



**ST. JOHN'S HOSPITAL
MEDICAL STAFF BYLAWS**

MEDICAL STAFF BYLAWS TABLE OF CONTENTS

While Bylaws and Credentials Policies are in process of revisions the table of contents will not be updated until final revisions are completed.

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PREAMBLE

St. John's Hospital is a non-profit corporation organized under the laws of the State of Illinois to serve as a general acute care teaching Hospital providing patient care, education, and research. The practice of medicine is the Medical Staff members' legal prerogative and responsibility. The quality of medical care in St. John's Hospital will be maintained and supervised by and through its Medical Staff. In helping to maintain the quality of medical care, St. John's Hospital's Board of Directors and management will cooperate and assist its Medical Staff in developing procedures to accomplish this end. The practitioners practicing in St. John's Hospital shall function in accordance with these Bylaws, Rules and Regulations, Medical Staff policies and the Ethical and Religious Directives for Catholic Hospitals and be subject to the statutory and regulatory responsibility and authority of the Hospital Board of Directors of St. John's Hospital. St John's Hospital and the Medical Staff of St John's Hospital shall work collaboratively to comply with applicable accreditation standards, and state and federal legal requirements for Hospitals and health care professionals.

ARTICLE I: MEDICAL STAFF PURPOSE & AUTHORITY

Section I.1 Name

- I.1.1 The Medical Staff members shall be known as the Medical Staff of St. John's Hospital, Springfield, Illinois.

Section I.2 Purpose

- I.2.1 The purpose of the Medical Staff is to provide all patients admitted to or treated in any of the facilities, departments, or services of the Hospital with competent health care and to provide an appropriate educational setting which will maintain scientific standards that will lead to continuous advancement in professional knowledge and skill, and which will foster basic and applied research.

- I.2.2 The purpose of the Bylaws is to:

- a. Delineate the duties, responsibilities, and privileges of Medical Staff members and Allied Health personnel;
- b. Serve as a standard for guidance in the care of patients and in the relations of members of the Medical Staff to one another and to the Hospital Board of Directors and the Chief Executive Officer;
- c. Establish a self-disciplinary mechanism to assure the adequacy and efficiency of health care services provided in the Hospital which may involve the continuous quality improvement concept;
- d. Acknowledge the mechanism of the ad hoc committee of the Board whereby issues and conflicts which arise between the members of the Medical Staff and the Board may be discussed and resolved;
- e. Establish Bylaws, Rules and Regulations and policies of the Medical Staff to govern the actions, professional responsibilities, and accountability of members of the Medical Staff; and
- f. Provide an appropriate educational setting which will maintain scientific standards, lead to continuous advancement in professional knowledge and skill, and encourage and support such clinical and basic research as is authorized from time to time by the Board.

Section I.3 Authority

- I 3.1 Subject to the authority granted by the Board, the Medical Staff will exercise such powers as reasonably necessary to discharge its responsibilities under these Bylaws and under the Corporate Bylaws of St. John's Hospital.

ARTICLE II: MEDICAL STAFF MEMBERSHIP

Section II.1 Nature of Medical Staff Membership

II.1.1 Membership on the Medical Staff of St. John's Hospital shall be extended only to professionally competent physicians, oral surgeons, dentists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws, Rules and Regulations and associated policies of the Medical Staff and religious directives of St. John's Hospital.

Section II.2 Qualifications for Membership

II.2.1 General qualifications include evidence of the following:

- a. current Illinois licensure to practice in the relevant profession,
- b. successful graduation from an approved school of medicine, osteopathy, oral surgery, dentistry, or podiatry,
- c. successful completion of a training program in the specialty in which privileges are held or sought, which program was, at the time attended, accredited by the American Council of Graduate Medical Education, or the American Osteopathic Association, or the equivalent agency, if any, in the location of the training program;
- d. recent clinical performance and competence within the last twenty-four (24) months with an active clinical practice or training in the area in which clinical privileges are sought,
- e. evidence of current competence and sound clinical judgment to warrant privileges requested,
- f. the ability to safely and competently meet the obligations of the Medical Staff category requested,
- g. demonstration to the satisfaction of the Hospital that patients they treat can reasonably expect quality medical care; and
- h. Board certification and maintenance of certification requirements as determined by individual departments and approved by the Medical Staff Executive Committee (MEC) for Active and Active Associate members. Board Certification and Maintenance of Certification is not required for Courtesy and Honorary Members.
- i. that any applicable office or residence location requirements established by the Medical Staff to promote timely care are satisfied;
- j. that any conflict of interest or other administrative requirements established by the Medical Staff are satisfied;
- k. compliance with professional liability insurance requirements as set out in these Bylaws, Rules and Regulations, and policies of the Medical Staff;
- l. an ability and willingness to work cooperatively with other members of the Medical Staff and Hospital staff in a professional manner and in compliance with established Bylaws, Rules and Regulations, and policies of the Medical Staff;
- m. current, valid, unrestricted drug enforcement administration (DEA) license if applicable to the privileges requested;

