HSHS St. Mary's Hospital - Decatur

MEDICAL STAFF BYLAWS

Volume I:
Governance and Function of the Medical Staff

Approved by Board of Directors: 11/09/2010, 03/24/2015, 03/21/2017, 08/20/2025

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DEFINITIONS

1. ADVERSE DECISION: A professional review action (as defined by the federal Health Care Quality Improvement Act in which the Board or MEC denies, terminates, limits, suspends, modifies a grant of privileges or medical staff membership for failure to adhere to the Hospital's code of conduct policy or for issues related to clinical competence.

2. ALLIED HEALTH PROFESSIONAL (AHP'S) means individuals other than members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. The categories of allied health professionals practicing at the Hospital are set forth in Appendix A. Allied Health Professionals are described as Licensed Independent Providers, Advanced Practice Providers or Surgical Providers in the Medical Staff bylaw documents.

    - ADVANCED PRACTICE PROVIDER means a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician.

    - LICENSED INDEPENDENT PROVIDER means an Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of their license and consistent with the clinical privileges granted.

    - SURGICAL PROVIDER means a type of Allied Health Professional who provides a medical level of care in performing surgical tasks consistent with granted privileges. Who is required by law and Hospital to exercise all of those clinical privileges under the direction of a supervising provider pursuant to a written supervision agreement.

3. BOARD, HOSPITAL BOARD or GOVERNING BOARD: The governing body of the Hospital.

4. BOARD CERTIFICATION: The designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Oral and Maxillofacial Surgery, or American Board of Podiatric Surgery (ABPS) as applicable, upon a physician, dentist, or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

5. BYLAWS: The three volumes that make up the Medical Staff Bylaws are: Volume I - Governance and Functions of the Medical Staff; Volume II - Credentials Procedures of the Medical Staff; and Volume III - Investigation, Corrective Action, Hearing and Appeal Procedures of the Medical Staff.

6. CHAIR: The individual responsible for directing the functions and meetings of a clinical service or a committee.

7. CHIEF EXECUTIVE OFFICER (CEO): The individual appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

8. CLINICAL SERVICE: Any group of physicians of a similar or like specialties who are authorized by the MEC to be recognized as a clinical service. The primary responsibility delegated to each medical staff clinical service shall be to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by members of the clinical service. Clinical services when organized may perform any of the following collegial and professional activities: continuing medical education; communication and dialogue regarding issues relevant to members of the clinical service; social networking; and interdisciplinary projects and coordination and other duties assigned by these Bylaws as authorized by the MEC or the Board.

9. CORRECTIVE ACTION: An action taken by the medical staff or Board which restricts, limits, denies, or terminates the privileges or medical staff membership of a practitioner for reasons of unprofessional conduct or concerns about clinical competence and which entitles the practitioner to procedural rights as outlined in the Investigation, Corrective Action and Fair Hearing Procedures of these Bylaws. Required evaluations, warning, reprimands, and performance monitoring are not considered corrective actions.

10. CREDENTIALS COMMITTEE: The Credentialing and Privileging Committee of the Hospital which reviews applications for initial membership, appointment and reappointment to the medical staff of the Hospital, makes recommendations regarding assignment of privileges, and recommends policies and procedures related to the credentialing of practitioners.

11. CVO: Credentials Verification Organization of the Hospital.

12. DATE OF RECEIPT: The date any notice, special notice, or other communication is delivered personally, by facsimile, or by electronic mail (email); or if such notice, special notice, or communication was sent by mail, it shall mean 72 hours after the notice, special notice, or if the communication was deposited, postage prepaid, in the United States mail.

13. DAYS: Calendar days, unless otherwise noted.

14. DELEGATION OF FUNCTIONS: When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

15. DENTIST: A dentist or oral surgeon holding a D.D.S., D.M.D, or equivalent degree and a valid license to practice dentistry in the State of Illinois.

16. EX OFFICIO: Service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

17. HOSPITAL: St. Mary’s Hospital and includes all of its related facilities and all of its personnel and organizational entities, including the medical staff.

18. HOSPITAL SISTERS HEALTH SYSTEM: Hospital Sisters Health System (HSHS) is a multi- institutional health care system that sponsors thirteen (13) hospitals in twelve (12) communities across Illinois and Wisconsin and an integrated physician network.

19. JOINT CONFERENCE: A meeting between representatives of the Board (appointed by the Board Chair) and representatives of the medical staff (appointed by the President of the Medical Staff).

20. MEDICAL EXECUTIVE COMMITTEE (MEC): The executive committee of the medical staff.

21. MEDICAL STAFF or STAFF: The formal organization created by the Governing Board to carry out delegated functions and comprised of all practitioners who are appointed to it by the Board.

22. MEDICAL STAFF YEAR: The period from January 1 to December 31.

23. MEMBER: A practitioner who has been appointed by the Board to the medical staff.

24. MONTHLY: Each month of the calendar year. Committees required by these Bylaws to meet "monthly" shall hold at least ten (10) meetings in a calendar year, at the discretion of such committee, but need not hold twelve (12) meetings.

25. NOTICE: A written or electronically transmitted communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the medical staff or Hospital.

26. ORGANIZED HEALTHCARE ARRANGEMENT: A clinically integrated care setting in which individuals typically receive health care from more than one provider and which is defined in 45 C.F.R. §164.501 commonly known as the HIPAA Privacy Regulations.

27. PATIENT CONTACTS: are defined as any admission, consultation, procedure, discharge, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities. It shall not include referrals for diagnostic tests or imaging.

28. PEER REVIEW: The process for review of a practitioner's professional conduct and/or competence as part of the medical staff's quality oversight, performance improvement and patient safety responsibilities.

29. PEER REVIEW COMMITTEE: Medical staff members and Hospital personnel who are organized to address matters of quality performance, competence and professional conduct on the part of a practitioner with privileges.

30. PHYSICIAN: A Doctor of Medicine (MD), a Doctor of Podiatric Medicine (DPM) or a Doctor of Osteopathy (DO) who is licensed to practice in the State of Illinois.

31. POLICIES: All medical staff and Hospital policies referred to in the Medical Staff Bylaws, Volume I, Governance and Function of the Medical Staff, Volume II the Medical Staff Credentials Procedures, or Volume III the Investigation, Corrective Action and Fair Hearing Procedures, of these Bylaws can be obtained through the medical staff office of the Hospital or the Hospital CEO.

32. PRACTITIONER: Any clinician who has been granted clinical privileges by the Governing

Board.

33. PRESIDENT OF THE MEDICAL STAFF: A member of the active medical staff or associate medical staff who is elected in accordance with these Bylaws to serve as chief officer of the medical staff of the Hospital.

34. PRIVILEGES: The permission granted by the Board to a practitioner to render or exercise specific diagnostic, therapeutic, medical, surgical or dental services and/or procedures in the Hospital.

35. PRONOUNS: The use of the male pronoun (he/his/him) throughout these Bylaws is applicable to either male or female individuals.

36. RULES & REGULATIONS: Medical staff policies approved by the MEC and ratified by the Board.

37. SPECIAL NOTICE: Written notification sent by hand delivery, certified or registered mail return receipt requested.

38. TIME LIMITS: All time limits referred to in these Bylaws, including the Investigation, Corrective Action and Fair Hearing Procedures, and in any other medical staff policies are advisory only, and are not mandatory unless a specific provision states that a particular right is waived by failing to take action within a specified time period.

ARTICLE I
PURPOSE

As part of an organized healthcare arrangement, the medical staff works with the Board and Hospital senior management to advocate for patients and physicians to perform effective quality monitoring, peer review, credentialing and governance within the medical staff consistent with the Hospital mission.

The medical staff shall exercise its power as reasonably necessary to meet the obligations under these Bylaws, rules and regulations and policies and procedures and Hospital bylaws, in compliance with law, accreditation standards and regulations subject to the approval and authority of the Board.

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff and Allied Health Staff set forth in the Bylaws or Bylaws - related documents Credentials Policy are eligible to apply for appointment to one of the categories listed below.

2.A. Active Staff

2.A.1. QUALIFICATIONS:

The Active Staff will consist of members of the Medical Staff who:

a) are involved in at least 24 unique patient contacts over a 24-month period; and

b) are willing to participate in Medical Staff functions and/or demonstrate a commitment to the Medical Staff and Hospital through service on Hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that their practice patterns have changed and that they will satisfy the activity requirements of this category:

* Any member who has fewer than 50 24 patient contacts per 24-month appointment term will not be eligible to request Active Staff status at the time of their reappointment.

** The member must select and be transferred to another staff category that best reflects their relationship to the Medical Staff and the hospital (options – Courtesy, Consulting, Coverage or Affiliate).

2.A.2. Prerogatives and Responsibilities:

Active Staff Members:

a) may admit patients in accordance with the member's admitting privileges, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;

b) may vote in all general and special meetings of the Medical Staff and applicable department and committee meetings, by any method (e.g., email, mail, ballot, facsimile) designated in a notice presenting a question for vote

c) may hold office, serve on Medical Staff committees, and serve as department chairperson and chairperson of committees; and

d) may exercise clinical privileges granted.

e) Active Staff members must assume all the responsibilities of the Active Staff, including:

f) serving on committees, as requested;

g) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

h) providing care for unassigned patients;

i) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their specialties);

j) accepting inpatient consultations, when requested;

k) must pay any applicable application fees, dues, and assessments; and

l) shall perform assigned duties.

m) Members of the Active Staff who are 65 years of age or older may request to be excused from rotational obligations, including providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department. The request will be reviewed by the Medical Staff Department chair, and a recommendation made to the Medical Staff Executive Committee and final action by the Board. In reviewing a request, consideration should be given to need and the effect on others who serve on the Emergency Department call roster. A member who is relieved of the obligation of providing coverage may be required to resume on-call duties if the Medical Staff Department determines, later that call coverage in the member's specialty area is not adequate.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff will consist of members of the Medical Staff who:

a) are involved in fewer than 24 unique patient contacts over a 24-month period;

b) at each reappointment time, provide quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of

confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that their practice patterns have changed and that they will satisfy the activity requirements of this category:

* Any member who has more than 24 patient contacts per 24-month period will be transferred to Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff Members:

a) may admit patients in accordance with clinical privileges granted;

b) may attend and participate in Medical Staff and department meetings (without vote);

c) may not hold office or serve as department chairperson or committee chairperson, unless waived by the Medical Staff Executive Committee and the Board;

d) may exercise clinical privileges granted;

e) may be invited to serve on committees (with vote);

f) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but will be required to provide specialty coverage if the Medical Staff Executive Committee finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

g) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician;

h) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department;

i) must cooperate in the professional practice evaluation and performance improvement processes;

j) must pay any applicable application fees, dues, and assessments; and

k) shall perform assigned duties.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff will consist of members of the Medical Staff who:

a) demonstrate professional ability and expertise and provide a service not otherwise available (or is in very limited supply) on the Active or Courtesy Staff;

b) provide services at the Hospital only at the request of other members of the Medical Staff

c) at each reappointment time, provide quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff Members:

a) may evaluate and treat, but not admit or provide overall patient management for, patients in conjunction with other members of the Medical Staff;

b) may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings (with vote);

c) may not hold office, serve as a department chairperson, or committee chairperson, unless waived by the Medical Staff Executive Committee and the Board;

d) may exercise clinical privileges granted;

e) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but will be required to provide specialty coverage if the Medical Staff Executive Committee finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

f) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician;

g) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department;

h) must cooperate in the professional practice evaluation and performance improvement processes;

i) must pay any applicable application fees, dues, and assessments; and

j) (shall perform assigned duties.

2.D. COVERAGE STAFF

2.D.1. Qualifications:

The Coverage Staff will consist of members of the Medical Staff who:

a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Medical Staff members who are members of their group practice or their coverage group;

b) at each reappointment time, provide quality data and other information to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians); and

c) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Medical Staff member(s) terminates for any reason.

2.D.2. Prerogatives and Responsibilities:

Coverage Staff Members:

a) when providing coverage assistance to a Medical Staff member, will be entitled to admit and/or treat patients who are the responsibility of the Medical Staff member who is being covered (i.e., the Active, Courtesy or Consulting Staff member's own patients or unassigned patients who present through the Emergency Department when the Medical Staff member is on call), if applicable;

b) will assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

c) may attend Medical Staff and department meetings (without vote); and applicable committee meetings (with vote);

d) must cooperate in the professional practice evaluation and performance improvement processes.

e) may not hold office or serve as department chairperson or committee chairperson;

f) may exercise clinical privileges granted;

g) must pay any applicable application fees, dues, and assessments; and

h) shall perform assigned duties.

2.E. AFFILIATE STAFF

2.E.1. Qualifications:

The Affiliate Staff will consist of members of the Medical Staff who:

a) desire to be associated with, but who do not intend to establish a practice at, this Hospital and wish to be membership-only category, with no clinical privileges being granted;

b) are interested in pursuing professional and educational opportunities, including continuing medical education, available at the Hospital;

c) are permitted to access hospital services for patients by referral of patients to Active Staff members for admission and care; and

d) must submit an application as prescribed by the Bylaws or Bylaws-related documents excluding privileges, satisfy the qualifications for appointment set forth in the Bylaws or Bylaws-related documents, but are exempt from the qualifications pertaining to response times, location within the geographic service area, emergency call, and coverage arrangements.

2.E.2. Prerogatives and Responsibilities:

Affiliate Staff Members:

a) may attend meetings of the Medical Staff and applicable department meetings (without vote);

b) may not hold office or serve as department chairperson or committee chairperson;

c) shall generally have no staff committee responsibilities, but may be assigned to serve on committees (with vote);

d) may attend educational activities sponsored by the Medical Staff and the Hospital;

e) may refer patients to members of the Medical Staff for admission and/or care;

f) are encouraged to communicate directly with members of the Medical Staff about the care of any patients referred, as well as to visit any such patients who are hospitalized;

g) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

h) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

i) are not granted inpatient or outpatient clinical privileges and, therefore, may not admit patients, attend patients, write orders or progress notes, perform consultations, assist in

surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

j) may refer patients to the Hospital's diagnostic facilities subject to the rules and policies of the hospital and the clinical departments;

k) are encouraged to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

l) must pay any applicable application fees, dues, and assessments.

m) The grant of appointment to the Affiliate Staff is a courtesy only, which may be terminated by the Board upon recommendation of the Medical Staff Executive Committee, with no right to a hearing or appeal.

2.F. TELEMEDICINE (Non-Staff)

2.F.1. Qualifications:

The Telemedicine (Non-Staff) providers will consist of providers who provide care, evaluation and treatment of patients only remotely via electronic communication, or sorely for the interpretation of diagnostic services.

a) at each reappointment time, provide quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.F.2. Prerogatives and Responsibilities:

Telemedicine (Non-Staff) Members:

a) may evaluate and treat (but not admit or provide overall patient management for) patients in conjunction with other members of the Medical Staff.

b) may not hold office or serve as department chairperson or committee chairperson, unless waived by the Medical Staff Executive Committee and the Board;

c) may attend meetings of the Medical Staff and applicable department meetings (without vote);

d) may be invited to serve on committees (with vote);

e) must participate in providing emergency department on-call and other coverage arrangements as defined by policy and/or contractual agreements;

f) must cooperate in the professional practice evaluation and performance improvement

processes;

g) may exercise clinical privileges granted;

h) must pay any applicable application fees, dues, and assessments; and

i) shall perform assigned duties.

2.G. Honorary Staff

2.G.1. Qualifications:

The Honorary Staff will consist of members of the Medical Staff and Allied Health Staff who:

a) have a record of previous long-standing service to the Hospital, have retired from the active practice of medicine; and, in the discretion of the Medical Staff Executive Committee, are in good standing at the time of initial application for membership on the Honorary Staff; and/or

b) are recognized for outstanding or noteworthy contributions to the medical sciences.

Once an individual is appointed to the Honorary Staff, that status is ongoing, at the continuing discretion of the Medical Staff Executive Committee. As such, there is no need for the individual to submit a reappointment application.

2.G.2. Prerogatives and Responsibilities:

Honorary Staff Members:

a) may not consult, admit, or attend to patients;

b) may attend Medical Staff and department meetings when invited to do so (without vote);

c) may not hold office or serve as department chairperson or committee chairperson;

d) may be appointed to committees (without vote);

e) are entitled to attend educational programs of the Medical Staff and the Hospital; and

f) are not required to pay application fees, dues, or assessments.

2.H. ALLIED HEALTH STAFF

2.H.1. Qualifications:

The Allied Health Staff consists of Allied Health Professionals who are granted clinical privileges and are appointed to the Allied Health Staff. The Allied Health Staff is not a category of the

Medical Staff but is included in this Article for convenient reference.

2.H.2. Prerogatives and Responsibilities:

Allied Health Staff:

a) may attend and participate in Medical Staff department meetings (without vote);

b) may not hold office or serve as department chairperson or committee chairperson;

c) may be invited to serve on committees (with vote);

d) must cooperate in the professional practice evaluation and performance improvement processes;

e) may exercise clinical privileges or scope of practice as granted; and

f) must pay any applicable application fees, dues, and assessments.

ARTICLE III
CREDENTIALING AND THE DETERMINATION OF PRIVILEGES

3.1 Appointment and Reappointment to Medical Staff Membership

The following steps describe the process for credentialing (appointment and reappointment) of medical staff members. Associated details may be found in the Medical Staff Credentials Procedures, Volume II of these Bylaws.

1. Individuals interested in appointment to the medical staff may request from the Hospital an application and a list of the eligibility requirements for membership. Current, eligible members of the medical staff will automatically be sent an application for reappointment in a timely fashion.

2. Upon completion and submission of the application to the medical staff office, a designated individual will verify the contents on a preliminary basis and confirm that the applicant is eligible to have the application processed further. If such preliminary review of the application confirms the applicant is not eligible for membership, he will be notified that no further evaluation or action will occur regarding the application.

3. A completed and verified application will be forwarded by the medical staff office to the appropriate clinical service chair (or designee) for review and evaluation. This review will include consideration of the practitioner's individual character, individual clinical competence, individual training, individual experience, and individual professional judgment and conduct. The clinical service chair will forward a report concerning appointment of the applicant to the medical staff Credentials Committee.
4. The Credentials Committee will review the application and forward its recommendation to the MEC.
5. The MEC will review the application and forward its recommendation to the Hospital Board regarding membership and if appropriate, staff category, and clinical service assignment. The MEC may refer an application back to the Credentials Committee if it feels more information or evaluation of the applicant is necessary.
6. The Hospital Board will review the application and determine whether to offer the applicant membership and whether any restrictions or conditions should be attached to an offer of membership or clinical privileges. Membership will be offered upon action by the Board and membership will become effective upon acceptance of the offer by the applicant.
7. Applicants may appeal adverse recommendations by the MEC and adverse decisions made by the Board in accordance with provisions in the Medical Staff Investigation, Corrective Action and Fair Hearing Procedures, Volume III of these Bylaws.

