# DEACONESS ILLINOIS MEDICAL CENTER
# MEDICAL STAFF BYLAWS
# INDEX

# MEDICAL STAFF BYLAWS

# OF

# HEARTLAND REGIONAL MEDCIAL CENTER

## P R E A M B L E

***WHEREAS, these Bylaws, originate with the medical staff, are adopted in order to provide for the organization of the Medical Staff of Deaconess Illinois Medical Center, to provide a framework for self-governance that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly implementation of those purposes. These Bylaws thus provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Hospital board, and relations amongst and between applicants, and the Medical Staff. These Bylaws, as adopted or amended, create a system of mutual rights and responsibilities between the Medical Staff and the Hospital.***

**THEREFORE,** these Bylaws are adopted for such purpose;

## D E F I N I T I O N S

1. "Active Staff" members shall be those physicians (D.O.'s, M.D.'s and Podiatrists) licensed in the State of Illinois that have the privilege of admitting patients, holding office and voting.

2. "Allied Health Professional" or "AHP" means a credentialed individual, other than a Practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a Practitioner who has been afforded privileges within their scope of practice to provide such care in the Hospital. For such purposes of these Medical Staff Bylaws, "AHP" shall be deemed to refer only to advance practice professionals who are credentialed as AHPs pursuant to the Medical Staff credentialing process. Such AHPs shall include, without limitation, physician assistants, certified nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, Physical Therapist and other such professionals. For purposes of these bylaws, "Allied Health Professional" shall not be deemed to include those non-credentialed individuals "Clinical Assistants" pursuant to the Hospital policy whose appointment and competencies are handled outside the Medical Staff process. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.

3. "Board" means Deaconess Illinois the Board of Directors governing Deaconess Illinois Medical Center.

4. "Board Certification" shall mean (i) for Physicians certification in a member board of the American Board of Medical Specialties, the American Board of Osteopathic Specialists, or an equivalent certifying board, as determined by the MEC and Board; (ii) for non-Physicians, appropriate and applicable specialty boards as determined by the MRC and Board.

5. "Chief Administrative Officer" or "CAO" means the individual appointed by the Corporation to provide for the overall management of the Hospital of his/her designee.

6. "Clinical Privileges" means the Board's recognition of the practitioners' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services.

7. "Corporation" means Marion Hospital Corporation.

8. "Data Bank" means the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

9. "Designee" means one selected by the CAO, President of the Medical Staff or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.

10. "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.

11. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a physician's or dentist's clinical privileges are adversely affected by a determination based on the physician's or dentist's professional conduct or competence. The Fair Hearing Plan is incorporated into these Bylaws and is contained in Appendix "A" hereto.

12. "Hospital" means Deaconess Illinois Medical Center.

13. "In good standing" means at the time of the assessment of standing, his/her membership and/or privileges are mot involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reason. Leave of absence is not an encumbrance for purposes of determining good standing."

14. "Investigation" or "investigate" means the formal medical staff process to review an issue or issues with the competence or professional conduct of a specific member/privilege holder. Investigations begin with the Medical Executive Committee decision to begin an investigation and terminate with the hospital's final action on the Medical Executive Committee's recommendation or the conclusion of the medical staff investigation without recommendation of adverse action. Members/privileges holders shall receive written notice upon the commencement of any investigation, disclosing the initiation and cope of investigation. Ongoing professional practice evaluation does not constitute an investigation; however, focused professional practice evaluation can constitute and investigation as defined by the National Practitioner Data Bank, and the definition of "investigation" for purposes of the Hospital's obligation to report to the National Practitioner Data Bank reporting is not limited by these Bylaws.

15. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.

16. "Medical Staff" means the formal organization of Practitioners who have been granted Medical Staff membership at the Hospital.

17. "Medical Staff Bylaws" means the Bylaws of the Medical Staff and the accompanying Rules & Regulations, Fair Hearing Plan and such other rules and regulations as may be adopted by the Medical Staff subject to the approval of the Board.

18. "Medical Staff Year" means May 1 through April 30.

19. "Member" means a Practitioner who has been granted Medical Staff membership pursuant to these By-laws.

20 "Oral and Maxillofacial Surgeon" means an individual who has successfully completed a post-graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education. As determined by the Medical Staff, the individual must be currently competent to perform a complete history and physical examination in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s).

21. "Peer Review Policy" means "the Medical Staff Policy Regarding Peer Review, Ongoing Professional Practice Evaluation (OPPE) & Focused Professional Practice Evaluation (FPPE)"the policy and procedure adopted by the Medical Staff with the approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all Practitioners with delineated clinical privileges, evaluate the competence of practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards. This policy is incorporated into these Bylaws and is contained in Appendix "D" hereto.

22. "Physician" means an individual with a D.O., M.D. D.P.M. degree who is properly licensed to practice medicine in Illinois.

23. "Practitioner" means a physician, dentist, or podiatrist who has been granted clinical privileges and/or Medical Staff membership at the Hospital.

24. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

25. President of the Medical Staff "means the member of the Active Medical Staff who is duly elected in accordance with these Bylaws to serve as Chief Officer of the Medical Staff of the Hospital or his/her designee."

26. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.

27. "Telemedicine" means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

28. "Patient Encounter or Contact" shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the Hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist or other Practitioner. When a patient has more than one procedure or diagnostic test performed or interpreted by the same Practitioner during a single Hospital stay, the multiple tests for that patient shall count as one patient contact.

## ARTICLE I
## NAME

The name of this organization shall be the Medical Staff of Deaconess Illinois Medical Center.

## ARTICLE II
## PURPOSES & RESPONSIBILITIES

### 2.1 Purpose

The purposes of the Medical Staff are:

2.1(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of Medical Staff membership may be fulfilled;

2.1(b) To foster cooperation with administration and the Board while allowing Medical Staff members to function with relative freedom in the care and treatment of their patients;

2.1 (c) To strive diligently to see all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive care consistent with or better than the standards in like or similar communities:

2.1. (d) To see that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive the same level of quality care commensurate with community resources, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other quality improvement activities in accordance with the Hospital's Quality Improvement Program as adopted by the Medical Executive Committee and approved by the Board of Directors who approval will not be unnecessarily withheld;

2.1.(e) To promote a high level of professional performance of all Practitioners authorized to practice in the Hospital;

2.1(f) To account to the Board for the quality of professional performance of all Practitioners and AHP's authorized to practice in the Hospital through delineation of clinical privileges, on-going review and evaluation of each Practitioner's performance in the Hospital, and supervision, review, evaluation and delineation of duties and prerogative of AHPs;

2.1(g) To provide an appropriate education setting that will maintain scientific standards that will lead to continuous improvement and advancement in professional knowledge and skill;

2.1 (h) To promulgate, maintain and enforce medical staff bylaws and rules and regulations for the proper functioning of the Medical Staff;

2.1.(i) To provide an organizational structure for the Medical Staff activities and a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff, the Board, and Administration.

2.1(j) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences; and

2.1(k) To accomplish its goals through appropriate committees and departments.

**2.2 Responsibilities**

The responsibilities of the Medical Staff include:

**2.2(a)** Encouraging Practitioners to cooperate with each other in caring for patients in the Hospital.

**2.2(b)** Accounting for the quality and appropriateness of patient care rendered by all Practitioners and AHPs authorized to practice in the Hospital, by taking action to:

(1) Assist the Board, the CAO and their designees in data compilation, medical record administration, review and evaluation of utilization and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;

(2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;

(3) Provide a continuing medical education program addressing issues of performance improvement and including the types of care offered by the Hospital; and require documentation of individual participation in such programs by all individuals with clinical privileges;

(4) Implement a utilization review program, based on the requirements of the Hospital's Utilization Review Plan as adopted by the Medical Executive Committee and approved by the Board of Directors, whose approval will not be unnecessarily withheld.;

(5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHPs;

(6) Initiate and pursue corrective action with respect to practitioners and AHPs, when warranted;

(7) Develop, administer and enforce these Bylaws, the Rules & Regulations of the Medical Staff and other Hospital policies related to medical care as adopted by the Medical Executive Committee and approved by the Board of Directors, whose approval will not be unnecessarily withheld.;

(8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment; and

(9) Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Practitioner Wellness Policy, which is incorporated herein and attached as Appendix “B” hereto.

**2.2(c)** Assist the Board in maintaining the accreditation status of the Hospital;

**2.2(d)** Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the National Practitioner Data Bank; and

**2.2(e)** Maintaining confidentiality with respect to the records and affairs of the Hospital and Medical Staff, except as disclosure is authorized by the Board or required by law.

## 2.3 Participation in Organized Health Care Arrangement

Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and all healthcare providers will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and providers to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement

# ARTICLE III
# MEDICAL STAFF MEMBERSHIP

## 3.1 Nature of Medical Staff Membership

Medical Staff membership is a privilege extended by the Hospital, and is not a right of any person. Membership on the Medical Staff shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Membership on the Medical Staff shall confer on the practitioner only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless he/she has been granted appropriate privileges to do so.

## 3.2 Basic Qualifications/Conditions of Medical Staff Membership

### 3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those Practitioners legally licensed in Illinois, who:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of Medical Staff responsibilities;

(3) Comply and have complied with federal, state and local requirements, if any, for their medical practice and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital as determined by the MEC and Board;

(4) Have professional liability insurance that meets the requirements of Section 14.2;

(5) Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, or certified by the Liaison Committee on Medical Education or Educational Commission for Foreign Medical Graduates (ECFMG);

(6) Have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA) and be currently board certified or become board certified within the eligibility timeframe defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association, not to exceed ten (10) years from initial eligibility. A podiatric physician (DPM) must have successfully

completed a two (2) year residency program in surgical, orthopedic or podiatric medicine approved by the Council on Medical Education of the American Podiatric Medical Association (APMA) and be board certified or become board certified within the eligibility timeframe determined by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Medicine, not to exceed ten (10) years from initial eligibility. The above requirements do not apply to any practitioner already a member of the Medical Staff as of November 1, 2012.

(7) Maintain a good reputation in his/her professional community; can work successfully with other professionals and have the physical and mental health to adequately practice his/her profession;

(8) Show evidence every three (3) years of CME credits. The education should be related to the Physician's specialty and to the provision of quality patient care in the Hospital;

(9) Have skills and training to fulfill a patient care need existing within the Hospital, and be able to adequately provide those services with the facilities and support services available at the Hospital; and

(10) Practice in such a manner as not to interfere with orderly and efficient rendering of services by the Hospital or by other Practitioners within the Hospital.

**3.2(b) Effects of Other Affiliations**

No practitioner shall be entitled to appointment to the Medical Staff, or to the exercise of particular clinical privileges in the Hospital, merely by virtue of the fact that he/she is duly licensed to practice in this or in any other state, or that he/she is a member of any professional organizations, or that he/she had in the past or present has, such privileges at another hospital, or because he/she is certified by any clinical board, or because he/she had, or presently has, Medical Staff membership at this Hospital or at another health care facility or in another practice setting, or 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 payor which contracts with this hospital.

**3.2(c) Non-Discrimination**

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of race, color, sex, national origin, religion, gender identify, sexual orientation or disability (except as such may impair the Practitioner's ability to provide quality patient care or fulfill his/her duties under these bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

**3.2(d) Ethics**

The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the member's certification that he/she has in the past and agrees that he/she will in the future; abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of ethics.

## 3.3 Basic Responsibilities of Medical Staff Membership

Each member of the Medical Staff shall:

**3.3(a)** Provide his/her patients with continuous care at the generally recognized professional level of quality;

**3.3(b)** Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;

**3.3(c)** Abide by the Medical Staff Bylaws and other lawful standards, policies (including Practitioner Wellness and Behavior that Undermines a Culture of Safety policies, Appendices "B" and "C" hereto), and Rules & Regulations of the Medical Staff;

**3.3(d)** Discharge the Medical Staff, department, committee and hospital functions for which he/she is responsible by Medical Staff category assignment, appointment, election or otherwise;

**3.3(e)** Cooperate with other members of the Medical Staff, management, the Board of Directors and employees of the Hospital;

**3.3(f)** Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital;

**3.3(g)** Be encouraged to be a member in good standing of respective professional societies and to participate in educational programs as contemplated by these Bylaws;

**3.3(h)** Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the Hospital drug testing program;

**3.3(i)** Abide by the ethical principles of his/her profession and specialty;

**3.3(j)** Refuse to engage in improper inducements for patient referral;

**3.3(k)** Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community;

**3.3(l)** Notify in writing the CAO and President of the Medical Staff within seven (7) days if:

(1) His/Her professional licensure in any state is suspended or revoked; or of any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her license;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) Any criminal charges, other than minor traffic violations, are brought/initiated against him/her; and any guilty or no contest pleas or convictions entered;

(5) He/She has been excluded debarred, suspended, or otherwise declared ineligible from any federal or state health program, including Medicare and Medicaid; has been convicted of a crime that meets the criteria for mandatory exclusion, debarment, suspension or ineligibility from such programs, or is under investigation by any such program;

(6) He/She has either voluntarily or involuntarily participated or is currently participating in any rehabilitation or impairment program or has ceased participation in such a program without successful completion; or has been diagnosed with any condition resulting in a material change in health status from the time the member submitted his/her application.

(7) There has been voluntary or involuntary limitation, reduction or loss of clinical privileges on any Medical Staff (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of a sanction or notice of intent to sanction from any peer review of professional review body) or agreement to refrain from practice while under investigation or to avoid such investigation.

(8) His/Her DEA registration number/controlled substance certificate or equivalent State credential is revoked, suspended or relinquished, or subject to any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her certification/credentialing.

(9) He/She is subject to the terms of a valid agreement that would prevent his/her from practicing at the Hospital (e.g., a non-compete agreement).

(10) He/She is subject to any pending or successful challenges to membership/fellowship in local, state or national professional organization; and/or;

(11) He/She is subject to any pending or successful challenges to, or the voluntary relinquishment of, specialty board certification.

Failure to provide any such notice, as required above, (except as to professional negligent actions that have not resulted in judgment or settlement), shall be reported to the Credentials Committee and/or Medical Executive Committee for possible action.

**3.3(m)** Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

## 3.4 Duration of Appointment

### 3.4(a) Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed three (3) years. Appointment may be granted for a period less than three (3) years with the imposition of any condition the MEC and Board deem necessary to monitor the applicant's practice. Conditional appointment for a period of less than three (3) years does not, in and of itself, entitle an application to fair hearing rights. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such prerogatives as may hereinafter be provided.

### 3.4(b) Declaration of Moratorium

The Board may from time to time declare moratoriums in the granting and exercising of clinical privileges, when the Board in its discretion, deems such a moratorium to be in the best interest of this Hospital and in the best interest of the health and patient care capable of being provided by the Hospital and its Medical Staff. The aforementioned moratoriums may apply to individual medical specialty groups, or any combination thereof. Prior to declaring a moratorium, the Board will seek the input of the Medical Staff regarding the needs of the Hospital and the patient community.

### 3.4(c) Reappointments

Reappointment to the Medical Staff shall be for a period not to exceed three (3) years. Reappointment may be granted for a period less than three (3) years with the imposition of any condition the MEC and

Board deem necessary to monitor the applicant's practice. Conditional reappointment for a period of less than three (3) years does not, in and of itself, entitle an applicant to fair hearing rights.

## 3.5 Leave of Absence

### 3.5(a) Leave Status

A Medical Staff member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time period of the leave, which may not exceed one (1) year unless approved by the MEC and Board.

If the leave is granted, members will be excused from medical staff obligations during the period of the leave. All members' clinical activities are subject to focused review in advance of and upon their return.

If the staff member's period of appointment ends while the member is on leave, he/she must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for applications for initial appointment.

### 3.5(b) Termination of Leave

(1) At least sixty (60) days prior to the expiration of the leave period, or at any earlier time, the Medical Staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the CAO or his/her designee for transmittal to the MEC. The Medical Staff member shall submit a written summary of his/her relevant activities during the leave. The MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence prior to any recommendation for reinstatement.

The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges. Failure to request reinstatement in a timely manner, shall result in automatic termination of Medical Staff membership, privileges and prerogatives, without right of hearing or appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section, shall not be considered an adverse action.