- n. no record of current involuntary exclusion from participating in Medicare, Medicaid or any other federally-funded health care program. Participation in Medicare or any other funding program or health coverage contract or other arrangement is not a requirement for Medical Staff membership or privileges;
- o. no felony convictions or state sanctions within the last five years;

II.2.2 These qualifications specific to membership professions must be met in addition to General Qualifications:

- a. Physician applicants, MD or DO, must have successfully completed an allopathic or osteopathic residency program of at least three (3) years approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and meet any Board certification and recertification requirements applicable to the department membership and clinical privileges requested.
- b. Oral and maxillofacial surgeon applicants must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation, have appropriate residency training, and meet any Board certification and recertification requirements applicable to the department membership and clinical privileges requested.
- c. Dentist applicants must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation, and meet any Board certification and recertification requirements applicable to the department membership and clinical privileges requested.
- d. Doctors of Podiatric Medicine applicants, 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 meet any Board certification and recertification requirements applicable to the department membership and clinical privileges requested.

II. 2.3. Exemptions from any of these criteria may be allowed by the MEC when deemed appropriate for members of the Honorary category of Medical Staff membership.

Section II.3 Nondiscrimination

St. John's Hospital and its Medical Staff will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, or disability unrelated to the provision of patient care to the extent the applicant is otherwise qualified.

Section II.4 Conditions and Duration of Appointment

The Hospital Board of Directors shall make initial appointment and reappointments to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a

recommendation from the MEC. Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

Section II.5 Medical Staff Clinical Privileges

Requested clinical privileges will be considered only when the request demonstrates compliance with any threshold criteria recommended by the Department Chair, approved by the MEC and approved by the Board. In the event there is a request for a clinical privilege for which there is no approved criteria, the Board, with input from the MEC and Hospital administration, will first determine if it will allow the privilege to be practiced at the Hospital and, if so, direct the MEC to promptly develop appropriate privileging criteria. Once specific criteria for the clinical privilege have been recommended by the MEC and approved by the Board, the request for the clinical Privilege will be evaluated as described in Article VIII of these Bylaws.

Section II.6 Responsibilities of Each Medical Staff Member

- II.6.1 Each Medical Staff member must provide or provide for appropriate, timely, and continuous care of his/her patients.
- II.6.2 Each Medical Staff member must participate, as assigned, in quality/performance improvement/peer review activities and in discharging other staff functions as may be required.
- II.6.3 Each Medical Staff member must participate in the on call coverage of the emergency department and other coverage programs as determined by the departments and approved by MEC to see that patient care needs of the community are continuously met.
- II.6.4 Each staff member must submit to any type of health evaluation as requested by the MEC, or as part of a post-treatment monitoring plan consistent with the provisions of any Hospital or Medical Staff policies addressing member health or impairment and provide results of compliance with any health evaluation requirement adopted by the Medical Executive Committee. If the President of the Medical Staff perceives there is an emergency situation, a Medical Staff member is expected to submit to an appropriate diagnostic test or exam as requested. Any officer of the Medical Staff may act in the same manner if the President is not available.
- II.6.5 Each staff member must abide by the Bylaws, Rules and Regulations and policies of the Medical Staff and Hospital policies as they pertain to medical practice, including but not limited to the Medical Staff policies on professional conduct and behavior.
- II.6.6 Each staff member must provide evidence of professional liability coverage of a type and an amount established by the Medical Staff and approved by the Board. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession.

