Medical Staff meetings will result in a fine of \$100 payable with the next collection of medical staff dues. A single waiver of this requirement will apply to physicians appointed during the calendar year for which these fines are assessed.
- (c) Failure of appointed members to attend 50% of other committee or service line meetings will result in replacement.

7.3-7. SPECIAL APPEARANCE

Whenever a pattern or suspected deviation from standard clinical practice is identified within a physician's practice, the President of the Medical Staff or the applicable division chair may require the physician to confer with him/her or with a standing or ad hoc committee that is considering the matter. The Physician will be given special notice of the conference at least five (5) days prior to it, including the date, time and place, a statement of the issue involved, and that the physician's appearance is mandatory. Failure of a Physician to appear at any such conference, unless excused by the Medical Executive Committee upon a showing of good cause, will result in an automatic suspension of all or such portion of the physician's clinical privileges as the MEC may direct. A suspension under this Section will remain in effect until the matter is resolved by subsequent action of the MEC and board or through corrective action, if necessary.

ARTICLE 8
CREDENTIALING AND PRIVILEGING

The details associated with the following contained in the Credentials Policy in a more expansive form.

8.1. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff, or the Non-Physician Provider Staff, or for the grant of clinical privileges or scope of practice, an applicant must meet the threshold eligibility criteria set forth in these bylaws and the Credentials Policy, and demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges or scope of practice requested.

8.2. PROCESS FOR PRIVILEGING

- (a) Requests for privileges are provided to the applicable division chair or vice chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by Physician Services) stating whether the individual meets all qualifications. The division chair or vice chair then reviews the assessment, the application, and all supporting materials and makes a recommendation to the Medical Executive Committee. The Medical Executive Committee may accept the recommendation of the chair or vice chair, refer the application back to the chair or vice chair for further review, or state specific reasons for disagreement with the recommendation of the chair if it does not adopt the recommendation. If the recommendation of the Medical Executive Committee to grant privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the Medical Executive Committee is unfavorable for a medical staff applicant, the individual is notified by the President & Chief Executive Officer of the right to request a hearing.
- (b) When a Non-Physician Provider makes the request for privileges, a Non-Physician Provider as designated by the medical staff president shall review the credentials, make a recommendation to the division chair, and subsequently follow the process outlined above.
- (c) Once a request for clinical privileges or scope of practice is deemed complete, it is expected to be processed within 90 calendar days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

8.3. DIVISION RESPONSIBILITY FOR CRITERIA

Each division chair shall recommend to the Medical Executive Committee the criteria established by the division for every clinical privilege relevant to care provided in that division. Division criteria must be periodically reviewed and recommended for revision as necessary.

8.4. EMERGENCY PRIVILEGES

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, any medical staff member with clinical privileges is authorized and will be assisted to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the member's license but regardless of division affiliation, staff category or level of privileges.

8.5. DISASTER PRIVILEGES

Disaster privileges may be granted only when the Hospital Emergency Management Plan has been activated. Individuals with disaster privileges shall be identified and managed as described in the Hospital Emergency Management Plan. The medical staff bylaws and policies control in all matters relating to the exercise of disaster privileges.

The President of the Medical Staff or his designee may on a case-by-case basis, grant disaster privileges upon presentation of a valid picture identification issued by a state, federal or regulatory agency and any of the following:

- (a) A current Hospital picture identification.
- (b) A current license to practice.
- (c) Identification establishing that the individual is a member of a Disaster Medical Assistance Team (DMAT) or an Illinois Medical Emergency Response Team.
- (d) Identification granted by a federal, state or municipal entity establishing that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances.
- (e) Presentation by current hospital staff or medical staff member(s) with personal knowledge regarding the practitioner's identity and liability.

Verification of all credentials of individuals with disaster privileges is a high priority. Verification shall be initiated as soon as the immediate situation is under control. In accordance with Illinois code, the hospital is not required to collect credentials data. Although within 72 hours or as soon as possible, Physician Services Department will perform primary source verification of the state licensure, query the National Practitioner Data Bank and check the Health and Human Services/Office of the Inspector General (HHS/OIG) website. Also within 72 hours of the disaster privileges being granted the Hospital will determine if the disaster privileges should continue, when the emergency no longer exists, these temporary disaster privileges will expire. When disaster privileges expire, the individual will not be entitled to a hearing.

8.6. EXERCISE OF PRIVILEGES

A practitioner providing clinical services at this hospital may exercise only those clinical privileges specifically granted. Regardless of the level of privileges granted, each practitioner must obtain consultation when necessary for the safety of the patient or when required by policies of the staff, or any of its clinical units. Clinical privileges may be granted, continued, modified, or terminated by the governing body of this hospital only upon recommendation of the medical executive committee, only for reasons directly related to quality of patient care and other provisions of the medical staff bylaws, and only following the procedures outlined in these bylaws.

8.7. BASIS FOR PRIVILEGES DETERMINATION

Privileges governing clinical practice are granted in accordance with prior continuing education, training, experience, health status, and demonstrate a current competence and judgment as documented and verified in each physician's credentials file and accordance with the criteria set forth in these bylaws. The basis for privileges determination for current staff members in connection with reappointment or a requested increase in privileges must include ongoing observation and monitoring of the member's clinical performance and documented results of the staff's quality improvement program and related activities. Privileges determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a physician exercises clinical privileges. When available, the following shall be reviewed: (a) relevant practitioner – specific data as compared to aggregate data; and (b) morbidity and mortality data. This information shall be added to and maintained in the medical staff file established for a staff member.