(2) If a member requests leave of absence for the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC has satisfied itself as to the continuing competency of the returning staff member.

Any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.

(3) Reinstatement will ordinarily be automatic if a leave of absence is for an armed services commitment. However, if such a leave of absence occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to ensure continuing competence.

(4) If a member requests leave of absence for reasons other than further medical training or an armed services commitment, the MEC may, prior to reinstatement, require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

## 3.6. Resignation

A resignation of membership or privileges must be submitted to the Medical Staff Office or CAO in writing and signed by the Practitioner or AHP. The Practitioner or AHP shall make a good faith effort

to provide at least thirty (30) days' notice of the resignation, if possible. The CAO shall forward the resignation notice to the MEC. A resignation is effective upon the date designated in the written notice. If no date is indicated, the resignation will become effective immediately upon delivery to the CAO.

## ARTICLE IV
## CATEGORIES OF THE MEDICAL STAFF

**4.1 The Medical Staff**

The Medical Staff shall be organized into Active, Courtesy, Consulting, Senior Active, Honorary, Active Specialty Staff. There shall also be an Allied Health Professional Staff.

For purposes of determining whether a Practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the Hospital setting' performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist or other Practitioner. When a patient has more than one procedure or diagnostic test performed or interpreted by the same Practitioner during a single Hospital stay, the multiple tests for that patient shall count as one patient contact.

### 4.2 The Active Medical Staff

**4.2(a) Qualifications**

The Active Staff shall consist of members who regularly provide patient care in the Hospital, are located close enough to the Hospital in an emergency situation within 30 minutes to provide uninterrupted care to their patients, who admit more than eighteen (18) patients per year (or have eighteen (18) or more in-hospital patient encounters per year); or who assume all the functions and responsibilities of membership on the Active Staff, including, where appropriate, participation in the ER call schedule, (as determined by the relevant Medical Staff department subject to Executive Committee coordination and approval**;** and approval by the Board of Directors), consultation assignments, participation in quality evaluation and monitoring activities of the staff, supervision of members and serve on Medical Staff committees.

**4.2(b) Prerogatives**. The prerogatives of an Active Staff member shall be:

(1) Admit patients to the Hospital consistent with his/her granted clinical privileges and Section 4.2(a):

(2) To exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(3) To vote on all matters presented at general and special meetings of the Medical Staff;

(4) To vote and hold office in the Medical Staff organization and departments and on committees to which he/she is appointed; and

(5) To vote in all Medical Staff elections.

**4.2(c) Responsibilities.** Each member of the Active Staff shall:

(1) Meet the basic responsibilities set forth in Article III 3.2;

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

(3) Actively participate:

(i) in the performance improvement program and other patient care evaluation and monitoring activities required by these Bylaws;

(ii) in the emergency on-call panel as determined by the relevant Medical Staff department and approved by the Executive Committee and the Board of Directors. Members of the Active Medical Staff have an obligation; but not aright, to share on call duties for the Emergency Department.

(iii) in promoting effective utilization of resources consistent with delivery of quality patient care;

(iv) in discharging such other Medical Staff functions as may be required by the Executive Committee from time-to-time; and

(v) in consultation assignments.

(4) Be assigned to one of the departments and serve on Medical Staff committee, if appointed.

(5) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the department and committees of which he/she is a member.

(6) Pay reasonable dues as assessed by the Medical Executive Committee in addition to any application fees.

**4.2(d) Failure**. Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership.

## 4.3 Courtesy Staff

The Courtesy Staff shall consist of members each of whom:

**4.3(a)** Meets the basic qualifications for Medical Staff Appointment in Article III, 3.2.

**4.3(b)** Have an office and/or residence located within thirty (30) minutes of the Hospital to provide continuous care; unless requesting membership without delineated privileges.

**4.3(c)** Is a member of the Active or Associate Staff of another hospital where he/she actively participates in patient care and in the performance improvement program of that hospital or of a Federal Government Institution; such as the VA Hospital, or Federal Penitentiary, etc.

Courtesy Staff membership may also be granted to Practitioners whose primary practice is located outside the community, which shall be defined as a 40 minutes of the Hospital, when the MEC and Board determine that an applicant will provide services to meet an otherwise unfulfilled community need. A determination by the MEC and Board that a community need does not exist shall not entitle the applicant to fair hearing rights under these Bylaws. Such Courtesy Staff members are granted exemption from the requirements of subsection 4.3(b) and 4.3 (d)(2) herein and are permitted to be regularly involved in an unlimited number of cases in the Hospital in a calendar year as defined in Section 4.1.

**4.3(d) Prerogatives**. The prerogatives of a Courtesy Staff member shall be to:

(1) Have no more than 24 admissions/outpatient encounters per year and no less than two admissions per appointment year at this Hospital, except for services and procedures not provided by the current Active Medical Staff, if approved by Medical Executive Committee. The limitation on patient encounters shall not apply to Federal Government Employed physicians who serve on the Courtesy Staff solely for the purpose of providing services to Government Facility patients who would otherwise not have such service available to them.

(2) Have no voting power, may not hold office, are not eligible for committee membership, and are not required to attend meetings.

(3) Participate in the emergency department on-call rotation as directed by the MEC and Board when there is an inadequate number of current Active Staff members to address an important patient coverage need, as determined by the MEC and Board. Any unassigned patient encounters incurred as a result of and while participating on the emergency department on-call rotation as assigned by the MEC and Board shall not count toward the patient encounter limitation described in Section 4.3 (d)(2) of these Bylaws.

**4.3(e)** **Responsibilities**. Each member of the Courtesy Staff shall:
(1) Discharge the basic responsibilities specified in Article III, 3.2;

(2) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing service and;

(3) Pay reasonable dues as assessed by the Medical Executive Committee in addition to any application fees.

## 4.4 Consulting Staff

**4.4(a)** Any Practitioner may be requested to provide a consultation within the scope of the Practitioner's licenses and designated clinical privileges. The Consulting Staff shall consist of physicians of recognized professional ability, as evidenced by being Board Certified, or other appropriate training, in one of the medical specialties. Each member of the Consulting Staff shall meet the basic qualifications set forth for Medical Staff Appointment in Article III, Section 3. The Consulting Staff member shall be a member of the Active or Associate Staff of another hospital. He/she shall actively participate in patient care and in the Quality Assessment program, and if appropriate, shall provide the Credential's Committee, or MEC, with adequate documentation to allow a review of the practitioner's current competency and professional performance.

**4.4(b)** Consulting Staff members with appropriate delineated clinical privileges may provide an unlimited number of consultation reports/recommendations (without managing the direct patient care) during a calendar year. Except where otherwise provided, Consulting Staff members shall not admit patients to the Hospital, transfer patients from the Hospital, or act as the physician or primary care or responsibility for any patient within the Hospital.

**4.4(c)** Members of the Consulting Staff are not required to attend meetings, may not vote, may not hold office, and may serve on staff committees (except Medical Executive Committee) where his/her special training and knowledge are desirable.

**4.4(d)** Members of the Consulting Staff shall pay reasonable dues as assessed by the Medical Executive Committee in addition to any application fees.

## 4.5 Senior Active

An Active Staff member who has been on continuous Active Staff at Deaconess Illinois Medical Center for the preceding twenty (20) years, may upon his/her written request and that of the appropriate Department Chief and the Executive Committee, be appointed to Senior Active status after reaching fifty-seven (57) years of age. Such appointment exempts the practitioner from committee appointments and the emergency call list. All other staff responsibilities remain the same, including attendance at department and Medical Staff meetings. An Active Staff member under the age of fifty-seven (57), who for reasons of health or other valid circumstances determines it necessary to limit his/her practice of medicine for an indefinite period of time, may also be eligible for such appointment. Such as a staff member's continued Senior Active Staff status shall be reconsidered by the appropriate department at least annually.

Members of the Senior Active Staff shall be eligible to vote in service and Medical Staff meetings. Members of the Senior Active Staff shall pay reasonable dues as assessed by the Medical Executive Committee in addition to any application fees.

4.6 Honorary

The Honorary Staff shall consist of members recognized for their outstanding reputations and their previous long-standing services to the Hospital and nominated by the Medical Executive Committee and confirmed by a majority vote by the Medical Staff. Honorary Staff members are not eligible to admit patients or to exercise clinical privileges at the Hospital. They may, however, attend staff and service meetings and any staff or hospital education meetings. Honorary Staff members shall not be eligible to vote or to hold office and are not required to serve on committees. Members of the Honorary Staff shall not be required to pay medical staff dues. Honorary Staff members shall not be required to meet the qualifications set forth in Section 3.2.(a) of these Bylaws. Appointment and reappointment to the Honorary Staff is a courtesy which may be terminated by the Board of Directors, upon recommendation of the Medical Executive Committee, without affording the right to fair hearing proceedings.

**4.7 Active Specialty Staff**

The Active Specialty Staff shall consist of dentists and oral surgeons. Active Specialty Staff members shall conform to the Bylaws, Rules and Regulations of the Medical Staff with the following additions:

**7 (a)** Privileges granted to dentists and oral surgeons shall be based on their training, experience and demonstrated current competence and judgment. The scope and extent of procedures that each dentist or oral surgeon may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists or oral surgeons shall be under the overall supervision of the Chief of Surgery or his/her designee. All dental patients shall receive a baseline history and physical exam done by a physician, as do patients admitted to other services. Should a dentist or oral surgeon request privileges to perform physical exams for dental patients, relevant training which qualifies him/her to perform patient history and physicals, must be provided. A physician member of the Medical Staff shall be responsible for the general medical care of the patients including any medical problem that may be present at the time of admission or that may arise during hospitalization.

**4.7(b)** Complete records (dental and medical as applicable) shall be required

**4.7(c)** Applications for staff membership and clinical privileges of Specialty Staff members shall be processed in the manner specified in Articles VI.

**4.7(d)** Dentists and oral surgeons may attend staff and department meetings, but are not eligible to hold office. However, they may serve on and vote in Medical Staff committees, department meetings and staff meetings, but may not serve on the Executive Committee.

**4.7(e)** Active Specialty Staff members shall pay reasonable dues as assessed by the Medical Executive Committee in addition to any application fees.

**4.8 Membership Without Delineated Clinical Privileges**

**4.8 (a) Membership Only**

Practitioners who meet the general qualifications set forth in Article III, of these Medical Staff Bylaws and do not provide patient care in this Hospital may apply for medical staff membership without delineated clinical privileges. Practitioners who apply for Medical Staff membership only may apply for appointment in Courtesy, Consulting, Senior Active, Active Specialty Staff or Honorary.

**4.8(b) Membership with "Refer & Follow" Privileges Only**

Practitioners who do not wish to actively treat patients within the Hospital may seek "refer and follow" privileges only. These will permit the practitioner to refer patients to the hospital for outpatient testing and refer patients to the Medical Staff members or Hospitalist for procedures or inpatient treatment within the facility. If the admitting/attending physician agrees, a practitioner with Membership with "refer and follow" privileges may visit his/her patients in the hospital, review medical records and receive information concerning the patient's medical condition and treatment. However, under no circumstances shall a practitioner with "refer and follow" privileges participate in any treatment or procedure, make entries in the medical record, or admit a patient to the Hospital. Reappointment to this category does not allow any voting rights of the physician to this category. Members may attend meetings and hospital functions. Members with refer and follow privileges shall not be subject to the requirements for ongoing professional practice evaluation or focused professional practice evaluation. Individuals requesting Refer & Follow Staff appointment shall be required to submit an application for initial appointment or reappointment as prescribed by Article VI of these Bylaws with the exception of the requirement to provide information regarding the demonstration of current competency and other exceptions approved by the MEC and Board. Appointment and reappointment to the Refer & Follow Staff is a courtesy which may be terminated by the Board of Directors, upon recommendation of the Medical Executive Committee, without affording the right to fair hearing proceedings.

**4.8(c) Dues**

Pay reasonable dues as assessed by the Medical Executive Committee in addition to any application fees.

**4.8(d) Qualification and Prerogative of Medical Student, Physician Assistant Students**

Medical Students shall engage in activity in the Hospital only pursuant to a written affiliation agreement between the Hospital and an approved medical college and only upon express consent of the Medical Executive Committee as reflected in its minutes. Medical students in training at the Hospital shall be permitted to engage in those activities outlined in the medical college affiliation agreement, the Hospital's student manuals, and policies of the Graduate Medical Education Committee. They are not members of the Medical Staff and shall be limited in scope to those activities expressly authorized by the affiliation agreement and any addenda thereto, and shall comply with all applicable state and federal laws for their activities within the facility.

## ARTICLE V
## ALLIED HEALTH PROFESSIONALS (AHP)

**5.1 Categories**

This article shall pertain only to Advanced Practice Allied Health Professionals ("AHPs") shall be identified as an individual, other than a Practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a Practitioner who has been afforded privileges within their scope of practice to provide such care. Clinical Assistants are not Advanced Practice Allied Health Professionals and are not credentialed pursuant to the Medical Staff process shall be governed by the applicable human resource policies of the Hospital. Allied Health Professional may be employed by physicians who are members of the medical staff ; but whether or not so employed, must be under the supervision and direction of a medical staff member physician who maintains clinical privileges to perform procedures in the same specialty area as the AHP (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules & Regulations) and not exceed the limitations of practice set forth by the AHP's respective licensure.

## 5.2 Qualifications

Only AHPs holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.

**5.2(a)** AHPs must:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

(2) Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective profession, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;

(3) Have professional liability insurance in the amount required by these Bylaws;

(4) Provide a needed service within the Hospital; and

(5) Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff member has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

## 5.3 Prerogatives

Upon establishing experience, training and current competence, AHPs, as identified in Section 5.1, shall have the following prerogatives:

**5.3(a)** To exercise judgment within the AHP's area of competence, providing that a physician member of the Medical Staff has the ultimate responsibility for patient care;

**5.3(b)** To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a member of the Medical Staff; and

**5.3(c)** To participate as appropriate in-patient care evaluation and other quality assessment and monitoring activities required of the Medical Staff and to discharge such other Medical Staff functions as may be required from time-to-time.

## 5.4 Conditions of Appointment

**5.4(a)** AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of Practitioners. Each AHP shall be assigned to one (1) of the clinical departments and shall be granted clinical privileges relevant to the care provided in that department. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these Bylaws.

**5.4(b)** Appointment of AHP's must be approved by the Board and may be terminated by the Board or the CAO. Adverse actions or recommendations affecting AHP privileges and their reduction or termination shall not be covered by the provisions of the Fair Hearing Plan. However, the affected

AHP shall have the right to request an appearance before the MEC with an opportunity to rebut the basis for termination. Upon receipt of a written request, the MEC shall afford the AHP an opportunity for an interview concerning the AHP's grievance. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto at the interview. A record of the interview shall be made. The MEC shall, after conclusion of the investigation, submit a written decision simultaneously to the Board and to the AHP.

**5.4(c)** The AHP shall have a right to appeal to the Board any decision rendered by the MEC. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the decision. The written request shall be delivered to the President of the Medical Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved, which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested, the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review, which shall not be less than fifteen (15) days, nor more than ninety (90) days, from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

**5.4(d)** AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising physician member's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon, the CRNA's privileges shall be unaffected by the termination of a given surgeon's privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.

**5.4(e)** If the supervising Practitioner employs or directly contracts with the AHP for services, the Practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges. If the supervising Practitioner does not employ or directly contract with the AHP, the Practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the Practitioner in question.

**5.4(f)** Allied Health Professionals who are employed by a physician or physicians serving on the Medical Staff and who accompany the physician to the Hospital, but do not actively treat patients within the Hospital, must have been granted Allied Health Staff membership and "follow as physician extender" privileges. These will permit the AHP to visit the employing physician's patients in the Hospital, pull and review patient medical records and receive information concerning the patient's medical condition and treatment. However, under no circumstances shall an AHP with "follow as physician extender" privileges participate in any direct patient treatment or procedure or make any entries in the medical record. AHPs with "follow as physician extender" privileges are credentialed for Allied Health Staff membership in the same manner as provided in Article V, and shall be subject to the

requirements of ongoing professional practice evaluation and focused professional practice evaluation. since they do not exercise privilege.