This requirement notwithstanding, subject to approval of the Board, the MEC may, for good cause shown by a physician, oral surgeon dentist, or podiatrist, waive the minimum liability insurance requirement, if any, with regard to the physician, oral surgeon, dentist, or podiatrist. In determining whether an individual exception is appropriate, the following factors may be considered:

- a. Whether the physician, oral surgeon, dentist, or podiatrist has applied for the requisite insurance;
- b. Whether the physician, oral surgeon, dentist, or podiatrist has been refused insurance, and, if so, the reasons for such refusal;
- c. Whether insurance is available, and, if not, the reasons for its unavailability;
- d. Whether the physician, oral surgeon, dentist, or podiatrist has available alternative means of assuring financial solvency in the event of being named as a defendant in a civil action or actions involving professional capability.

II.6.7 Each staff member must notify the Medical Staff Office immediately of any loss or change of liability insurance.

II.6.8 Each staff member must notify the Medical Staff Office promptly within five (5) business days of any suspension, limitation or change of licensure, DEA certification, or participation in State or Federal medical programs.

II.6.9 Each member must promptly inform the Medical Staff Office of any changes requiring an update of the Health Care Professional Credentialing and Business Data Gathering Update Form.

Section II.7 Medical Staff Member Rights

II.7.1 Each member of the Medical Staff in the Active category has the right to an audience with the MEC on matters relevant to the responsibilities of the MEC. In the event such Medical Staff member is unable to resolve a matter of concern after working with his/her Department Chair or other appropriate Medical Staff leader(s), that Medical Staff member may, upon written notice to the President of the Medical Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

II.7.2 Each member of the Medical Staff in the Active category may request a special staff meeting to discuss a matter relevant to the Medical Staff. Upon presentation of a petition signed by 10% of the members of the active category, the MEC shall schedule a special staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

II.7.3 Each member of the Medical Staff in the active category may call for a Department meeting by presenting a petition signed by 15% of the members

of the Department, but not less than three (3) members. Upon presentation of such a petition the Department Chair will schedule a Department meeting.

II.7.4 The above sections 7.1-7.3 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. These Bylaws provide recourse in these matters.

II.7.5 Any Medical Staff member has a right to an appeal and hearing pursuant to the Medical Staff's hearing and appeal procedure as set forth in these bylaws.

Section II.8 Staff Dues

II.8.1 Medical Staff dues, if any, shall be determined by the MEC. Failure of a Medical Staff member to pay dues shall be considered a voluntary resignation from the Medical Staff. The MEC may pass policies from time to time which exempt certain categories of membership or members holding specified leadership positions or may require additional assessments.

II.8.2 The Medical Staff fund will be controlled and maintained by the MEC with sufficient reserves to meet current and anticipate future expenditures.

ARTICLE III: CATEGORIES OF THE MEDICAL STAFF

Section III.1. 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. Categories, with the respective prerogatives and responsibilities, are summarized in the chart attached as Appendix A to these Bylaws.

Section III.2. ACTIVE STAFF

III.2.1. Qualifications:

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

- a. are involved in at least 24 unique patient contacts at the Hospital over a 24- year month period; and/or
- b. are willing to participate into Medical Staff functions and/or demonstrated 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 24 patient contacts per 24-month appointment term period will not be eligible to request Active Staff status at the time of his/her 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).

III.2.2.

Prerogatives and Responsibilities:

Active Staff Members: may:

- a. may admit patients, in accordance with the member's admitting privileges, if any 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.

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

- a. serving on committees, as requested;
- b. 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;
- c. providing care for unassigned patients;
- d. 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);
- e. accepting inpatient consultations, when requested;
- f. must pay any applicable application fees, dues, and assessments; and
- g. shall perform assigned duties.

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 Board determines, later, that call coverage in the member's specialty area is not adequate.

Section III.3. COURTESY STAFF

III.3.1. 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.

III.3.2. 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 such clinical privileges as are 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.

Section III.4

CONSULTING STAFF

III.4.1.

Qualifications:

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

- a. are of demonstrated 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).

III.4.2.

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.

Section III.5. COVERAGE STAFF

III.5.1. 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 such 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.

III.5.2. 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 Active 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.

Section III.6. AFFILIATE STAFF

III.6.1. 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;
- 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.

III.6.2. 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;
- l. must pay any applicable any applicable application fees, dues, and assessments.

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.

Section III.7. TELEMEDICINE (Non-Staff)

III.7.1. Qualifications:

The Telemedicine (Non-Staff) providers will consist of providers who provide care, evaluation and treatment of patients only remotely via electronic communication, or solely 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).

III.7.2. 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 chairpersons, 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 May perform assigned duties.

Section III.8. HONORARY STAFF

III.8.1. 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.

III.8.2. 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.

Section III.9. ALLIED HEALTH STAFF

III.9.1 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.