3.2 Granting of Clinical Privileges

The following steps describe the process for granting clinical privileges to qualified practitioners. Associated details may be found in the Medical Staff Credentials Procedures, Volume II of these Bylaws and on medical staff delineation of privileges documents. Practitioners shall be entitled to exercise only those privileges specifically granted to them by the Board. The medical staff may recommend clinical privileges for

Allied Health Professionals (AHP) who are not members of the medical staff but who hold a license to practice independently consistent with the AHP policies as recommended by the MEC and approved by the Board.

1. Practitioners initially applying for medical staff membership or for reappointment must complete the appropriate forms to request specific privileges. Practitioners' ineligible for medical staff membership but eligible for privileges will complete the appropriate request forms. These forms are available from the Hospital medical staff office.
2. Upon completion and submission of the appropriate forms to the medical staff office, a designated individual will confirm that the applicant is eligible to have the requests processed further. Privilege requests that don't demonstrate compliance with eligibility requirements will not be processed further.
3. Completed privilege request forms will be forwarded by the medical staff office to the appropriate clinical service chair (or designee) for review and evaluation. This review will include consideration of the practitioner's individual character, individual clinical competence, individual training, individual experience, and individual professional judgment and conduct.
4. The clinical service chair will forward a recommendation to the medical staff Credentials Committee.

5. The Credentials Committee will review the applicant's requests and the input of the clinical service chair and recommend a specific action to the MEC.
6. The MEC will review the privileging requests and recommend specific actions on them to the Hospital Board.
7. The Hospital Board will review the privileging requests and either reject the requests, modify them, or grant the privileges being sought.
8. Applicants may appeal adverse recommendations by the MEC and adverse decisions made by the Board in accordance with provisions in Volume III, The Medical Staff Investigation, Corrective Action and Fair Hearing Procedures, of these Bylaws.

3.3 Medical Staff Credentials Procedures, Volume II of these Bylaws

Associated details elaborating on the credentialing and privileging process can be found in the Medical Staff Credentials Procedures which will be adopted and amended from time to time consistent with the amendment process in Article 11.3 of these Bylaws.

ARTICLE IV
OFFICERS

4.1 Officers of the Medical Staff

The officers of the Medical Staff shall be:
President of the Medical Staff
President-Elect of the Medical Staff
Immediate Past President of the Medical Staff

4.2 Qualifications

Officers of the medical staff must satisfy the following criteria at the time of nomination and continually throughout the term of their office:

1. be appointed to either the active or associate staff;
2. have no pending adverse recommendation before the Board concerning staff appointment or clinical privileges;
3. have constructively participated in medical staff activities, including, but not limited to activities such as performance improvement, peer review and credentialing;
4. have the ability and be willing to discharge faithfully the duties and responsibilities of the position;
5. have experience in a leadership position, or other involvement in performance improvement functions for at least two years;
6. be willing to attend continuing education programs relating to medical staff leadership and/or peer review and credentialing functions prior to or during the term of office;
7. be in compliance with any and all policies of the medical staff and Hospital including the Conflicts of Interest Policy;
8. must have demonstrated an ability to work well with and communicate well with others.

4.3 Selection

The MEC will appoint a Leadership Selection Committee four (4) months in advance of the annual general medical staff meeting. The Leadership Selection Committee shall select nominees for placement on the election ballot for officers using the following process. The Leadership Selection Committee is made up of the Immediate Past President of the Medical Staff, who shall serve as chairperson. The MEC shall appoint one other member of the MEC and two (2) at-large members of the general medical staff who will serve as voting members.

1. The Leadership Selection Committee will meet at least ninety (90) days prior to the general staff meeting at which the results of the election will be announced.
2. The Leadership Selection Committee will produce a slate of nominees with at least one (1) name placed on the ballot for election to each medical staff officer position.
3. The Leadership Selection Committee shall circulate and formally post its list of nominees to the members of the medical staff in the active and associates medical staff categories at least thirty (30) days prior to the annual meeting at which an election will be held.

4. In order for a nominee to be placed on the ballot the following criteria must be met:
   a) Candidates must meet the qualifications listed in these Bylaws for the position to which they wish to be elected. The Leadership Selection Committee will have discretion to determine if these criteria have been met.
   b) Candidates must be approved by the Leadership Selection Committee for placement on the ballot and candidates must agree to be placed on the ballot.
   c) A petition signed by at least ten percent (10%) of the members of the medical staff who are either in the active or associate staff categories may also make nominations. Such petition must be submitted to the president of the medical staff at least forty-five (45) days prior to the election for placement on the ballot. The candidate nominated by petition must be confirmed by the MEC to meet the qualifications in Section 4.2 above before he can be placed on the ballot.

4.4 Election

1. Officers of the medical staff shall be elected using a secret ballot which may be distributed to eligible voting members of the medical staff at a general medical staff meeting, by mail, or electronically. The mechanics of distributing ballots and counting votes will be determined by the MEC. Only members of the active medical staff and associate medical staff categories shall be eligible to vote. The winner of an election shall be the individual who receives the greatest number of votes from the medical staff members who received ballots and voted. Voting by proxy is not permitted.
2. Officers shall be eligible to assume office once the Governing Board has ratified their election. Such ratification cannot be unreasonably withheld.
3. Elections for officers will take place in October as scheduled by the MEC.

4.5 Term

All officers shall serve a term of two (2) years from the first day of January next following their election, or until their successors are elected. All officers may be re-elected. The Immediate Past President of the Medical Staff will serve until a current President of the Medical Staff completes a term and steps down from that office.

4.6 Duties of Elected Officers (See also, detailed position descriptions appended to Volume I of these Bylaws)

1. President of the Medical Staff:

   The President of the Medical Staff shall serve as the chief administrative officer and principal elected official on the medical staff.

2. President-Elect of the Medical Staff:

   The President-Elect of the Medical Staff shall be a member of the MEC and shall be required to assist the President of the Medical Staff and to perform such duties as may be assigned by the President of the Medical Staff. In the absence of the President of the Medical Staff or upon the occurrence of a vacancy in the office of President of the Medical Staff, the President-Elect of the Medical Staff shall assume the responsibilities, exercise the authority, and perform the duties assigned to the President of the Medical

Staff until the President of the Medical Staff returns consistent with Section 4.8 of these Bylaws. This officer will also collaborate with the Hospital's medical staff office, assure maintenance of minutes, attend to correspondence, act as medical staff treasurer, and coordinate communication within the medical staff. The President-Elect shall serve as Chair of the Quality and Safety Committee.

3. Immediate Past President of the Medical Staff:

   The Immediate Past President of the Medical Staff shall be a member of the MEC and shall serve as an advisor to the President of the Medical Staff and serve as the Chair of the medical staff Credentials Committee, Chair the Leadership Selection Committee, provide performance feedback to the President and the President-Elect on an annual basis and perform those functions delegated to him by the President of the Medical Staff.

4.7 Removal

1. Officers of the medical staff may be removed by an affirmative vote of two-thirds (2/3) of the medical staff present and voting at any general or special meeting of the general medical staff, subject to the approval of the Governing Board, in circumstances where such removal is necessary to protect the interests of the Hospital.

   Each of the following conditions constitutes cause for removal of an officer from office:
   a) Failure to comply with or support enforcement of the Medical Staff Bylaws, medical staff rules, regulations, or policies.
   b) Failure to perform the required duties of the office;
   c) Failure to adhere to professional ethics;
   d) Abuse of office;
   e) Conduct unbecoming a medical staff member;
   f) Failure to continuously satisfy the criteria set forth in Article IV.4.2 of these Bylaws.

2. At least ten (10) days prior to the initiation of any removal action, the individual shall be given special notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the medical staff prior to a vote on removal.

3. Automatic removal will occur (without need for a vote) in the event any of the following affects the officer in question:
   a) Loss or suspension of the officer's medical license in the State of Illinois;
   b) Ineligibility of membership in the active or associate staff category;

4. Recommendation by the MEC to the Board for the imposition of corrective action or the acceptance of such recommendation by the Board.

5. Where the President of the Medical Staff is removed from that position, he shall be ineligible to hold the office of Immediate Past President of the Medical Staff.

4.8 Vacancies

If the President of the Medical Staff is temporarily unable to fulfill the responsibilities of the office, the President-Elect of the Medical Staff shall assume these responsibilities until the President of the Medical Staff can resume those duties. When a permanent vacancy occurs in the President of the Medical Staff, the President-Elect of the Medical Staff will assume this position for the remainder of the existing term and also serve the term he/she was elected to serve. The MEC shall then appoint a President-Elect of the Medical Staff until a vote of the general medical staff can be taken. If the Immediate Past President resigns or is not eligible to hold this position, the President of the Medical Staff shall appoint another former President of the Medical Staff to fulfill the remainder of the term or it shall remain vacant until the current President of the Medical Staff becomes available to carry out the role.

ARTICLE V
CLINICAL SERVICES

5.1 Designation of Clinical Services

The medical staff shall be divided into the following clinical services:

1. Anesthesiology
2. Emergency Medicine
3. Family Medicine
4. Internal Medicine
5. Maternal/Child
6. Pathology
7. Radiology
8. Surgery

The Governing Board, with input from the MEC, may create additional medical staff clinical services where this would improve the effectiveness of the medical staff in carrying out its responsibilities.

5.2 Organization of Clinical Services

Each clinical service shall be organized as an organizational division of the medical staff and shall have a qualified chair that has the authority, duties, and responsibilities set forth in these Bylaws. Each clinical service is accountable to the oversight and authority of the MEC and the Board.

5.3 Functions of Clinical Services

1. Review and Evaluation Activities

   The primary responsibility delegated to each medical staff clinical service shall be to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided by members of the clinical service. These may include discussion of information relevant to the care and treatment of patients served by members of the clinical service along with the detailed consideration of relevant cases, including, without limitation, operative and other procedure review, medical record review, infection control review, pharmacy and therapeutic review, blood utilization review, efficiency of clinical practice patterns, significant departures from established patterns of clinical practice, quality and peer review reports, patient safety initiatives, and medical assessment and treatment of patients within the clinical service and the Hospital.

2. Additional Activities

   At the discretion of clinical service members and its chair, the clinical service may organize and promote any of the following collegial and professional activities: continuing medical education; communication and dialogue regarding issues relevant to members of the clinical service; social networking; and interdisciplinary projects and coordination.

3. Member Accountability

Members assigned to the clinical service are accountable to the clinical service chair and must be responsive to requests for information, participation in clinical service activities, participation in a mandatory special meetings, and compliance with hospital, medical staff, or clinical service rules, regulations, policies, procedures, or requirements.

5.4 Clinical Service Chair

1. Qualifications

Each clinical service chair shall be:

a) A member of either the active or associate staff category;
b) board certified by a specialty board recognized by the ABMS or AOA or found to have comparable competency by actions of the Credentials Committee and MEC;
c) qualified by experience within the clinical service and by administrative ability to supervise the functions of the clinical service; and
d) willing and able to discharge the functions of the clinical service chair.

2. Selection

a) Except as otherwise provided by a contract initiated and implemented by the Board, each clinical service chair shall be elected by a plurality of the votes cast by members of the clinical service in the active and associate staff categories. Where the Board has determined the position of clinical service chair will be filled through a contract mechanism, the chair will be selected by the Hospital CEO and ratified by the Board. Members of the clinical service will be informally consulted for input on this decision and to give feedback to the Hospital CEO regarding the performance of the clinical service chair.
b) Elections will be held by ballot at a clinical service meeting every two years or as requested by the MEC. If there is a vacancy prior to completion of a term of office, an election will take place at the next scheduled meeting of the clinical service to select an interim chair to complete the unfilled term. Elections will be organized and conducted by each clinical service in a manner satisfactory to the MEC.
c) Any member of the clinical service may be placed by request on the ballot unless he does not meet the qualifications in 5.4 (a) above. A member must give assent to be placed on the ballot.

3. Term

a) Each clinical service chair shall serve a term of two (2) years.
b) A clinical service chair may be elected for successive terms, unless otherwise provided by the MEC or Board.

5.5 Removal of Clinical Service Chair

Upon petition by twenty-five percent (25%) of clinical service members or upon

recommendation of the MEC, the Medical Staff Office shall arrange for a recall vote of a clinical service chair at the next scheduled meeting of the clinical service. Removal may be accomplished by a two-thirds (2/3) vote of those eligible members of the clinical service voting and following ratification of the action by the Hospital Board.

5.6 Clinical Service and Clinical Service Chair Activities

1. The MEC may recognize any group of practitioners interested in forming a clinical service. When such a clinical service exists, the chair may, as appropriate, lead the members of the clinical service in performing its activities, including without limitation:

    a) Provide a forum for discussion for clinicians in a particular specialty or interdisciplinary group of specialties.
    b) Offer continuing medical education and discussion of patient care issues.
    c) Sponsor "grand rounds", morbidity & mortality (M&M) conferences, or clinico-pathologic conferences (CPCs).
    d) Provide a vehicle for discussion of policies & procedures or equipment needs in a specialty or service line area.
    e) Create an opportunity for networking and collegial interaction among practitioners with common interests.
    f) Develop recommendations for submission to the MEC.
    g) Participate in the development of criteria for clinical privileges when requested for input by the Credentials Committee or MEC.
    h) Participate in the development of clinical protocols when asked to by the MEC or an appropriate medical staff committee.
    i) Discuss a specific issue at the request of a medical staff committee.

2. Clinical services are not required to hold regular meetings, keep minutes or track attendance, and have no regularly assigned responsibilities. A written report to document a specific position is required only when the service is making a formal report to the MEC. The President of the Medical Staff and the clinical service chair will decide if the report is placed on the MEC agenda and whether the clinical service chair (or designee) will attend the MEC meeting to present the report and participate in the vote of the MEC on that specific issue. The President of the Medical Staff may seek input from any officer(s) in determining the level of participation at the MEC meeting by the clinical service chair.

ARTICLE VI
MEDICAL STAFF COMMITTEES AND LIAISONS

6.1 Types of Committees

There shall be an executive committee of the medical staff (referred to in these Bylaws as the Medical Executive Committee or MEC) and standing committees of the medical staff accountable to the MEC as may be established in these Bylaws or created by the President of the Medical Staff or MEC to accomplish medical staff functions. The medical staff shall also carry out its responsibilities through participation in committees of the Hospital.

The current standing committees of the medical staff are: the Credentials Committee and the Performance Improvement and Quality Committee. The MEC will assign physician membership to other medical staff or Hospital committees that are involved with clinical aspects of patient care. Other medical staff committees that may be formulated are generally time limited and/or ad hoc in nature to address specific matters which may occur episodically or on a recurring basis with relative infrequency.

6.2 Committee Chairs

1. Selection: With the exception of the MEC and clinical service committees, the chair of each medical staff committee shall be appointed, and vacancy filled, by the President of the Medical Staff, subject to the approval of the MEC. The President of the Medical Staff shall serve as chair of the MEC.

2. Term: Unless specified otherwise in these Bylaws, each committee chair shall be appointed to a term of two (2) years.

6.3 Membership and Appointment

1. Eligibility

   a) Members of the active staff and associate staff shall be eligible for appointment to any committee of the medical staff established to perform one or more of the functions required by these Bylaws.

   b) Where specified in these Bylaws, or where the Medical Executive Committee deems it appropriate to the functions of a committee of the medical staff, members of the honorary staff category and representatives from various services of the Hospital, including, without limitation, Administration, Laboratory, Nursing, Information and Quality Management and Pharmacy Services, shall be eligible for appointment in a non-voting capacity, to specific committees of the medical staff.

2. Chief Executive Officer

   Unless otherwise provided in these Bylaws, the Hospital's Chief Executive Officer or his designee shall serve as an ex-officio member, without a vote, on all medical staff committees.

3. Voting

Only medical staff members who are either in the active or associate staff categories may vote on medical staff committees, unless specified otherwise in these Bylaws or medical staff policies or procedures.

4. Term

Unless specified otherwise in these Bylaws, each medical staff committee member shall be appointed to a term of two (2) years, and may be reappointed as often as the individual or party responsible for such reappointment may deem advisable.

6.4 Medical Executive Committee

1. Membership

All active staff and associate staff members are eligible for MEC membership.

2. Composition

The MEC shall consist of the following voting members:

1. President of the Medical Staff
2. President-Elect of the Medical Staff
3. Immediate Past President of the Medical Staff
4. The clinical service chairs of: Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Woman and Child, Pathology, Radiology and Surgery
5. One (1) at-large member of the active staff or associate staff elected by the general medical staff, preferably from a specialty that is otherwise not over represented on the MEC as determined by the Leadership Selection Committee.

The following will be non-voting members of the MEC:

1. Hospital CEO
2. Chief Medical Officer (CMO) and
3. Chief Nursing Officer (CNO).

The MEC may invite additional guests as needed to assist in carrying out its work.

3. Election and Appointment of MEC members

The at-large member of the MEC will be voted on using the same methodology as elections for medical staff officers. Any member in the active category or associate category of the medical staff may run for an at-large spot by notifying the Leadership Selection Committee thirty (30) days prior to the election. The Quality and Safety Committee and the Credentials Committee voting members of the MEC will be appointed by the President of the Medical Staff and their term shall run concurrent with that of the President of the Medical Staff who appointed them.

4. Removal from the MEC

Membership on the MEC held by officers and clinical service and medical staff committee chairs will automatically terminate if an individual is removed from their position as an officer, clinical service or committee chair as described elsewhere in these Bylaws. At-large and appointed members of the MEC may be removed by an affirmative vote of two-thirds (2/3) of the MEC membership. Grounds for removal include but are not limited to:

a) Failure to meet the attendance requirements for MEC members;
b) Failure to comply with the Medical Staff Conduct of Behavior Policy; and
c) Failure to carry out assigned duties as an MEC member.

Physician members of the MEC will be considered to have voluntarily resigned from the committee if any of the following occur:

a) Termination or suspension of the member's license to practice in the State of Illinois;
b) Loss of membership on the active staff or associate staff category;
c) The MEC recommends to the Board that the member be subject to corrective action.