**5.5 Responsibilities**

Each AHP shall:

**5.5(a)** Provide his/her patients with continuous care at the generally recognized professional level of quality;

**5.5(b)** Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;

**5.5(c)** Discharge any committee functions for which he/she is responsible;

**5.5(d)** Cooperate with members of the Medical Staff, administration, the Board of Directors and employees of the Hospital;

**5.5(e)** Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

**5.5(f)** Participate in performance improvement activities and in continuing professional education;

**5.5(g)** Abide by the ethical principles of his/her profession and specialty; and

**5.5(h)** Notify the CAO and the President of the Medical Staff immediately if :

(1) His/Her professional license in any state is suspended or revoked; or if any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her license or certification:

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) Any criminal charges other than minor traffic violations are brought/initiated against him/her; and any guilty pleas or convictions entered;

(5) He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP appointment and/or clinical privileges.

(6) He/She has been excluded, debarred, suspended, or otherwise declared ineligible, from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted or a crime that meets the criteria for mandatory exclusion, debarment, suspension or ineligibility from such programs or is under investigation by any such program;

(7) He/She is currently either voluntarily or involuntarily participating in any rehabilitation or impairment program, or has ceased participation in such a program without successful completion; or has been diagnosed with any condition resulting in a material change in health status from the time the AHP submitted his/her application;

(8) There has been a voluntary limitation, reduction or loss of clinical privileges on any Allied Health Staff (including relinquishment of such medical staff membership or clinical privileges after an investigation or competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of sanction or notice of intent to sanction from any peer review or professional review body or agreement to refrain from practice while under investigation or to avoid such investigation);

(9) His/Her DEA registration number/controlled substance certificate or equivalent state credential is revoked, suspended or relinquished, or he/she is subject to any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her certificate/credential; and/or;

(10) He/She is subject to a valid agreement that would prevent him/her from practicing at the Hospital (e.g., a non-compete agreement).

Failure to provide any such notice, as required above, shall result in immediate loss of Allied Health membership and clinical privileges, without right of fair hearing procedures.

**5.5(i)** Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital when requested.

**5.5(j)** AHP members shall pay reasonable dues as assessed by the Medical Executive Committee in addition to any application fees.

**5.5(k)** Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;

**5.5(l)** Refuse to engage in improper inducements for patient referral.

## ARTICLE VI
## PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

### 6.1 General Procedures

### 6.1(a) Review and Determination

The Medical Staff through its designated committees and departments shall evaluate and consider each complete application for appointment or reappointment to the staff and each request for modification of Medical Staff membership status and shall adopt and transmit recommendations thereon to the Board. The Board shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or clinical privileges.

### 6.1(b) Credentials Verification Organization

In accordance with applicable laws and accreditation standards, the Hospital may enter into an agreement to allow a credentials verification organization (CVO) to collect, receive and verify information necessary to credential applicants. The CVO shall be responsible for obtaining a complete application within the time frame established by the Hospital and provide a report to the Medical Staff summarizing the verified information. Notwithstanding the foregoing, the Medical Staff and Board shall utilize its own independent judgment and will have sole discretion in determining whether an applicant will be granted Medical Staff membership and/or clinical privileges.

## 6.2 Content Of Application For Initial Appointment

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form adopted by the Medical Executive Committee and approved by the Board, and signed by the applicant. The Hospital shall verify all active state licenses and current DEA registration/controlled substance certificate (for all Practitioners except pathologists), and any other Practitioner whose scope of practice does not require DEA registration/controlled substance certificate as determined by the MEC and Board). A signed Medicare penalty statement and a certificate of insurance must be submitted with the application. Any application fee or Medical Staff dues shall be approved by the MEC and Board and addressed in Medical Staff policy. Applicants shall supply the Hospital with all information requested on the application.

The application form shall include, at a minimum, the following:

**6.2(a) Acknowledgment & Agreement:** A statement that the applicant has received and read the Bylaws, Rules & Regulations and Fair Hearing Plan of the Medical Staff and that he/she agrees:

(1) to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and

(2) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted membership and/or clinical privileges.

**6.2(b) Administrative Remedies:** A statement indicating that the applicant agrees that he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her Medical Staff membership, Medical Staff status, and/or clinical privileges;

**6.2(c) Criminal Charges:** Any current criminal charges pending against the applicant and any past convictions or pleas. The Practitioner shall notify the CAO and the President of the Medical Staff within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

**6.2(d) Fraud and Civil Judgments related to Medical Practice:** Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid; and any civil judgments or settlements related to the delivery of health care;

**6.2(e)Health Status:** Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of Medical Staff membership and exercising the privileges requested. In instances where there is doubt about an applicants' ability to perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board;

**6.2(f) Program Participation:** Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion. In addition, the practitioner shall have a continuing duty to notify the MEC, through the CAO, or his/her designee, of the initiation of participation in any rehabilitation or impairment program. The CAO or his/her designee, shall be responsible for notifying the MEC of all such actions;

**6.2(g) Information on Malpractice Experience:** Information concerning dates and brief description of malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the practitioner to notify the MEC of the initiation of any professional liability action against him/her. The Practitioner shall have a continuing duty to notify the MEC, through the medical staff office, within seven (7) days of receiving notice of the initiation of a professional liability action against him/her.

**6.2(h) Education:** Detailed information concerning the applicant's education and training.

**6.2(i) Insurance:** Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time. Each practitioner must, at all times, keep the informed of changes in his/her professional liability coverage;

**6.2(j) Notification of Release and Immunity Provisions:** Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions of these Bylaws.

**6.2(k) Professional Sanctions:** Information as to previously successful or currently pending challenges to, or the voluntary or involuntary relinquishment of, any of the following:

(1) membership/fellowship in local, state or national professional organizations excluding any voluntary surrender of membership/fellowship while in good standing and there are no pending investigations or disciplinary proceedings);

(2) specialty board certifications;

(3) license to practice any profession in any jurisdiction;

(4) Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists and any other Practitioner whose scope of practice does not require DEA number/controlled substance license as determined by the MEC and Board); (including any sanction or notice of intent to sanction or to revoke, suspend or modify his/her DEA number/controlled substance license);

(5) medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; (including relinquishment of such medical staff membership or clinical privileges after an investigation of his/her competence, professional conduct, or patient care activities has commenced or to avoid such investigation; and receipt of a sanction or notice of intent to sanction from any peer review or professional review body); or

(6) the practitioner's management of patients, which may have given rise to investigation by the state medical board; or

(7) participation in any private, federal or state health care or procurement program, including Medicare or Medicaid including conviction of a crime that meets the criteria for mandatory exclusion from such program regardless of whether such exclusion has yet become effective.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The practitioner shall have a continuing duty to notify the MEC through the medical staff office within seven (7) days of receiving notice of the initiation of any of the above actions against him/her.

**6.2(l) Qualifications:** Detailed information concerning the applicant's experience and qualifications for the requested Medical Staff category, including information in satisfaction of the basic qualifications specified in these bylaws, and the applicant's current professional license and federal drug registration numbers;

**6.2(m) References:** The names of at least three (3) practitioners (excluding when determined by the MEC and Board to be feasible, partners, associates in practice, employers, employees or relatives),who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others;

**6.2(n) Request**: Specific requests stating the Medical Staff category and specific clinical privileges for which the applicant wishes to be considered;

**6.2(o) Practice Affiliations:** The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;

**6.2(p) Photograph:** A recent, wallet sized photograph of the applicant;

**6.2(q)Citizenship Status:** Proof of United States citizenship or legal residency, including but not limited to copies of a U.S. passport, U.S. civil issued birth certificate, or naturalization/citizenship certificate;

**6.2(r)Professional Practice Review Data:** For all new applicants and Practitioners requesting new or additional privileges, evidence of the applicant's or Practitioner's professional practice review, volumes and outcomes from organization(s) that currently privilege the applicant unless such organization(s) refuse to provide this information to the Hospital and/or the applicant after sufficient efforts to obtain the requested information. If the organization(s) refuse to provide the requested information after sufficient efforts, the Hospital must at lease obtain case logs specific to the requested privileges for the most recent appointment period from organization(s) that currently privilege the application; and

**6.2(s) Dues**: Pay reasonable dues as assessed by the Medical Executive Committee in addition to any application fees.

## 6.3 Processing The Application

### 6.3(a) Request for Application

A practitioner wishing to be considered for Medical Staff appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her request for an application form to the Medical Staff Office.

### 6.3(b) Applicant's Burden

By submitting the application, the applicant:

(1) Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical staff membership and clinical privileges;

(2) Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and

qualifications; and agrees to execute a formal agreement regarding such authorization and release of information upon the Hospital's request.

(3) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for Medical Staff membership;

(4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Hospital of any change in any of the information furnished in the application;

(5) Acknowledges that provision of false or misleading information, or omission of information, shall be grounds for immediate rejection of his/her application without fair hearing rights;

(6) Acknowledges that, if he/she is determined to have made a misstatement, misrepresentation, or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of Medical Staff membership and clinical privileges, automatically removed, without fair hearing rights.

(7) Pledges to provide continuous care for his/her patients treated in the Hospital; and

**6.3(c) <u>Statement of Release & Immunity from Liability</u>**

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges to practice his/her profession in the Hospital during his/her term of appointment or reappointment. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment or clinical privileges the applicant expressly accepts these conditions during the processing and consideration of his/her application, and at all times thereafter, regardless of whether or not he/she is granted appointment or clinical privileges.

I hereby apply for Medical Staff appointment as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

As an applicant for appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Hospital with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the Hospital or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated and acted upon. I hereby signify my willingness to appear for the interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges without fair hearing rights. I further acknowledge that if I am reasonably determined to have made a misstatement, misrepresentation, or omission in connection with an application that is discovered after appointment and/or the granting of clinical privileges, I

shall be deemed to have immediately relinquished my appointment and clinical privileges without fair hearing rights.

If granted appointment, I accept the following conditions:

(1) I extend immunity to, and release from any and all liability, the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

(i) applications for appointment or clinical privileges, including temporary privileges;

(ii) periodic reappraisals;

(iii) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;

(iv) summary suspension;

(v) hearings and appellate reviews;

(vi) medical care evaluations;

(vii) utilization reviews;

(viii) any other Hospital, Medical Staff, department, service or committee activities;

(ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and

(x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Hospital.

(2) I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to the Medical Staff, as well as to inspect or obtain any all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Hospital and its authorized representatives upon request.

(3) The term "Hospital" and "its authorized representatives" means the Hospital Corporation, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the CAO or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and his/her partners, associates or designees, and all appointees to the Medical Staff. The term "third parties" means all individuals, including appointees to the

Medical Staff, and appointees to the medical staffs of other hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

I acknowledge that: (1) Medical Staff appointments at this Hospital are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws and Rules & Regulations; (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final; (4) I have the responsibility to keep this application current by informing the Hospital through the Medical Staff Office, of any change in the areas of inquiry contained herein; and (5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities related thereto. Appointment and continued clinical privileges shall be granted only on formal application, according to these Bylaws and Rules & Regulations, and upon final approval of the Board.

I understand that before this application will be processed that: (1) I will be provided a copy of the Medical Staff Bylaws and Rules & Regulations of the Medical Staff presently in force; and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such medical staff bylaws, policies, and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise clinical privileges at the Hospital.

If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee-splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patient to any other Practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any Practitioner providing treatment or services; (4) seek consultation whenever necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff.

**6.3(d) <u>Submission of Application & Verification of Information</u>**

The application, together with all documentation required by these Bylaws shall be submitted to the Medical Staff Office. After responsive references and other materials, including query of the National Practitioner Data Bank and any additional references deemed pertinent and necessary by the Credentials Committee Chair are received and verified, the Medical Staff Office shall transmit the application, including all supporting materials, to the relevant Department for evaluation as hereinafter provided. In the event the required or requested materials, information, or references are not received within sixty (60) days of the application or request, the Medical Staff may return the application to the applicant as incomplete and no further processing of the application shall occur until resubmitted. The application shall not be transmitted to the relevant Department until the file is deemed complete by the Medical Staff Office. Such determination shall not be binding on the relevant Department and the Credentials Committee. The application shall be returned to the applicant and shall not be processed further if one (1) or more of the following applies:

(1) <u>Not Licensed</u>. The applicant is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff; or a state licensing entity has revoked the applicant's license to practice in any state; or

(2) Privileges Denied or Terminated. The applicant (i) has had his/her application for medical staff appointment denied, (ii) has resigned his/her medical staff appointment or any clinical privileges during the pendency of an active investigation which could have led to revocation of his/her appointment, or any clinical privileges (iii) has had his/her appointment revoked or terminated at this Hospital; or had an application rejected as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty; at this Hospital within one (1) year immediately preceding the application or at another hospital at any time preceding the application; or

(3) Exclusive Contract or Moratorium. The applicant practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board upon acceptance of applications within the applicants' specialty; or

(4) Inadequate Insurance. The applicant does not meet the liability insurance coverage requirements of these Bylaws; or

(5) Ineligible for Medicare Provider Status. The applicant has been excluded, suspended or debarred or otherwise declared ineligible from any state or federal health care program, or procurement program, or is currently the subject of a pending investigation by any such program; or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible);

(6) No DEA number. The applicant's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists) and any other Practitioner whose scope of practice does not require DEA number/controlled substance license as determined by the MEC and Board; or

(7) Application Incomplete. The applicant has failed to provide any information required by these Bylaws or requested on the application, has provided false or misleading information on the application, or has failed to execute an acknowledgment, agreement or release required by these Bylaws or included in the application.

(8) Felony. The applicant has plead guilty or no contest to a felony charge or has been convicted of a felony.

The refusal to further process an application form for any of the above reasons shall not entitle the applicant to any further procedural rights under these bylaws.

In the event that none of the above apply to the application, the Medical Staff Office or CVO pursuant to agreement with the Hospital shall promptly seek to collect or verify the references, licensure and other evidence submitted. The Medical Staff Office shall promptly notify the applicant, in writing, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within a timely manner or receipt of such notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of current licensure, through the primary source internet site, or by telephone, is also acceptable so long as verification is documented. When collection and verification are accomplished, the application and all supporting materials shall

be transmitted to the Chairperson of the applicable department. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

An applicant who withdraws his/her application after it has been deemed complete may not resubmit an application for membership or clinical privileges for one (1) year after the date of withdrawal unless good cause is shown. The determination of good cause shall be made by the MEC and Board in their sole discretion.

**6.3(e) Description of Initial Clinical Privileges**

Medical Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the Hospital. Each practitioner who is appointed to the Medical Staff of the Hospital shall be entitled to exercise only those clinical privileges request and specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the clinical privileges he/she requests.

Each recommendation concerning the appointment of a staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant's experience, ability, and current competence by the Credentials Committee, MEC and Board.

**6.3 (f) Action by Department Chief & Completion of Application**

Upon receipt of the application and all relevant information pertaining thereto, the Chief of the appropriate department or designee shall review said application and information, and shall forward same to the Credentials Committee, along with a recommendation for or against appointment. Upon receipt thereof, the Credentials Committee shall review said application and information to determine, in their opinion, if the application is complete. If the Credentials Committee determines that the application is incomplete and additional information is needed to properly evaluate the applicant, the Credentials Committee may in writing request such additional information to be furnished by the applicant within thirty(30) days. If the requested information is not furnished by the applicant within thirty (30) days and good cause is not shown why such information is not furnished to the Credentials Committee within the time described the Credentials Committee may determine the application is incomplete and return it to the Medical Staff Office.

**6.3(g) Action by Credentials Committee**

After receipt of the completed application, the Credentials Committee shall review said application and information for the purpose of making a finding as to the applicant's fitness and qualification to be allowed Medical Staff privileges and for clinical privileges. The Credentials Committee shall make findings concerning (1) qualifications for Medical Staff appointment, and (2) clinical privileges requested and applicant's qualifications and evidence of clinical performance. At the next scheduled meeting of the Executive Committee, occurring subsequent to the Credentials Committee's findings concerning the application, the Credentials Committee shall present the application and all relevant information pertaining to the application to the Executive Committee.