III.9.2. Prerogatives and Responsibilities:

Allied Health Staff Members:

- 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 IV: OFFICERS OF THE MEDICAL STAFF

Section IV.1 Officers of the Medical Staff

IV.1 President of the Medical Staff
President-Elect
Secretary
Immediate Past President

Section IV.2 Qualifications of Officers

- IV.2.1 An officer must;
- a. Be a member in good standing of the Active category;
 - b. Have previously served in a significant leadership position on a Medical Staff;
 - c. Indicate a willingness and ability to serve;
 - d. Have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges;
 - e. Have a history of attendance at continuing education relating to Medical Staff leadership or be willing to do so during their term of office
 - f. Have a demonstrated an ability to work well with others and compliance with the professional conduct policies of the Medical Staff, and
 - g. Have excellent administrative and communication skills.
- IV.2.2 A member of Medical Staff Executive Committee (MEC) or chairman of a Medical Staff Committee may not serve concurrently as a member of the Hospital Board of Directors.
- IV.2.3 The Nominating Committee will have discretion to determine if a staff member wishing to run for office meets the above mentioned qualifications.

Section IV.3 Election of Officers

- IV.3.1 Nominating Committee: Annually the Medical Staff President shall appoint a Nominating Committee, which shall consist of the Past President of the Medical Staff, the current President, the current President-Elect and two other Active staff members. The Past President shall act as chairperson. The Chief Executive Officer and Chief Medical Officer may serve as advisors. The committee shall offer at least two (2) nominees for each office. The nominations must be announced, and the names of the nominees distributed to all members of the Active Medical Staff at least thirty (30) days prior to the election.
- IV.3.2 A petition signed by at least 25 Active staff members or greater than 5% of the Active membership, whichever is less, may also make nominations. Such petition must be submitted to the President of the Medical Staff at least fourteen (14) days prior to the election for placement on the ballot. The

candidate nominated by petition must be evaluated by the Nominating Committee.

- IV.3.3 Officers shall be elected every other year at the annual meeting of the Medical Staff by a majority vote of those casting ballots at the meeting. Only members of the Active category shall be eligible to vote. If quorum at the annual meeting is not met, alternative balloting by a method to be determined by MEC will be used.

Section IV.4 Term of Office

- IV.4.1 All officers serve a term of two (2) years. Officers shall take office immediately on election.
- IV.4.2 All other members of the MEC serve a term of 3 years.

Section IV.5 Vacancies of Officers

- IV.5.1 The MEC shall fill vacancies of elected² officers for the balance of the unexpired term and such persons shall assume office immediately upon the appointment by the MEC.

Section IV.6 Duties of Officers

- IV.6.1 President of the Medical Staff – The President shall serve as the chair of the MEC and will fulfill duties as follows:
- a. Act as the chief clinical officer of the Hospital, in coordination and cooperation with the Chief Executive Officer and Chief Medical Officer, in matters of mutual concern involving the Hospital;
 - b. Call, preside at, and be responsible for the agenda of all regular and special meetings of the Medical Staff;
 - c. Serve as ex-officio member of all Medical Staff committees, other than the Executive Committee, on which the President will serve as Chairman and a voting member;
 - d. Appoint committee chairmen and members to all standing and special Medical Staff committees, except the MEC, and recommend in conjunction with the Chief Medical Officer, practitioners for appointment to Hospital or multi-disciplinary committees;
 - e. Represent the views, policies, needs, and grievances of the Medical Staff and report on the medical activities of the Medical Staff to the Board and to the Chief Executive Officer;
 - f. Review and interpret the policies of the Board to the Medical Staff;

² Refer to section IV.6.4, where a proposed vacancy process for Immediate Past President would address the situation for that non-elected officer position.

- g. Report to the Board the Medical Staff's recommendations and concerns at each of its meetings,
- h. Confer with the Chief Medical Officer and Chief Executive Officer as needed regarding the performance and maintenance of quality with respect to the Medical Staff's provision of medical care;
- i. Act as a spokesman for the Medical Staff in its external professional and public relations;
- j. Be responsible for the educational activities of the Medical Staff in conjunction with accredited CME organizations;
- k. Be responsible for providing continuous compliance with necessary accreditation requirements; and
- l. Be responsible for the enforcement and review of these Bylaws, Rules and Regulations, and medical staff policies.