5. Responsibilities

a) The MEC shall represent the medical staff, assume responsibility for the effectiveness of all medical activities of the medical staff, act on matters of concern and importance to the medical staff and act at all times as the authorized delegate of the medical staff in regard to general and specific functions of the medical staff.
b) The MEC is empowered to act for the medical staff in intervals between general medical staff meetings.
c) The MEC receives and acts on reports and recommendations from medical staff committees, clinical services, Hospital committees, consultants, and other relevant individuals.
d) The MEC consults with Hospital senior management and the Board on quality-related aspects of contracts for patient care service with entities outside the Hospital.
e) The MEC carries out investigations in accordance with the Investigation, Corrective Action and Fair Hearing Procedures, Volume III of these Bylaws before making recommendations to the Board to terminate, limit, or restrict a practitioner's membership or privileges.
f) The MEC is responsible for making medical staff recommendations directly to the Board for its approval. Such recommendations pertain to at least the following:
    (a) The medical staff's structure;
    (b) The mechanism used to review credentials and to delineate individual clinical privileges;
    (c) Recommendations of individuals for medical staff membership;
    (d) Recommendations for delineated clinical privileges for each eligible individual;
    (e) The participation of the medical staff in organization performance

improvement activities;
(f) The mechanism by which medical staff membership may be terminated;
(g) The mechanism for investigation, corrective action and fair-hearing procedures; and
(h) The MEC's review of and actions on reports of medical staff committees, clinical services, and other assigned activity groups.

6. Meetings

The MEC shall meet monthly, no fewer than ten times per year and shall maintain a permanent record of all proceedings and actions at its meetings. The President of the Medical Staff or designee will preside at all meetings of the MEC.

7. Call of Special Meeting

The President of the Medical Staff may call special meetings of the MEC at any time. Such meetings may be held in person or through telephonic or electronic conferencing.

8. Notice

Notice of a special meeting of the MEC shall be by means of facsimile, telephone, posting of notice or e-mail.

6.5 Medical Staff Representation on Hospital Committees

In order to further carry out the functions of the medical staff and to provide medical staff input where appropriate, the President of the Medical Staff may appoint members to Hospital committees which may include, but are not limited to: Utilization Review, Cancer Conference, Ethics, Disaster Management, Emerging Technology, Infection Control, Critical Care and Pharmacy & Therapeutics. When medical staff members sit on a Hospital committee the minutes of that committee shall be available, upon request to the MEC. It shall be the responsibility of the medical staff member(s) sitting on a Hospital committee to bring to the attention of the MEC or a medical staff officer any matter brought before such committee that requires the attention of the medical staff leadership.

6.6 Medical Staff Liaisons

When the medical staff is required by regulatory bodies or internal policies to collaborate with Hospital staff in carrying out a particular function, the President of the Medical Staff may appoint a member of the medical staff to serve as a formal liaison for that work. The liaison will report periodically to the MEC or other appropriate committee when matters require the attention of medical staff leaders.

6.7 Special Committees

The President of the Medical Staff or MEC may appoint special committees to address specific issues or concerns on behalf of the medical staff. In establishing such

committees, there will be a notation made in the minutes of the MEC enumerating the committee's purpose and charge, and timeframes for its work, and the duration of its appointment. Such committees will report to and be accountable to the MEC as a committee of the MEC.

ARTICLE VII
GENERAL MEDICAL STAFF MEETINGS

7.1 General Medical Staff Meetings

1. Frequency & Content

There shall be at least one meeting of the entire medical staff held each year during fourth quarter. Thirty (30) days written notice of the meeting shall be sent to all medical staff members in a manner determined reasonable and appropriate by the Medical Staff Office. The MEC shall determine the time and place at which the meeting shall be held. The President of the Medical Staff or MEC may call additional general meetings for any reason they deem appropriate, including to promote communication with the medical staff, provide a forum for discussion on matters of medical staff interest, review quality and safety data and concerns, present educational programs, or address proposed changes to the Medical Staff Bylaws.

7.2 Special Meetings of the Medical Staff

1. Call of Special Meeting

A special meeting of the medical staff may be called at any time by the President of the Medical Staff, and shall also be called at the request of the Governing Board, the MEC or in response to a petition presented to the President of the Medical Staff and signed by twenty-five percent (25%) of the medical staff members who are in the active or associate staff category. No business shall be transacted at any special meeting, except that for which the meeting is called and stated in the notice of such meeting.

2. Notice

Notice stating the time, place and purpose(s) of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff in a manner determined by the medical staff office at least seven (7) days before the date of such meeting. The attendance of a member of the medical staff at the meeting shall constitute a waiver of notice of such meeting.

7.3 Attendance at General Medical Staff Meetings

Members of the medical staff are encouraged to attend general medical staff meetings.

7.4 Quorum

Those active staff and associate staff members present and voting shall constitute a quorum at the general medical staff meeting and at any meeting, unless otherwise specified in these Bylaws.

7.5 Minutes

Minutes of each regular and special meeting of the medical staff shall be prepared and shall include a record of the attendance of members and any votes taken on matters presented at the meeting. The minutes shall be signed by the presiding officer and maintained in a permanent file in the medical staff office. Minutes shall be made available to any medical staff member upon request, in a manner that protects the confidentiality of peer review information consistent with state peer review protection statutes.

7.6 Conduct of Meetings

Meetings of the medical staff and meetings of committees and clinical services will be run in a manner determined by the chair (or designee) who presides at such a meeting. Compliance with rules of parliamentary procedure is not required.

ARTICLE VIII
COMMITTEE AND CLINICAL SERVICE MEETINGS

8.1 Regular Meetings

Clinical services and committees may, by resolution, establish the time for holding regular meetings without providing their respective members notice other than by announcement of such resolution in meeting minutes.

8.2 Special Meetings

A special meeting of any committee or clinical service may be called by or at the request of the chair thereof, by the President of the Medical Staff, or by written request signed by twenty-five (25%) percent of the current members of the committee or clinical service, but not by fewer than two (2) such members. Such meetings will be held within a reasonable period of time after their request as determined by the chair.

8.3 Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or any regular meeting, to each member of the committee or clinical service that is to meet, not less than five (5) days before the time of such meeting. If mailed, the notice of the meeting shall be posted to the member, at his address as it appears on the records of the medical staff, at least seven (7) days before the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

8.4 Quorum

A quorum for the MEC and the Credentials Committee will be at least fifty-one percent (51%) of the voting membership of the committee attending in person or via telephonic or electronic conferencing.

For all other committees and clinical services, unless otherwise specified in these Bylaws, a quorum will be those active staff and associate staff members present and voting, so long as at least two (2) members are present.

8.5 Manner of Action

The action of a majority of the members present at a committee or clinical service meeting at which a quorum is present shall be the action of such committee or clinical service. Action may be taken without a meeting by unanimous consent in writing, setting forth the action so taken and signed by each member who would be entitled to vote at that meeting.

8.6 Minutes

Minutes of required committees and any special meetings shall be prepared, including a record of the members in attendance and the results of any votes taken at the meeting. The

minutes shall be signed by the presiding officer and copies thereof shall be submitted to the attendees for approval. All minutes shall be made available to the MEC. Each committee and clinical service shall maintain a permanent file in the medical staff office of the minutes of each meeting.

8.7 Attendance Requirements

Members of the MEC and the Credentials Committee are expected to attend at least seventy-five percent (75%) of committee meetings held each year. Failure to attend at least fifty percent (50%) of the meetings will make the member eligible for removal by action of the President of the Medical Staff with ratification by the MEC.

8.8 Mandatory Special Appearance Requirement

Mandatory attendance is required when requested by a peer review committee or the MEC. Failure by any person to attend any meeting to which he was given notice that attendance was mandatory, unless excused by the Medical Executive Committee upon showing of good cause, shall result in an automatic suspension of all or such portion of the person's clinical privileges as the MEC may direct, and such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate, including, without limitation, corrective action. Such persons may make timely request for postponement of such meeting supported by an adequate showing that his/her absence will be unavoidable, in which case the presentation may be postponed at the discretion of the chairperson of the committee, the President of the Medical Staff or the Medical Executive Committee if the President is the person involved.

ARTICLE IX
CONFIDENTIALITY, IMMUNITY, AUTHORIZATIONS AND RELEASES

9.1 Authorizations and Releases

Each practitioner shall, when requested by the Hospital, as part of initial appointment or reappointment to the medical staff or as part of an application for privileges, execute general and specific releases and provide documents when requested by the President of the Medical Staff, Chair of the Credentials or Medical Staff Peer Review Committee, the Hospital CEO or their respective designees. Failure to execute such releases or provide requested documentation shall result in an application for appointment, reappointment, and/or clinical privileges being deemed voluntarily withdrawn, and it shall not be further processed. By submitting an application for medical staff appointment or reappointment, or by applying for or exercising privileges or providing specified patient care services within the Hospital, all practitioners, without limitation:

1. Authorize representatives of the Hospital and of the medical staff to solicit, procure, provide, and/or act upon information bearing on or reasonably believed to bear upon the practitioner's professional abilities and qualifications;

2. Agree to be bound by the provisions of these Bylaws and Hospital policies, medical staff rules, regulations and policies regardless of whether membership or clinical privileges are granted or subsequently restricted;

3. Acknowledge that the provisions of this Article are express conditions to an application for, or acceptance of, medical staff membership, and the continuation of such membership and/or the exercise of privileges or provision of specified patient care services at the Hospital;

4. Agree to release from legal liability and hold harmless the Hospital, medical staff, and any representative of the Hospital or medical staff who acts to carry out medical staff or Hospital policies or functions, including all persons engaged in processing medical staff applications and reapplications as well as those who participate in peer review and performance improvement activities. In addition, all practitioners agree that their sole remedy for any corrective action or peer review action taken or recommended by the MEC for failure to comply with these Bylaws or medical staff or hospital policies, will be the right to seek legal or equitable relief after they have exhausted the administrative remedies in these Bylaws.

5. Agree to release from legal liability and hold harmless any individual who or entity which provides information (including peer review information) regarding the practitioner to the Hospital or its representatives within the limitations provided by law;

6. Authorize the release of information (including peer review information) about the practitioner to other HSHS affiliated healthcare facilities where the practitioner has or requests membership or privileges.

9.2 Confidentiality

Information with respect to any practitioner submitted, collected or prepared by any representative of the Hospital or any other health care facility or organization or medical staff, for the purpose of evaluating and improving quality patient care, reducing morbidity or mortality, promoting efficiency, or contributing to medical education or clinical research, shall, to the fullest extent permitted by law, be confidential except as otherwise provided herein. Confidential information shall not be disseminated to anyone other than a representative(s) of the Hospital or of the medical staff with a legitimate need for access in order to carry out required functions or third party health care entities performing legitimate credentialing and peer review activities. Such confidentiality shall also extend to information of like kind that may be provided by third parties.

9.3 Immunity from Liability

1. For Actions Taken

   Representatives of the Hospital and the medical staff shall have absolute release from any and all liability in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as such representatives, after a reasonable effort under the circumstances to ascertain the facts underlying such actions, statements or recommendations and in the reasonable belief that the action, statement or recommendation is warranted by such facts.

2. Providing Information

   Representatives of the Hospital, the medical staff and any third party shall have absolute release from any and all liability in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or of the medical staff or to any other hospital, organization or health professionals, or other health-related organizations, concerning practitioners who are or have been an applicant to or member of the staff or who did or does exercise privileges or provide specified services at this Hospital.

9.4 Activities and Information Covered

1. Activities

   The provisions of this article shall apply to acts, communications, reports, recommendations, or disclosures in connection with this or any other health-related institution’s or organization’s activities to the extent provided by law:

   a) Applications for appointment, clinical privileges or specified services
   b) Periodic reappraisals for reappointment, clinical privileges or specified services
   c) Disciplinary measures, including warnings and reprimands
   d) Investigations and corrective actions
   e) Hearings and appellate reviews

f) Performance improvement activities including the creation and dissemination of performance profiles
g) Peer review activities, including external peer review
h) Utilization and claims reviews
i) Other Hospital, clinical service or committee activities related to monitoring and maintaining of quality patient care and appropriate professional conduct

2. Information

The acts, communications, reports, disclosures and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical or procedural abilities, judgment, character, physical and mental health, emotional stability, professional ethics, professional conduct or any other matter that might directly or indirectly affect patient care.

9.5 Cumulative Effect

Provisions in these Bylaws and in application forms relating to authorizations, releases, confidentiality of information and immunities from liability shall be in conformance with and in addition to other protections provided by local, state and federal law and not in limitation thereof.

ARTICLE X
GENERAL PROVISIONS

10.1 Medical Staff Rules, Regulations, and Policies

Subject to approval by the Governing Board or its designee, the medical staff shall adopt such rules, regulations and policies as may be necessary to carry out the responsibilities and functions of the medical staff and implement its operations. There shall be no substantive distinction between medical staff rules, regulations, and policies.

10.2 Payment of Fees

All members of the medical staff are required to pay an initial and reappointment application fee in an amount determined by the MEC and ratified by the Board.

10.3 Conflict of Interest

All members of the medical staff are required to abide by any conflict of interest policies adopted by the medical staff and the Hospital. In any instance in which a member of a committee or clinical service has a conflict of interest in any matter involving another medical staff member, or issue that comes before a committee, or in any instance in which a member of a committee brought the complaint against that member, that member shall not participate in the discussion or vote on the matter and shall absent her/himself from the meeting during that time; although the member may be asked to answer any questions concerning the matter before leaving the meeting.

10. 4 MEC & Board Conflict Resolution Process

1. Unless otherwise set forth in these Bylaws or Hospital bylaws, the medical staff, in partnership with the Hospital Board, establishes the following process for addressing conflicting recommendations made by the Board and the medical staff:
    a) The medical staff, in partnership with the Board will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, the communities served by the Hospital, and the members of the medical staff.
    b) When the Board plans to act or is considering acting in a manner contrary to a recommendation by the MEC, the medical staff officers shall meet with the Board, or a designated committee of the Board and management seek to gather information and resolve the conflict through informal discussions.
    c) If these informal discussions fail to resolve the conflict, the Medical Staff President or the chairperson of the Board may request initiation of a formal conflict resolution process.
    d) The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process to address the conflict.
    e) The Joint Conference Committee shall be comprised of MEC representatives and/or designees, Board members and/or designees, and the CEO or designee.
    f) If the Joint Conference Committee cannot produce a resolution to the conflict

acceptable to the MEC and the Board within thirty (30) days of this initial meeting, the medical staff and the Board shall enter into mediation facilitated by an outside party.

g) The MEC and Board shall agree upon the selection of the third party mediator.
h) The MEC and Board shall use best efforts to collaborate together and with the third party mediator to resolve the conflict. The Board and the MEC shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approvals of the MEC and the Board.
i) If, after ninety (90) days from the date of the initial request for mediation from an outside party, the MEC and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.
j) If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the Hospital, the Board may take action which will remain in effect only until the conflict resolution process is completed.

2. Any officer of the medical staff, senior management or the Board may request the convening of a meeting to discuss any matter of controversy or concern that would benefit from enhanced dialogue between medical or administrative staff and Board leaders.

ARTICLE XI
ADOPTION AND AMENDMENT OF MEDICAL STAFF GOVERNING DOCUMENTS

11.1 Formulating and Reviewing Bylaws Amendments

The medical staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any medical staff bylaws, rules, regulations, policies, procedures, and amendments as needed, which shall be effective when approved by the Board. The medical staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership. Neither the Board nor the medical staff shall unilaterally amend the Medical Staff Bylaws.

11.2 Methods of Adoption and Amendment to Volume I, Governance and Function and the Volume III, Investigation, Corrective Action & Fair Hearing Procedures of these Bylaws

These Bylaws may be amended at anytime by a proposal from the MEC or by a petition signed by twenty percent (20%) of the medical staff members who are in the active or associate staff category. A proposed amendment shall be reviewed by the MEC. If compliant with Joint Commission standards and regulatory requirements, the proposal will be disseminated to all members of the active and associate staff. The MEC shall present the proposed amendment with its recommendation to the active staff and associate staff members for a vote. Each active staff member and each associate staff member will be eligible to vote on the proposed amendment to these Bylaws via printed or secure electronic ballot in a manner determined by the MEC. All active staff members and associate staff members of the medical staff shall receive at least thirty (30) days advance notice of the proposed amendment prior to a vote. To be adopted, such proposed amendment must receive an affirmative vote of a majority of the votes cast by the medical staff members eligible to vote. All ballots must be marked in the affirmative or negative to be considered in any final vote count. Votes (including absentee ballots), will be counted by the medical staff office on the "count date" listed on each ballot. Ballots submitted after that time shall not be counted.

11.3 Amendment of the Medical Staff Policies and Procedures, Rules and Regulations and Volume II, Credentials Procedures of these Bylaws.

1. Amendments to the medical staff policies and procedures, rules and regulations and Volume II, Credentials Procedures of these Bylaws shall be effective when approved by a two thirds (2/3) vote of the MEC and is approved by the Board. The MEC shall distribute a copy of the proposed amendments to the active staff and associate staff members within seven (7) days after the MEC vote. Voting members of the active staff and associate staff may then submit, within twenty-one (21) days after the MEC meeting, comments to the President of the Medical Staff concerning the MEC's proposed amendments. The President of the Medical Staff will consider any comments that are received from medical staff members and either:
   a) send the proposed amendments back to the MEC for reconsideration; or,
   b) forward the proposed amendments, with or without comment, to the Board for review and action.

11.4 The MEC may adopt such amendments to the Medical Staff Bylaws, policies and procedures, rules and regulations that are, in the MEC's judgment, technical or legal modifications or clarifications, consist of reorganization or renumbering of material, or are needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments must be approved by the Board.

11.5 Method for Medical Staff Members to Submit Bylaws Amendments

Any medical staff member may also submit amendments or request repeal of the Bylaws Volumes I, II, III and medical staff policies and procedures directly to the Board. The member must first obtain a petition signed by twenty percent (20%) of the medical staff members who are in the active or associate medical staff categories supporting their position and communicate their intent to the MEC. Proposed amendments submitted by the medical staff member will be forwarded to the Board with the MEC's recommendation if different from that of the medical staff member.

11.6 Adoption of the Bylaws

These Bylaws, upon adoption by the medical staff, shall replace and supersede existing Bylaws and shall become effective when approved by the Board. They shall, when adopted and approved, be equally binding by the Board and the medical staff.