8.8. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

- (a) Completed applications are provided to the applicable division chair or vice chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by Physician Services) stating whether the individual meets all qualifications. The division chair or vice chair then reviews the assessment, the application, and all supporting materials and makes a recommendation to the Medical Executive Committee. The Medical Executive Committee may accept the recommendation of the chair or vice chair, refer the application back to the chair or vice chair for further review, or state specific reasons for disagreement with the recommendation of the chair if it does not adopt the recommendation. If the recommendation of the Medical Executive Committee to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the recommendation of the

Medical Executive Committee is unfavorable, the individual is notified by the President & Chief Executive Officer of the right to request a hearing.

- (b) When a nurse practitioner makes the request for permission to practice, the Chief Nursing Officer shall review the credentials and make a recommendation to the division chair and subsequently follow the process outlined above.
- (c) Once an application is deemed complete, it is expected to be processed within 90 business days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

8.9. UPDATING INFORMATION

Throughout the application process, applicants, medical staff members, and non-physician providers must provide updates to the information submitted in the initial application or reapplication forms using the State of Illinois approved update gathering form within five (5) business days as they relate to the following developments; licensure revocation, federal drug enforcement agency license revocation, Medicare or Medicaid sanctions, revocation of hospital privileges, any lapse in professional liability coverage required by a health care entity, health care plan, hospital, or conviction of a felony. Any other changes in the information provided in the forms must be sent within forty-five (45) days from the date the applicant or member "knew of the change."

8.10. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

Appointment and clinical privileges or permission to practice may be automatically relinquished if an individual:

- (a) Fails to do any of the following:
 - 1. Satisfy threshold eligibility criteria;
 - 2. Provide requested information, including documentation to support clinical competence;
 - 3. Undergo a requested evaluation or execute any of the appropriate releases;
 - 4. Attend a special meeting to discuss issues or concerns;
 - 5. Complete and/or comply with training, counseling, or educational requirements; or
 - 6. Pay applicable Medical Staff dues in a timely manner;
- (b) Makes a misstatement or omission on an application form;
- (c) Is convicted of a felony
- (d) Remains absent on leave for longer than one (1) year, unless an extension is granted by the Medical Executive Committee; or
- (e) Fails to begin practice within 120 days of being granted medical staff membership or permission to practice and clinical privileges. Practitioners that fail to begin practice within the required timeframe will also be required to wait a period of one (1) year to reapply.
- (f) Except as otherwise provided in the Credentials Policy, an automatic relinquishment of appointment and clinical privileges or scope of practice will be effective immediately upon actual or special notice to the individual without right to a hearing. An automatic relinquishment is considered an administrative action and, as such, it does not trigger an obligation on the part of the Medical Center to file a report with the National Practitioner Data Bank.

8.11. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an Investigation or a determination that there is sufficient information upon which to base a recommendation, the Medical Executive Committee may recommend suspension or revocation of appointment or clinical privileges or scope of practice based on concerns about

- (a) Clinical competence or practice;

- (b) Safety or proper care being provided to patients;
- (c) Violation of ethical standards or the Bylaws, policies, or
- (d) Conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

8.12. EFFECT OF STAFF MEMBERSHIP TERMINATION

Because practice at the hospital is always contingent upon continued staff membership and is constrained by the extent of clinical privileges enjoyed, an exclusive contract physician's right to use hospital facilities is automatically terminated when staff membership expires or is terminated.

8.13. EFFECT OF CONTRACT EXPIRATION OR TERMINATION

- (a) The effect of expiration or other termination of a contract upon a practitioner's staff membership status, permission to practice, and clinical privileges will be governed solely by the terms of the practitioner's contract with the hospital except that if a member holds staff privileges in other areas aside from services covered by a hospital contract, those privileges will remain in effect unless otherwise altered or changed in accordance with the provisions of these bylaws.
- (b) If the hospital contract is silent on the matter or if there is no written contract, then contract expiration or other termination alone will not affect the practitioner's staff membership status, permission to practice, and clinical privileges.
- (c) If the practitioner is terminated or resigns from a medical group with which the hospital holds an exclusive contract, medical staff membership, permission to practice and clinical privileges will be automatically terminated. The practitioner is not entitled to the procedural rights outlined in these bylaws.
- (d) If the hospital terminates its exclusive contract with a medical group, it shall so notify the Medical Executive Committee reasonable in advance of the termination date. All practitioners who have been granted medical staff membership, permission to practice and clinical privileges in accordance with the exclusive agreement shall be terminated effective on the date of the group's termination date. The practitioner(s) are not entitled to the procedural rights outlined in these bylaws.

ARTICLE 9
CONFIDENTIALITY, IMMUNITY AND RELEASES

9.1. AUTHORIZATIONS AND CONDITIONS

By submitting an application for staff membership or by applying for or exercising clinical privileges or providing specified patient care services in this hospital, a physician:

- (a) Authorizes representatives of the hospital and the medical staff to solicit, provide and act upon information bearing on his/her professional ability and qualifications.
- (b) Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.
- (c) Acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, staff membership and the continuation of such membership and to his/her exercise of clinical privileges or provision of specified patient services at this hospital.