IV.6.2 President-Elect – In the absence of the President, the President Elect shall temporarily assume all the duties and have the authority of the President of the Medical Staff. This officer shall perform such further duties to assist the President as the President may from time to time request. The President-elect will chair the Clinical Performance Committee.

IV.6.3 Secretary – This Officer will collaborate with the Medical Staff Office, assure maintenance of minutes, attend to correspondence, and coordinate communication within the Medical Staff. This officer shall perform such further duties to assist the President as the President may from time to time request. In the absence of the President and President-Elect, the Secretary shall assume the responsibilities of the President.

IV.6.4 Immediate Past President – This Officer will serve as a consultant to the President of the Medical Staff and President-Elect of the Medical Staff and provide feedback to the Officers regarding their performance of assigned duties on an annual basis. This officer shall perform such further duties to assist the President as the President may from time to time request. In the absence of all other officers the Immediate Past President shall assume the responsibilities of the President. The Immediate Past President will chair the Credentials Committee.

Should the office of Immediate Past President be vacated, the Medical Executive Committee may³ appoint a Past President to fulfill the responsibilities of the Immediate Past President set forth in these bylaws for the remainder of the term. Should the Medical Executive Committee choose not to fill the position of Immediate Past President, it may instead appoint an

³ May, not must-in case there is no Past President available or appropriate to serve. No one can¹⁷ be named an Immediate Past President who was never Past President.

Active Staff member as Credential Committee Chair,⁴ who will also serve as a MEC member, but without vote.⁵

⁴ Permits the Credential Committee Chair to be replaced even if no Past President is available or appropriate to serve.

⁵ Since this is an appointed rather than elected member.

Section IV.7 Removal and Resignation from Office

- IV.7.1 The Medical Staff may remove from office any Officer by petition of 15% of the Active staff members and a subsequent two-thirds (2/3) affirmative vote by ballot of the Active staff with quorum present.
- IV.7.2 The MEC with a two-thirds (2/3) vote with quorum present may immediately remove a Medical Staff officer for failure to conduct those responsibilities assigned within these Bylaws, failure to comply with Rules and Regulations or policies of the Medical Staff, or for conduct or statements damaging to the Hospital, its goals, or programs, or an automatic or summary suspension of clinical privileges.
- IV.7.3 Resignation: Any ⁶ officer of the Medical Staff may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt or at a mutually agreed upon date.

⁶ Clarification that Immediate Past Presidents can resign, although they were not elected to that office. 19

ARTICLE V: MEDICAL STAFF ORGANIZATION

Section V.1 Organization of the Medical Staff

V.1.1 The Medical Staff of St. John's Hospital shall be organized as a departmentalized staff. The Medical Staff may create Clinical Sections within a Department in order to facilitate Medical Staff activities.

The Medical Staff Executive Committee (MEC), with approval of the Board, may designate new Medical Staff Departments or Clinical Sections or dissolve current Departments or Clinical Sections as it determines will best meet the Medical Staff functions of promoting performance improvement, patient safety, and effective credentialing and privileging.

V.1.2 The currently recognized Departments are the following:

Anesthesiology
Cardiology
Emergency Medicine
Family Medicine
General Surgery
Internal Medicine
Laboratory Medicine
Medical Neurology
Obstetrics/Gynecology
Ophthalmology
Oral & Maxillofacial Surgery
Otolaryngology and Head and Neck Surgery
Orthopedics
Pediatrics
Plastic Surgery
Podiatric Medicine
Psychiatry
Radiation Oncology
Radiology
Surgical Neurology
Thoracic Surgery
Urology
Vascular Surgery

Section V.2 Qualifications, Selection, Term, and Removal of Department Chair

V.2.1 Each Department Chair shall serve a term of two (2) years commencing on January 1st and is eligible to serve successive terms. All Chairs must be members of the Active staff with relevant clinical privileges and certified by an appropriate specialty Board or have affirmatively established comparable competence through the privilege delineation process.

- V.2.2 Department Chairs and (and Vice Chairs if appropriate) will be selected by a majority vote of the Active members of the department, subject to ratification by MEC. Each department shall establish procedures for identifying and selecting candidates and these procedures must be ratified by MEC.
- V.2.3 Department Chairs may be removed from office by the MEC upon receipt of a recommendation of two-thirds (2/3) of the members of the department. In addition, MEC may remove a Chair on its own by a two-thirds vote if any of the following occurs:
- V.2.3.1 The Chair may be removed upon ceasing to be an Active member in good standing of the Medical Staff.
 - V.2.3.2 The Chair suffers an involuntary loss or significant limitation of practice privileges, or,
 - V.2.3.3 The Chair fails to effectively carry out the responsibilities of the position to the satisfaction of MEC or the Board.
 - V.2.3.4 If removal is required, a new Chairman will be selected according to the established departmental procedures and approval by MEC.