**6.3 (h) Action by Executive Committee**

The Executive Committee shall present to the Credentials Committee within thirty (30) days of such scheduled meeting any objections or adverse comments received from the Executive Committee concerning the application. Such comments or objections shall be made in accordance with the provisions of these Bylaws relating to immunity for peer review activities. Upon receipt of such comments or objections, the Credentials Committee shall as soon as practicable formally make the required findings and transmit the same to the Executive Committee, which shall then make any required findings.

**6.3(i) Effect of Medical Executive Committee Action**.

(1) Deferral: Action by the MEC to defer a complete application for further consideration, must be followed up within ninety (90) days, with a recommendation for either provisional appointment with specified clinical privileges, or for rejection for staff membership. An MEC decision to defer an application, shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same.

In no event shall the MEC defer action on a completed and verified application, for more than ninety (90) days beyond receipt of same.

(2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CAO or his/her designee shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Department Chief. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action, if additional information or clarification of existing information is needed, or if verification is not yet complete.

(3) Adverse Recommendation:
When the recommendation of the MEC is adverse to the applicant, the Fair Hearing Plan will apply. For the purpose of this section, and "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. Upon completion of the Hearing process, the Board shall act in the matter as provided in these bylaws.

**6.3(j) Board Action In the Absence of A Hearing**

(1) Decision; Deadline. The Board of Directors may accept, reject or modify the MEC recommendation. The Secretary of the Board shall reduce the decision to writing and shall set forth therein the reasons for the decision. The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Board of Directors shall make every reasonable effort to render its decision within forty-five (45) days following receipt of the MEC's recommendation.

(2) Favorable Action. In the event that the Board of Directors' decision is favorable to the applicant, such decision shall constitute final action on the application. The CAO or his/her designee shall promptly inform the applicant that his/her application has been granted. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action, even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of quality improvement that does not materially restrict the applicant's ability to exercise the requested clinical privileges.

(3) Adverse Action. In the event that the MEC's recommendation was favorable to the applicant, but the Board of Directors' action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan.

**6.3(k) Interview** - An interview may be scheduled with the applicant during any of the steps set out Section 6.3(f)-6.3(j). Failure to appear for a requested interview, without good cause, may be grounds for denial of the application.

**6.3(l) Reapplication After Adverse Appointment Decision.** An applicant who has received a final adverse decision regarding appointment, shall not be allowed to reapply to the Medical Staff unless and until the defect constituting the grounds for the adverse decision is corrected. An applicant who has received a final adverse decision, as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require. For purposes of this section, "final adverse decision" shall include denial after exercise or waiver of fair hearing rights and/or rejection or refusal to further process an application (or relinquishment of privileges) due to the applicant's provision of false or misleading information on, or the omission of information from, or failure to timely update the application materials.

**6.3(m) Time Period for Processing. Complete** applications for Medical Staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The Medical Staff Office shall transmit a completed application to the department Chief upon completing his/her verification tasks, but in any event within ninety (90) days after receiving the completed application, unless the applicant has failed to provide requested information needed to complete the verification process. Notwithstanding the foregoing, an application will not be processed until the applicant submit a complete application.

**6.3(n) Denial for Hospital's Inability to Accommodate Applicant**

A decision by the Board to deny staff membership, staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan:

(1) On the basis of the hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or

(2) On the basis of inconsistency with the hospital's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or

(3) On the basis of professional contracts the hospital has entered into for the rendition of services within various specialties.

However, upon written request of the applicant, the application shall be kept in a pending status for the succeeding three (3) years. If during this period, the hospital finds it possible to accept applications for staff positions, for which the applicant is eligible, and the hospital has no obligation to applicants with prior pending status, the CAO or his/her designee, shall promptly so inform the applicant of the opportunity by special notice.

Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 6.2 for initial appointment shall apply.

**6.3(o) Appointment Considerations**

Each recommendation concerning the appointment of a Medical Staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant's experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant's proficiency in areas such as the following:

(1) Patient Care with the expectation that practitioners provide patient care that is compassionate, appropriate and effective;

(2) Medical/Clinical knowledge of established and evolving biomedical clinical and social sciences, and the application of the same to patient care and educating others;

(3) Practice-Based Learning and Improvement through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;

(4) Interpersonal and Communication Skills that enable establishment and maintenance of professional working relationships with patients, patient's families, members of the Medical Staff, Hospital Administration and employees, and others;

(5) Professional behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and

(6) Systems-Based Practice reflecting an understanding of the context and systems in which health care is provided.

## 6.4 Reappointment Process

### 6.4(a) Information Form for Reappointment

At least ninety (90) days prior to the expiration date of a practitioner's present Medical Staff appointment, and/or clinical privileges, the Medical Staff Office, shall provide the practitioner a reapplication form for use in considering reappointment. The Medical Staff member or AHP who desires reappointment or renewal of clinical privileges shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the Medical Staff Office. Failure to return a completed application form shall result in termination of the expiration of the membership at the conclusion of the member's or AHP's current term.

### 6.4(b) Content of Reapplication Form

The Reapplication Form shall include, at a minimum, updated information regarding the following:

(1) Education:
Continuing training, education, and experience during the preceding appointment period that qualifies the applicant for the privileges sought on reappointment;

(2) License: Current licensure;

(3) Health Status: Current physical and mental health status only to the extent necessary to determine the practitioner's ability to perform the functions of Medical Staff membership or to exercise the privileges requested;

(4) Program Participation: Information concerning the applicant's current and /or previous participation in any rehabilitation or impairment program, or termination of participation in such program without successful completion. In addition, the practitioner shall have a continuing duty to notify the MEC, through the CAO or his/her designee, of the initiation

of participation in any rehabilitation or impairment program. The CAO or his/her designee shall be responsible for notifying the MEC of all such actions;

(5) Previous Affiliations: The name and address of any other health care organization or practice setting, where the applicant provided clinical services during the preceding appointment period;

(6) Professional Recognition: Memberships, awards or other recognitions conferred or granted by any professional health care societies, institutions or organizations during the preceding appointment period;

(7) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary or involuntary relinquishment of, any of the following during the preceding appointment period:

(i) membership/fellowship in local, state or national professional organizations; or

(ii) specialty board certification; or

(iii) license to practice any profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except for pathologists and any other Practitioner whose scope of practice does not require DEA registration/controlled substance certificate as determined by the MEC and Board); or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of a sanction or notice of intent to sanction from any peer review or professional review body); or

(vi) participation in any private, federal or state health program, including Medicare or Medicaid, including conviction of a crime that meets the criteria for mandatory exclusion from such program, regardless of whether such exclusion has yet become effective.

(8) Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;

(9) Criminal Charges: Any current criminal charges pending against the applicant and any convictions or pleas during the preceding appointment period. The practitioner shall notify the CAO and the President of the Medical Staff within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

(10) Fraud and Civil Judgments related to Practice: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health

insurance program, including Medicare or Medicaid during the preceding appointment period; and any civil judgments or settlements related to the delivery of health care:

(11) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws, together with a letter from the insurer stating that the Hospital will be notified should the applicant's coverage change at any time. Each practitioner must, at all times, keep the CAO informed of changes in his/her professional liability coverage;

(12) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of departmental evaluations of care, and peer evaluations. Such evidence shall include as the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Practitioners who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing evidence of the practitioner's professional practice review, volumes and outcomes from organizations that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment.

Practitioners who refer their patients to a Hospitalist for inpatient treatment may satisfy this requirement by producing the above information in the form of quality profiles from other facilities where the practitioner has actively practiced during the prior appointment period; quality profiles from managed care organizations with whom the practitioner has been associated during the prior appointment period, or by submitting relevant medical record documentation from his/her office or other practice locations that demonstrates current competency for the privileges he/she is seeking. Practitioners who refer their patients to a Hospitalist for inpatient treatment shall have a written evaluation from the Hospitalist or Hospitalists treating their patients. The Hospitalist shall provide his/her evaluation of the practitioner's care based upon consultation and interaction with the practitioner with regard to the practitioner's hospitalized patients. The Hospitalist shall provide his/her opinion as to the practitioner's current competency based upon the condition of the practitioner's patients upon admission or readmission to the Hospital, with particular emphasis on any readmission related to complications of a previous admission;

(14) Notification of Release & Immunity Provisions: The acknowledgments and statement of release set forth in Sections 6.3(b) and (c);

(15) Information on Ethics/Qualifications: Such other specific information about the applicant's professional ethics and qualifications that may bear on his/her ability to provide patient care in the Hospital; and

(16) References: At the request of the Credentials Committee, the MEC, or the Board, when based on the opinion of the same, there is insufficient data concerning the applicant's exercise of privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least three (3) practitioners (excluding when determined by the MEC and Board to be feasible, partners, associates in practice, employers, employees or relatives), who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others.

(17) Continuing Education and Training: Evidence of satisfactory completion of continuing education requirements and other MEC director education or safety training as required by this Hospital, and to the provision of quality patient care in the hospital.

(18) Dues: Pay reasonable dues as assessed by the Medical Executive Committee in addition to any application fees.

**6.4(c) Verification of Information**

The Medical Staff Office or CVO pursuant to agreement with the Hospital, shall, in timely fashion, verify the additional information made available on each Reapplication Form and collect any other materials or information deemed pertinent, including information regarding the applicant's professional activities, performance and conduct in the Hospital and the query of the Data Bank. Peer recommendations will be collected and considered in the reappointment process. When collection and verification are accomplished, the Medical Staff Office shall transmit the Reapplication Form and supporting materials to the Chairperson of the appropriate department. An application shall not be deemed complete, nor shall a final action on the application be taken, until verification of all information, including query of the Data Bank, is complete.

**6.4(d) Action on Application**

The application for reappointment shall thereafter be processed as set forth as described in Section 6.3(f) - 6.3(m) for initial appointment; except that an individual whose application for reappointment is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

**6.4(e) Basis for Recommendations**

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in Article VI as they impact upon determinations regarding the member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of Medical Staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other Practitioners and with patients, results of the medical staff peer review process, including Practitioner-specific information compared to aggregate information from performance improvement activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Hospital as described in these Bylaws.

## 6.5 Request for Modification of Appointment

A Medical Staff member or AHP may, either in connection with reappointment or at any other time, request modification of his/her Medical Staff category or clinical privileges, by submitting a written application to Administration on the prescribed form. Such application shall be processed in substantially the same manner as provided in these bylaws for reappointment. No Medical Staff member or AHP may seek modification of privileges or Medical Staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience. Modifications of Medical Staff category or clinical privileges shall remain in effect until the next regularly scheduled reappointment period. Any increase, diminution or change in clinical privileges will be communicated immediately by the Medical Staff Office to the CAO, who shall be responsible for timely notification of all Hospital staff and systems relevant to implement the change in clinical privileges.

**6.5(a) Initial and Additional Grants of Privileges**

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice evaluation for a period of not less than six (6) months. The period of review may be renewed for additional period up to the conclusion of the member's period of initial appointment or initial grant of new or additional privileges. Results of the focused professional practice evaluation conducted during the period of focused review shall be incorporated into the practitioner's evaluation for reappointment.

## 6.6 Expedited Appointment and Reappointment

Completed application for membership or membership renewal can be expedited if it documents each of these criteria:

- No current or previously successful challenges to any professional licensure or registration;
- No current exclusion from Medicare or Medicaid;
- No involuntary termination of medical staff membership at any other organization;
- No involuntary limitation, reduction, denial, or loss of clinical privileges to date;
- No excessive number or unusual pattern of professional liability actions resulting in final judgment against the applicant.

Such applications shall be reviewed by the relevant department chair(s); if approved, by the Credentials Chair; if approved, by the Executive Committee, in lieu of the application process described in these bylaws. If any of these medical staff authorities makes any adverse recommendation, the application shall no longer be eligible for expedition, and shall revert to the regular application process. An expedited application may be acted upon by a committee of the Board, if permitted by hospital bylaws or policy.

# ARTICLE VII
# DETERMINATION OF CLINICAL PRIVILEGES

## 7.1 EXERCISE OF PRIVILEGES

Every Practitioner providing direct clinical services at this Hospital shall, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those clinical privileges or services specifically granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the Practitioner to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations, for each category of Practitioner, and each Practitioner shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

## 7.2 DELINEATION OF PRIVILEGES IN GENERAL

**7.2(a) Requests**

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges, must be supported by documentation demonstrating the Practitioner's qualifications to exercise the privileges

requested. In addition to meeting the general requirements of these Bylaws for Medical Staff membership, each Practitioner must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria, applicable to the privileges requested. A request by a Medical Staff member for a modification of privileges, must be supported by documentation supportive of the request, including at least one (1) peer reference.

**7.2(b) Basis for Privileges Determination**

Granting of clinical privileges shall be based upon community and Hospital need, available facilities, equipment and number of qualified support personnel and resources, as well as on the Practitioner's education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from performance improvement activities, when available. For Practitioners who have not actively practiced in the Hospital within the prior appointment period, information regarding current competence, shall be obtained in the manner outlined in Section 6.4(b)(12) herein. In addition, those Practitioners seeking new, additional or renewed clinical privileges (except those seeking disaster or temporary privileges), must meet all criteria for Medical Staff membership as described in Article VI of these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results, that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings, shall be added to and maintained in the Medical Staff file established for a Medical Staff member.

**7.2(c) Procedure**

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed three (3) years. The Data Bank shall be queried each time new privileges are requested.

**7.2(d) Limitations on Privileges**

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients, or direct the course of treatment for the conditions for which the patients were admitted.

**7.2(e) Initial and Additional Grants of Privileges**

All initial appointments and grants of new or additional privileges, to existing members of the Medical Staff, shall be subject to a period of focused professional practice evaluation. The period of review may be renewed and extended for additional periods. Results of the focused professional practice evaluation, conducted during the period of focused review, shall be incorporated into the practitioner’s evaluation for reappointment. The period of focused professional practice evaluation and any renewal or extension must be approved by the MEC and Board.

**7.3 Special Conditions for Podiatric and Dental Privileges**

Requests for clinical privileges from podiatrists, dentists, and oral surgeons, shall be processed, evaluated and granted in the manner specified in Article VI. Surgical procedures, performed by podiatrist, dentists and oral surgeons, shall be under the overall supervision of the Chief of Surgery, however, other podiatrists, dentists and/or oral surgeons, shall participate in the review of the Practitioner through the performance improvement process. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission, or that may be discovered

during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4. Special Conditions for Direct Access to Physical Therapy

In accordance with state rules and regulations, a patient may be evaluated and treated by a licensed physical therapist without a provider order in the following circumstances:

- Licensed to provide physical therapy within the state, and
- Granted membership and privileges as an allied health member of the medical staff.

A physical therapist providing services without a referral from a health care professional must notify the patient's treating health care professional within five (5) business days after the patient's first visit that the patient if receiving physical therapy. This does not apply to physical therapy services related to fitness or wellness, unless that patient presents with an ailment or injury.

- A physical therapist shall refer a patient to the patient's treating health care professional of record or, in the case where there is no health care professional or record, to a health care professional of the patient's choice, if:
    - The patient does not demonstrate measurable or functional improvement after ten (10) visits or 15 business days, whichever occurs first, and continued improvement thereafter;
    - The patient returns for services for the same or similar condition after 30 calendar days of being discharged by the physical therapist; or
    - The patient's condition, at the time of evaluation or services, is determined to be beyond the scope of practice of the physical therapist.

Wound debridement services may only be provided by a physical therapist with written authorization from a health care provider.

A physical therapist shall promptly consult and collaborate with the appropriate health care professional anytime a patient's condition indicates that it may be related to temporomandibular disorder so that a diagnosis can be made by the health care professional for an appropriate treatment plan.

## 7.5 Clinical Privileges Held By Non-Medical Staff Members: Temporary Privileges

### 7.5(a) Temporary Privileges – Important Patient Care Need – Pending Application

Temporary privileges may be granted when there is an important patient care, treatment, or service need that mandates an immediate authorization to practice, for a limited period of time, to a new applicant with a fully completed, fully verified application that raises no concerns following review and recommendation by the Department Chair and pending MEC review and Board approval. "New applicant" includes an individual applying for clinical privileges at the Hospital for the first time and an individual currently holding clinical privileges who is requesting one or more additional privileges.