Originally adopted by the Medical Staff:	10/20/2010
Originally approved by the Board:	11/09/2010
Revisions adopted by the Medical Staff:	2017
Revisions approved by the Board:	03/24/2015, 2017

APPENDIX A

Those individuals currently or have the potential to practicing as Licensed Independent Providers at HSHS St. Mary's Hospital are as follows:

Licensed Independent Provider

- Includes:
    - Audiologists
    - Psychologist

APPENDIX B

Those individuals currently or have the potential to practicing as Advanced Practice Provider at HSHS St. Mary's Hospital are as follows:

Advanced Practice Provider

- Includes:
    - Advanced Practice Registered Nurses (all Nurse Practitioners)
    - Certified Physician Assistants
    - Certified Nurse Midwives
    - Clinical Nurse Specialists
    - Certified Registered Nurse Anesthetist

Those individuals currently or have the potential to practicing as Surgical Provider at HSHS St. Mary's Hospital are as follows:

Surgical Provider

- Includes:
    - Certified Surgical First Assistant
    - Certified Surgical Assistant
    - Certified Surgical Technologist
    - Registered Nurse First Assist
    - Certified Anesthesiologist Assistant
    - Orthopaedic Technologist Certified

*Except as specifically indicated in article 8 and Appendix A and B outlining types of Allied Health Professionals, individuals who are not directly employed by the hospital system but are authorized to deliver patient care under oversight and guidance of a licensed provider are referred to as Healthcare Clinical Assistants (HCA's) or Depending Healthcare Providers (DHP's). Their clinical practice will be assessed and managed in accordance with Human Resource policies and procedures, and the provisions of this policy specially will not apply.

HSHS Saint Mary's Hospital- Decatur

Medical Staff Bylaws

Volume II:
Credentials Procedures

Approved by
MEC: 11/11/2010,
02/14/17
Board of Directors:
11/09/2010, 03/24/2015,
03/21/2017, 08/20/2025

St. Mary's Hospital Credentials Procedures

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ARTICLE I.

MEDICAL STAFF MEMBERSHIP

1.1 ELIGIBILITY AND QUALIFICATIONS FOR MEMBERSHIP

The basic eligibility criteria and qualifications for membership on the Medical Staff of the Hospital are found in Volume I of these Medical Staff Bylaws in Article II, Section 2.1. In addition, the Board may impose further requirements on specific Practitioners where it believes these are warranted after a review of the Practitioner's credentials file, performance data, or other relevant material.

1.2 CONDITIONS AND DURATION OF APPOINTMENT

1.2-1 Initial Appointment and Reappointment

a) Initial appointment and reappointment to the Medical Staff shall be made by the Hospital Board. The Board shall act on appointments and reappointments only after there has been a recommendation or an opportunity for a recommendation from the MEC.

b) Appointment to the Medical Staff will be for periods of twenty-four (24) calendar months (each an "appointment period").

c) Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board.

1.2-2 Reapplication After Modifications of Membership Status or Privileges

A Practitioner who has received a final adverse decision by the Board regarding membership or privileges, or who has resigned or withdrawn an application for appointment or reappointment or privileges while under investigation or to avoid investigation, will be ineligible to reapply to the Medical Staff or for privileges for a period of five (5) years from the date of such resignation or withdrawal or the date of notice of a final adverse action by the Board.

1.3 LEAVE OF ABSENCE (LOA)

1.3-1 Written Notice

A Medical Staff member may request, in writing, a voluntary leave of absence from the Medical Staff. Such request shall be received in the Medical Staff Services Department, at a minimum of thirty (30) days prior to the requested leave date. Request shall state the reason the Medical Staff member requests the leave and the exact period of leave time requested, which may not exceed one (1) year (exclusive of the time necessary to process an initial request or a request for reinstatement). Such request shall be submitted to the member's Clinical Service Chair, Medical Staff Credentials Committee, and MEC, which shall review such requests and recommend approval or disapproval to the Governing Board. The Governing Board shall make the final decision whether to approve or disapprove such request. Requests for a leave of absence will not be considered if the requesting member is under investigation, as described in Volume III, Investigation, Corrective Action and Fair Hearing Procedures of the Bylaws. In the event that a request for a leave of absence is approved, the Medical Staff member shall make necessary

arrangements to provide alternate coverage for patient care during his or her absence and shall complete all patient medical records before beginning his or her leave of absence. During the period of a leave, the staff member's membership status, Clinical Service affiliation, privileges and prerogatives, duty to pay Medical Staff dues, if any, and attendance requirements at Medical Staff , or Clinical Service meetings shall be suspended. In the event that the Board disapproves the request for a leave of absence, the affected staff member shall not be entitled to procedural rights unless otherwise provided in the Investigation, Corrective Action and Fair Hearing Procedures of the Medical Staff Bylaws.

1.3-2 Obligations

A request for leave of absence shall not be considered until all obligations to the Hospital have been met, including completion of all medical records, payment of any outstanding dues, and fulfillment of any Emergency Department or other call obligations.

1.3-3 Request to Return from LOA

Not less than forty-five (45) days prior to the termination of the leave, the Medical Staff member must request, in writing, reinstatement of his or her privileges. The Medical Staff member must submit a written summary of his or her relevant activities during the leave if so requested by members of the Clinical Service, Credentials Committee or MEC. Permission for reinstatement must be given by the Board. If the requested return date is past the time for the member's reappointment, he or she must submit a reapplication form and be reappointed before resuming his or her staff position.

1.3-4 Failure to Request to Return from LOA

The failure of a Medical Staff member to request reinstatement from a LOA shall result in automatic relinquishment of membership status, Clinical Service affiliation and Privileges. The affected Practitioner shall not be entitled to procedural rights as outlined in the Investigation, Corrective Action and Fair Hearing Procedures of these Bylaws.

1.4 PHYSICAL HEALTH STATUS

1.4-1 Health Requirements

Members of the Medical Staff and Practitioners holding privileges must maintain the physical and mental ability to deliver patient care and exercise privileges safely and at an appropriate level of quality at all times.

1.4-2 Notification of Health Status

A Medical Staff member or Practitioner holding privileges must immediately report in writing to his or her Clinical Service Chair (or his or her designee), Chair of the Medical Staff Credentials Committee, or an Officer of the Medical Staff when he has a mental or physical condition that has the potential or likelihood to impair judgment or affect functional capability to perform granted privileges safely and at an appropriate level of quality at all times (as determined by the Practitioner, a treating physician, or a health care facility). Failure to do so may result in Corrective Action.

1.4-3 Health Examination

At any time that the MEC or Board have any reason to question whether a Practitioner has the requisite physical and/or mental health status to care for patients safely and with an appropriate level of care and skill, it may require that Practitioner to undergo an appropriate health examination. The nature and scope of the exam (including drug testing) and the examining clinician may be determined at the discretion of the MEC and/or Board. Where there is a concern that a Practitioner may be impaired by use of or addiction to drugs or alcohol, such examination may include the imposition of random drug or alcohol testing. Refusal of a Practitioner to comply with a request to submit a health examination will be considered a voluntary resignation from the Medical Staff and/or relinquishment of privileges.

ARTICLE II

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

2.1 GENERAL PROCEDURE

The Medical Staff through designated Clinical Services, committees, and officers shall evaluate and consider each application for appointment or reappointment and clinical privileges and each request for modification of staff membership or privileges and shall adopt and transmit recommendations to the Hospital Board. In the processing of applications for membership and privileges, references to Hospital shall include the organization's Medical Staff Services Department and its personnel.

2.1-1 CREDENTIALS COMMITTEE

Composition

Membership of the Medical Staff Credentials Committee shall consist of at least five (5) members of the Medical Staff who are in the Active or Associate Medical Staff category and who are experienced leaders. The Medical Staff President, with input from the Clinical Service Chairs and with the confirmation of the MEC, will appoint the chair and other members of the Credentials Committee. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third 1/3 of the members will be appointed each year. The chair will be appointed for a three (3) year term. The chair and members may be reappointed for additional terms without limit. Any member, including the chair, may be relieved of his or her committee membership by a two-thirds (2/3) vote of the MEC. The committee may also invite ex officio members as desired.

Meetings

The Medical Staff Credentials Committee shall meet at least monthly. More frequent meetings may be scheduled upon on the request of the Credentials Committee chair.

Responsibilities

To review and recommend action on all applications and reapplications for membership on the Medical Staff including assignments of Medical Staff category;

To review and recommend action on all requests regarding Privileges from eligible Practitioners;

To recommend eligibility criteria for the granting of Medical Staff membership and Privileges;

To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, Medical Staff members or Hospital leaders;

To perform such other functions as requested by the MEC.

Confidentiality

The Credentials Committee shall function as a Peer Review committee consistent with federal and state law. All members of the Credentials Committee shall, consistent with medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the Credentials Committee.

The credentials file is the property of the Hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the Hospital in locked file cabinets or in secure electronic format. Medical Staff officers and the CMO or his or her designee may access credential files for appropriate Peer Review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the CEO or designee.

Individual Practitioners may review their credentials file under the following circumstances:
Upon request which is authorized by the Credentials Committee chair**,** Clinical Service chair or the CMO**.** Review of such files will be conducted in the presence of the Medical Staff Services Department, a Medical Staff officer, or a designee of Hospital administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a Practitioner. Nothing may be removed from the file. The Practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of any review.

2.2 APPLICATION FOR INITIAL APPOINTMENT

2.2-1 Application Request form and Application Form

Any qualified practitioner who wishes to apply for membership on the Medical Staff shall contact the Hospital to request an application. Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form issued by the Hospital and signed by the applicant.

Upon request for an application, the Medical Staff Services Department will forward the Practitioner an application request form as well as an application for appointment to the medical staff and/or request for clinical Privileges. The packet will also contain a complete set or overview of the Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, and other required documents or reference to an electronic source for this information. The information provided to the applicant will enumerate the eligibility requirements for medical staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership and/or Privileges (if such expectations have been adopted by the Medical Staff).

If the applicant believes he/she meets the outlined eligibility criteria, he/she will so attest by signing the application request form and then may complete the application and return both documents along with applicable delineation of privilege forms to the Medical Staff Services Department. Upon receipt of the application request form, the information provided will be reviewed to determine the applicant's eligibility to apply for membership and/or privileges. If it is determined that the applicant is not eligible to apply, the applicant will be so informed. If it is determined the applicant is eligible to apply, the submitted application will be processed.

2.2-2 Content of Application Form:

The application for appointment shall be in a form determined by the Hospital in consultation with the Medical Staff Credentials Committee and MEC. The completed application and its attachments shall include, but are not limited to, the following information:

a) Acknowledgement and Agreement: A statement signed by the applicant to the effect that he or she has read and agrees to be bound by the Bylaws and any Medical Staff policies or procedures that are provided to the applicant as part of the application process. The applicant also agrees to be bound by these documents in all matters relating to consideration of his application whether or not he is granted membership and/or clinical privileges. Furthermore, the applicant agrees that if he is granted Medical Staff membership and/or privileges, he agrees to follow and be bound by any and all Medical Staff, Hospital, and Hospital policies and meet all the responsibilities of Medical Staff membership.

b) Qualifications: Detailed information concerning the applicant's qualifications, including information in order to satisfy the Basic Eligibility and Qualifications of Medical Staff Membership (Article II of the Bylaws) and of any additional qualifications necessary to be granted any Privileges requested.

c) Requests: Specific requests stating the Clinical Service and the Privileges for which the applicant wishes to be considered. The applicant shall be eligible to request only those privileges for a clinical service the Board has authorized the Hospital to perform.

d) Peer References: The names of at least two (2) practitioners who have worked with applicant and observed his or her professional performance and who can provide references as to the applicant's professional ability and judgment, ethical character, and ability to work cooperatively with other Practitioners and Hospital personnel, such that patients treated by him receive quality care delivered in a professional and efficient manner. Information provided by the reference should address the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. In general, peer references should be submitted on a peer reference form provided by the Hospital and/or the reference should answer specific questions posed on this form.

e) Ethical Pledges: A pledge signed by the applicant agreeing to provide professional services in an ethical manner and to adhere to generally recognized professional ethics, the Medical Staff Code of Conduct Policy, and the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops.

f) Professional Sanctions: Information as to whether the applicant's membership status and/or medical staff privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation not applicable to all other Practitioners in the same medical staff category, or not renewed at any other Hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:

- membership/fellowship in a local, state or national professional organization;
- staff membership status or clinical privileges at any other Hospital or health care institutions;
- specialty board certification;
- licensure to practice any profession in any jurisdiction;
- Drug Enforcement (DEA) registration or a state controlled substance license; or
- Information as to any current or pending sanctions, affecting participation in any Federal Healthcare Program or any actions which cause the Practitioner to become ineligible for such programs.

If any such actions were ever taken or if any such actions are currently pending, the particulars of these actions shall be included.

g) Criminal Proceedings: Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.

h) Felony Convictions: Information as to whether the applicant has ever been convicted of a felony or submitted a plea of guilty or no contest, if a felony prosecution is now pending against the applicant, and the particulars of any such conviction, settlement or prosecution, if any.

i) Alcohol or Substance Abuse: The applicant shall attest to past instances of alcohol and/or substance abuse and shall submit to any testing required by the Hospital and/or Medical Staff prior to being granted privileges.

j) History of Medical Staff Membership: A chronological history listing all of the applicant's past medical staff memberships and associated privileges, including the full addresses of the facilities at which such memberships or privileges were held.

k) Professional Employment History: A chronological history of applicant's entire employment history as a health care professional.

l) Education and Training History: A chronological history of the applicant's undergraduate education, all graduate education in the health care field, and all post-graduate training (internships/residencies) in a health care field.

m) Notification of Release and Immunity Statement: Such releases, waivers, and authorizations as are presented to the applicant by the Hospital or HSHS. These will include a statement signed by the applicant authorizing and consenting to allow Medical Staff and Hospital representatives to provide other Hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any relevant information the Hospital or Medical Staff may have concerning the applicant. This statement will also release from liability the Hospital, its Medical Staff, and their representatives for sharing with appropriate health care and licensing entities information concerning the professional competence, ethics, and other qualifications of the applicant for staff appointment and privileges, including information otherwise privileged or confidential, to the full extent permitted by Illinois law. The applicant promises not to sue and to hold harmless all individuals who either provide information from or to the Hospital pertaining to the evaluation of the application, reapplication or privileges being requested.

n) Professional Liability Actions: Particulars regarding medical malpractice claims filed against the applicant, any adverse and/or pending malpractice decisions or settlements, and information concerning any cancellation, non-renewal, or limitation of malpractice insurance coverage.

o) Miscellaneous Information: Such other information relating to evaluation of the applicant's professional qualifications, ethical character and professional conduct, current competence, and prior professional experience, including utilization of Hospital resources, as may be deemed relevant by the MEC and the Hospital Board.

p) Minimum Basic Criteria: The following basic criteria must be appropriately documented and the information reasonably confirmed:

- Evidence of Current Licensure: (unrestricted Illinois State License, unrestricted Federal DEA as appropriate to specialty). Licensure is verified with the primary source, copies of license are not necessary unless otherwise required.

- Relevant Training, Board Certification, and/or Experience for Physicians (MD/DO): Relevant training and experience will be verified via the primary source or a designated equivalent, when feasible. A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) in the area of requested privileges.

Board certification or board status will be verified through the primary source or a designated equivalent source. Applicants will be currently board certified in the area of requested privileges or become board certified within six (6) years of becoming eligible as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association or equivalent as determined by the Credentials Committee and will be required to maintain board certification in the area of requested privileges.

Exceptions: All practitioners who are current medical staff members and/or hold privileges as of January 1, 2011 and who have met prior qualifications for membership and/or privileges shall be exempt from initial board certification requirements. If board certified, these individuals shall be required to maintain board certification to maintain clinical privileges.

- Relevant Training and/or Experience for Dentists: Relevant training and experience will be verified via the primary source, when feasible. A dentist, DDS or DMD, must have graduated from an American Dental Association-approved school of dentistry accredited by the Commission of Dental Accreditation.

- Relevant Training, Board Certification, and/or Experience for Podiatric Physicians: Relevant training, board certification, and/or experience will be verified via the primary source, when feasible. A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within six (6) years of completing formal training as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine.

- Current Competence: Recent letters of verification from the applicant's residency program director or designee if residency training was within ten years of initial application. Confirmation of board certification or qualification for certification from the appropriate specialty board. Written documentation from individuals personally acquainted first hand with the applicant's recent professional and clinical performance including, if available and applicable, types of surgical procedures performed, outcomes for invasive procedures performed, types of medical conditions managed as the responsible physician, clinical judgment and technical skills, and professional conduct.

- Ability to Perform Privileges Requested (Health Status): A health status statement provided by the Hospital and signed by the applicant indicating that no physical or mental health problems exist that could affect his or her practice, Medical Staff membership and the privileges granted by the Board. This document should be confirmed by the director of the applicant's training program, a chief of service or Medical Staff President at another Hospital, or a qualified physician who has examined the applicant.

- Possess current, valid professional liability insurance that covers all privileges requested with an insurance carrier authorized by the State of Illinois Department of Insurance as a licensed provider of professional malpractice insurance. Insurance must be carried in a form and amount as determined from time to time by the Board, and in no event less than $1 million/$3 million dollars in the aggregate coverage;

- Have a practice or residence close enough to the Hospital to provide timely and continuous care for their patients as determined by the Board;

- Be eligible to participate in Medicare, Medicaid, and other federally sponsored health programs;

- Be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect at all times. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided in information from training programs, peers, and other facility affiliations.

The Board may approve exceptions to the above Section 2.2-2, (p) on a case-by-case basis and after consultation with the MEC.

2.3 APPLICATION FEE

A non-refundable fee, in an amount established by the MEC and ratified by the Board, shall be payable upon request at the time of application for appointment or reappointment. Applications submitted without an accompanying fee will not be accepted for processing.

2.4 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, the applicant:

a) Agrees to provide in a timely fashion any information to complete the application and to resolve any questions relating to his application that are requested or posed by Medical Staff, Hospital, or Board representatives. A completed application must be signed and dated and must include: a current picture ID card issued by a state or federal agency; copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency; a completed privilege delineation form; completed reference forms from peers knowledgeable about the applicant's competence to perform the privileges being requested; practitioner specific quality and clinical outcome data if available; all applicable fees.

b) Agrees to appear for interview(s) upon request.

c) Authorizes Hospital representatives to consult with other Hospitals and medical staffs who have been associated with the applicant and with anyone who may have information bearing on the applicant's clinical competence and qualifications for Medical Staff membership or privileges.

d) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his professional and ethical qualifications for staff membership.

e) Agrees that in the event of any adverse recommendations or decisions with respect to staff membership or privileges, as defined in these Bylaws, the applicant shall exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

f) Releases from liability all individuals and organizations that provide information, including otherwise legally privileged or confidential information to Hospital representatives concerning the applicant's competence, professional ethics, character, physical and mental health, professional conduct, and other qualifications for staff appointment and clinical privileges.

g) Signifies that the information submitted in his or her application is true to the best of his knowledge and belief and that he/she understands that any significant misstatement(s) on or omission(s) from his application shall constitute grounds for rejection of the application.

h) Agrees to provide to the Medical Staff Services Department, any requested information needed to process the application within forty-five (45) days of request or the application will be considered to be voluntarily withdrawn.