Section V.3 Duties of Department Chair

- V.3.1 The Medical Staff chair of each department is responsible for the ongoing, effective operation of the department and for assessing and improving activities. Such responsibilities encompass not only the internal functioning but also the integration of each department into the overall functioning of the organization.

Each department chair is responsible for the following:

- a. Clinically related activities of the Medical Staff department;
- b. Administratively related activities of the department unless otherwise provided by the Hospital, e.g. department meeting minutes or written department recommendations to the MEC;
- c. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges;
- d. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department including requirements for Board certification and recertification.;
- e. Recommending clinical privileges for each member of the department;
- f. Assessing and recommending to MEC and the Hospital contracted sources for patient care services not provided by the department or organization;

- g. Integration of the department into the primary functions of the organization;
- h. Coordination and integration of interdepartmental and intradepartmental services;
- i. Development and implementation of Hospital policies and procedures that guide and support the provision of services;
- j. Recommendation for a sufficient number of qualified and competent persons to provide care or service;
- k. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services;
- l. Continuous assessment and improvement of the quality of care and services provided;
- m. Maintenance of quality control programs, as appropriate;
- n. Orientation and continuing education of all persons in the department or service;
- o. Recommendation for space and other resources needed by the department or service;
- p. Discuss policies and procedures and recommend same to the MEC for approval as requested or as initiated by members of the clinical services;
- q. Development of the departmental emergency service call schedule and written departmental policies and procedures as necessary; and
- r. May attend MEC meetings as desired or requested.

Section V.4 Assignment to Department

- V.4.1 The MEC will, after consideration of the recommendations of the Chair of the appropriate Department, recommend Department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary department. A member may also be assigned to a secondary department with MEC approval in consultation with the respective departments.
- V.4.2 Clinical privileges are independent of department assignment.

ARTICLE VI. COMMITTEES

Section VI.1 Designation, Substitution and Confidentiality

- VI.1.1 Designation: There shall be a Medical Staff Executive Committee (MEC) and such other standing and special committees as established by the MEC. The standing committees will include a Credentials Committee, Clinical Performance Committee, Nominating Committee, Bylaws Committee, Professional Wellness Committee, Infection Control Committee and Oncology Committee. Other special committees and task forces may be appointed by the MEC as deemed necessary by MEC to address time-limited or specialized tasks. Those functions requiring participation of, rather than direct oversight by the Medical Staff, may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions.
- VI.1.2 Substitution: The MEC may, at any time it deems necessary and desirable for proper discharge of the functions required by the Medical Staff and these Bylaws, by resolution and, if appropriate, upon consultation with the Chief Executive Officer of the Hospital, establish, eliminate, or merge standing or special committees and change the functions and structure of any committee.
- VI.1.3 Confidentiality: All committees involved in peer review or otherwise functioning as peer review committees and all members of such committees shall keep in strict confidence all papers, reports, and information obtained by the committee and by virtue of membership on the committee and shall otherwise comply with any Medical Staff confidentiality policies and any additional provisions for confidentiality, immunity and releases in these Bylaws.
- VI.1.4 With the exception of MEC and the Credentials Committee, the removal and replacement of a committee member may be at the recommendation of the committee chairman and approved by the MEC. A committee member may resign at any time by giving written notice to the committee chair.

Section VI.2 Medical Staff Executive Committee

VI.2.1 Composition

- VI.2.1.1 Composition: The voting members of the MEC shall consist of the officers of the Medical Staff, the Immediate Past President, all of which serve two year terms, and six (6) members elected at large from the Active staff for three (3) year terms. Advisory members may include the Chief Executive Officer, the Chief Medical Officer, the Chief Operating Officer, the Chief Nursing Officer and the Division Director of the Quality Resource Management Department or their designee. The chairperson will be the

President of the Medical Staff. Department chairpersons can attend MEC meetings as desired or requested. Licensed independent practitioners are eligible to serve if elected but a majority of committee members must be physicians.

VI.2.1.2 Removal and resignation from membership: An officer who is removed from his position in accordance with Article IV, Section 7 will automatically lose membership on the MEC. Other members of the MEC may be removed or resign in accordance with Article IV, Section 7.