In these cases only, the CAO or his/her designee, upon recommendation of the Medical Staff President may grant such privileges upon establishment of current competence for the privileges requested, completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query, and upon verification that there are no current or prior successful challenges to licensure or registration, that the Practitioner has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility. Such privileges may be granted for no more than one hundred and twenty (120) days. Temporary privileges automatically terminate if the applicant's initial membership application is withdrawn.

The letter approving temporary privileges shall identify the specific privileges granted. Except as provided above, temporary privileges may not be granted pending processing of applications for appointment or reappointment.

**7.5(b) Temporary Privileges – Important Patient Care Need – No Pending Application**

Temporary privileges may be granted by the CAO upon recommendation of the Medical Staff President when there is an important patient care, treatment or service need that mandates an immediate authorization to practice, for a limited period of time, when no application for medical staff membership or clinical privileges is pending. An example would be situations in which a physician is involved in an accident or becomes suddenly ill, and a Practitioner is needed to cover his/her practice immediately upon receipt of a written request, an appropriately licensed person who is serving as a substitute for a member of the Medical Staff during a period of absence for any reason, or a Practitioner temporarily providing services to cover an important patient care, treatment or services need (which may include care of one (1) specific patient), may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days (for no more than sixty (60) consecutive days), but only upon the Practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board in no event to exceed one hundred and twenty (120) days of services within a calendar year. All Practitioners providing coverage for other Practitioners must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of temporary privileges pursuant to this section. Further, prior to award of temporary privileges, due to important patient care need, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these Bylaws, evidence of the practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner's primary hospital. The letter approving temporary privileges shall identify the specific privileges granted.

Members of the Medical Staff seeking to facilitate coverage for their practice via a substitute Practitioner shall, where possible, advise the Hospital at least thirty (30) days in advance of the identity of the Practitioner and the dates during which the services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective Action.

**7.5(c) Proctoring Privileges**

Upon receipt of a written request, an appropriately licensed person who is serving as a proctor for a member of the Medical Staff, may without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive periods, not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board, and in no event to exceed the period of proctorship, or a maximum of one hundred twenty (120) days. The Data Bank query must be completed prior to any award of proctoring privileges pursuant to this section. Further, prior to award of proctoring privileges, the applicant must submit a completed application, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and confirmation of privileges at the practitioner's primary hospital. The letter approving proctoring privileges, shall identify the specific privileges granted. In these cases, only the CAO or his/her designee, upon recommendation of the President of the Medical Staff, Chairperson of the Credentials Committee and Chairperson of the applicable department, may grant such privileges upon completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query.

**7.5(d) Conditions**

Temporary and proctoring privileges shall be granted only when the information available, reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the President of the Medical Staff, including a requirement that the patients of such practitioner, be admitted with dual admission with a member of the Active Staff. Before temporary privileges are granted, the practitioner must acknowledge in writing, that he/she has received and read the Medical Staff Bylaws, Rules & Regulations, and that he/she agrees to be bound by the terms thereof, in all matters relating to his/her privileges.

Temporary privileges may not be granted to extend a Medical Staff appointment period absent a documented important/immediate patient care need and compliance with all other requirement of these Medical Staff Bylaws.

**7.5(e) Termination**

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a practitioner's qualifications or ability to exercise any or all of the privileges granted, the CAO may, after consultation with the President of the Medical Staff terminate any or all of such practitioner's temporary, one-case or locum tenens privileges. Where the life or well-being of a patient is endangered, by continued treatment by the practitioner, the termination may be affected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the Practitioner's patients then in the hospital, shall be assigned to another Practitioner by the President of the Medical Staff. The wishes of the patient shall be considered, if feasible, in choosing a substitute Practitioner.

**7.5(f) Rights of the Practitioner**

A practitioner shall not be entitled to the procedural rights afforded by these bylaws because of his/her inability to obtain temporary, one-case or locum tenens privileges, or because of any termination or suspension of such privileges.

**7.5(g) Term**

No term of temporary or proctoring privileges shall exceed a total of one hundred and twenty (120) days.

## 7.6 Clinical Privileges Held by Non-Medical Staff Members: Emergency Treatment and Disaster Privileges

For the purpose of this section, an “emergency” is defined as a condition in which serious or permanent harm to a specific patient is imminent, or in which the life of a specific patient is in immediate danger, delay in administering treatment immediately would add to that danger, and no appropriately credentialed individual can be available in the time required to respond. A “disaster,” for purposes of this section, is defined as a community-wide disaster or mass injury situation in which the number of existing, available Medical Staff members or AHPs, is not adequate to provide all clinical services required by the citizens served by this facility. In the case of an emergency, as defined herein, any Practitioner, or AHP, to the degree permitted by his/her license and regardless of staff status or clinical privileges, shall, as approved by the CAO or his/her designee, or the President of the Medical Staff, be permitted to, and be assisted by Hospital personnel, in doing everything reasonable and necessary to save the life of a patient, or to prevent imminent harm to the patient.

Disaster privileges may be granted by the CAO or President of the Medical Staff, when and for so long as the Hospital’s emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges, the volunteer Practitioner, or AHP, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at

least one of the following: a current Hospital picture ID, which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster; or ID of a current Medical Staff member who possesses personal knowledge regarding the volunteer Practitioner's qualifications. The CAO/or President of the Medical Staff are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the Practitioner shall undergo the same verification process outlined in Section 7.4(a) for temporary privileges; when required to address an emergency patient care need. In extraordinary circumstances, in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours, it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer's credentialing file, why primary source verification cannot be performed in the required time frame, the efforts of the Practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the President of the Medical Staff, or his or her designee, shall review the decision to grant the Practitioner disaster privileges, and shall, based on information obtained regarding the professional practice of the Practitioner, make a decision concerning the continuation of the Practitioner's disaster privileges.

In addition, each Practitioner granted disaster privileges, shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the Practitioner, and the scope of the Practitioner's disaster responsibilities and/or privileges. A member of the Medical Staff shall be assigned to each disaster volunteer Practitioner, for purposes of overseeing the professional performance of the volunteer Practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

## 7.7 Clinical Privileges Held By Non-Medical Staff Members: Telemedicine

### 7.7(a) Scope of Privileges

The Medical Staff shall make recommendations to the Board of Directors regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means, shall be provided consistent with commonly accepted quality standards. Physicians applying for clinical privileges to provide treatment to Hospital patients through telemedicine shall not be permitted to serve as the attending physician.

### 7.7(b) Telemedicine Physicians

Any physician who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital, through a telemedicine procedure (the "telemedicine physician"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. An exception is outlined below, for those circumstances in which the Practitioner's distant-site entity or distant-site hospital, is Joint Commission accredited.

In circumstances, in which the distant-site entity or distant-site hospital is Joint Commission accredited, the Medical Staff and Board may rely on the telemedicine physician's credentialing information from the distant-site entity or distant-site hospital, to credential and privilege the telemedicine physician, ONLY if the Hospital has ensured through a written agreement with the distant-site entity or distant-site hospital that all of the following provisions are met:

(1) The distant-site entity or distant-site hospital meets the requirements of 42 CFR § 482.12(a)(1)-(7), with regard to the distant-site entity's or distant-site hospital's physicians and practitioners providing telemedicine services;

(2) The distant-site entity, if not a distant-site hospital, is a contractor of services to the Hospital, and as such, in accordance with 42 CFR § 482.12(e), furnishes the contracted services in a manner that permits the Hospital to comply with all applicable federal regulations for the contracted services;

(3) The distant-site organization is either a Medicare-participating hospital, or a distant-site telemedicine entity, with medical staff credentialing and privileging processes and standards, that at least meet the standards set forth in the CMS Hospital Conditions of Participation;

(4) The telemedicine physician is privileged at the distant-site entity or distant-site hospital providing the telemedicine services, and the distant-site entity or distant-site hospital provides the Hospital with a current list of the telemedicine physician's privileges at the distant-site entity or distant-site hospital;

(5) The telemedicine physician holds a license issued or recognized by the state in which the Hospital is located; and

(6) The Hospital has evidence, or will collect evidence, of an internal review of the telemedicine physician's performance of telemedicine privileges at the Hospital, and shall send the distant-site entity or distant-site hospital such performance information (including, at a minimum, all adverse events that result from telemedicine services provided by the telemedicine physician and all complaints the Hospital has received about the telemedicine physician) for use in the periodic appraisal of the telemedicine physician by the distant-site entity or distant-site hospital.

The Hospital will remain responsible for primary source verification of licensure, Medicare/Medicaid eligibility and for the query of the Data Bank. The Hospital shall also remain responsible for primary source verification of professional liability insurance unless the distant-site entity has provided the Hospital with a current certificate of insurance meeting the requirements set forth in these Bylaws and a malpractice claims history consistent with the standard claims history required for members of the Medical Staff. The Medical Staff shall comply with the Hospital telemedicine credentialing procedures manual when credentialing telemedicine physicians.

For the purposes of this Section 7.6, the term "distant-site entity," shall mean an entity that: (1) provides telemedicine services; (2) is not a Medicare-participating hospital; and (3) provides contracted services in a manner that enables a hospital using its services to meet all applicable CMS Hospital Conditions of Participation, particularly those related to the credentialing and privileging of physicians providing telemedicine services. For the purposes of this Section 7.6, the term "distant-site hospital," shall mean a Medicare-participating hospital that provides telemedicine services.

If the telemedicine physician's site, is also accredited by Joint Commission, and the telemedicine physician is privileged to perform the services and procedures, for which privileges are being sought in the Hospital; then the telemedicine physician's credentialing information, from that site, may be relied upon to credential the telemedicine physician in the Hospital. However, this Hospital will remain responsible for primary source verification of

licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank.

**7.8 History and Physical**

Only those granted privileges to do so may conduct history and physicals, or update histories and physicals. History and physical privileges must be carried out consistent with the requirements of these Bylaws.

**7.8(a) Physicians**

Physicians who are medical staff members, or who are applying for temporary privileges, may be granted privileges to conduct a history and physical, or to update a history and physical upon application approval through the privileging and credentialing process.

**7.8(b) Oral/Maxillofacial Surgeons**

Privileges to conduct or update histories and physicals, only for those patients admitted solely for oral/maxillofacial surgery, are granted to qualified oral/maxillofacial surgeons; who are members of the medical staff, or seeking temporary privileges and who apply and are approved through the privileging and credentialing processes.

**7.8(c) At Admission**

Each patient admitted for inpatient care shall have a complete admission history and physical examination recorded by a physician or oral/maxillofacial surgeon or a podiatrist as provided in the Medical Staff Rules & Regulations, holding history and physical privileges, within twenty-four (24) hours after admission or registration and prior to any surgery or procedure requiring anesthesia. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care. Should the admitting practitioner or podiatrist fail to ensure that the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission or registration and prior to any surgery or procedure requiring anesthesia, the record shall be considered delinquent and the Medical Staff President, or his/her designee, or the CAO or his/her designee, may take appropriate steps to enforce compliance. If the history and physical is completed by an AHP who is not a physician or oral and maxillofacial surgeon, the finding, conclusions and assessment of risk must be endorsed by a member holding history and physical privileges prior to surgery, invasive diagnostic or therapeutic interventions, inductions of anesthesia, or other major high risk procedures.

At a minimum the medical history and physical examination must contain an age specific assessment of the patient including (a) the chief complaint, which is a statement that established medical necessity in concise manner based upon the patient's own words; (b) a history of the patient illness; outlining the location, quality, severity, duration, timing, context and modifying factors of the complaints; (c) medications, including both prescribed and over-the-counter remedies; (d) allergies and intolerances, including a description of the effects caused by each agent; (e) past medical and surgical history; (f) health maintenance/immunization history; (g) family history and social history, including socioeconomic factors, sexual and substances use/abuse issues, advance directives and potential discharge or disposition challenges; (h) comprehensive physical examination, including vital signs, general appearance, mental status and abnormal and pertinent normal finding from each body system; (i) diagnostic data that is either available or pending at the time of admission; (j) clinical impression outlining the provisional diagnoses and/or differential diagnoses for the patient's symptoms; and (k) the plan outlining the evaluation and treatment strategy, any limitations including patient and/or family requests and discharge planning initiation.

An initial assessment of all patients must be performed by the responsible Medical Staff member within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit must be performed no later than two (2) hours after admission or sooner if warranted by the patient's condition.

**7.8(d) Prior to Admission**

A history and physical performed within thirty (3) days prior to Hospital admission may be used, as long as the medical record contains durable, legible Practitioner documentation indicating the H & P was reviewed and the patient was examined, and noting any changes in the patient's condition not consistent or otherwise reflected in the H & P. this updated H & P review and examination information must be documented with twenty-four (24) hours after admission or registration and prior to any surgery or procedure requiring anesthesia.

**7.8(e) Outpatients**

Each department or service will determine for its members which outpatient procedures require a history and physical examination as a prerequisite, and if required, the scope of such history and physical. Notwithstanding the foregoing, a history and physical examination shall be required for all invasive operative procedures performed in the outpatient setting. Where required, a history and physical must be completed and documented in accordance with the timeframes described above.

7.9 Referring Practitioners

A Practitioner who is not a member of the Medical Staff or an Allied Health Provider with clinical privileges who wishes to order outpatient laboratory, radiology or cardiology tests/examinations, physical, occupational or speech therapy for his/her patient to be performed at Deaconess Illinois Medical Center will provide his/her office address, telephone numb er, NPI number, and a valid order. This will also apply for orders from a provider for a therapeutic infusion/injection of a substance on the hospital formulary or blood/blood products. High risk medical or substances such as chemotherapeutic agents are excluded from this practice. Deaconess Illinois Medical Center will verify NPI, current license and screen for exclusions. A Pharmacist will review the therapeutic infusion/injection order prior to administration.

## ARTICLE VIII
## CORRECTIVE ACTION

**8.0 Focus 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 focused review process. When circumstances warrant, the President of the Medical Staff shall appoint an already existing or a special committee of impartial medical staff members to conduct the review as peers, set the time frame for the focused review and establish the parameters for participation of the subject under review in the process.

**8.1(a) Interviews**

When the Executive Committee or Board is considering initiating an adverse action concerning a Practitioner, it shall give the Practitioner an interview. The interview shall not constitute a hearing; shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The Practitioner shall be informed of the nature of the claims against him/her and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

## 8.1 Routine Corrective Action

**8.1(a) Criteria for Initiation**. Whenever activities, omissions or any professional conduct of a Practitioner with clinical privileges are or may reasonably be anticipated to become detrimental to patient safety or to the delivery of quality patient care, corrective action against such Practitioner may be requested by an officer of the Medical Staff, by the CAO or the Board. All corrective action shall be taken in good faith, in the interest of optimum quality patient care.

Every adverse Medical Staff membership and clinical privileges decision based substantially on economic factors shall be reported, pursuant to the Illinois Hospital Licensing Act, before the decision takes effect.

**8.1(b) Request and Notices.** All requests for corrective action under this Section 8.1 shall be submitted in writing to the Executive Committee and supported by reference to the specific activities or conduct, which constitutes the grounds for the request. The President of the Medical Staff shall promptly notify the CAO in writing of all requests for corrective action received by the MEC and shall continue to keep the CAO fully informed of all action taken in conjunction therewith. Should the Executive Committee determine there is cause to investigate the request, notice shall immediately be given to the practitioner.

**8.1(c) Investigation by the Medical Executive Committee**

The Medical Executive Committee shall begin to investigate the matter within forty-five (45) days, or at its next regular meeting, whichever is sooner, or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of ~~i~~mpairment, the Medical Executive Committee shall assign the matter to an ad hoc committee of three (3) members; who shall operate apart from this corrective action process, pursuant to the provisions of the Deaconess Illinois Medical Center Policy Regarding Practitioner Wellness. When the MEC is considering initiating an adverse action concerning a Practitioner, it may in its discretion give the Practitioner an interview. The Practitioner shall be informed of the general nature of the concerns and may present relevant information in response. Within sixty (60) days after the investigation begins, a written report of the investigation shall be completed.