2.5 PROCESSING OF INITIAL APPLICATIONS

2.5-1 APPLICANT'S BURDEN

The applicant shall have the burden of producing adequate information for a proper evaluation of his experience, background, training, professional conduct, clinical competence, and ability to adequately perform the privileges requested, and of resolving any doubts about these or any of the other qualifications specified in the Medical Staff Bylaws or in associated Medical Staff procedures. The applicant must be able to demonstrate to the satisfaction of the MEC and Board proficiency in the following six general competencies as described by the Accreditation Council for Graduate Medical Education (ACGME): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

2.5-2 APPLICANT INTERVIEW

All applicants for appointment to the Medical Staff and/or clinical Privileges may be required to participate in an interview at the discretion of the Clinical Service Chair, Medical Staff Credentials Committee, MEC, or Board. The interview may take place in person or by telephone, video or computer link at the discretion of the party calling for the interview. The interview will be used to gather information about the applicant, to ask clinical questions pertaining to the privileges being requested and to communicate information to the applicant concerning Medical Staff responsibilities and expectations.

2.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completed application to the Hospital, which shall in a timely fashion, seek to collect or verify the references, licensure, and other qualifications evidence submitted. The Hospital shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information and provide it to the Hospital in a timely manner. Once collection and verification is completed, the Hospital shall forward a complete verified application and supporting materials to the Clinical Service Chair to which the applicant will be assigned if granted staff membership.

If the requirements of Article II, Volume II of these Bylaws are not met, the applicant will be notified that he or she is ineligible to apply for membership or privileges. The application will not be processed and no right to due process or to a hearing will be triggered.

2.5.4 CLINICAL SERVICE CHAIR REVIEW

The relevant Clinical Service Chair, or designee, shall review the completed and verified application and supporting documentation for completeness and for the purposes of determining the character, professional competence, qualifications, and ethical standing of the applicant to fulfill the requirements of Staff membership and/or the Privileges requested.

The Clinical Service Chair may conduct an interview with applicant and shall utilize appropriate sources of information, request additional information from the applicant or elsewhere as needed, and evaluate applicant references, to determine whether the applicant satisfies the criteria set forth in the Bylaws relating to membership on the Medical Staff, and to determine whether the applicant possesses those professional and ethical qualities necessary to the provision of quality medical care. The Clinical Service Chair shall transmit a written report to the Medical Staff Credentials Committee and MEC as to Medical Staff appointment and, if appointment is recommended, as to the Staff category, Clinical Service affiliation, clinical Privileges to be granted, and any special conditions to be attached to the appointment. A Clinical Service Chair may also recommend that the Credentials Committee defer action on the application. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Chair, all of which shall be transmitted with the report.

2.5-5 CREDENTIALS COMMITTEE ACTION

Once the Clinical Service Chair has reported on an application, the verified application and its supporting materials shall be forwarded by the Medical Staff Services Department to the Medical Staff Credentials Committee. This Committee shall review the application, supporting documentation, the Clinical Service Chair's report; and such other information available to it that may be relevant to consideration of the applicant's qualifications and it may conduct a personal interview.

After its review of the applicant's credentials, the Credentials Committee shall submit, together with the Clinical Service Chair report, a written recommendation to the MEC. This recommendation shall address the applicant's request for Medical Staff membership and category, or Clinical Service affiliation, Privileges, and any specific conditions relating to appointment and/or Privileges. Minority views regarding any or all recommendations of the Credentials Committee may also be included.

2.5-6 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next meeting after receipt of the reports and recommendations of the Clinical Service Chair and the Medical Staff Credentials Committee, the MEC shall review the applicant's request for membership and/or privileges. The MEC may utilize additional sources of information, including personal interviews with the applicant, as it deems necessary to complete its evaluation.

After completing its review of the applicant's qualifications the MEC shall transmit to the Hospital Board a written report and recommendation regarding appointment and/or privileges for the applicant, indicating whether the applicant's requests should be accepted, accepted with modifications or qualifications, or rejected. Where appointment is recommended, the MEC shall also recommend Staff category and Clinical Service affiliation. Where the MEC recommends that the applicant's requests for membership and/or privileges be rejected, modified, qualified, or otherwise restricted, the report of the MEC shall set forth reasons for such recommendation(s).

If an MEC recommendation is not unanimous, a minority report may be submitted to the Board.

2.5-7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE (MEC) ACTION

Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the recommendation together with supporting documentation shall be forwarded to the Board.

Deferred: Any action by the MEC to defer a recommendation on the application in order to carry out further evaluation must be followed up within sixty (60) days with a recommendation to the Board.

Adverse Executive Committee Recommendation: When the MEC recommends denial or a restriction of membership or a requested privilege based on a determination of unprofessional conduct or inadequate clinical competence, the Medical Staff President or CEO shall inform the Practitioner by special notice within ten (10) days. The Practitioner shall be entitled to the procedural rights as provided in the Investigation, Corrective Action and Fair Hearing Procedures of the Medical Staff Bylaws. The Hospital CEO and Hospital Board shall also be notified.

2.5-8 ACTION OF THE HOSPITAL BOARD

Applicants for Consideration by the Full Board

At its next meeting after receipt of the reports and recommendations of the MEC regarding an initial application for membership and/or privileges, the Hospital Board shall consider and act on such recommendations. If the Hospital Board decides to defer action on the application pending further consideration by the MEC, or if the Hospital Board does not accept the recommendation of the MEC, it shall refer the application back to the MEC for further consideration, subject to the requirement that a final recommendation be provided to the Hospital Board by the MEC within sixty (60) days. At the meeting next following the receipt of the second report of the MEC, the Hospital Board shall render its final decision regarding the application.

If the Board accepts a favorable MEC recommendation it shall act to grant the requested membership and/or privileges. The Board's decision and the notice of appointment shall include:

- the Staff category to which the applicant is appointed;
- the Clinical Service to which he or she is assigned;
- the Privileges he or she may exercise; and
- any special conditions attached to the appointment or exercise of privileges

If the recommendation of the MEC is adverse to the applicant because of concerns about professional competence or conduct, the Board will then determine its decision on the request for membership and/or privileges. Following the Board's adverse decision, if the applicant requests a fair hearing, the Board will make a determination on the applicant's requests which takes into consideration the findings of the hearing panel. Where the applicant further requests an appellate review by the Board, the Board's final determination will result from the decision made by the Board appellate review panel.

Board Consideration of Expedited Applications:

A Board Executive Committee, composed of at least two (2) voting members of the Board may conduct an expedited credentials review when applicants present applications that raise no clear concerns from the MEC and/or members of the Board Executive Committee. In particular, the following criteria must be met in order to complete an expedited credentials review:

(1) Applicant submits a completed application;
(2) MEC makes a final positive recommendation and without limitation(s);
(3) There are no current challenges or previously successful challenges to the applicant's licensure or registration;
(4) Applicant has never received an involuntary termination of medical staff membership at another organization;
(5) Applicant has never received involuntary limitation, reduction, denial, or loss of clinical privileges; or
(6) There is not an unusual pattern of, or extensive number of, professional liability actions.

This list is not exhaustive and the Hospital Board or the Board Executive Committee shall have the discretion to determine whether or not an application qualifies for expedited review.

After reviewing the recommendations of the MEC, a positive decision by the Executive Committee of the Board shall result in the status and/or privileges requested. If the decision by the Executive Committee of the Board is adverse the matter will be referred to the full Board for further evaluation at its next regularly scheduled meeting.

The full Board shall consider and ratify all positive committee decisions at its next regularly schedule meeting. If the Board does not ratify the positive recommendation of its Executive Committee, the application will be handled as in the same manner as an application that has not received expedited review.

2.5-9 CONFLICT RESOLUTION

Whenever the Board's proposed decision will be contrary to the MEC's recommendation, the Board shall submit the matter for conflict resolution through the use of meetings and, if necessary, formation of a Joint Conference Committee as provided in Section 10.4 of Volume I of these Medical Staff Bylaws. Any such joint conference will be held as soon as practicable and the Board will postpone any final determination on an applicant until such conference is held.

2.5-10 NOTICE OF FINAL DECISION

Notice of the final action of the Hospital Board on an applicant shall be given to the Hospital CEO who will provide the applicant with either a written offer of membership and/or Privileges and/or special notice of any adverse action on the application in a timely manner. The Hospital Board shall give notice of its final decision through the Hospital CEO to the Medical Staff President, the MEC, and the appropriate Clinical Service Chair.

2.5-11 TIME PERIODS FOR PROCESSING

Applications for Medical Staff appointment and/or privileges shall be considered timely and in good faith by all individuals and groups required by Medical Staff Bylaws and policies to act upon them and a shall be processed whenever possible within the time periods specified in this section. Any application that remains incomplete after six (6) months shall be considered voluntarily withdrawn.

Within forty-five (45) days after receipt by the Clinical Service Chair of a completed application for membership and/or clinical privileges, the Clinical Service Chair report shall be submitted to Medical Staff Credentials Committee.

Within sixty (60) days after the receipt of the Clinical Service Chair's report, the Medical Staff Credentials Committee through its Chair shall submit a written recommendation to the Medical Executive Committee.

Within sixty (60) days after receipt of recommendations from the Medical Staff Credentials Committee or its Chair, the MEC shall submit a recommendation regarding appointment and/or privileges to the Hospital Board.

The Hospital Board will act on recommendations from the MEC at its next regularly scheduled meeting that shall occur within ninety (90) days.

The time periods in this section are guidelines and deviations will not entitle the applicant to any procedural due process rights.

2.6 REAPPOINTMENT PROCESS

2.6-1 APPLICATION FOR REAPPOINTMENT

Reappointment will be for a period of two (2) years. At least one hundred twenty (120) days prior to the expiration date of current appointment of membership and/or privileges, the Hospital shall provide each Practitioner with an updated application form for reappointment and any required Hospital specific forms and documents for completion which must be received prior to the reappointment application being acted upon. Each Practitioner who desires reappointment shall, at least sixty (60) days prior to such expiration date must complete such forms and return them to the Hospital. Failure to return the completed form(s) prior to such expiration date may, at the discretion of the Hospital, be considered a voluntary resignation of membership and clinical privileges effective at the end of the Staff member's current term.

2.6-2 CONTENT OF APPLICATION

The application for reappointment shall be in a prescribed form setting forth, without limitation, the following information:

a) Specific requests setting forth the category of Staff membership to which the applicant seeks to be reappointed, the Clinical Service to which the applicant seeks membership, and the privileges for which the applicant wishes to be considered.

b) Continuing training, education, and experience that qualify the Staff member for the privileges sought on reappointment. Continuing education must relate, at least in part, to the privileges requested and is provided to the Hospital upon request.

c) A statement that no health problems exist that could affect the applicant's ability to perform the privileges requested.

d) The name and address of any other health care organization or practice setting where the Staff member provided professional services during the preceding appointment period.

e) Any membership, awards, or other recognition conferred or granted by any professional health care societies, institutions or organizations.

f) Current, unrestricted State License, Drug Enforcement (DEA) and State Board of Pharmacy License, as applicable.

g) Information as to whether the applicant's membership status and/or medical staff privileges have ever been voluntarily or involuntary revoked, suspended, reduced, subjected to restrictions or limitation if not applicable to all other Practitioners in the same medical staff category, or not renewed at any other Hospital or health care institution, and as to whether any of the following has ever been voluntary or involuntarily suspended, revoked, or denied:.

1) staff membership status or clinical privileges at any other Hospital or health care institutions;
2) membership/fellowship in a local, state or national professional organization;
3) licensure to practice any profession in any jurisdiction; or
4) Drug Enforcement (DEA) registration;

If any such actions were ever taken or if any such actions are now pending, the particulars thereof shall be included.

h) National Practitioner Data Bank (NPDB) information which will also be checked during reappointment/renewal of privileges and whenever new privileges are requested.

i) Information as to whether the applicant has ever been prosecuted for, convicted of or pled no contest to a felony and, if so, the particulars of any such convictions.

j) Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.

k) Evidence of continuous malpractice insurance coverage in an amount that may be determined from time to time by action of the Board,

l) A list of all malpractice complaints filed against the Practitioner and the particulars regarding any adverse malpractice decisions or settlements.

m) Such other specific information about the Staff member's professional ethics, qualifications, and ability that may bear on his ability to provide medical or surgical care in the Hospital.

2.6-3 COMPLETION AND VERIFICATION OF INFORMATION

The information provided on each application for reappointment and all other supporting materials and documentation, including information regarding the Staff member's professional activities, performance and conduct in the Hospital and query reports from the National Practitioner Data Bank shall be collected and verified. The applicant shall have the burden of producing adequate information for a proper evaluation of his qualifications and of resolving any questions regarding such qualifications. When collection and verification has been completed and the Hospital has determined that the application is complete, it shall transmit the application and all supporting material to the Clinical Service Chair to which the applicant is assigned.

2.6-4 CLINICAL SERVICE CHAIR REVIEW

The Clinical Service Chair or designee shall review the application for reappointment and all other pertinent information, including all supporting documentation. Such review shall consist of an appraisal of the following factors, without limitation:

a) Professional performance, including applicant's patterns of practice in the performance improvement program, data from ongoing professional practice evaluation, utilization review, infection control activities, blood utilization, operative and invasive procedure review, medical records review, and pharmacy and therapeutic review, as appropriate.

b) The privileges currently exercised by the applicant and the basis for any requested modifications.

c) Applicant's health status, where relevant to ensure the safe practice of the privileges requested.

d) Applicant's participation in relevant continuing education programs.

e) Applicant's attendance at meetings of the Medical Staff and of the Clinical Service, as applicable.

f) Applicant's service on Medical Staff and Hospital committees.

g) Applicant's record relating to timely completion of medical records.

h) Applicant's demonstrated ability to work cooperatively with other Practitioners and Hospital personnel, to comply with policies on professional conduct, and to avoid unprofessional conduct in the Hospital that may have a disruptive effect on patient care or impede the efficient and safe operation of the Hospital.

i) Applicant's record of compliance with the Medical Staff Bylaws, rules, regulations and policies of the Medical Staff and with Hospital policies applicable to Medical Staff members or Practitioners granted privileges.

2.6-5 ACTION OF THE CLINICAL SERVICE CHAIR

The Clinical Service Chair shall review the application and information in the Practitioner's file and shall submit his/her recommendation or report to the Credentials Committee regarding the reappointment of and/or privileges to be exercised by such member. The Clinical Services Chair report shall contain the following, without limitation:

a) Recommendation or report for reappointment or denial of reappointment, including any suggested restrictions or conditions on reappointment.
b) Report for Clinical Service affiliation and Staff category.
c) The Privileges to be granted, including any restrictions on such Privileges.

2.6-6 MEDICAL STAFF CREDENTIALS COMMITTEE ACTION

The Medical Staff Credentials Committee shall review each application and all other relevant information available to it, including the relevant Clinical Service Chair report. The Credentials Committee may choose to interview the applicant prior to rendering a recommendation. The Credentials Committee shall make a report to the Medical Executive Committee regarding its recommendations on the application for reappointment. The report of the Credentials Committee shall contain the same specific types of recommendations contained in the Clinical Service Chair report as set forth in the section above. The report of the Credentials Committee shall be accompanied by all relevant documentation, including the application, supporting information, and the Clinical Service Chair report.

2.6-7 MEDICAL EXECUTIVE COMMITTEE ACTION

The Executive Committee shall review each application for reappointment and all other relevant information available to it. The MEC may choose to interview the applicant prior to rendering a recommendation. The MEC shall make a report to the Hospital Board regarding its recommendations on the application for reappointment. The report of the MEC shall contain the same specific types of recommendations contained in the report of the Credentials Committee. The report of the MEC shall be accompanied by all relevant documentation, including the application, supporting information, and the report of the Credentials Committee.

2.6-8 FINAL PROCESSING AND BOARD ACTION

Following the report of the Executive Committee to the Hospital Board, the procedure provided in the Credentials Procedures relating to initial applications shall be followed and the Hospital Board shall render a decision prior to the expiration date of the applicant's appointment. Where the Board disagrees with the recommendation of the MEC, the matter will be addressed through the conflict resolution process as described in Section 10.4 in Volume I of these Bylaws.

2.6-9 BASIS FOR RECOMMENDATION

Each recommendation concerning the reappointment of a Practitioner's membership and/or Privileges shall be based upon review not only of those matters set forth in the Medical Staff bylaws and policies pertaining to such Practitioner, but also on any other information bearing on the ability and willingness of the Practitioner to contribute to the rendering of quality health care within the Hospital and to contribute to the mission of the Hospital.

2.7 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS AND/OR PRIVILEGES

A Medical Staff member may, either in connection with reappointment or at any other time, request modification of his staff category, department affiliation, or clinical Privileges by submitting a written application to the Hospital in such form as may be prescribed by the MEC and the Hospital Board. Such Staff member shall have the burden of justifying such modification(s). Such application shall be processed in substantially the same manner as applications for reappointment to Medical Staff membership, except that the pertinent time limits shall be those applicable to appointments to Medical Staff membership, as provided in this Credentials Procedures.

2.8 EFFECTIVE DATE OF REAPPOINTMENT/MODIFICATIONS OF APPOINTMENTS AND/OR STAFF PRIVILEGES

Reappointments approved by the Hospital Board, including privileges awarded in connection with such reappointments, modifications of categories of Staff membership, Department, Division or Clinical Service affiliation, and/or Privileges, shall take effect on the date such modifications are approved by the Hospital Board.

ARTICLE III

DETERMINATION OF PRIVILEGES

3.1 EXERCISE OF PRIVILEGES

Practitioners providing clinical services at the Hospital shall be entitled to exercise only those Privileges specifically granted to them by the Hospital Board, or emergency or disaster privileges as described in these Credentialing Procedures.