VI.2.1.3 Unexpired portions of a member's term are to be filled as determined by MEC, however, only MEC members elected by the Medical Staff can vote⁷. In addition, MEC may adjust the length of elected terms of at large members to maintain continuity.

VI.2.2 Responsibilities: The responsibilities of the MEC and its members as delegated by the medical staff shall be to:

- a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws, Rules and Regulations and policies of the Medical Staff and provide oversight for all Medical Staff functions;
- b. Coordinate the implementation of policies adopted by MEC;
- c. Submit recommendations to the Board of Directors concerning all matters relating to appointment, reappointment, staff category, Medical Staff department assignment(s), clinical privileges, and corrective action;
- d. Account to the Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided in the Hospital by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;
- e. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Medical Staff appointees including collegial and educational interventions and investigations, when warranted;
- f. Make recommendations to the Board on medical administrative and Hospital management matters;
- g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;
- h. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

⁷Limits voting rights to those elected, rather than appointed.

- i. Represent and act on behalf of the Medical Staff, except in the election of officers and amendment and ratification of medical staff bylaws, rules and regulations and policies, and subject to such other limitations as may be imposed by these Bylaws;
- j. Formulate and recommend to the Board all Medical Staff policies;
- k. Request evaluations of Medical Staff members privileged through the Medical Staff process in instances in which there is question about an applicant's or member's ability to perform privileges requested or currently granted;
- l. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;
- m. Consult with administration on the quality, timeliness, and appropriateness of aspects of contracts for patient care services provided to the Hospital by entities outside the Hospital;
- n. Oversee that portion of the corporate compliance plan that pertains to the Medical Staff;
- o. Hold Medical Staff leaders, committees, and departments accountable for fulfillment of their duties and responsibilities;
- p. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws, Rules and Regulations and medical staff policies;
- q. Attend at least seventy-five percent (75%) of the meetings; and
- r. Maintain confidentiality

The medical staff can remove the Medical Executive Committee's delegated authority temporarily, as appropriate to protect the medical staff's interests, by vote of at least two-thirds of the membership.

VI.2.3

Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained. A quorum will exist when 50% of the members are present.

VI.2.3.1

Special Meetings: A special meeting may be called by the President of the Medical Staff or any three (3) members of MEC. A super majority of at least six (6) members must be present. A chairman for this meeting can be appointed by a vote of those in attendance.

Section VI. 3 Credentials Committee

VI.3.1 Composition: Membership of the Medical Staff Credentials Committee shall consist of the Immediate Past President and at least six (6) members of the Active Medical Staff. The Immediate Past President will be the chair. The President of the Medical Staff with approval of MEC will appoint other members. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The members may be reappointed for additional terms without limit. Any member of the Medical Staff Credentials Committee, including the Chair, may be relieved of his committee membership by a two-thirds (2/3) vote of the MEC. The Chief Medical Officer will serve as an advisor to this committee.

VI.3.2 Responsibilities: The responsibilities of the Credentials Committee shall be:

- a. To review and recommend action on all applications and reapplications for membership on the St. John's Hospital Medical Staff;
- b. To review and recommend action for all requests for privileges for practitioners eligible for privileges at St. John's Hospital;
- c. To review the recommended criteria for the granting of Medical Staff membership and clinical privileges for St. John's Hospital and provide recommendation to MEC;
- d. To develop, recommend, and consistently implement policy for all credentialing activities at St. John's Hospital;
- e. Recommend corrective action when appropriate;
- f. Perform such other functions as requested by the MEC;
- g. Attend at least seventy-five percent (75%) of the meetings held;
- h. Maintain confidentiality as described under Article VI, Section 1.3.

VI.3.3 Meetings: The Credentials Committee shall meet monthly or on call of the Chair or President of the Medical Staff. A quorum will exist when 50% of the members are present.

VI.3.4 Reporting: The Credentials Committee reports to the MEC.

Section VI.4 Clinical Performance Committee

VI.4.1 Composition: The Clinical Performance Committee (CPC) will be comprised of at least eight (8) members of the Active Medical Staff. The Chair of the Committee will be the President-Elect. The President of the Medical Staff is an ex-officio member of the Committee without vote. Medical Staff members currently serving as members of the Board or Quality Care Committee of the Board cannot serve on the Committee. Committee members will be appointed

by the President of the Medical Staff and approved on an annual basis by the MEC. In addition to Committee Medical Staff members, the Chief Operating Officer, Chief Medical Officer, Chief Nursing Officer, Division Director of Quality Resource Management, Director of Health Information Management, Director of Case Management and invited guests may attend the Committee meetings.