9.2. CONFIDENTIALITY OF INFORMATION

Information with respect to any physician submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research, determining that health care services are professionally indicated or were performed in compliance with the applicable standard of care, or establishing and enforcing guidelines to keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative, nor be used in any way except as provided herein or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's record.

9.3. IMMUNITY FROM LIABILITY

9.3-1. FOR ACTION TAKEN

No individual who is a member, agent, or employee of a hospital, hospital medical staff, hospital administrative staff, or hospital governing board shall be liable for civil damages as a result of any Peer Review action taken by a peer review committee including, but not limited to, the acts, omissions, decisions, or any other conduct of a medical utilization committee, medical review committee, patient care audit committee, medical care evaluation committee, quality review committee, peer review committee, or any other committee whose purpose, directly or indirectly, in internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital, or the improving or benefiting of patient care and treatment, whether a hospital or not, or for the purpose of professional discipline.

9.3-2. FOR PROVIDING INFORMATION

No representative of the hospital or medical staff and no third party shall be liable to a physician or the hospital for damages or other relief by reason of providing information including otherwise privileged or confidential information, to a representative of this hospital or medical staff or to any other health care facility or organization of health professionals concerning a physician who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges or provide specified services at this hospital, provided that such information is related to the performance of the duties and functions of the recipient and is reported in a factual manner.

9.4. ACTIVITIES AND INFORMATION COVERED

9.4-1 ACTIVITIES

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facilities or organizations concerning, but not limited to:

- (a) Applications for appointment, clinical privileges or specified services.

- (b) Periodic reappraisals for reappointment, clinical privileges or specified services.
- (c) Corrective or disciplinary action.
- (d) Hearings and appellate reviews.
- (e) Quality improvement program activities.
- (f) Utilization reviews.
- (g) Claims reviews.
- (h) Malpractice loss prevention.
- (i) Other hospital and staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

9.4-2. INFORMATION

The information referred to in this Article may relate to a physician's professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

9.5. CUMULATIVE EFFECT

Provisions in these bylaws and in application forms relating to authorization, confidentiality or information and immunities from liability are in addition to other protections provided by law and not in limitation thereof.

ARTICLE 10
FOCUSED REVIEW AND CORRECTIVE ACTION

10.1 SPECIAL REVIEW

The Medical Executive Committee shall define, on a continuing basis, the circumstances warranting further intensive review of a member or other practitioner's services provided under privileges held and establish the parameters for participation of the subject under review in the special review process. When circumstances warrant, the president shall appoint a special committee of impartial medical staff members whose professional credentials establish their competence to analyze the grounds for the review and the performance of the practitioner. The panel shall conduct the review or utilize an external peer review resource following the time frames set for that special review by the MEC. The hospital will assist in this process.

10.2 REQUESTING ROUTINE REMEDIAL ACTION

10.2-1 CRITERIA FOR INITIATION

Whenever the activities or professional conduct of any physician with clinical privileges are, or are reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care or are, or are reasonably likely to be, in violation of the medical staff bylaws, remedial action against such physician may be requested by any officer of the medical staff, by the chairman of any standing committee of the medical staff, by the chief executive officer, or by the board.

10.2-2 REQUESTS AND NOTICES

All requests for remedial action shall be in writing, submitted to the medical executive committee (MEC), and supported by reference to the specific activities or conduct which constitute the grounds for the request. The chairman of the MEC shall promptly notify the chief executive officer in writing of all requests for corrective action received by the committee and shall continue to keep the member fully informed of all action taken in conjunction therewith.

10.3 INTERVIEW PRIOR TO REMEDIAL ACTION

Prior to initiating remedial action involving a Physician, the MEC offer to afford the Physician a formal interview. The Physician shall be provided written notice of the basis for the request, along with any information supporting the request, in advance of the interview. At this meeting, the circumstances prompting the request for corrective action are discussed and the Physician is permitted to present relevant information in his/her own behalf. A formal interview must be initiated by special notice to the Physician, with copies transmitted to the president of the staff, to the medical director, if appointed, and to the chief executive officer (CEO). A written record reflecting the substance of the interview must be made and transmitted to the physician, the president, the CEO and the board. The CEO may, at the option of the MEC, be present as an observer at a formal interview. If the Physician fails to respond to the special notice or declines to participate in the interview, remedial action must immediately proceed in accordance with these bylaws. The formal interview option is not a procedural right of the physician and need not be conducted according to the procedural rules provided in these bylaws.

If in the opinion of the president, or after the discretionary interview or deliberation, in the opinion of the MEC, the conduct underlying a request for corrective action is deemed to be due to the physician's impairment by physical or emotional problems, or by substance abuse, such request shall be referred to the Practitioner Health Committee.

10.4 INVESTIGATION

After deliberation, the MEC may either act on the request or direct that investigation concerning the grounds for the remedial action request be undertaken. The MEC may assign the investigation to a medical staff officer, division, other clinical unit, standing or ad hoc committee, or other organizational component. This investigative process is not a "hearing" as that term is used in the fair hearing. It shall include a meeting with the physician involved and with the individual or group making the request and with other individuals who may have knowledge of the events involved and the information on which the remedial action was requested shall be available at this meeting. If the investigation is accomplished by a group or individual other than the MEC, that group or individual must forward a written report of the investigation to the MEC as soon as is practicable after the assignment to

investigate has been made. The MEC may at any time within its discretion, terminate the investigative process and proceed with action as provided below.