**8.1(d) Medical Executive Committee Action**

Within sixty (60) days following receipt of the report, the Medical Executive Committee shall take action upon the request. Its action shall be reported in writing and may include, but not limited to:

(1) Rejecting the request for corrective action and concluding the investigation;

(2) Recusing itself from the matter and referring same to the Board, without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include, but are not limited to, a conflict of interest due to direct economic competition or economic interdependence with the affected physician;

(3) Issuing a warning or a reprimand, to which the practitioner may write a rebuttal, if he/she so desires;

(4) Recommending a period of focused professional practice evaluation (FPPE)

(5) Recommending terms of probation, education, or required consultation;

(6) Recommending reduction, modification, suspension, or revocation of clinical privileges;

(7) Recommending reduction of Medical Staff category or limitation of any Medical Staff prerogatives;

(8) Recommending suspension or revocation of Medical Staff membership;

(9) Recommending concurrent case review; or

(10) Recommending consultation requirements.

With the Medical Executive Committee action, the investigation is closed.

**8.1(e) Procedural Rights**

Any action by the MEC pursuant to medical staff bylaws provision (where such action materially restricts a physician's or dentist's exercise of privileges) or any combination of such actions, shall entitle the physician or dentist to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

**8.1(f) Other Action**

If the MEC's recommended action does not materially restrict a practitioner's exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board.

**8.1(g) Board Action**

When routine corrective action is initiated by the Board pursuant to the Fair Hearting Plan, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board in conjunction with MEC and shall entitle the practitioner to the procedural rights as specified in the Fair Hearing Plan.

If the MEC fails to investigate or to adequately investigate, or to take appropriate disciplinary action contrary to the weight of the evidence, the Board may direct the MEC to initiate or perform additional investigation or take disciplinary action or additional disciplinary action. If the MEC fails to take appropriate action in response to the Board's direction, the Board may initiate corrective action pursuant to the terms described in this Section 8.1.

## 8.2 SUMMARY SUSPENSION

**8.2(a) Criteria & Initiation**

Notwithstanding the provisions of Section 8.1 above, whenever a Practitioner's conduct may require that immediate action be taken to prevent immediate danger to any patient, employee or other person, then the CAO, in conjunction with the President of the Medical Staff and Chief of Department, shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. Subsequently, the CAO shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the Practitioner.

Immediately upon the imposition of summary suspension, the President of the Medical Staff shall designate a physician with appropriate clinical privileges, to provide continued medical care for the suspended Practitioner's patients still in the Hospital. The wishes of the patient shall be considered, in the selection of the assigned physician.

It shall be the duty of all Medical Staff members, to cooperate with the President of the Medical Staff and the CAO, in enforcing all suspensions and in caring for the suspended Practitioner's patients.

**8.2(b) Medical Executive Committee Action**

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. However, if the MEC met as a full body to impose the summary suspension for investigational purposes (not to exceed fourteen (14) days) the MEC is not required to meet again within seventy-two (72) hours. The MEC may recommend modification, ratification, continuation with further investigation, or termination of the summary suspension.

**8.2(c) Procedural Rights**

If the summary suspension is terminated or modified within fourteen (14) days of the original imposition, such that the Practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

Upon ratification of the summary suspension or modification, which materially restricts the Practitioner's clinical privileges, the Practitioner shall be entitled to the procedural rights provided in these Bylaws. Should the summary suspension be upheld, a hearing shall be commenced within fifteen (15) days of the suspension and completed without undue delay, unless the Practitioner requests additional time. The terms of the summary suspension, as sustained or as modified by the Medical Executive Committee, shall remain in effect pending a final decision by the Board.

If the summary suspension is continued for purposes of further investigation, the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension, and shall modify, ratify or terminate the summary suspension.

## 8.3 Automatic Suspension

**8.3(a) License**

A Medical Staff member or AHP whose license, certificate, or other legal credential, authorizing him/her to practice in any state is revoked, relinquished, or suspended, shall immediately and automatically be suspended from the Medical Staff and from practicing in the Hospital. Allowing license or certificate in another state to expire shall not result in automatic suspension, so long as no investigation, sanction or other action is active or pending. The President of the Medical Staff shall designate a physician to provide continued medical care for the suspended practitioner's patients.

**8.3(b) Drug Enforcement Administration (DEA) Registration Number**

Any Practitioner or AHP (except a pathologist and any other Practitioner or AHP whose scope of practice does not require DEA number/controlled substance license or state equivalent as determined by the MRC and Board) whose DEA registration number/controlled substance certificate or equivalent state credential is revoked, suspended or relinquished shall immediately and automatically be suspended from the Medical Staff and practicing in the Hospital until such time as the registration is reinstated.

**8.3(c) Medical Records**

(1) Automatic suspension of a Practitioner's or AHP's privileges, shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations. The suspension shall continue until such records are completed unless the practitioner satisfies the President of the Medical Staff that he/she has a justifiable excuse for such omissions.

(2) Medical Records- Expulsion: Any Medical Staff member or AHP who accumulates forty-five (45) or more consecutive days of automatic suspension under said subsection 8.3(c)(1) shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45th) consecutive day of such automatic suspension.

**8.3(d) Malpractice Insurance Coverage**

Any Practitioner or AHP, unable to provide proof of current medical malpractice coverage, in the amounts prescribed in these Bylaws, will be automatically suspended until proof of such coverage is provided to the Medical Executive Committee and CAO.

**8.3(e) Failure to Appear/Cooperate**

Failure of a Practitioner or AHP to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner of AHP's clinical privileges as the MEC may direct.

**8.3(f) Exclusions/Suspension from Medicare**

Any Practitioner or AHP, who is excluded, debarred, suspended, or otherwise declared ineligible from any state or federal government health care program or procurement program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible, will be automatically suspended.

**8.3(g) Contractual Prohibitions**

Any Practitioner or AHP who is subject to any valid agreement (e.g., a non-compete agreement) that prevents him/her from practicing at the Hospital shall be immediately and automatically suspended from the Medical Staff and practicing at the Hospital. The affected Practitioner or AHP shall not be reinstated unless or until the agreement is terminated or expires.

**8.3 (h) Felony**

Any Practitioner or AHP who pleads guilty or no contest to or who has been convicted of a felony shall be immediately and automatically suspended from the Medical Staff and practicing at the Hospital.

**8.3 (i) Effect of Automatic Suspension**

Notwithstanding the provisions of Section 8.3©, any Practitioner or AHP who has been automatically suspended pursuant to this Section 8.3 for at least ninety (90) consecutive days shall have his/her Medical Staff membership and/or clinical privileges automatically terminated without any hearing rights. Any attempt to reapply for membership or privileges at the Hospital shall be processed in accordance with these Bylaws as an initial applicant.

**8.3(j) Automatic Suspension/Termination – Fair Hearing Plan Not Applicable**

No Medical Staff member whose privileges are automatically suspended or terminated under this Section 8.3, shall have the right of hearing or appeal as provided under Article IX of these Bylaws. The Medical Staff President shall designate a physician to provide continued medical care for any suspended/terminated Practitioner's patients.

**8.3(k) President of Staff**

It shall be the duty of the President of the Medical Staff, to cooperate with the CAO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CAO or his/her designee shall periodically keep the President of the Medical Staff informed of the names of Medical Staff members who have been suspended or expelled under Section 8.3.

**8.3(l) Procedural Rights**

Notification of automatic revocation or suspension shall be given to the practitioner by special notice from the President of the Medical Staff. A Hearing must be commenced within fifteen (15) days after any automatic suspension if such suspension will exceed fourteen (14) days.

## 8.4 Confidentiality

To maintain confidentiality, participants in the corrective action process, shall limit their discussion of the matters involved to the formal avenues provided in these bylaws for peer review and corrective action.

## 8.5 Protection from Liability

All members of the Board, the Medical Staff and hospital personnel assisting in Medical Staff peer review, shall have immunity from any civil liability to the fullest extent permitted by state and federal law.

## 8.6 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 deemed appropriate by the medical staff department, peer review committee and/or the Medical Executive Committee or Board of Directors. No practitioner can require the hospital or medical staff to obtain external peer review, if it is not deemed appropriate by the medical staff department or the Medical Executive Committee or Board of Directors:

**8.6(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.

**8.6(b)** Lack of internal expertise, when no one on the medical staff has adequate expertise in the clinical procedure, or area under review.

**8.6(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.

**8.6(d)** To promote impartiality in peer review.

The Medical Executive Committee, or Board of Directors, may require external peer review in any circumstances deemed appropriate by either of these bodies.

## 8.7 Reapplication After Adverse Action

An applicant who has received a final adverse decision pursuant to Section 8.1 or 8.2 shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

## 8.8 False Information on Application

Any Practitioner or AHP who, after being granted appointment and/or clinical privileges, is determined to have made a misstatement, misrepresentation, or omission in connection with an application, shall be deemed to have immediately relinquished his/her appointment and clinical privileges. No practitioner or AHP who is deemed to have relinquished his/her appointment and clinical privileges, pursuant to this Section 8.8 shall be entitled to the procedural rights under these Bylaws and the Fair Hearing Plan, except that the MEC may, upon written request from the practitioner or AHP, permit the practitioner or AHP to appear before it and present information solely as to the issue of whether the practitioner or AHP made a misstatement, misrepresentation, or omission, in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented by the practitioner or AHP and render a decision as to whether the finding; that he/she made a misstatement,

misrepresentation, or omission was reasonable. The MEC decision shall be subject to the approval of the Board.

## ARTICLE IX
## OFFICERS

### 9.1 OFFICERS OF THE STAFF

**9.1(a) Identification**
The officers of the Medical staff shall be:

(1) President
(2) Vice-President
(3) Immediate Past-President

**9.1(b) Qualification of Officers**
Officers must be practitioners on the Active Medical Staff (as defined in Article IV, Section 4) at the time of nomination and election and must remain in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

**9.1(c) Election of Officers**

(1)Officers shall be elected at the biannual meeting of the Medical Staff. Only members of the active and Senior Active Medical Staff shall be eligible to vote.

(2)The Nominating Committee shall present a slate of one (1) or more nominees for each office at the annual meeting.

(3)At least ten (10) days prior to the election, the staff will be notified in writing that elections will be held at the next meeting.

(4)Nominations may be made from the floor at the meeting. In addition, nominations may be submitted in writing to the CAO any time up to twenty-four (24) hours prior to the meeting. Nominations should contain the name of two (2) physicians, one (1) who nominates and one (1) who seconds the nominations

(5) When there is more than one (1) candidate for an office, the voting will be by secret ballot. In the event no candidate receives a majority, the two (2) top vote recipients will compete in a run-off. The Medical Staff Office will tally the votes.

9.1(d) Term of Office
All officers shall serve a two (2) year term from the date of their taking office, or until a successor is elected. Officers shall take office on the first day of the Medical Staff year. (May 1st in odd numbered years.)

**9.1 (e) Vacancies in Office**
If there is a vacancy in the office of the President; the Vice-President shall assume the responsibility of the Presidency. All vacancies shall be filled by a nomination of the Executive Committee and confirmed by a vote of the Medical Staff at its next regular meeting.

**9.1 (f) Duties of Officers**

(1) President. The President shall serve as the principal official of the Medical Staff to:

(i) Act in coordination and cooperation with the CAO, on all matters of mutual concern within the Hospital and aid in coordinating the activities of the

Hospital administration, the nursing and other non-physician patient care services with those of the Medical Staff;

(ii) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and Executive Committee.

(iii) Serve as an ex-officio member of all other Medical Staff committees without vote;

(iv) Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions; where these are indicated and for the Medical Staff's compliance with procedural safeguards, in all instances where corrective action has been requested against a practitioner;

(v) Appoint staff practitioners to all standing, special, and multi-disciplinary Medical Staff committees, except the Executive Committee and Department Chiefs;

(vi) Serve as an ex-officio (non-voting) member of the Board and represent the views, policies, and grievances of the Medical Staff to the Board and CAO.

(vii) Receive, and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality, with respect to the Medical Staff's delegated responsibility to provide medical care; be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the staff; work with the Board in implementation of the Board's quality, performance, efficiency and other standards; serve as the individual responsible for the organization and conduct of the Medical Staff, with who the Governing Body shall directly consult on all matters related to the quality of medical care provided to patients at the Hospital and any other matters of mutual concern.

(viii) In concert with the MEC and clinical departments, develop and implement methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;

(ix) Be responsible for the educational activities of the Medical Staff;

(x) Report to the Board and the CAO concerning the opinions, policies, needs and grievances of the Medical Staff; and

(xi) Be the spokesman for the Medical Staff in its external professional and public relations.

(2) Vice-President. In the absence of the President, he/she shall assume all the duties and have the authority of the President. Perform other such duties pertaining to his/her office and other duties mentioned in these Bylaws or otherwise as assigned by the President.

(3)Immediate Past-President shall be a member of the Executive Committee of the Medical Staff.

**9.1(g) Removal of Officers**

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff, undermining a culture of safety, or to be disruptive to or interfering with the operations of the medical staff the officer may be removed by a two-thirds (2/3) majority of the Active Staff or Board. . Reasons for removal may include, but shall not be limited to violation of these bylaws, breaches of confidentiality or unethical behavior. Such removal shall not affect the officer's Medical Staff membership or clinical privileges and shall not be considered an adverse action.

**9.1(h) Conflict of Interest**

The best interests of the community, Medical Staff and the Hospital are served by Medical Staff members and AHPs who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision-making process of the Medical Staff may be altered by interests or relationships, which might in any instance, either intentionally or coincidentally, bear on that member's or AHP's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff, for relationships of any Medical Staff member or AHP which may influence the decisions related to the Medical Staff and Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff member, shall use his/her position, to obtain or accrue any improper benefit. All Medical Staff members shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Either prior to or within thirty (30) days of being granted appointment to the Medical Staff and/or clinical privileges or appointed as an AHP and granted privileges, and at such other intervals as deemed appropriate by the Board of Directors upon recommendation of the MEC (but no more frequently than annually), each Medical Staff member and AHP shall file with the MEC a written statement describing each actual or proposed relationship of that member or AHP, whether economic or otherwise, other than the member's status as a Medical Staff member, AHP's status and grant of privileges at the Hospital, and/or a member of the community, which in any way and to any degree may impact ~~on~~ the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

(1) Any leadership position on another medical staff or educational institution that creates a fiduciary obligation on behalf of the Practitioner or AHP, including but not limited to membership on the governing body, executive committee, or service or department chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

(2) Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;

(3) Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

(4) Business practices that may adversely affect the hospital or community.

This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest, which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures, of which he/she is uncertain, on the side of disclosure; including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

In addition to the foregoing, a new Medical Staff leader (defined as any member of the Medical Executive Committee, Chair or Vice-Chair of any department, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Board of Directors) shall file the written statement immediately upon being elected or appointed to his/her leadership position. Between regular disclosure dates, any new relationship of the type

described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The Medical Staff Office will provide each MEC member with a copy of each leader's written disclosure at the next MEC meeting following filing by the leader for review and discussion by the MEC.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. Failure to disclose a conflict, as required by this Section 9.1(h), or failure to abstain from voting on an issue, in which the Medical Staff member has an interest; other than as a fiduciary of the Medical Staff, may be grounds for corrective action. In the case of Medical Staff leaders, a breach of these provisions is deemed sufficient grounds for removal of a breaching leader from his/her leadership position by the remaining members of the MEC or the Board on majority vote.

## ARTICLE X
## DEPARTMENTS

### 10.1 Organization of Departments

There shall be the departments of Medicine and Surgery. Department composition is defined in the Medical Staff Rules and Regulations. Each department will elect a Department Chief and an Assistant Chief of Department from Active Staff members. They will serve a two (2) year term.

### 10.2 Functions of Departments

**10.2(a)** The primary function of each department is to implement specific review and evaluation activities, that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this overall function, each department shall establish its own criteria and review the specific privileges consistent with the policies of the Medical Staff and the Board, for the granting of clinical privileges in the department.

**10.2(b)** Each department shall require that patient care evaluations be performed and that appointees exercising privileges within the department, be reviewed on an ongoing basis and upon application for reappointment.

**10.2(c)** Each department shall conduct a review of completed records of discharged patients, and other pertinent sources of medical information to patient care, for the purposes of maintaining continuous quality improvement (CQI) cases, in accordance with the Medical Staff Quality Improvement Plan for presentation at the regularly scheduled meetings that will contribute to the continuing education of every practitioner and to the process of developing criteria to assure quality patient care.