3.2 DELINEATION OF PRIVILEGES IN GENERAL

3.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical Privileges desired by the applicant. Practitioners who are ineligible for Medical Staff membership may apply for Privileges by requesting an application form from the Hospital. A request by a Practitioner for Privileges or the modification of privileges must be supported by all requested documentation regarding appropriate licensure, training and the evidence of current competence. Privilege requests will not be processed where the applicant does not meet the eligibility requirements to be granted the privilege at St. Mary's Hospital.

3.2-2 Basis for Determinations of Privileges

Privileges shall be determined on the basis of the Practitioner's prior and continuing education, training, experience, utilization patterns and demonstrated current competence, including observed professional performance and documented results of Practitioner-specific performance improvement activities. Information concerning professional performance obtained from other sources will be considered when available, especially from other institutions and health care settings where a Practitioner exercises privileges. It is the burden of the Practitioner applying for Privileges to provide all information requested by the Medical Staff and Board as they determine necessary to evaluate the request.

Residents or fellows in training in an approved ACGME program and acting under the auspices of that program will not be required to request specific privileges. They must carry out any clinical care in accordance with the written educational protocols developed by the Hospital CMO and their training program. These protocols must delineate the roles, responsibilities, and scope of clinical activities applicable to such trainees. They must also describe the requirements for oversight of trainees, the types of orders they may write, and when such orders must be countersigned and by whom. The protocols will describe how trainees' level of responsibility and scope of practice may expand over time and how this information will be transmitted to staff and personnel working in the Hospital. These protocols must be periodically reviewed and approved by the MEC. In addition, training programs will periodically communicate with the MEC regarding the performance of its trainees and alert it to any performance concerns or matters that may threaten patient safety. The training program must work with the MEC to assure that all supervising Practitioners hold privileges commensurate with their oversight activities.

3.2-3 Procedure

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article II of this document (Volume II). Requests for privileges will not be processed where the Board has made a determination that the Hospital will not support or authorize the exercise of a particular privilege for any Practitioner at the Hospital; where the privilege requested is covered by an exclusive contract granted by the Hospital Board and the requesting Practitioner is not a party to the contract or provider under the contract; or where the requesting Practitioner does not meet the eligibility requirements to request or exercise a privilege as described in the Hospital's delineation of privileges documents.

3.2-4 New Technology or Cross-Specialty Privileges

In the event a Practitioner requests a privilege for which the Hospital has not adopted criteria (e.g. for a new technology, procedure, modality or multi/cross-specialty privilege), the request may be tabled for a reasonable period of time, usually not in excess of ninety calendar days. During this time the MEC and Board will review the community, patient, and Hospital need for the privilege and determine if the institution can make available the necessary resources to adequately support the exercise of thatprivilege.
Senior management will resolve any non – exclusive or exclusive contract issues as appropriate to avoid violating the contract provisions. The Medical Staff Credentials Committee will research appropriate eligibility criteria for the safe and effective exercise of the requested privilege and establish, with input of the MEC and approval by the Board, the necessary education, training, experience and evidence of current competence that will be required to request and be granted the privilege. Once these steps are taken, a request for the privilege will be evaluated.

The procedure to be used in determining if a procedure, modality of care or treatment requires new/updated/different competency criteria prior to being eligible to request and be granted the privilege by the Board is as follows:

When the Clinical Service Chief, or two (2) or more members of the Credentials Committee determine that two (2) or more of the following criteria are significantly different than the current privilege; new/additional competency criteria will be developed by the Credentials Committee: skill, knowledge, technique, equipment, risk, judgment or ability to manage complications the procedure, modality of care or treatment.

3.3 Confirmation of Competency to Hold Privileges

All Privileges that are initially requested by new applicants or existing members of the Medical Staff are subject to a time limited period of focused professional practice evaluation (FPPE). The Credentials Committee, after receiving a report from the Clinical Service Chair will define the conditions that warrant review/evaluation of the performance of each practitioner as part of the initial grant of clinical privileges at the Hospital. Review and monitoring may utilize retrospective, prospective, or concurrent review, including but not limited to: chart review, the monitoring and review of performance (factors) or indicators, external peer review, simulations, clinical reviews, and discussion with other healthcare individuals who have observed and/or participated in patient care with that practitioner. The Credentials Committee will define the duration for FPPE and the triggers that indicate the need for performance review and evaluation.

The medical staff participates in ongoing professional practice evaluation (OPPE) to identify practitioner practice outcomes and trends that impact the safety and quality of patient care. Information from the OPPE process will be used by leaders to determine if existing privileges are maintained, revised or revoked prior to or at the time of reappointment. The OPPE is part of the medical staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to a FPPE when issues affecting the provision of safe, high quality patient care are identified. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

3.4 TEMPORARY CLINICAL PRIVILEGES

3.4-1 Circumstances

Temporary privileges may be granted to a Practitioner who meets one of the following circumstances and the minimum criteria as defined below:

a) Important Patient Care Need

Temporary privileges may be granted on a case-by-case basis when an important patient care need or service mandates an immediate authorization to practice for a limited time—up to 120 days.

In special circumstances upon receipt of a written request, an appropriately licensed Practitioner of documented competence, who is not an applicant for membership or privileges, may be granted temporary privileges for the care of one or more specific patients.

At a minimum, the Practitioner must possess an unrestricted Illinois state license, unrestricted DEA registration, unrestricted State controlled substances certificate, certificate of current professional liability insurance in amounts satisfactory to the Hospital, membership in good standing in a primary practicing facility, acceptable National Practitioner Data Bank report, verbal or written reference establishing competency for the privileges requested.

b) Pendency of Application for Permanent Medical Staff:

Temporary clinical privileges may be granted for permanent medical staff membership and privileges, provided the application is complete, and the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges. All required verifications and processes as outlined in Article II of Volume II of these Bylaws must be completed and the application is awaiting review and recommendation of the Medical Executive Committee. Such persons may only attend patients for a period not to exceed 120 days.

3.4-2 Conditions

Temporary privileges shall be granted by the Hospital CEO (or designee) acting on behalf of the Board and based on a recommendation of the Medical Staff President (or designee) and Clinical Service Chair. Before temporary privileges are granted, the Practitioner must first acknowledge in writing that he or she has received and read copies of the Medical Staff Bylaws and all other Medical Staff and Hospital policies relevant to his performance of temporary privileges, and that he agrees to be bound by them.

3.4-3 Termination

On discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, the Medical Staff President or, in his absence, the Clinical Service Chair of which the Practitioner is a member, may terminate any or all of such Practitioner's temporary privileges. Where the life or well-being of a patient is determined to be endangered by continued treatment by a Practitioner exercising temporary privileges, the termination may be effected by any person entitled to impose Precautionary Suspensions under the Bylaws. In the event of such termination, the patients of such Practitioner then in the Hospital shall be assigned to another Practitioner by the Medical Staff President or, in his absence, by the Chair of the appropriate Department or Clinical Service Chair. Where feasible, the wishes of the patient shall be considered in choosing a substitute Practitioner.

3.4-4 Procedural Rights

A Practitioner shall not be entitled to procedural rights because of the denial of any request for temporary privileges, or because of any termination or suspension of temporary privileges, whether in whole or in part, unless based on a determination of demonstrated incompetence or unprofessional conduct.

3.5 EMERGENCY PRIVILEGES

In case of an emergency, any Medical Staff member attending a patient shall be expected and permitted to do everything in his or her power and to the degree permitted by his or her license, to save the life of the patient or prevent significant and disabling morbidity regardless of the member's Medical Staff status, Clinical Service affiliation or privileges. This duty shall be subject to the Medical Staff member's concurrent duty to take into account or abide by a patient's directive under the Illinois law to withhold or withdraw life-sustaining procedures, or to take into account and abide by the requirements of sound medical practice. For purposes of this section, an emergency is defined as a condition or set of circumstances in which any delay in administering treatment would increase the danger to the patient's life or the danger of serious harm. When such an emergency situation no longer exists, the patient shall be assigned to an appropriate member of the Medical Staff who holds privileges appropriate to address the patient's medical conditions.

3.6 DISASTER PRIVILEGES

3.6-1 Authority

The authority to implement disaster privileges is at the direction of the Hospital Command Center, in consultation with the Medical Staff leadership, in the event the Emergency Management Plan is activated and the Hospital is unable to handle immediate patient care needs. One of the following individuals may grant disaster privileges once appropriate identification is obtained from a physician who has offered to volunteer during a disaster:

- CEO or designee
- Medical Staff President or any elected Officer of the Medical Staff
- Credentials Chair
- Clinical Service Chair

3.6-2 Eligible Physician

Disaster privileges may be granted only to physicians, who hold a license in the State of Illinois to practice medicine and who volunteer their services but do not possess medical staff privileges at St. Mary's Hospital.

Primary source verification of licensure will begin as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer physician presents to the Hospital. Primary source verification applies only to volunteer physicians who provided care, treatment and services while under disaster privileges.

In extraordinary circumstances where primary source verification cannot be completed within 72 hours, it will be completed as soon as possible. Reason for the Hospital's inability to verify will be documented with the following:

1) Reason primary source verification not completed in the specified time period
2) Evidence of a demonstrated ability to continue to provide adequate care, treatment, and series; and
3) Attempts to rectify the situation as soon as possible.

3.6-3 Scope of Privileges

Volunteering physicians shall be paired with and supervised by a currently credentialed medical staff member. An approved form of identification must be worn at all times while volunteering at the Hospital. Scope of privileges for the volunteering physician shall be consistent with minimum core privileges and as determined by the onsite-supervising physician.

Within 72 hours of disaster privileges being granted the medical staff leadership will make a determination of the professional practice of the volunteer physicians and the need for continuation of disaster privileges.

3.6-4 Termination of Privileges

Disaster privileges will be for the duration of the emergency situation. Privileges will automatically be canceled when it is determined by the Hospital that an emergency situation no longer exists. In the event that any information received through the verification process or the professional practice review indicates adverse information suggesting the person is not cable of rendering services in an emergency such privileges shall be immediately terminated.

3.7 Telemedicine Privileges

Telemedicine privileges shall be granted to Practitioners who have either total or shared responsibilities for patient care, treatment, and services through a telemedicine link.

All Practitioners who provide services via a telemedicine linkshall be credentialed and privileged to do so at the Hospital using the same processes as any other applicant for Medical Staff Privileges. If the applicant holds telemedicine privileges at more than ten (10) facilities within the United States, a random representative sample of at least 5 (five), including the primary facility along with the most recent 3 (three), facilities will be chosen for affiliation verifications and demonstrated competence.

The Practitioner must concurrently maintain privileges at a primary facility for the same scope of services as he or she is requesting at the Hospital.

The approval process for telemedicine staff privileges shall be the same process as outlined in Article II, Procedures for Appointment and Reappointment of the Credentials Procedures, Volume II.

Practitioners requesting telemedicine privileges shall be eligible for temporary privileges via the process outlined in the Temporary Privileges section of these Credentials Procedures.

3.8 Dental and Podiatry Privileges:

The scope and extent of surgical procedures that a dentist or podiatrist may perform shall be specifically delineated by the appropriate Clinical Service Chair. All such surgical procedures shall be performed under the overall responsibility of the appropriate Clinical Service Chair. A physician member of the Medical Staff shall be responsible for the care of any medical problems of a dental or podiatry patient that may be present or arise during hospitalization.

ARTICLE IV

PRACTITIONERS PROVIDING CONTRACTED SERVICES

4.1 Exclusive Agreements

The Hospital Board may from time to time determine that specified Hospital clinical services will be provided on an exclusive basis pursuant to a contract or letters of agreement between the Hospital and specific qualified Practitioners. Privileges covered by such exclusive agreements will be available only to Practitioners who are specified under the terms of such agreements. Applications for initial appointment to provide services or requesting privileges that are covered under the exclusive arrangement will not be eligible for consideration and processing unless submitted in accordance with such arrangements. Practitioner's who have previously been granted privileges that become subject to an exclusive arrangement made by the Hospital will not be able to exercise those privileges unless they become a party to the agreement. Any Practitioner who will provide clinical services pursuant to an exclusive agreement issued by the Hospital will be required to meet the same qualifications and undergo the same evaluation and approval process for privileges as any other applicant. However, the exclusive contract may require such Practitioner to meet higher qualifications for privileges than those established for applicants who are not subject to the exclusive agreement.

4.2 Termination of Contracted Arrangements

The effect of expiration or other termination of a contract for employment or professional services between the Hospital and a Practitioner upon that Practitioner's staff appointment and privileges will be governed solely by the terms of the Practitioner's contract with the Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the Practitioner's staff appointment status or privileges. Where Medical Staff membership or privileges are terminated under the terms of such contracts the Practitioner will not have recourse to the due process provisions described in the Medical Staff Investigation, Corrective Action and Fair Hearing Procedures.

Saint Mary's Hospital

MEDICAL STAFF BYLAWS

Volume III:

INVESTIGATION, CORRECTIVE ACTION and FAIR HEARING PROCEDURE

Approved by Board of Directors: 11/09/2010, 03/24/2015, 08/20/2025

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Collegial Intervention

It is the policy of the medical staff of the Hospital to work collegially with its members to assist them in delivering safe and good quality medical care, to continually improve their clinical skills, to comply with medical staff and Hospital policies, and to meet all performance expectations as established from time to time by the medical staff. Medical staff policies, including those on peer review, performance improvement, conduct, and physician health and impairment describe some of the collegial interventions available to medical staff leaders in working with colleagues whose clinical performance or professional conduct is problematic. Collegial intervention may include letters of warning/concern, a reprimand, a notice that the physician's conduct will be monitored for a period of time and/or that similar conduct in the future will be reported to the MEC for a formal peer review investigation, a voluntary agreement to attend meetings, CME courses, obtain consultations, or other appropriate action. Collegial intervention is not considered disciplinary action and shall not entitle a practitioner to a hearing or appeal. However, the results of the collegial intervention will be documented and signed by the participants and retained in the credentials file in a sealed envelope labeled "confidential collegial intervention". The envelope may be reviewed by the individual and appropriate medical staff leaders involved in the credentialing and peer review processes. The reason for, date of and identity of the person conducting a review of the "confidential collegial intervention" will be documented directly on the envelope. The envelope and contents will be kept in the credentials file for a time period consistent with State law.

The provisions of this procedure describe the steps that the medical staff and Hospital will undertake when such collegial efforts fail or are insufficient to protect the well being of patients, staff, colleagues, or the Hospital.

When appropriate, nothing in these Bylaws, the medical staff rules and regulations, or Hospital policies shall prohibit initial informal efforts by clinical service chairpersons, staff leadership, or Hospital administration to improve or correct the level of care provided by staff members, prior to or instead of proceeding through a formal peer review process.

ARTICLE I
INVESTIGATIONS

1.1 Criteria for Formal Initiation

Any person may provide information to any member of the MEC or other medical staff leader about the conduct, performance, or competence of medical staff members. When reliable information indicates a member may have exhibited in any location acts, demeanor, or conduct, reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical or illegal; (3) contrary to the Medical Staff Bylaws, associated procedures, Hospital or medical staff policies and/or any rules and regulations; (4) harassing or intimidating to Hospital employees, medical staff colleagues, patients or their families; (5) disruptive of Hospital or medical staff operations; (6) below applicable professional standards for competency or as established by the medical staff; or (7) harmful to the reputation of the Hospital and/or medical staff, a request for an investigation or action against such member may be initiated by the President of the Medical Staff, MEC, Chief Medical Officer, or the Hospital CEO. The purpose of an investigation is to determine if a MEC recommendation to the Board for corrective action is warranted or determine what additional information should be gathered or collegial interventions attempted prior to making such a recommendation. Routine peer review and performance monitoring (e.g. focused and ongoing professional practice evaluation) will not be considered "investigations" as described in this Article.

1.2 Initiation

A request for an investigation may be submitted by one of the above parties to the MEC and supported by reference to the specific activities, concerns, or conduct alleged to warrant the investigation. If the MEC authorizes the investigation it shall make a record of this action in its official minutes.

1.3 Procedure

If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken by a designated subcommittee or medical staff committee. The MEC may ask the Hospital to undertake external peer review if it believes such a step is warranted to conclude its investigation. Strong consideration should be given to use of external peer review if any of the following circumstances is present:

1. The MEC and the Credentials Committee are presented with ambiguous or conflicting recommendations from medical staff reviewers or committees, or where there does not appear to be a strong consensus for a particular recommendation.

2. There is a reasonable probability that litigation may result in response to an MEC recommendation regarding the practitioner under review;

3. There is no one on the medical staff with expertise in the subject under review, or when the only practitioners on the medical staff with the requisite expertise are direct competitors, partners, or associates of the practitioner under review.

The investigation shall proceed within ten (10) calendar days following the date the MEC determines that the investigation is warranted. A written report of the investigation findings will be submitted to the MEC as soon as practicable. The report may include recommendations for appropriate corrective action. The medical staff member at issue shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the Credentials Committee deems appropriate. The MEC may, but is not obligated to, conduct interviews with persons knowledgeable about the practitioner under review, however, such investigation shall not constitute a "hearing" as that term is used in this Investigation, Corrective Action and Fair Hearing Procedure, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action it feels may be warranted by the circumstances to protect the Hospital, its staff, and its patients, including suspension or limitations on the exercise of privileges as provided herein. Any report of an external peer review provider shall be made part of the Hospital's internal peer review process and copies shall be provided to both the Hospital's Peer Review Committee and the practitioner under review. Any response to the external peer review reports made to the Board within thirty (30) days of the report shall be considered by the Board as part of its consideration.

1.4 Completion of Formal Investigation

The Credentials Committee shall strive to conclude investigations within sixty (60) days of a referral from the MEC. Where the MEC believes it is necessary, an investigation can be extended for an additional sixty (60) day period or longer by mutual agreement of the MEC and the practitioner.

When the Credentials Committee submits a report of its investigation the MEC will determine if it is complete and sufficient for the MEC to make a determination whether corrective action should be recommended. When it makes this decision the MEC will indicate in its minutes that the investigation is completed and so notify the practitioner involved.

1.5 Reporting to the National Practitioner Data Bank (NPDB) and Regulatory Agencies

If the practitioner under investigation resigns membership or privileges while the investigation is underway, the MEC will inform the medical staff office and a report will be made in accordance with the requirements of the National Practitioner Data Bank. Reports regarding investigations and corrective actions will also be made to state regulatory agencies as required under state regulations and statutes.

1.6 Medical Executive Committee Action

As soon as practicable after the conclusion of the investigation, the MEC shall take action that may include, without limitation:

1.6.1 Determining no corrective action is necessary.

1.6.2 Deferring action if it believes more information is needed. However, such deferral

should not be longer than one hundred and twenty (120) days from the formal recommendation for an investigation.