10.5 MEDICAL EXECUTIVE COMMITTEE ACTION

10.5-1 ACTION RESULTING FROM INVESTIGATION

As soon as is practicable after the conclusion of the investigative process, if any, but in any event within ten (10) days after receipt of the request for corrective action unless deferred, the MEC acts upon such request. Its action may include, without limitation:

- (a) Recommending rejection of the request for corrective action;
- (b) Recommending a warning or a formal letter of reprimand;
- (c) Recommending a probationary period with retrospective review of cases but without special requirements of prior or concurrent consultation or direct supervision;
- (d) Recommending suspension of membership prerogatives that do not affect clinical privileges;
- (e) Recommending individual requirements of consultation or supervision;
- (f) Recommending reduction, suspension or revocation of clinical privileges;
- (g) Recommending reduction of staff category or suspension or limitation of any prerogatives directly related to the physician's provision of patient care;
- (h) Recommending suspension or revocation of staff membership.

10.5-2 DEFERRAL

If additional time is needed to complete the investigative process, the MEC may defer action on the request but only upon written consent of the affected physician. A subsequent recommendation for any or more of the actions provided above must be made within the time specified in the consent, and if no time is specified, then within ten (10) days of the deferral.

10.5-3 PROCEDURAL RIGHTS

An MEC recommendation deemed adverse as defined in the medical staff bylaws entitles the physician to the procedural rights contained in the bylaws.

10.5-4 OTHER ACTION

An MEC recommendation on a request for corrective action that is not deemed adverse is transmitted to the Board together with all supporting documentation. The Board may adopt or reject, in whole or in part, the recommendation of the MEC or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Following deferral if any, the Board of Director's decision shall be final. However, if the Board's action on any such recommendation, or the MEC's action upon reconsideration as directed by the Board represents an adverse decision, then the affected physician shall be entitled to the procedures set forth in these bylaws.

10.6 SUMMARY SUSPENSION

10.6-1 CRITERIA FOR INITIATION

Whenever a continuation of a Physician's practice constitutes an immediate danger to the health or safety of the public, including patients, visitors, and hospital employees and staffs, two (2) of the following individuals together, either an officer of the medical staff, or the chairman of a division, or the chief executive officer of the hospital shall have the authority to summarily suspend the medical staff membership status or any portion of the clinical privileges of such Physician. A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists which must be available when the suspension decision is made. Such summary suspension shall become effective immediately upon imposition,

and the CEO shall promptly give special notice stating the cause of the suspension to the physician and of the physician's right to request a hearing. In the event of any such suspension, the Physician's patients then in the hospital whose treatment by such physician is terminated by the summary suspension shall be assigned to another member of the medical staff with similar clinical privileges by the division chairman. The wishes of the patient shall be considered, where feasible, in choosing a substitute physician.

10.6-2 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after a summary suspension is imposed, the MEC convenes as soon as it is reasonably possible, but in no event longer than five (5) days after the suspension was imposed, to review and consider the facts under which such action was taken. The MEC may affirm, list, expunge or modify the suspension. The MEC may also recommend such further corrective action as is appropriate to the facts, including limitation of prerogatives, which recommendation if subject to hearing rights under these bylaws, would be combined with any remaining summary suspension action as the bases for the hearing. An MEC recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights is transmitted immediately, together with all supporting documentation, to the board, or a committee of the board for review on an expedited basis. If the suspension is re-imposed or other adverse action under Section 11.2 is taken, the physician shall be entitled to those hearing rights set forth under Article XI.

10.6-3 PROCEDURAL RIGHTS

The Physician so affected is entitled to the procedural rights contained in these bylaws, except that the time basis shall be as follows:

- (a) The Physician must request the hearing within ten days of receiving special notice.
- (b) A fair hearing shall be commenced within fifteen days after the suspension (unless an extension is agreed to in writing by the parties) and shall be completed without delay.

10.7 AUTOMATIC SUSPENSION, REVOCATION, AND RESTRICTION

10.7-1 LICENSE

- (a) Revocation: Whenever a Physician's or Non-Physician Provider's license to practice in Illinois is revoked, his/her staff membership and clinical privileges are immediately and automatically revoked.
- (b) Restriction: Whenever a Physician's or Non-Physician Provider's license is partially limited or restricted in any way, those clinical privileges which he/she has been granted that are within the scope of the limitation or restriction are similarly limited or restricted, automatically.
- (c) Suspension: Whenever a Physician's or Non-Physician Provider's license is suspended, his/her staff membership and clinical privileges are automatically suspended effective upon and for at least the term of the suspension.
- (d) Probation: Whenever a Physician or Non-Physician Provider is placed on probation by his/her licensing authority, his/her voting and office holding prerogatives are automatically suspended effective upon and for the term of the probation.
- (e) Expiration: Whenever a Physician's or Non-Physician Provider's license to practice in this state expires, his/her staff membership and clinical privileges are immediately and automatically suspended until proof of official renewal is provided.