**10.2(d)** Each department shall conduct, participate in, and make recommendations regarding the need for continuing education programs, pertinent to changes in current professional practices and standards.

**10.2(e)** Each department shall monitor on an ongoing basis, the compliance of its members with applicable professional standards, these Bylaws, and the Rules & Regulations, policies, and procedures.

**10.2(f)** Each department shall coordinate the patient care provided by the department's members with nursing, administrative, and other non-Medical Staff services.

**10.2(g)** Each department shall foster an atmosphere of professional decorum within the department.

**10.2(h)** Each department shall review all deaths occurring in the Department and all unexpected patient care events and report findings to the MEC.

**10.2(i)** Each department shall submit, through its Chief of Department, written reports to the MEC on a regular basis concerning:

(1) Findings of the department review and evaluation activities, actions taken thereon, and the results thereof;

(2) Recommendations for maintaining and improving the quality of care provided in the service and in the Hospital; and

(3) Such other matters as may be requested from time to time by the MEC.

**10.2(j)** Each department may utilize section committees as needed to perform the duties and functions of the Medical Staff.

## 10.3 Services

In addition to the departments of the Medical Staff, there shall be services within the departments of the Medical Staff. The various services within the Medical Staff (e.g., anesthesiology service, radiology service, emergency service, pathology service, etc.) shall not constitute departments, as that term is used herein without the express designation by the MEC and the Board of Directors. Each service shall be headed by a chief selected in the manner and having the authority and responsibilities set forth in these Bylaws. The purpose of the services shall be to provide specialized care within the Hospital and to monitor and evaluate the quality of care rendered in the service and to be accountable to the department to which such service is assigned for the discharge of these functions.

## 10.4 Functions of Department Chief

**10.4(a)** Each Department shall have a Chief elected by the department members, who shall be a member of the Active Staff, qualified by training, certification by an appropriate specialty board or equivalent, experience and administrative ability for the position. Department Chiefs may be removed by affirmative vote of two-thirds (2/3) of the Department members or Board whenever the activities, professional conduct or leadership abilities of a Department Chief are believed to be below the standards established by the Medical Staff, undermining a culture of safety, or to be disruptive to or interfering with the operations of the Hospital. Reasons for removal may include but shall not be limited to violation of these Bylaws, breaches of confidentiality or unethical behavior. Such removal shall not affect the Department Chief's Medical Staff membership or clinical privileges and shall not be considered an adverse action.

**10.4(b)** Each Chief shall:

(1) Be accountable for all professional/administrative activities within his/her Department;

(2) Be a member of the Executive Committee;

(3) Maintain continuing review of the professional performance of all practitioners with clinical privileges in his/her department and shall make appropriate recommendations to the Credentials Committee regarding specific clinical privileges;

(4) Be responsible for development, implementation and enforcement of the Medical Staff Bylaws and Rules and Regulations and supportive policies and procedures within his/her department;

(5) Be responsible for implementation within his/her department of actions taken by the Executive Committee of the Medical Staff;

(6) Transmit to the Executive Committee his/her department's recommendations concerning staff classifications, reappointment and delineation of clinical privileges for all practitioners in his/her department;

(7) Assure that a formal process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the department is carried out;

(8) Assure the participation of department members in department orientation, continuing education programs and required meetings; be responsible for teaching and education in his/her department when appropriate;

**(**9) Assure participation in risk management activities related to the clinical aspects of patient care and safety;

(10) Assure that required performance improvement and quality control functions including surgical case review, blood usage review, drug usage evaluation, medical record review, pharmacy and therapeutics, risk management, safety, infection control and utilization review, are performed within the department, and that findings from such activities are properly integrated with the primary functions at the department level;

(11) Participate in administration of his/her department through cooperation with the nursing service and Hospital administration in matters which affect patient care including personnel, supplies, special regulations, and otherwise integrates the department and its services with the Hospital's primary functions and other departments' services;

(12) Assist in the preparation of such reports as may be required by the Executive Committee, CAO or the Board;

**(**13) Assess and recommend to the CAO, any off-site sources for needed patient care services not provided by the department or organization; and

(14) Make recommendations for adequate space and resources and a sufficient number of qualified and competent persons to provide care or services within the department.

(15) Recommend to the Medical Executive Committee the criteria for clinical Privileges relevant to the care provided in the department.

(16) Integration of the department into the primary functions of the organization and coordination and integration of inter and intradepartmental services.

(17) Determination of the qualifications and competence of department or service personnel who are not Practitioners or AHPs, but and who provide patient care, treatment and services.

## 10.5 Assignment to Departments

The Executive Committee shall, after consideration of the recommendations of the Credentials Committee, recommend initial department assignments for all Medical Staff practitioners and all other approved practitioners with clinical privileges. Assignment to the appropriate Department(s) will be completed at the time of appointment/reappointment by the Medical Executive Committee for all Medical Staff Practitioners and all other approved practitioners with clinical privileges.

## 10.6 Organization of Department

**10.6(a)** All organized departments shall have written rules and regulations which govern the activity of the department. These rules and regulations shall be approved by the Medical Executive Committee and Board of Directors. The exercise of clinical privileges within any department is subject to the department rules and regulations and to the authority of the Department Chief.

**10.6(b)** Each Department shall meet separately, but such meetings shall not release the members from their obligations to attend the general meetings of the Medical Staff, as provided in Article XIII of these Bylaws. Additionally, each department shall meet quarterly to conduct clinical review of practice within their department. Written minutes must be maintained and furnished to the Medical Executive Committee.

**10.6(c)** Each Medical Staff member, at the beginning of each year, shall designate his/her primary department and he/she may only vote for the Chairperson of that Department. The Practitioner's designation of department shall be approved by the Medical Executive Committee and shall be the department in which the Practitioner's practice is concentrated. Should the Practitioner exercise

privileges relevant to the care in more than one (1) department, each department shall make a recommendation to the MEC regarding the granting of such privileges.

## ARTICLE XI
## COMMITTEES & FUNCTIONS

### 11.1 Standing Committee

**11.1(a).** Meeting times and dates will be determined by a majority vote of each Medical Staff Committee**.** The following are the Standing Committees:

(1) Executive Committee;
(2) Credentials Committee;
(3) Quality Improvement/Peer Review

### 11.2 Medical Executive Committee

**11.2(a) Composition.** The Executive Committee shall consist of:

(1) President – presiding officer
(2) Vice-President
(3) Immediate Past President
(4) Department Chiefs ( 1-Medicine, 1-Surgery)
(5) Assistant Department Chiefs (1-Medicine, 1-Surgery)
(6) Chief Administrative Officer (ex-officio without vote)

Executive Committee members shall be removed from the Committee upon resigning or being removed by operation of these Bylaws from the leadership position qualifying for Committee membership.

**11.2(b) Functions**. The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board and shall be empowered to act for the Medical Staff, in the intervals between Medical Staff meetings. All Active Staff members shall be eligible to serve on the MEC. The functions and responsibilities of the MEC are delegated by the medical staff, and authority can; if consistent with law and accreditation standards, be removed temporarily, as appropriate to protect the medical staff's interests, by vote of at least two-thirds of the membership. The Committee's functions shall include at least the following:

(1) To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.
(2) To coordinate the activities and general policies of the various services.
(3) To receive and act upon department and committee reports.
(4) To implement policies of the Medical Staff not otherwise the responsibility of the services.
(5) To provide liaison between Medical Staff and the CAO and the Board.
(6) To recommend action to the CAO on matters of a medico-administrative nature.
(7) To make recommendations on hospital management matters and for long range planning to the Board through the CAO.
(8) To fulfill the Medical Staff's accountability to the Board, for the medical care rendered to patients in the Hospital.
(9) To work toward keeping the Medical Staff apprised of Joint Commission and other accreditation programs and informed of the accreditation status of the Hospital.
(10) To provide for the preparation of continuing education programs, either directly or through delegation to a program committee or other suitable agent.

(11) To take all reasonable steps to ensure professional, ethical conduct and competent clinical performance on the part of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted by these Bylaws. A practitioner whose clinical performance is scheduled to be reviewed at an Executive Committee meeting shall be so notified and be expected to attend such meeting.

(12) To review Medical Staff Bylaws regularly, as may be required, or appoint an ad hoc committee to do so, but at least every two years.

(13) To report at each Medical Staff meeting.

(14) To nominate Medical Staff members for appointment to a Professional Review Committee by the Board.

(15) To recommend to the Board all matters relating to appointment, reappointment, delineation of clinical privileges, Medical Staff category and corrective action.

(16) To develop and implement programs to inform the Medical Staff about physician health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness, or delegating such responsibilities to the Aid Committee.

(17) To assure regular reporting of quality improvement and other Medical Staff issues to the MEC and to the Board of Directors and making recommendations to the Board regarding quality improvement processes and activities.

(18) To evaluate areas of risk in the clinical aspects of patient care and safety and propose plans and recommendations for reducing these risks.

(19) To assure that an annual evaluation of the effectiveness of the Hospital's performance improvement program is conducted.

**(**20) To initiate an investigation of any incident, course of conduct, or allegation indicating that an appointee to the Medical Staff may not be complying with the Bylaws, may be rendering care below the standards established for appointees to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment, or clinical privileges without limitation, further training, or other safeguards;

(21) To participate in identifying community health needs and in setting Hospital goals and implement programs to meet those needs;

(22) To develop and monitor compliance with these Bylaws and the Rules & Regulations, policies and

(23) To make recommendations to the Board regarding the Medical Staff structure, the mechanism for hearing procedures and the mechanism by which Medical Staff membership may be granted and terminated.

Should conflict arise between the actions taken by the Executive Committee and the Medical Staff, they shall be resolved as a special meeting of the Staff, called consistent with the requirements of these Bylaws.

**11.2(c) <u>Meetings</u>**. The Executive Committee shall meet not less than ten (10) times a year (may be concurrent with the general staff meeting) and may also be called more frequently, at the request of the President and shall maintain a permanent record of its proceedings and actions. The CAO attends the meetings without vote.

**11.2(d) <u>Special Meeting of the Medical Executive Committee</u>**

A special meeting of the MEC may be called by the President of the Medical Staff, when a quorum of the MEC can be convened.

**11.2(e) Removal of MEC Members**

Members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership provisions. Officers of the Medical Staff, who are ex officio members of the MEC, shall be removed in accordance with the procedures described in Section 10.1(e). Department Chairpersons, who are ex officio members of the MEC, shall be removed in accordance with the procedures described in Section 11.4(a).

## 11.3 Credentials Committee

**11.3(a) Composition.** The Credentials Committee shall meet as needed, but at least quarterly and shall consist of at least five (5) Physicians medical staff members appointed by the President of the Medical Staff, including the Vice-President. One (1) of the members shall be appointed Chair.

**11.3(b) Functions.** The duties of the Credentials Committee shall be:

(1) Review and evaluate the qualifications of each applicant for initial appointment, reappointment, or modification for appointment for membership and clinical privileges.

(2) Submit a report, in accordance with these Bylaws, to the Executive Committee on the qualifications of each applicant for staff membership for particular clinical privileges. Such report shall include recommendation with respect to appointment/reappointment, staff category, service affiliation, clinical privileges and any special conditions attached thereto.

(3) Fulfill other duties as mentioned in these Bylaws or assigned by the Medial Executive Committee.

## 11.4 Medical Staff Quality Improvement /Peer Review Committee

**11.4(a) Composition.** The Medical Staff Quality Improvement/Peer Review Committee (MSQIPRC)shall be composed of at least six providers, including but not limited to: an ED physician, a primary care provider, a Surgeon, a Hospitalist, an intensivist, and 1 – 3 ad hoc members of appointed from the active or consulting medical staff. Non-voting members may include the Quality Director and Quality department staff, the Patient Safety Officer, the CNO and the CAO or his/her designee.

**11.4(b) Functions: The duties of the MSQIPRC** include but are not limited to:

(1) To review and recommend to the MEC any and all changes to, and to coordinate and integrate the Medical Staff's quality management program, which encompasses quality assessment and improvement, clinical risk management, infection control and peer review including all aspects of Appendix D of these bylaws;

(2) Collect data on the appropriateness of practice, analyzing patterns and significant departures from established guidelines and report to appropriate committees for needed follow up (OPPE/FPPE);

(3) Monitor operative and invasive procedures;

(4) Conduct and make determinations on peer review cases using the medical staff established process as outlined in Appendix D;

(5) To report significant findings to the Medical Executive Committee and others as appropriate for further evaluation and improvement as needed;

(6) To develop criteria/screens for quality studies, peer review and other medical staff efforts to reduce morbidity and mortality;

(7) Recommend formal team-based quality improvement projects; and

(8) Recommend needed education or other action(s) for improvement of practitioner performance.

**11.4(c) Meetings:** These Committees shall meet monthly, but not less than ten (10) times per year.

## 11.5 Ad Hoc Committees

### 11.5(a) Nominating Committee

(1) Composition. The Nominating Committee shall consist of three (3) available Past-Presidents who are Active Staff members. The Chairperson shall be the most senior Past-President.

(2) Duties. The Nominating Committee shall present a slate of candidates for the election at the annual meeting in conformance with these Bylaws in Article VIII, Section 3(B).

### 11.5(b) Bylaws Committee

(1) Composition. Members of this committee shall be appointed by the President of the Medical Staff.

(2) Duties. The duties of the Bylaws Committee shall be:

(i) to conduct a review of the Bylaws, Rules & Regulations and forms promulgated in connection therewith, as instructed by the MEC but at least bi-annually.

(ii) submit recommendations to the Executive Committee for changes in these documents.

(iii) to act upon all matters as may be referred through and by the Executive Committee or Medical Staff.

### 11.5(c) Other Ad Hoc Committees

(1) Composition. Members of the staff appointed by the President from time to time as may be required to properly carry out the duties of the staff.

(2) Duties. Such Committees shall confine their work to the purposes for which they were appointed and shall report to the Executive Committee. They shall not have the power of action, unless such is specifically granted by the motion that created the committee.

## 11.6 Medical Staff Functions

**11.6(a). Assignment.** Where not specifically assigned by these bylaws, the MEC shall assign the following functions of the Medical Staff to appropriate departments, ad hoc or standing committees.

**11.6(b). Functions.** The functions of the Medical Staff are to:

**(**1) Monitor, evaluate and improve care provided in and develop clinical policy for special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, home care and other ambulatory care services;

(2) Provide continuing education opportunities responsive to quality improvement activities, new state-of-the-art developments, and other perceived needs and supervise Hospital's professional library services;

(3) Plan for response to fire and other disasters, for hospital growth and development, and for the provision of services required to meet the needs of the community;

(4) Direct Medical Staff organizational activities, including Medical Staff Bylaws review and revision, Medical Staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

(5) Provide for appropriate physician involvement in and approval of the multi-disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Staff, with the care provided by the nursing service and with the activities of other Hospital patient care and administrative services;

(6) Develop and maintain surveillance over drug utilization policies and practices;

(7) Research and control nosocomial infections and monitor the Hospital's infection control program;

(8) Provide as part of the Hospital and Medical Staff's obligation to protect patients and others in the organization from harm, a mechanism for addressing the health of all licensed individual practitioners including a Practitioner Wellness Policy (attached hereto as Appendix "B" and incorporated herein by reference). The purpose of the mechanism is to provide education about Practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from a potentially impairing condition. The Practitioner Wellness Policy affords resources separate from the corrective action process, to address physician health. The policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling or referrals.