1.6.3 Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude clinical service chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file.

1.6.4 Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of privileges, including, without limitation, requirements for co-admissions and co-management of patients, mandatory consultation, or monitoring.

1.6.5 Recommending denial, restriction, modification, reduction, suspension or revocation of clinical privileges.

1.6.6 Recommending reductions of medical staff membership status or limitation of any prerogatives directly related to the member's delivery of patient care.

1.6.7 Recommending suspension, revocation, or probation of medical staff membership.

1.6.8 Taking other actions deemed appropriate by the MEC under the circumstances.

ARTICLE II
IMPOSITION OF PRECAUTIONARY SUSPENSION OR DISCIPLINARY RESTRICTION OF PRIVILEGES OR MEMBERSHIP

2.1 Authority to Temporarily Suspend Privileges

The President of the Medical Staff, a clinical service chair, or the Board Chairperson shall each have the authority to temporarily suspend all or any portion of the clinical privileges of a medical staff appointee or practitioner holding privileges whenever he perceives a reasonable possibility that the continued practice of the member or practitioner constitutes an immediate danger to the public, including patients, visitors and Hospital employees and staff (and can document or provide other reliable information relevant thereto). Such a suspension will not become effective until agreed to by the Hospital CEO or other individual designated by the CEO. Unless otherwise indicated, this suspension will take place immediately and the President of the Medical Staff, the Hospital Board Chair, and the affected practitioner will be promptly informed. The imposition of the suspension will result in a meeting of the MEC as soon as reasonably possible (and in any event no more than fourteen (14) days) to determine whether the suspension should be affirmed, lifted, expunged or modified.

Suspensions undertaken to protect the well-being of patients are considered precautionary in nature and will be described as 'Precautionary Suspensions'; which term is considered the synonymous with the term "summary suspension" as such term is used in State and Federal laws.

2.2 Assignment of Patients

Where any or all of the privileges of a medical staff member or practitioner are terminated, revoked, or restricted, such that she/he can no longer treat all or some of his patients at the Hospital for any period of time, such patients who are then in the Hospital shall be assigned for the period of such termination, revocation, or restriction to another qualified practitioner by the President of the Medical Staff, or, in his absence, by the chair of the affected practitioner's clinical service. Where feasible, the wishes of the patient shall be considered in choosing a substitute practitioner.

2.3 Interview

When a practitioner has had privileges or membership status suspended, the practitioner will be afforded an interview with the MEC upon request. The interview shall not constitute a hearing, shall be informal in nature, and shall not be conducted according to the procedural rules provided with respect to hearings under this Investigation, Corrective Action and Fair Hearing and appeal procedure. Request to meet with the MEC must be made within five (5) business days of notification of the precautionary suspension of privileges or medical staff membership. Request must be made in writing and delivered to the President of the Medical Staff or designee within the designated timeframe. Meeting with the MEC will be scheduled as soon as practicable after imposition of the suspension, but in no event later than forty-five (45) days.

2.4 Medical Executive Committee Action

As soon as reasonably possible after the imposition of a precautionary suspension, the MEC shall recommend to the Governing Board whether the suspension should be modified, continued or terminated, including whether further corrective action should be taken or whether there is a need for an investigation by the Credentials Committee. Unless the precautionary suspension was imposed by action of the Governing Board, such recommended action by the MEC shall take immediate effect and remain in effect pending a final decision after expedited consideration by the Board. The MEC shall give notice to the affected medical staff member of its recommendations as soon as possible or within five (5) days of the adoption of such recommendation.

2.5 Procedural Rights of Practitioners Subject to Precautionary Suspension

Whenever a practitioner has been suspended for more than fourteen (14) days or when the MEC makes a recommendation, he will be entitled to request a fair hearing as described below in Article VI of this procedure within fifteen (15) days of the imposition of the suspension.

2.6 Disciplinary Restriction

The MEC may, with approval of the Hospital CEO and/or the Chair of the Governing Board or their designees, institute one or more disciplinary restrictions of a practitioner for a cumulative period not to exceed fourteen (14) consecutive days in a calendar year. A disciplinary restriction may be instituted only when:

1. The action that has given rise to the restriction relates to non-compliance with a medical staff and Hospital policies on professional conduct, completion of medical records, or on-call coverage requirements;

2. The practitioner has received at least two (2) written warnings within the last twenty-four (24) months regarding the policy violation in question. Such warnings must state the conduct or behavior, or policy violation that is questioned and specify or refer to the applicable policy, and state the consequence(s) of repeat violations of the policy, including the possibility of a disciplinary restriction, or;

3. The affected practitioner has been requested to meet with the MEC or a designated subcommittee prior to the imposition of the disciplinary restriction. Failure on the part of the practitioner to accept the MEC offer of a meeting will constitute a violation of the Bylaws regarding “mandatory meetings” described in Section 8.8 Volume I of these Bylaws.

ARTICLE III
AUTOMATIC SUSPENSION, LIMITATION, OR VOLUNTARY RELINQUISHMENT OR RESIGNATION OF MEDICAL STAFF MEMBERSHIP AND/OR PRIVILEGES

This article addresses automatic suspensions and limitations on membership and privileges and voluntary resignations/relinquishments of membership and privileges when these occur for administrative reasons relating to failure to meet eligibility requirements of membership or comply with additional requirements for membership or privileges found in the Bylaws and medical staff policies and procedures. These actions are not considered professional review actions, are not based on determinations of competence or unprofessional conduct, and are not entitled to the hearing or appeal procedures provided under these Bylaws and described in this procedure.

3.1 Suspension or Revocation of License

A medical staff member or practitioner with privileges, whose license, certification, or other legal credential authorizing practice in this or another state is suspended, the practitioner shall be immediately suspended from practicing in the Hospital pending final resolution and outcome by the applicable licensing agency. During this time the practitioner will be considered ineligible for medical staff membership or privileges and will not be entitled to the procedural due process rights provided in this procedure. If the licensing agency reinstates the practitioner without any limitations or conditions, the suspension may be lifted. If the licensing agency reinstates practitioner's license with limitations or conditions, suspension will remain in effect pending an interview with the Credentials Committee and recommendation from the MEC for action by the Governing Board.

If the practitioner's license, certification, or other legal credential authorizing clinical practice in this or another state is revoked, the practitioner shall immediately and automatically lose medical staff membership and/or privileges at the Hospital. This will not be considered a professional review action, but an administrative action for noncompliance with the medical staff eligibility requirements for membership and/or privileges. The practitioner shall not be entitled to the procedural due process rights outlined in this procedure.

3.2 Conviction of a Felony

A practitioner who has been convicted of, or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of wrongful or depraved conduct in any jurisdiction shall automatically relinquish medical staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction, or plea, regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

3.3 Suspension for Failure to Complete Medical Records

An administrative suspension of privileges to admit new patients or to schedule new procedures shall be imposed for failure to complete medical records within the time

periods established by the MEC and reflected in medical staff or Hospital policies. Such suspension shall not apply to patients already admitted or scheduled at the time of the suspension, to emergency patients, or to attendance at imminent deliveries. Temporary suspension shall be lifted upon completion of the delinquent records. The administrative suspension shall become an automatic permanent suspension for failure to complete all medical records within sixty (60) calendar days. However, affected practitioners may request reinstatement during a period of thirty (30) calendar days following permanent suspension if all delinquent records have been completed. Thereafter, such practitioners shall be deemed to have voluntarily resigned from the medical staff and must reapply for membership and privileges.

3.4 Failure to Attend Specially Notices Committee or Clinical Service Meeting when Requested

A practitioner, who fails to appear at a meeting where his or her special appearance is required under Section 8.8 of the Medical Staff Bylaws, shall automatically be suspended from exercising all clinical privileges unless he can establish good cause to the satisfaction of the President of the Medical Staff for missing the meeting. Failure to appear for a rescheduled meeting on more than one occasion shall be considered a voluntary resignation from the medical staff. Unless the practitioner was under formal investigation at time of this voluntary resignation, there will be no entitlement to the fair hearing and appeals procedures provided in this procedure.

3.5 Revocation or Suspension of DEA Number or State Pharmacy Board License

A medical staff member whose Drug Enforcement Administration (DEA) number or State Pharmacy Board license is relinquished, revoked or suspended shall immediately and automatically be divested of his privilege to prescribe drugs covered by such number/licenses within the Hospital. This is not a professional review action (unless conduct or competence-related) and the practitioner shall not be entitled to procedural due process as described in this procedure. As soon as possible, the Credentials Committee shall investigate the facts under which the medical staff member's DEA number was revoked or suspended, and may recommend to the MEC further corrective action if indicated.

3.6 Failure to Maintain Liability Insurance

A practitioner's medical staff appointment and/or privileges shall be immediately suspended for failure to maintain the minimum amount of professional liability insurance required by the Board and these Bylaws. Affected practitioners may request reinstatement during a period of ninety (90) calendar days following suspension upon presentation of proof of the required amounts of insurance. Thereafter, such practitioners shall be deemed to have voluntarily resigned form the staff and must reapply for medical staff membership and/or privileges.

3.7 Exclusion from Federal or State Insurance Programs or Conviction for Insurance Fraud

If a practitioner appears on the list of "Excluded Individuals/Entities" maintained by the HHS Office of Inspector General, or is excluded from any Federal insurance programs, the practitioner shall be considered to have automatically resigned from medical staff

membership and/or privileges. Similarly, any practitioner convicted of violations of the Federal False Claims Act or of insurance fraud shall be considered to have automatically relinquished his medical staff membership and/or privileges.

3.8 Failure to Participate in an Evaluation or Assessment

A practitioner who fails or refuses to participate in an evaluation or assessment of his or her qualifications for medical staff membership and/or privileges as requested by the Clinical Service Chair, Credentials Committee Chair or the President of the Medical Staff as required under these Bylaws shall be automatically suspended. If, within thirty (30) days of the suspension the practitioner agrees to and participates in the evaluation or assessment, the practitioner shall be reinstated. After thirty (30) days, the practitioner will be deemed to have voluntarily resigned his or her medical staff membership and/or privileges.

3.9 Failure to Notify Hospital of Disciplinary or Final Malpractice Actions

A practitioner who fails to notify the President of the Medical Staff and the CEO in writing within ten (10) days of any of the following shall be automatically suspended:

1. if privileges in any hospital have been revoked or limited in any way;

2. if corrective action has been taken to revoke or limit privileges in any way at another health care facility or institution;

3. if a professional malpractice action has been settled;

4. if there is a change in his/her license to practice medicine or prescribe drugs in any State;

5. if removed or not renewed as an insurance plan provider due to quality of care issues; or

6. if s/he fails to notify the Hospital of any action taken by the Medical Board against the practitioner.

The suspension may be lifted by the MEC when the practitioner provides adequate documentation to the MEC of the circumstances that triggered the suspension. Failure to provide the information will be considered a voluntary resignation from medical staff membership and/or privileges.

3.10 Failure to Return from a Leave of Absence

If a practitioner granted a leave of absence (LOA) does not request reinstatement or an extension before the LOA expires, he will be considered to have voluntarily resigned his medical staff membership and/or privileges.

ARTICLE IV
ADDITIONAL EXCEPTIONS TO HEARING RIGHTS

4.1 Impact of Exclusive Contracts

4.1.1 Privileges can be reduced or terminated as a result of a decision by the Governing Board to limit the exercise of clinical privileges to practitioners engaged by the Hospital under the terms of an exclusive contract consistent with Volume III, Article IV, sections 4.1 and 4.2. These actions are not considered professional review actions and are not based on a determination of professional competence or unprofessional conduct. There is no right to a hearing or appeal of the loss of privileges or membership resulting from implementation of an exclusive contract.

4.1.2 The affected medical staff member/practitioner shall be provided with at least sixty (60) days advance notice of the effect on medical staff membership and/or privileges by an exclusive contract.

4.1.3 Any adverse decision on medical staff membership or privileges based on substantially economic factors under this section, after conclusion of all hearings, shall only occur after fifteen (15) days written notice is provided to the effected practitioner.

ARTICLE V
REPORTING REQUIREMENTS

5.1 Reporting to the National Practitioner Data Bank

Professional review actions based on reasons related to professional competence or conduct adversely affecting clinical privileges for longer than thirty (30) days or voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation must be reported to the National Practitioner Data Bank ("NPDB"). The report must be made to the NPDB within fifteen (15) days of the final decision of the action. Precautionary suspensions lasting longer than thirty (30) days must be reported to the NPDB within fifteen (15) days of the MEC action. A copy of the NPDB report will be forwarded to the State Medical Board as required by the NPDB.

5.2 Reporting to State Agencies

Actions affecting privileges shall be reported to the appropriate State licensing board or other state regulatory agencies consistent with State law.

ARTICLE VI
INITIATION OF HEARING

6.1 Grounds for Hearing

Except as otherwise provided in these Bylaws, a recommendation by the MEC, or an action taken by the Board for one or more of the following adverse actions, or their imposition, if based on a determination of clinical incompetence or unprofessional conduct, shall constitute grounds for a hearing:

1. Denial of initial appointment to the medical staff;

2. Denial of reappointment to the medical staff;

3. Revocation of appointment to the medical staff;

4. Denial of some or all requested clinical privileges;

5. Revocation of some or all clinical privileges;

6. Suspension or restriction of some or all privileges for more than fourteen (14) days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct; (e.g. mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual medical staff member).

6.1.1 The following will **not** constitute grounds for a hearing (this list is by way of example and is not meant to be a proscriptive):

1. Having a letter of guidance, warning, or reprimand issued to the practitioner or placed in the credentials or performance file of the practitioner;

2. Automatic relinquishment of privileges or membership as described in Article III above;

3. Imposition of a precautionary or disciplinary suspension that does not last for more than fourteen (14) days;

4. Denial of a request for a leave of absence or for an extension of a leave of absence;

5. Determination by the Hospital that an application for appointment or reappointment is untimely or incomplete for failure to submit all requested information;

6. A decision not to process an application under the available procedures for expedited review;

7. Assignment to a particular medical staff clinical service or category;

8. Imposition of a proctoring or monitoring requirement where such does not include a restriction on privileges;

9. Failure to process a request for a privilege when the applicant/member does not meet the eligibility requirements to hold that privilege;

10. Conduct of focused peer review (including external peer review) or a formal investigation;

11. Requirement to appear for a mandatory meeting under the provision of the Medical Staff Bylaws;

12. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

13. Determination that an applicant for membership does not meet the requisite qualifications or criteria for membership;

14. Ineligibility to request membership or privileges or continue the exercise of privileges because a relevant specialty is closed under a medical staff development plan adopted by the Board or covered under an exclusive provider agreement approved by the Board;

15. Termination of any contract with or employment by the Hospital;

16. Any recommendation voluntarily accepted by the member as a result of peer review;

17. Removal or limitation of Emergency Department call obligations;

18. Any requirement by the MEC or Board to complete an educational assessment;

19. Any requirement by the MEC or Board to undergo a mental, behavioral, or physical evaluation to determine fitness for practice;

20. Appointment or reappointment for a duration of less than twenty-four (24) months;

21. Refusal of the Board to reinstate medical staff membership or privileges following a leave of absence;

22. Actions taken by the affected practitioner's licensing agency or any other governmental agency or regulatory body.

6.2 Notice to Practitioner

A practitioner with respect to whom adverse action listed in Section 6.1 above has been

taken shall promptly be given written notice thereof by the President of the Medical Staff or, if such notice was prompted by action of the Governing Board, by the Chair of the Governing Board. This notice will include a description of the adverse action and the reasons for it, a copy of this Investigation, Corrective Action and Fair Hearing and Appeal Procedure, and an offer to provide the practitioner a hearing. The notice will also inform the practitioner that the corrective action or recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank. The practitioner shall have thirty (30) days following the date of receipt of such notice within which to request a hearing.

6.3 Practitioner's Request for Hearing

A practitioner's request for a hearing shall be made by means of written notice delivered either in person or by certified or registered mail to the Hospital CEO within thirty (30) days following the receipt of notice of a corrective action or recommendation.

6.4 Waiver of Hearing by the Practitioner

A practitioner who fails to request a hearing within the time attempted and in the manner specified above waives any right to a hearing to which he might otherwise have been entitled. Such waiver in connection with:

1. A decision or proposed decision by the Governing Board shall constitute acceptance of such decision, which shall thereupon become effective as the final decision of the Governing Board and will be reported as required by law.

2. A recommendation by the MEC shall constitute acceptance of such recommendation, which shall thereupon become and remain effective pending the final decision of the Governing Board.

The practitioner may also waive the right to a hearing by delivering a signed waiver to the Hospital CEO.

6.5 Stay of Adverse Decision

A request for a hearing does not automatically operate to stay any adverse recommendation of the MEC or adverse decision of the Governing Board, including the imposition of a precautionary suspension, and such recommendation or decision shall remain effective pending the final decision of the Governing Board.

ARTICLE VII
HEARING PREREQUISITES

7.1 Notice of Time and Place for Hearing

Upon receipt of a timely request for hearing, the Hospital CEO shall inform the President of the Medical Staff, MEC and Governing Board. Within thirty (30) days after receipt of such request the Hospital CEO shall schedule and arrange for a hearing. At least thirty (30) days prior to the hearing, the practitioner will be sent a special notice of the time, place, and date of the hearing, together with a statement of the matters to be considered and a list of witnesses (if any) expected to testify at the hearing on behalf of the MEC or Hospital Board. The hearing date shall commence not less than thirty (30) days nor more than sixty (60) days from the date of receipt of the request for hearing, unless the affected practitioner and Hospital CEO mutually agree to an earlier date. Once the date is set, the Hospital CEO and practitioner shall mutually agree to any change in the hearing date, however, neither party may change the date more than one time.

7.2 Statement of Issues and Events

As part of or together with the notice of the hearing, there shall be provided a written statement, in concise language, of the acts or omissions which support the decision to impose or recommend a corrective action against the medical staff member or practitioner, and the identification of any medical records (by chart or patient number where available) or other information or data which form the basis for the action. This statement and the list of supporting information may be amended or enhanced at any time, including during the hearing, if the additional material is relevant to the continued appointment or clinical privileges of the practitioner, requesting the hearing and the practitioner and his counsel have sufficient time to study the material and rebut it.

7.3 Limited Right of Discovery

There shall be no right to discovery except as specifically provided in these Bylaws.

1. The Hospital CEO will provide the names of any hearing panel members, hearing officer, or presiding officer to the practitioner requesting the hearing within five (5) days of their appointment.