10.7-2 DRUG ENFORCEMENT ADMINISTRATION (DEA)

- (a) Revocation: Whenever a Physician's or Non-Physician Provider's DEA or other controlled substance number is revoked, he/she is immediately and automatically divested at least of his/her right to prescribe medications covered by the number
- (b) Restriction: Whenever a Physician's or Non-Physician Provider's use of his/her DEA or other controlled substance number is partially restricted or limited in any way, his/her right to prescribe medications

covered by the number is similarly restricted or limited effective upon, for at least the term of, and consistent with any other conditions of the restriction or limitation.

- (c) Suspension: Whenever a Physician's or Non-Physician Provider's DEA or other controlled substance number is suspended, he/she is immediately and automatically divested of his/her right to prescribe medications covered by the number effective upon and for at least the term of the suspension.
- (d) Probation: Whenever a Physician or Non-Physician Provider is placed on probation insofar as the use of his/her DEA or other controlled substance number is concerned, the MEC determines whether any corrective action is warranted.
- (e) Orders for narcotics and controlled substances will not be honored unless the physician's or Non-Physician Provider's DEA or other controlled substance number is active.

10.7-3 MEDICARE OR MEDICAID

A practitioner whose participation as a provider of services in the Medicare or Medicaid programs is involuntarily suspended or revoked is subject to suspension of his or her privileges until such time as participation is reinstated. Failure to obtain or be able to obtain reinstatement within one year will result in revocation of privileges and Staff membership.

10.7-4 MEDICAL RECORDS

Timely Completion: After written warning of delinquency of failure to complete medical records in a timely fashion, a physician's admitting and consulting privileges (except with respect to patients already in the hospital and any outpatients already scheduled), and the doctor's rights to admit patients and to consult with respect to patients (a consultation consists of examination of the patient and the record, and an opinion including recommendations and plan of treatment, this includes pre-anesthesia evaluations), are automatically suspended effective on the date specified in the written warning and continuing until the delinquent medical records are completed.

10.7-5 PROFESSIONAL LIABILITY INSURANCE

For failure to maintain the minimum amount of professional liability insurance, if any, required under these bylaws, a Physician's or Non-Physician Provider's medical staff membership and clinical privileges are immediately suspended.

10.7-6 FURTHER ACTION

As soon as practicable (a) after a Physician's license is suspended, restricted revoked, not renewed, or placed on probation, or (b) after the his/her controlled substances number is revoked, restricted, suspended, not renewed, or placed on probation, the MEC convenes to review and consider the facts under which such action was taken. The MEC may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation, including limitation of prerogatives. If the action recommended by the MEC is subject to hearing rights under these bylaws, hearing procedures regarding that recommendation should immediately commence. If the recommendation is not subject to hearing rights, it is transmitted to the Board together with all supporting documentation. The Board may adopt or reject, in whole or in part, such recommendation or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Following deferral if any, the Board of Director's decision shall be final. However, if the Board's action on any such recommendation, or the MEC's action upon reconsideration as directed by the Board is subject to hearing rights, then the affected physician shall be entitled to the hearing procedures in these bylaws.

10.7-7 PROCEDURAL RIGHTS

The Physician who is the subject of an automatic suspension, revocation, and/or restriction of membership or privileges as provided herein shall be notified of his or her right to request an Article XI hearing, the scope of which shall be limited to whether or not the factual basis on which the suspension was imposed is or is not accurate.

- (a) The Physician must request the hearing within ten days of receiving special notice.
- (b) If requested, a fair hearing shall be commenced within fifteen days after the suspension (unless an extension is agreed to in writing by the parties) and shall be completed without delay.

10.8 EXTERNAL PEER REVIEW

External peer review will take place in the context of focused review, investigation, application processing or at any other time only under the following circumstances, if and only if deemed appropriate by the medical staff division or the MEC or board; however, a practitioner subject to focused review or investigation can require the hospital or medical staff to obtain external peer review if it is not deemed appropriate by the medical staff division or the MEC or board.

- (a) Ambiguity when dealing with vague or conflicting recommendations from committee review(s) where conclusions from this review could directly impact an individual's membership or privileges.
- (b) Lack of internal expertise, when no one on the medical staff has adequate expertise in the clinical procedure or area under review.
- (c) 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.
- (d) To promote impartiality in peer review.
- (e) Upon the reasonable request of a practitioner.

The MEC or board may require external peer review in any circumstances deemed appropriate by either of these bodies

- (f) Any external review report that is utilized by the hospital or medical staff shall be in writing and shall be part of the internal peer review process under the bylaws.
- (g) The report shall be shared with the medical staff committee or person authorized to request the report and the individual under review.
- (h) If the committee or individual requesting the report or individual under review submits a written response within thirty (30) days after receipt of the report, the board must take this response into consideration before implementing any action which would affect the individual's membership or clinical privileges.

ARTICLE 11
PROCEDURAL RIGHTS

11.1 RIGHT TO FAIR HEARING

When a member of the medical staff is subject to an adverse recommendation or decision made by the medical executive committee or board of directors, the member is entitled, upon a timely and proper request, to procedural rights consistent with this Article.

11.2 ADVERSE ACTIONS

11.2-1 ADVERSE ACTIONS DEFINED

The following recommendations or decisions are adverse when made by the Medical Executive Committee or by the Board of Directors under circumstances where no prior right to request a fair hearing existed:

- (i) Denial of reappointment.
- (j) Suspension of Medical Staff membership.
- (k) Revocation of Medical Staff membership.
- (l) Revocation of permission to practice
- (m) Reduction in clinical privileges.
- (n) Suspension of clinical privileges.
- (o) Non-renewal of clinical privileges.
- (p) Revocation of clinical privileges.
- (q) Denial of clinical privileges.
- (r) Denial of an initial application for medical staff membership and privileges that is reportable to the National Practitioner Data Bank.
- (s) Requirement for mandatory consultations prior to exercising a privilege.
- (t) Any action requiring a data bank report.