(9) Provide leadership in activities related to patient safety;

(10) Engage in other functions reasonably requested by the MEC and Board or those which are outlined in the Medical Staff Rules & Regulations, or other policies of the Medical Staff;

**(**11) Provide Medical Staff leadership for process measurement, assessment and improvement for the following processes, which are dependent on the activities of individuals with clinical privileges:

(i) medical assessment and treatment of patients;
(ii) use of medications, use of blood and blood components;
(iii) use of operative and other procedure(s);
(iv) efficiency of clinical practice patterns; and
(v) significant departure from established patterns of clinical practice;

(12) Promote Medical Staff participation in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:

(i) education of patients and families;
(ii) coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and
(iii) accurate, timely and legible completion of patients' medical records; including history and physicals;
(iv) patient satisfaction;
(v) sentinel events; and

**(**13) Ensure that when the findings of assessment processes are relevant to an individual's performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a practitioner's competence;

(14) Recommend to the Board, policies and procedures which define the circumstance, trends indications, deviated expectations or outcomes, or concerns that trigger a focused review of a Practitioner's performance and evaluation of a Practitioner's performance by peers. The process and procedure for focused professional review, shall be substantially in accord with the Medical Staff Policy Regarding Peer Review, Ongoing Professional Practice Evaluation (OPPE) & Focused Professional Practice Evaluation (FPPE).

(15) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules and Regulations, and review same on a regular basis;

(16) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;

(17) Review, on a periodic basis, applications for reappointment including information regarding the competence of Medical Staff members; and as a result of such reviews, make recommendations for the granting of privileges and reappointments;

(18) Investigate any breach of ethics that is reported to it;

(19) Review AHP appeals of adverse privilege determinations as provided in Section, 5.4(b); and;

(20) To prepare and recommend a slate of nominees for the officers of the Medical Staff.

## 11.7 Aid Committee

**11.7(a) Composition.** The medical staff aid committee shall be comprised of no less than three (3) active members of the medical staff, a majority of which, including the chair, shall be physicians. Except for initial appointments, each member shall serve a term of two years, and the terms shall be staggered as deemed appropriate by the executive committee to achieve continuity. Insofar as possible, members of this Committee shall not serve as active participants on other peer review or quality assessment and improvement committees, while serving on this Committee.

**11.7(b) Functions.** The medical staff aid committee may receive reports, including self-referrals, related to the health, well-being, or impairment of medical staff members and shall determine the credibility of each and if warranted, evaluate such reports in a manner it deems appropriate**.** The Committee shall refer subject members to appropriate sources for evaluation and treatment and establish and engage systems to monitor subject members as needed. Such activities shall be confidential; however, in the event information received by the Committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action. The Committee shall also consider general matters related to the health and well-being of the medical staff and, with the approval of the executive committee, develop educational programs or related activities.

**11.7(c) Meetings.** The Committee shall meet as often as necessary, but at least quarterly. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities, on a routine basis, but at least quarterly, to the Medical Executive Committee.

## 11.8 Conflict Resolution Committee

The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. Said Committee shall consist of two (2) member of the Medical Staff who are selected by the Medical Executive Committee (and may or may not be members of the Board), two (2) non-physician board members, who are selected by the Board Chair, and the CAO. The committee shall meet, as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, to resolve the conflict, and to protect the safety and quality of care.

## ARTICLE XII
## GENERAL MEDICAL STAFF MEETINGS

### 12.1 Annual Medical Staff Meeting

13.1(a) The staff meeting that precedes May 1st in the odd numbered years shall be the bi-annual staff meeting at which an election of officers for the ensuing period shall be conducted.

### 12.2 Regular Meetings

13.2(a) The number of Medical Staff meetings shall be established by the Medical Staff and the number of such meetings shall be set forth in the Medical Staff Rules and Regulations and shall not be less than four (4) times a year. The purpose of such Medical Staff meetings shall be, among other things, to review and evaluate the medical performance of the Medical Staff, audit activities of the respective departments, and to consider and act upon committee reports.

13.2(b) The Executive Committee shall, by standing resolution, designate the time and place for all regular Medical Staff meetings. Notice of the original resolution and any changes thereto shall be given to the Medical Staff in the same manner as provided in Section 12.4 of this Article, for notice of a special meeting.

### 12.3 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Board, the President of the Medical Staff, the MEC or by written request of one-fourth (1/4) of the Active Staff and shall be held at the time and place designated by the President. No business shall be transacted at any special meeting; except that stated in the meeting notice.

### 12.4 Notice

Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be posted on the designated Medical Staff bulletin board and transmitted by interoffice memo, not less than two (2) nor more than ten days (10) before the date of such meeting, or at the direction of the President (or other persons authorized to call the meeting). Notice may also be sent to members of other Medical Staff groups. The attendance of a member of the Medical Staff at a meeting, shall constitute a waiver of notice of such meeting.

### 12.5 Quorum

The presence/or by ballot of fifty percent (50%) of the active Medical Staff at any regular or special meeting shall constitute a quorum.

### 12.6 Agenda

**12.6(a**)The agenda at any regular Medical Staff meeting is suggested to be:

(1) Call to order;
(2) Approval of the minutes of the last regular and of all special meetings;
(3) Old business;
(4) Report from the CAO of the Hospital;
(5) Reports of committees;
(6) New business (including; elections, where appropriate);
(7) Adjournment.

**12.6(b**) The agenda at special meetings is suggested to be:

(1) Reading of the notice calling the meeting;
(2) Transaction of business for which the meeting was called; and
(3) Adjournment.

**12.7 Manner of Action**

The action of a majority present at a meeting, at which a quorum is present, shall be the action of a Medical Staff meeting. Action may be taken, without a meeting of the committee, if a majority consent in writing setting forth the action to be taken if signed by each member entitled to vote.

**12.8 Rules of Procedure**

Meetings of the Staff, departments and committees will be conducted according to Robert's Rules of Order Newly Revised (RONR), Tenth Edition; unless superseded by a more recent edition. In the event of conflict between the Rules and any provision of the Medical Staff bylaws or Rules and Regulations, the latter are controlling.

**12.9 Attendance**

Members of the Medical Staff are encouraged to attend the regular and special meetings of the Medical Staff, as well as the meetings of those departments and committees of which they are members.

**12.10 Special Appearances; Cooperation with Medical Executive Committee**

Any committee or department of the Medical Staff may request the appearance of a Medical Staff member at a committee meeting when the committee or department is questioning the Practitioner's clinical course of treatment. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these Bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, advance notice of the time and place of the meeting, shall be given to the Practitioner. When such special notice is given, it shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice, and/or failure to comply with any reasonable directive of the MEC, shall unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

## ARTICLE XIII
## COMMITTEE AND DEPARTMENT MEETINGS

13.1 Regular Meetings

Chairs of Committees and Departments shall call meetings at least as frequently as required by these Bylaws. Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

13.2 Special Meetings

A special meeting of any committee or department, may be called by, or at the request of the chairman or chief thereof, or by the President of the Medical Staff.

13.3 Notice of Meetings

Written or oral notice stating the place, day and hours of any special meeting or of any regular meeting, not held pursuant to resolution, shall be given to each member of the committee or department not less than 48 hours before the time of such meeting, by posting on the Medical Staff bulletin board and by interoffice memo by the person or persons calling the meeting.

13.4 Quorum

Not less than two (2) of the Active Medical Staff members shall constitute a quorum at any meeting.

13.5 Manner of Action

The action of a majority of the members present at a meeting, shall be the action of a committee or service. Action may be taken, without a meeting, by written response (setting forth the action so taken) signed by each member entitled to vote**.** Such writing must indicate a majority vote in favor of the action taken.

13.6 Ex-Officio Members

Persons serving under these Bylaws, as ex-officio members of a committee, shall not vote nor be counted in determining the existence of a quorum.

13.7 Minutes

Minutes of each regular and special meeting, of a committee or department, shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and copies thereof shall be promptly distributed to the attendees and a copy forwarded to the Executive Committee. Each committee and department, shall maintain a permanent file of the minutes of each meeting.

**13.8 Remote Meeting**

Each medical staff committee and department can hold meetings or any other functions, including elections, by telephone or internet conference, or other electronic means by which all persons participating in the meeting can hear one another at the same time. The chair of the meeting or a majority of those entitled to vote in the meeting, shall determine whether to hold the meeting solely by electronic means, or by meeting in person, or by a combination of in-person meeting and individual participation by telephone or other electronic means. The action of meetings held electronically has the same weight as meeting held in person. The hospital shall support electronic communication among medical staff leadership and members, who are obligated to supply and update contact information. All documents that are a basis of deliberation or action in the meeting must be made available for review by all members attending the meeting remotely, via secure or encrypted delivery method appropriate to protect the confidentiality and/or privilege associated with such documents.

## ARTICLE XIV
## GENERAL PROVISIONS

**14.1 Rules and Regulations**

**14.1(a)The Medical Staff**

The Medical Staff shall adopt such Rules & Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board. Such Rules & Regulations, shall be a part of these Bylaws, except that they may be amended or repealed at any regular Medical Staff meeting, at which a quorum is present and without previous notice, or at any special Medical Staff meeting on notice, by a majority of those present of the active Medical Staff. Such changes shall become effective when approved by the Board, which approval shall not be withheld unreasonably, or automatically after 45 days, if no action is taken by the Board. In the latter event, the Board shall be deemed to have approved the Rule(s)& Regulation(s) adopted by the Medical Staff. The Rules & Regulations shall be reviewed as needed, but at least every two (2) years. Applicants and members of the Medical Staff shall be governed by such Rules & Regulations as are initiated and adopted pursuant to these bylaws. If there is a conflict between the Bylaws and the Rules &Regulations, the Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules & Regulations.

**14.1(b) Medical Staff Policy**

The medical executive committee shall review, develop and adopt policies which will be binding upon the medical staff and its members and those otherwise holding clinical privileges. Such policies must be consistent with the Medical Staff Bylaws and Rules & Regulations. Only policies adopted by the medical executive committee and approved by the Board of Directors are binding upon the Medical Staff and its members. Amendments to 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.

**14.1(c) Notice of Proposed Adoption or Amendment**

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

**14.1(d) Provisional Adoption by MEC**

In cases of a documented need for urgent amendment to Rules & Regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 15.1(c) of this Article shall be implemented.

**14.1(e) Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments**

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC, as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the Medical Staff or the MEC, or to limit the Board's final authority as to such issues.

**14.1(f) Final Authority of the Board**

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and (except in the case of a provisional adoption provided for in Section 15.1(b) of the Article) no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.

## 14.2 Professional Liability Insurance

Each Practitioner or AHP granted clinical privileges and/or Medical Staff membership in the Hospital, shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions thereto; or, should the state have

no minimum statutory requirement, in an amount not less than $1,000,000.00 in indemnity limits per occurrence and $3,000,000.00 in indemnity in the aggregate. Policies of insurance in which defense costs reduce the available indemnity limits ("wasting policies") do not meet the requirements of this provision. The insurance coverage contemplated by this paragraph shall be with a carrier reasonably acceptable to the Hospital and shall be on an occurrence basis or, on a claims made basis, the Practitioner shall agree to obtain tail coverage covering his/her practice at the Hospital. Each Practitioner shall also provide annually to the MEC and the CAO details of such coverage in December including evidence of compliance with all provisions of this paragraph. He/She shall also be responsible for advising the MEC and the CAO of any change in such professional liability coverage.

## 14.3 Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be developed by the Medical Executive Committee, subject to adoption by the Board. Such forms shall meet all applicable legal requirements, including non-discrimination requirements.

## 14.4 Construction of Terms and Headings

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular and plural, as the context requires. The captions or headings in these Bylaws are for convenience and are not intended to limit or define the scope or effect of any provision of these Bylaws.

## 14.5 Transmittal of Reports

Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the CAO or his/her designee.

## 14.6 Confidentiality and Immunity Stipulations and Releases

### 14.6(a) Reports to be Confidential

Information with respect to any Practitioner, including applicants, Medical Staff members or AHPs, submitted, collected or prepared by any representative of the Hospital including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

### 14.6(b) Release from Liability

No representative of the Hospital, including its Board, CAO, administrative employees, Medical Staff or third party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the Hospital including its Board, CAO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a Practitioner who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the Hospital, provided such disclosure or representation is in good faith and without malice.

### 14.6(c) Action in Good Faith

The representatives of the Hospital, including its Board, CAO, administrative employees and Medical Staff shall not be liable to a Practitioner for damages, or other relief, for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief

that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

**14.6(d) Indemnification**

The Hospital shall provide a legal defense for, and shall indemnify to the fullest extent permitted by law, any member of the medical staff serving on or assisting any hospital or medical staff committee, or assisting in peer review or quality management activities involving care provided at the Hospital, involved in claims arising out of such activities, so long as the member of the medical staff acted in good faith and within the scope of the formal medical staff peer review and quality management process.

## ARTICLE XV
## ADOPTION & AMENDMENT OF BYLAWS

### 15.1. Development

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board, which may be recommended by the Medical Staff Bylaws or Executive Committee, or which may be proposed from the floor at a medical staff meeting. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the hospital and the community. These Bylaws shall remain in effect until further bylaws are adopted, regardless of any relocation of the facility or expansion of hospital services.

### 15.2 Adoption, Amendment & Reviews

**15.2(a)** The Bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the Bylaws and will be revised to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

(1) Medical Staff. The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of a two-thirds (2/3) of the Active, Active Specialty and Senior Active Medical Staff members eligible to vote, who are present and voting at a meeting, at which a quorum is present, provided at least fourteen (14) days written or electronic notice, accompanied by the proposed Bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of a two-thirds (2/3) vote of the Board, which approval shall not be withheld unreasonably by the Board.

(2) Board. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, and when immediate action is needed to provide for immediate protection of patient welfare; the Medical Executive Committee and the Board, acting jointly, shall have the authority to adopt and immediately implement Medical Staff Bylaw amendments required to resolve the problem. Immediate notification to the Medical Staff will be required that the Bylaw amendments have been enacted and will be discussed at the next regularly scheduled meeting.

### 15.3 Documentation & Distribution of Amendments

**15.3(a)** Amendments to these Bylaws approved as set forth herein shall be documented by either:

(1) Appending to these Bylaws the approved amendment, which shall be dated and signed by the President of the Medical Staff, the CAO and the chairperson of the Board of Directors; or

(2) Restating the Bylaws, incorporating the approved amendments and all prior approved amendments, which have been appended to these Bylaws since their last restatement, which restated Bylaws shall be dated and signed by the President of the Medical Staff, the CAO and the chairperson of the Board.

Each member of the Medical Staff shall be given a copy of any amendments to these Bylaws in a timely manner.

### 15.4 Nature of the Bylaws

The Hospital and the Medical Staff shall comply with these Medical Staff Bylaws.

## ARTICLE XVI:
## PRACTITIONERS PROVIDING CONTRACTUALPROFESSIONAL SERVICES

### 16.1 Qualifications & Processing

A Practitioner who is providing contract services to the Hospital must meet the same qualifications for membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules & Regulations and must fulfill all of the obligations for his/her membership category as any other applicant or Medical Staff member.

### 16.2 Requirements for Service

In approving any such Practitioners for Medical Staff membership, the Medical Staff must require that the services provided meet Joint Commission requirements, are subject to appropriate quality controls, and are evaluated as part of the overall Hospital Quality Assessment and Improvement program.

### 16.3 Termination

The contract for services may provide that termination of the contract shall automatically result in concurrent termination of Medical Staff membership and clinical privileges. If the contract so provides, the contracting physician waives any right to the procedures set forth in the Rules of Procedure. In such a case, the contract shall control over this termination section these Bylaws.

If the Hospital enters into an exclusive contract and that contract results in the total or partial termination or reduction of Medical Staff membership or clinical privileges of a current Medical Staff member, the Hospital shall provide the affected Medical Staff member sixty (60) days prior notice of the effect on his/her Medical Staff membership or privileges. A Medical Staff member who is so affected and has not waived such hearing rights, is entitled to a hearing under these bylaws, but must request this hearing within fourteen (14) days after the date he/she is notified of the effect on his/her Medical Staff membership or clinical privileges. The requested hearing shall be commenced and completed in accordance with these bylaws.

After exhaustion of all remedies under these bylaws, the Hospital shall give the Practitioner written notice, fifteen (15) days in advance of implementation of any adverse staff decision based substantially on economic factors, whether resulting from an exclusive contract or other economic decision

**MEDICAL STAFF BYLAWS**
**REVISIONS APPROVED:**

**MEDICAL STAFF:**

By: _____ _____
President of the Medical Staff Date

**BOARD OF DIRECTORS:**

By: _____ _____
Chairperson Date

**DEACONESS ILLINOIS MEDICAL CENTER**

By: _____ _____
Chief Administrative Officer Date