2. The Hospital or practitioner shall have the right to require up to ten (10) days before the scheduled date of the hearing, production of any documents or charts that are to be used as evidence at the hearing, except such documents or charts that are to be used only for impeachment purposes .

3. The Hospital CEO shall have the right to request, by special notice, a list of witnesses who will give testimony or evidence in support of the practitioner at the hearing. A party receiving such request shall, within ten (10) days of receipt of the request, furnish a list, in writing, of the names and addresses of the individuals, to the extent then reasonably known, who will be called as witnesses on his behalf and a brief summary of the nature of the anticipated testimony.

4. There shall be no right to discover the name of any individual who has produced evidence relating to the charges made against the practitioner who requested the hearing unless such individual is to be called as a witness at the hearing or unless the deposition or other written statement of such individual is to be evidence at the hearing.

5. There shall be no right to the discovery of credentials or quality files of other members of the medical staff, or peer review committee minutes or minutes of any other medical staff committee or activity unless specifically created and limited to addressing the competence and/or conduct concerns of the practitioner requesting the hearing.

7.4 Hearing Panel, Presiding Officer, Hearing Officer

7.4.1 Appointment of Hearing Panel Members

The President of the Medical Staff on behalf of the medical staff, after consultation and agreement by the Hospital CEO on behalf of the Board, shall appoint a Hearing Panel and a Presiding Officer or a Hearing Officer. A Hearing Panel shall be composed, whenever possible, of not fewer than three (3) voting members of the medical staff who meet the qualifications below. In the event that it is not possible to staff the Hearing Panel with three (3) voting members of the medical staff, physicians from outside the Hospital medical staff may be invited to serve as Hearing Panel members. The Presiding Officer will not have voting privileges on the Hearing Panel. The practitioner requesting the hearing will be notified of the Hearing Panel members appointed by the President of the Medical Staff and will have five (5) days from receipt of notice to lodge in writing with the President of the Medical Staff any objections to any appointee. The practitioner requesting the hearing is not entitled to veto any appointee's participation.

A hearing occasioned by corrective action of the Board pursuant to Article 6.1 shall be conducted by a hearing committee appointed by the Board Chairperson and composed of five (5) persons who are qualified to serve. At least two (2) medical staff members shall be included on this committee. One (1) of the appointees to the committee shall be designated as chair. The three (3) non-medical members of the hearing committee shall be members of the Board.

7.4.2 Qualification of Members

Voting members of the hearing panel shall be licensed physicians who are voting medical staff members at the Hospital or other physicians consistent with 7.4.1 and who shall not have previously participated in the deliberations on the matter involved. If the practitioner requesting the hearing is other than a physician, at least one (1) member of the hearing panel shall be of the same general discipline (e.g. podiatrist, dentist).

Knowledge of the matter involved shall not preclude a person from serving as a member of the hearing panel. No member of the hearing panel may be a direct competitor of the member under review.

7.4.3 Presiding Officer

The Hospital CEO will appoint a Presiding Officer to chair the panel, set procedure for the hearing, and conduct all business before the panel, and support the panel in an advisory capacity. The Presiding Officer may be a physician on the medical staff, an active or retired judge or attorney, experienced physician executive, experienced human resources director, or any individual deemed by the CEO to have the capacity to manage the hearing effectively and efficiently. Any costs of using the Presiding Officer will be shared by the Hospital and the practitioner who requests the hearing.

7.4.4 Hearing Officer in Lieu of Panel

The Hospital CEO, after consultation with the President of the Medical Staff, may appoint a single Hearing Officer in lieu of a Hearing Panel where the issue triggering the hearing is unprofessional conduct rather than professional competency. The Hearing Officer may be a lawyer, physician executive, retired judge or other individual familiar with due process. The Hearing Officer may not be legal counsel to the Hospital, any individual who is in direct economic competition with the practitioner requesting the hearing, and cannot have been previously involved in the deliberations triggering the hearing. The Hearing Officer will not act as a prosecuting officer or as an advocate for either side at the hearing. In the event that a Hearing Officer is appointed instead of a Hearing Panel, all references in this Investigation, Corrective Action and Fair Hearing Procedure to "Hearing Panel" or "Presiding Officer" shall be deemed to refer instead to the Hearing Officer, unless the context would clearly require otherwise. The cost of utilizing a Hearing Officer will be shared by the Hospital and the practitioner who requests the hearing.

ARTICLE VIII
HEARING PROCEDURE

8.1 Personal Presence

The personal presence of the practitioner who requested the hearing shall be required. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his rights and thereby to have voluntarily accepted the corrective action that triggered the hearing.

8.2 Presentation

The hearings provided for in these Bylaws are quasi-judicial in nature, focused on resolution of matters bearing on professional conduct or competency. Accordingly, the presiding officer shall have the discretion to limit the role of legal counsel for either side. This means that the presiding officer may rule that the person requesting the hearing shall be required to have his or her case presented at the hearing only by a practitioner who is licensed to practice medicine in the State of Illinois and who, preferably, is a member in good standing of the medical staff. Where this is the case, the Hospital shall appoint a representative from the medical staff to present its recommendation and to examine witnesses. The foregoing shall not be deemed to deprive the practitioner or Hospital of the right to utilize legal counsel at his own expense in preparation for the hearing and such counsel may be present at the hearing, advise his or her client, and participate in resolving procedural matters.

8.3 Presiding Officer

The Presiding Officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present appropriate oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process. The Presiding Officer shall act to ensure that decorum is maintained throughout the hearing and to prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, abusive, or that causes undue delay. The Presiding Officer shall be entitled to determine the order of procedure during the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on all matters of procedure, including the admissibility of evidence. The Presiding Officer may conduct argument by counsel on procedural points and may do so outside the presence of the Hearing Panel. The Presiding Officer may, in his sole discretion, set reasonable time limits on the duration of the hearing, testimony by witnesses, or arguments by parties to the hearing. Unless extenuating circumstances exist, it is expected that both sides will have equal time to present their case. In an attempt to respect the time commitment of all hearing participants, the approximate time the hearing is expected to last will be estimated at the pre-hearing conference.

In addition, the Presiding Officer will act in such a way that the Hearing Panel in formulating its recommendations considers all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing. The

presiding officer may seek legal counsel when he feels it is appropriate and may use Hospital or medical staff legal counsel for such advice.

8.4 Hearing Officer

Where a Hearing Officer is employed instead of a Hearing Panel, the Hearing Officer shall have the same authority as a Presiding Officer to determine the manner in which the hearing will be conducted and rule on all matters of procedure and evidence.

8.5 Pre-hearing Conference

The Presiding Officer or Hearing Officer may require a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference. To the degree practicable, pre-hearing conferences shall occur at least ten (10) days prior to a hearing. At the pre-hearing conference, the Presiding Officer or Hearing Officer shall resolve all procedural questions, including any objections to exhibits or witnesses and the time to be allotted to each witness's testimony and cross-examination.

8.6 Record of Hearing

The Hearing Panel shall maintain a complete record of the hearing by having a certified court reporter present to make a record of the hearing. The cost for the certified court reporter shall be born by the Hospital. The Presiding Officer may, but shall not be required to, order that evidence shall be taken only upon oath or affirmation administered by any person entitled to notarize documents in Illinois. The record of the hearing may be requested by the practitioner requesting the hearing and will be forwarded to him/her by the Hospital upon payment of reasonable reproduction costs and payment of all outstanding fees owed to the Hospital, including any fees for compensation of a Hearing Officer.

8.7 Rights of Parties

The practitioner shall have a limited right, as determined by the Presiding Officer, to inquire as to possible biases of the Hearing Panel. Inquiry shall not be allowed into the medical qualifications or expertise of any such member.

During a hearing, subject to the provisions of this Article VIII, each of the parties shall have the right to:

1. call and examine witnesses
2. introduce exhibits
3. cross-examine any witness on any matter relevant to the issues
4. impeach any witness
5. rebut any evidence

If the practitioner who requested the hearing does not testify in his own behalf, such practitioner may be called and examined as if under cross-examination.

8.8 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence relating to the examination of witnesses or presentation of evidence. Any relevant evidence may be admitted by the Presiding Officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law, unless such evidence is deemed by the Presiding Officer to be cumulative. Hearsay evidence is admissible and shall be sufficient to support the decision of the Hearing Panel.

8.9 Official Notice

The Presiding Officer shall have the discretion to take official notice of any generally accepted technical or scientific matter relating to the issues under consideration or of any other matter that may be judicially noticed by the courts of the state. Participants in the hearing shall be informed of the matters to be officially noticed, and such matters shall be noted in the record of the hearing. Any party shall have the opportunity, upon timely request, to request that a matter be officially noticed or to refute the noticed matters by relevant evidence or by written or oral presentation of authority in a manner determined by the Hearing Panel. Reasonable or additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

8.10 Burden of Production or Proof

8.10.1 Burden of Production

In all cases in which a hearing is conducted, it shall be incumbent on the body whose action or decision prompted the hearing (i.e. the MEC or Governing Board) to come forward initially with evidence in support of its action or decision. Thereafter, the burden shall shift to the practitioner who requested the hearing to come forward with evidence in his support.

8.10.2 Burden of Proof

In all cases in which a hearing is conducted, after all the evidence has been submitted by both parties, the Hearing Panel shall rule against the practitioner who requested the hearing unless it finds that such person has proved, by clear and convincing evidence, that the factual allegations against the practitioner are untrue in total or in substantial part or unless it concludes, based on its findings of facts that the action of the entity whose decision prompted the hearing was arbitrary, unreasonable, or appears to be unfounded or unsupported by credible evidence. It is the burden of the practitioner requesting the hearing to demonstrate that s/he satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and/or clinical privileges, and that he/she complies with all medical staff and hospital policies.

8.11 Presence of Panel Members and Vote

A majority of the members of the Hearing Panel must be present throughout the hearings and deliberations; provided; however, that, at the discretion of the Presiding Officer, if a member is absent from an insubstantial part of the hearing, such member may be allowed to read the transcript of the missed proceedings and, after doing so, may thereafter

participate in the deliberations of the Panel.

8.12 Recesses and Conclusions

The Presiding Officer may recess the hearing and reconvene the same at any time for the convenience of the participants, without additional notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Panel shall then conduct its deliberations outside the presence of either party to the hearing.

8.13 Postponements and Extension

Postponements and extensions of time beyond the times expressly permitted in these Bylaws may be requested by anyone, but shall be permitted only if the Hearing Panel, or the Presiding Officer acting on its behalf, determines that good cause has been shown.

ARTICLE IX
HEARING COMMITTEE REPORT AND FURTHER ACTION

9.1 Hearing Committee Report

Within thirty (30) days after the conclusion of the hearing, the Hearing Panel shall make a detailed written report signed by each panel member and setting forth separately each charge against the practitioner, a summary of the evidence that supports or rebuts such charges, its findings on each fact at issue, and recommendations based on such findings with respect to the matter. This report, together with the hearing record and all other documentation considered by it, will then be forwarded to the body whose recommendation or decision prompted the hearing (MEC or Board). All findings and recommendations by the Hearing Panel shall be supported by reference to the hearing record and relevant documentation considered by the Hearing Panel. If the panel's decision is not unanimous, a minority report or reports may be issued. The practitioner requesting the hearing shall be provided the Hearing Panel's written recommendation and statement of the basis for it by special notice. The practitioner may also, upon request inspect all pertinent information in the Hospital's possession regarding the decision. The hearing panel shall have independent authority to recommend action to the Board.

9.2 Action on Hearing Committee Report

Within thirty (30) calendar days after receipt of the report of the Hearing Panel, the MEC or Governing Board, as the case may be, shall consider the same and affirm, modify or reverse its previous recommendation, decision or proposed decision in the matter. The applicable body shall indicate its action in writing, and shall transmit a copy of its written recommendation together with the hearing record, the report of the Hearing Panel, and all other relevant documentation, to the MEC or Governing Board. The practitioner has the right to receive the written decision of the MEC or Hospital Board, including a statement of the basis for the decision.

9.3 Notice and Effect of Results

The notice of the action taken by the Hearing Panel shall be given to the President of the Medical Staff, Hospital CEO and, by special notice, to the involved practitioner.

9.3.2 Effect of Favorable Result

1. Adopted by the Board
   If the Governing Board's action is favorable to the practitioner, such action shall constitute the final decision of the Board and the matter shall be considered finally closed.

2. Adopted by the MEC
   If the MEC's action is favorable to the practitioner, it shall be promptly forwarded, together with all supporting documentation, to the Board for its decision. The Board shall either adopt or reject the MEC's recommendation, in whole or in part, or refer the matter back to the MEC for further reconsideration. Any such referral shall include a statement of the reasons

therefore and set a time limit within which a subsequent recommendation to the Board must be made. After receipt of such subsequent recommendation, the Board shall render its decision. The practitioner will be sent a special notice informing him or her of each action taken. A favorable decision shall constitute the final action of the Board, and the matter shall be considered finally closed. If the Board's decision is adverse, the special notice shall inform the practitioner of his or her right to request an appellate review by the Board as provided in this Investigation, Corrective Action and Fair Hearing and Appeal Procedure.

The practitioner shall be provided with written notice of the final adverse decision by the Governing Board.

3. Effect of Adverse Action
   If the action of the Governing Board or MEC continues to be adverse to the Practitioner, the special notice required shall inform the practitioner of his or her right to request an appellate review by the Governing Board.

ARTICLE X
INITIATION AND PREREQUISITE OF APPELLATE REVIEW

10.1 Request for Appellate Review

Within thirty (30) calendar days after receipt of the notice given, the practitioner who requested the hearing may request in writing an appellate review by the Governing Board. Such request shall be delivered to the Hospital CEO either in person or by certified or registered mail. The written request for an appeal shall also include a brief statement of the reasons for appeal.

10.2 Waiver by Failure to Request Appellate Review

If such appellate review is not requested within the time and in the manner specified in Section 10.1., the practitioner shall be deemed to have waived his right to appeal and to accept the action so noticed, and it shall thereupon become final and effective immediately.

10.3 Notice of Time and Place

In the event of any appeal to the Governing Board, the Board shall, within thirty (30) calendar days after the receipt of such notice of appeal, schedule and arrange for an appellate review. The Governing Board shall cause the practitioner to be given special notice of the time, place and date of the appellate review. The date of the appellate review shall be not less than fourteen (14) days nor more than sixty (60) days from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is made by a member who is under a suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than thirty (30) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Governing Board for good cause.

10.4 Appellate Review Body

The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by a special or adhoc Appellate Review Committee of not less than three (3) members of the Board appointed by the Chair of the Board. The Chair of the Board or his designee shall be the Presiding Officer and shall have the same responsibilities as the Presiding Officer at the initial hearing. If an Appellate Review Committee is appointed, the Board shall delegate to such committee full authority to render a final decision on behalf of the Board. Members of the appellate review panel (the "Review Panel") may not be direct competitors of the practitioner under review and should not have participated in any formal investigation or deliberations leading to the recommendation for corrective action under consideration.

ARTICLE XI
APPELLATE REVIEW PROCEDURE

11.1 Grounds for Appeal

The grounds for appeal to the Governing Board shall be limited to the following:

1. There was substantial failure to comply prior to the hearing with the provisions contained in the Medical Staff Bylaws or this Investigation, Corrective Action and Fair Hearing Procedure so as to deny basic fairness or reasonable due process; or

2. the recommendation(s) of the MEC was made arbitrarily, capriciously, or with prejudice; or

3. the recommendation of the MEC and/or Hearing Panel was not supported by the hearing record.

In making this assessment the Governing Board will consider the record of the hearing before the Hearing Panel and any written statements submitted by parties to the hearing.

11.2 Written Statements

Each party shall have the right to present a written statement in support of its position on appeal, provided that such statement is submitted to the Board or the Committee of the Board, at least fifteen (15) days prior to the date of the appellate review, unless otherwise provided by the Board or the Appellate Review Committee of the Board. A copy shall be provided of each submitted written statement to the opposing party at least seven (7) days prior to the date of the appellate review.

11.3 Submission of Additional Evidence

The Review Panel may, but is not required to, accept additional oral or written evidence subject to the same cross-examination and admissibility provisions adopted at the hearing panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.

11.4 Action

The Governing Board or the Committee of the Board, may affirm, modify or reverse the action which is the subject of the appeal, or refer the matter back to the MEC for further review and recommendation. If the matter is referred back to the MEC for further review and recommendation, the Review Panel shall promptly conduct its review and make its recommendations to the Governing Board or the Appellate Review Committee of the Board, in accordance with the instructions given to the Governing Board or the Appellate Review Committee of the Board. This further review process shall in no event exceed thirty (30) days in duration, except as the parties may otherwise stipulate.

ARTICLE XII
FINAL DECISION OF THE BOARD

12.1 Final Board Decision

Within thirty (30) calendar days after the conclusion of the proceeding before the Governing Board or the Appellate Review Committee of the Board, the Governing Board or the Appellate Review Committee of the Board shall render a final decision in writing and shall deliver copies thereof to the MEC and, by special notice, to the practitioner. This decision shall be effective immediately and shall not be subject to further review.

ARTICLE XIII
GENERAL PROVISIONS

13.1 Exhaustion of Administrative Remedies

By applying for membership on the medical staff or for privileges, each applicant agrees that, in the event of any corrective action or decision with respect to his medical staff membership and/or privileges, the applicant or medical staff member shall exhaust the administrative remedies afforded by the Medical Staff Bylaws, including this Procedure, before resorting to formal legal action.

13.2 Limit of One Appellate Review

Except as otherwise provided in this section, no applicant or member shall be entitled as a matter of right to more than one appellate review in total before the Governing Board or the Appellate Review Committee of the Board on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the MEC or the Governing Board, or the Appellate Review Committee of the Board or a combination of actions by such bodies.

13.3 Waiver

If at any time after receipt of special notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this Investigation, Corrective Action and Fair Hearing Procedure, or to proceed with the matter, he shall be deemed to have consented to such adverse recommendation, action, or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the Medical Staff Bylaws then in effect or under this Procedure with respect to the matter involved.

ARTICLE XIV
ADOPTION AND AMENDMENT

14.1 Amendment

This Investigation, Corrective Action & Fair Hearing Procedure, may be amended or repealed, in whole or in part, as described in Article XI of the Bylaws.

Originally adopted by the Medical Staff:	
Originally approved by the Board:	
Revisions adopted by the Medical Staff:	08/12/2025
Revisions approved by the Board:	11/9/2010, 03/24/2015, 03/21/2017, 08/20/25