11.2-2 ACTION NOT DEEMED ADVERSE

The listed actions shall not be considered adverse recommendations and therefore do not entitle the practitioner to any hearing rights under these bylaws, including but not limited to:

- (a) Issuance of a warning or formal letter or reprimand.
- (b) Imposition of a probationary period with retrospective review of practice or special requirements of consultation or supervision.
- (c) Mandatory consultations not requiring prior approval.
- (d) Imposition of a probationary period with concurrent monitoring.

- (e) Automatic lapse or voluntary resignation/withdrawal of Medical Staff privileges or clinical privileges.
- (f) Denial, termination or reduction of temporary or emergency privileges unless the hospital is required to report this action to the National Practitioner Data Bank.
- (g) Denial of an initial application, unless the hospital is required to report the denial to the National Practitioner Data Bank.
- (h) Any other action aside from those specified in Section 11.2-1 of this Article.

11.3 PROCEDURES FOR FAIR HEARING AND REVIEW

11.3-1 THE FAIR HEARING

The hearing is a forum for the resolution of issues involving professional conduct and competence on an intraprofessional basis. The hearing will be guided by principles of fairness and, subject to subsections 11.3-4 and 11.3-5 below, will be carried out in accordance with reasonable procedural rules developed in advance by the hearing committee (the "committee"). The hearing is not a formal legal or adversarial proceeding, and rules of law governing the questioning of witnesses or the presentation of evidence shall not apply.

If the aggrieved Physician desires to have his/her attorney or other representative of choice present, the doctor must so notify the hospital in the doctor's written request for the hearing. In which case, the hospital, on behalf of the medical staff, also may request that an attorney or representative of choice be present. The committee also may request the presence of a hearing officer, who may or may not be an attorney and additionally seek the presence of outside legal counsel to advise it during the hearing. In the alternative, the committee may consult with legal counsel for the Physician and for the medical staff on procedural issues during the hearing if legal counsel is permitted.

The role of legal counsel shall be at the sole discretion of the hearing committee, either limited to assisting their clients prior to the hearing or in the event of review by the board of directors and to advising clients during the hearing or more participatory including the ability to make formal presentations or question persons presenting information.

11.3-2 INITIATION OF HEARING PROCESS

- (a) The Physician shall be promptly notified in writing (return receipt requested) of any adverse recommendation or decision. This notification shall contain a statement of the decision, a description of the reasons supporting it and any supporting documentation. Notification that Physician has a right to request a hearing within thirty (30) days following such notice, and a summary of rights to which Physician is entitled during the hearing.
- (b) The Physician shall have thirty (30) days following notification to request a hearing. All requests should be made in writing to the chief executive officer. If a hearing is not requested, the adverse decision immediately becomes effective subject to final action by the board of directors.
- (c) As soon as is reasonably practicable after a hearing is requested, the chief executive officer of his/her designee shall schedule the hearing and shall notify the Physician in writing (return receipt requested) of the place, date and time it is to take place and of any persons expected to provide oral or written information at the hearing on behalf of the medical staff. The hearing must be scheduled for not less than thirty (30) days after the date of the request unless otherwise agreed to by the parties.
- (d) Notwithstanding any other provision contained herein, a Physician who has been subject to a summary or automatic suspension of medical staff membership or clinical privileges, must request the hearing within ten days of receiving notice, and, following any such request, shall be entitled to obtain a hearing within fifteen days of the effective date of the summary or automatic suspension (unless the parties agree in writing to extend such time frame).

- (e) If the Physician fails to appear for the hearing without good reason, he or she shall automatically be deemed to have waived his/her right to a hearing.

11.3-3 HEARING COMMITTEE

The president of the medical staff and the chief executive officer shall appoint a committee before which the Physician may appear to present relevant information on his/her behalf. This committee shall be comprised of at least three (3) medical staff members with no prior involvement in the matter and who are not in direct competition with the Physician but at least one (1) of whom should be in the same or similar specialty as the physician. If it is not possible to appoint three (3) unbiased medical staff members to the hearing committee, non-member Physicians may be appointed. The president of the medical staff shall designate one (1) member of the committee to serve as the chairperson. The Physician has the right to object in writing to any of the committee members. The president of the medical staff and chief executive officer shall review the issues of the objection and then make a final decision on whether or not to replace the member(s).

11.3-4 RULES OF PROCEDURE

Subject to the presentation rules below, the committee chairperson or hearing officer, as appropriate, will determine the proper sequence for presentation of information. Any relevant information, including written, oral, and other media may be received by the committee. The Physician and medical staff, the latter of which shall be represented at the hearing by a Physician presenter chosen by the president of the medical staff, may also call and question individuals presenting oral or written information. At the close of the hearing the physician and the physician presenter may submit a written statement to the committee. Disagreements regarding the information presented or the sequence of such shall be referred to the committee chairperson or to the hearing officer in the event a hearing officer is utilized.

- (a) **Recording**
A verbatim recording of the hearing by a court reporter shall be kept. The Physician may obtain a copy of this record upon payment of any reasonable charges associated with its preparation.
- (b) **Hearing Advisor**
Unless a hearing officer shall have been appointed to preside at the hearing the committee shall appoint its chairperson or another qualified person to act as hearing advisor, whose function shall be to assure that proper decorum is maintained throughout. The advisor may participate in the committee's deliberations but unless the advisor is a member of a committee, may not vote in the final decision.

11.3-5 PRESENTATION OR REVIEW

The Physician shall be entitled to present relevant written documentation, oral or other forms of presentations from hospital or other personnel and to ask the Physician questions. The affected Physician has the right to inspect pertinent information with regard to the basis on which adverse decision was made. The Physician shall then have the same opportunity to present information in support of his/her position. This includes the member's right to present witnesses and other evidence at the hearing on the decision. The committee has the authority to seek additional information if necessary.

In the case of an automatic suspension, the scope of the hearing shall be limited to a factual determination of whether the cause for the automatic suspension is true and accurate. The physician shall have the burden of establishing that the adverse decision is not supported by a preponderance (majority) of the evidence or that the decision was unreasonable, arbitrary or capricious.

11.3-6 DECISION

At the conclusion of the hearing committee members shall consult with one another outside the presence of all other persons except the hearing advisor. When the committee reaches its decision, a written report of the proceedings along with the committee's findings concerning the nature of each basis for any adverse recommendations and its own recommendations and the reasons therefore shall be delivered to the Board of Directors with copies to the chief executive officer. The committee's decision shall be in writing and must be supported by findings of fact from information submitted during the hearing. In its written report, the committee

shall recommend to the board of directors the acceptance, rejection or modification of the prior corrective action recommendation.

The chief executive officer promptly shall forward a copy of the report and recommendations of the committee to the Physician, the body which made the initial adverse recommendation or decision, and the medical executive committee. These materials shall include a statement of reasons for the committee's recommendation.

11.3-7 REVIEW OF THE BOARD OF DIRECTORS

Upon forwarding to the Physician a copy of the committee's report and recommendations, the Physician shall be advised when the board of directors shall next convene at its regularly scheduled meeting to review these recommendations. In the event that the Physician or MEC disagrees with the committee's report or recommendations, each party shall be given an opportunity to present his/her objections to the board in writing. These written objections must be received at least seven (7) days prior to the board's meeting. The Physician and/or the MEC, shall have an opportunity to make an oral presentation to the board if specifically permitted to do so by the board. The Physician and/or MEC may not submit any additional information for the board's consideration unless it was not otherwise available prior to the hearing and is deemed relevant by the board. The board shall have the authority to ask for any additional information from either the Physician or the medical staff, which it believes necessary in order to make a final determination. Within a reasonable period of time, but in no event more than forty-five days, the board of directors shall make a final decision, and shall promptly notify the Physician, the division chairs and the medical executive committee of this decision, and the reasons therefore, in writing. The board of directors' decision shall be final and there shall be no additional opportunity for internal review.

ARTICLE 12
GENERAL PROVISIONS

12.1. MEDICAL STAFF POLICIES

The Medical Executive Committee shall review, develop and adopt policies, which will be binding upon the medical staff, its members, and those otherwise granted permission to practice or holding clinical privileges. Such policies must be consistent with the medical staff bylaws. Only policies adopted by the Medical Executive Committee are binding upon the medical staff, its members, and those otherwise granted permission to practice. Amendments to the medical staff policies are to be distributed in writing to medical staff members and those otherwise holding clinical privileges in a timely and effective manner.

12.2. DIVISION POLICIES

Subject to the approval of the Medical Executive Committee each division will formulate its own written policies for the conduct of its affairs and the discharge of its responsibilities.

12.3 WAIVER OF POLICY

The Medical Executive Committee or the President of the Medical Staff may issue a waiver of any medical staff policy if it is determined the conditions and corresponding extenuating circumstances require such a waiver. The waiver of any policy should be limited to those situations in which doing so protects the integrity of and the ability to provide adequate patient care. If a waiver is granted outside of a Medical Executive Committee meeting, the topic will be discussed at the next regularly scheduled or special meeting of the Medical Executive Committee meeting for ratification or revocation.

ARTICLE 13
AMENDMENTS

13.1. MEDICAL STAFF BYLAWS

- (a) Neither the Medical Executive Committee, the Medical Staff, nor the Board shall unilaterally amend these bylaws.
- (b) Amendments to these Bylaws must be reviewed by the Medical Executive Committee or by a petition signed by at least 10% of the voting members of the Medical Staff.
- (c) Early/Absentee Voting
 - i. Eligible voters may cast a ballot in person the day of the bi-annual meeting of the medical staff. Ballots will be available in Physician Services during their normal business hours of operation. As an alternative, voters can request that an electronic ballot be sent to him/her via email. All votes must be cast before the meeting.
- (d) Conference Call Attendee Voting
 - i. Eligible voters who participate via conference call in the bi-annual meeting of the medical staff will be sent an electronic ballot via email. The vote must be cast by adjournment of the meeting.
- (e) All proposed amendments to these Bylaws must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, (i) a quorum of at least 10% of the voting staff must be present, and (ii) the amendment must receive a majority of the votes cast by the voting staff at the meeting.
- (f) The Medical Executive Committee may also present proposed amendments to these Bylaws to the Active Hospital Staff and Active Community Staff by written ballot or e-mail, or electronic ballot to be returned to Physician Services by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 10% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.
- (g) The Medical Executive Committee shall have the power to adopt technical, non-substantive amendments to these Bylaws, which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.
- (h) All amendments shall be effective only after approval by the Board.
- (i) If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the representatives of the Board and the Officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be

scheduled by the President & Chief Executive Officer to take place within two (2) weeks after receipt of a request.

13.2. OTHER MEDICAL STAFF DOCUMENTS

- (a) In addition to the Medical Staff Bylaws, there shall be policies and procedures that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies and procedures shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These documents include the Credentials Policy and Medical Staff Organization Manual.
- (b) The Medical Staff Organization Manual, and all policies of the Medical Staff may be adopted and amended by a majority vote of the Medical Executive Committee. No prior notice is required.
- (c) The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Medical Staff Bylaws and/or Medical Staff policies that are needed in order to comply with a law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have 14 days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee with regard to adoption of the provisional amendments, the amendments shall stand. If there is conflict over the provisional amendments that are supported by a petition signed by 10% of the Active Hospital Staff, then the process for resolving conflicts set forth below shall be implemented.
- (d) Amendments to the Medical Staff Organization Manual and all policies of the Medical Staff may also be proposed by a petition signed by at least 10% of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee, which may comment on the amendments before they are forwarded to the Board for its final action.
- (e) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual and other Medical Staff policies will become effective only when approved by the Board.

13.3. CONFLICT MANAGEMENT PROCESS

13.3-1 Conflicts between the Medical Staff and Medical Executive Committee

- (a) When there is a conflict between the Medical Staff and the Medical Executive Committee, supported by a petition signed by 10% of the Active Hospital Staff, with regard to the adoption of a new or amended Medical Staff policy proposed by the Medical Executive Committee, a special meeting of the Medical Staff to discuss the conflict may be called. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the new or amended policy at issue.
- (b) If the differences cannot be resolved, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Board for final action.
- (c) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.
- (d) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the President & Chief Executive Officer, who will forward the request for communication to the Chair of the Board. The President & Chief Executive Officer will also provide notification to the Medical Executive Committee by informing the President of the Medical Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

13.3-2. Conflicts between the Medical Staff, Hospital Administration, and the Board:

- (a) In the event there are irreconcilable differences between the Medical Staff, the Hospital Administration, and/or the Board with regard to proposed corrections, changes, adoption, and/or amendments to the Medical Staff Bylaws, upon written request submitted to the Chairman of the Board by a member of the Medical Executive Committee or a member of the Board, an ad hoc committee comprised of the Chairman of the Board, the President & Chief Executive Officer, the President of the Medical Staff, and the President-Elect of the Medical Staff shall make a recommendation to the Board to resolve such conflict within 60 days of said written request. After consideration of the recommendation of the ad hoc committee, the Board shall make the final decision on the proposed correction, changes, adoption, or amendments.

- (b) Any difference in the recommendation of the Medical Staff, Hospital Administration, and/or the Board concerning Medical Staff appointments, reappointments, terminations of appointments, and the granting or revision of clinical privileges shall be addressed by the Joint Conference Committee in a good faith effort to resolve such differences within a reasonable period of time. A description of the composition and duties of the Joint Conference Committee is contained in the Medical Staff Organization Manual.

ARTICLE 14
ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Board superseding and replacing any and all previous Medical Staff Bylaws, policies, manuals, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: 9/01/2020

Approved by the Board: 9/29/2020

Approved by the Board 9/28/2021

Approved by the Board 9/26/2023

Approved by the Board 9/24/2024

Adopted: 12/81; Revised: 12/83; 03/85; 04/85; 12/85; 06/87; 12/89; 09/90; 12/92; 09/93; 06/94; 09/95; 12/95; 03/96; 03/97; 06/97; 01/99; 03/00; 06/00; 12/00; 03/01; 12/01; 03/02; 06/03; 12/04; 12/05; 10/06; 06/07; 03/08; 09/08; 06/09; 09/09; 08/10; 03/11; 03/12; 03/13; 04/13, 06/14, 09/14. 09/15. 8/16. 9/17. 9/18. 9/19. 9/20, 9/21, 09/2023; 09/2024

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active Hospital	Consulting	Active Community	Honorary	Non-Physician Providers
Basic Requirements					
Board eligible	Y	Y	Y	N	N/A
Certification	Y	Y	Y	N	Y
Rights					
Admit	Y	N	N	N	N
Exercise clinical privileges	Y	Y	Y*	N	Y
May attend meetings	Y	Y	Y	Y	Y
Voting privileges	Y	Y	Y	N	N
Hold office	Y	N	Y	N	N
Prerogatives and Responsibilities					
Serve on committees	Y	Y	Y	Y	Y
Emergency call coverage	Y	N	N	N	N
Dues	Y	Y	Y	N	N
Participate in FPPE, OPPE and PI processes	Y	Y	Y*	N	Y

Y = Yes
 N = No
 P = Partial
 * = May be granted limited privileges for outpatient-related therapies

**Medical Staff Bylaws
Signature Page**

Signature: _____, Corporate Secretary

Date: _____

Signature: _____, Medical Staff President

Date: _____