VI.4.2

Responsibilities:

- a. Review the scope and appropriateness of quality assessment activities performed by Medical Staff and Hospital departments governing use of medication, blood and blood components; sentinel event data, patient safety data; and operative and other procedural data;
- b. Determine priorities for both investigating and resolving problems;
- c. Recommend corrective action when appropriate;
- d. Assign responsibility and request further investigation or additional information on potential problems or areas of concern. This may include a focused professional review;
- e. Assure action has been taken to resolve identified problems;
- f. Recommend alternative action strategies or further study for problems not resolved after action has been taken at a lower level;
- g. Provide monthly reports to the MEC on pertinent findings on quality assessment issues;
- h. Evaluate annually the effectiveness of the quality assessment program and make recommendations for change as appropriate;
- i. Assure necessary information is communicated by the committee chairperson to other departments when problems involve more than one department;
- j. Assure status of identified problems is tracked to assure improvement or resolution of identified problems;
- k. Assure information from departments and findings from quality assessment activities are used to detect trends, patterns of performance or potential problems that affect more than one department;
- l. Attend at least seventy-five percent (75%) of the meetings held. Committee members will be expected to participate in appropriate educational programs provided by the Hospital and Medical Staff to increase their knowledge and skills in performing the Committee's responsibilities; and
- m. Maintain confidentiality.

VI.4.3 Meetings: The committee will meet no less than quarterly. The presence of fifty percent 50% of voting committee members will constitute a quorum at a regularly scheduled meeting. A majority will consist of a majority of voting members present.

Section VI.5 Medical Staff Quality Committee:

The Medical Staff Quality Committee is the multidisciplinary peer review committee for physician performance of quality care in the hospital.

VI.5.1 Composition:
At least 8 members of the medical staff representative of the departments of the medical staff appointed by the president and approved by MEC.

VI.5.2 Responsibilities:

- Focused Professional Review of individual physician performance referred from department chairs based on incidents or findings of OPPE and other appropriate sources
- Notification of involved medical staff at onset of review with opportunity for medical staff to respond
- Review of quality improvement activities that involve the Medical Staff
- Recommend and monitor performance improvement plans of individual members of the medical staff as determined by the committee
- Recommend Corrective Action to the Medical Executive Committee when appropriate

Section VI.6 Infection Control Committee

VI.6.1 Committee Composition

The Infection Control Committee is a multidisciplinary committee composed of representatives of the Medical Staff including the Hospital infection control officer, nursing staff, infection control nurses, Central Sterile Supply, pharmacy and Hospital administration. Representation from the Medical Staff should include infectious disease specialist(s) or pathologist(s) involved in infection control and microbiology. The chairman will be appointed by the President of the Medical Staff. Medical Staff members will be appointed annually by the President.

VI.6.2 Hospital administration will designate the official Hospital infection control officer. The Infection Control Officer has the authority, in conjunction with the Chief Executive Officer or designee, to institute any infection prevention measure deemed necessary during epidemiologic investigation and outbreak management.

VI.6.3 Responsibilities

- a. Develop, implement and coordinate the Hospital-wide program for risk assessment, surveillance, prevention and control of infection.

- b. Develop and approve policies describing the type and scope of surveillance activities including:
 - Review of cumulative laboratory reports;
 - Determination of definitions and criteria for healthcare associated infections;
 - Review of prevalence and incidence studies, as appropriate; and
 - Collection of additional data as needed.
- c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information.
- d. Evaluate and revise the type and scope of surveillance annually.
- e. Develop a surveillance plan for sampling of patients or personnel and environments.
- f. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections.
- g. Implement any surveillance, prevention, and control measures or studies, based on risks identified.
- h. Develop handling and disposal of contaminated material in a manner designed to prevent the transmission of the infectious agent.

VI.6.4 Meetings: The committee shall meet at least quarterly. Minutes shall be recorded by Infection Control manager or designee.

VI.6.5 Reporting: The committee shall report to the Clinical Performance Committee.

Section VI.7 Bylaws Review Committee

VI.7.1 The Bylaws Review Committee will conduct periodic reviews of the Medical Staff Bylaws and Rules and Regulations and medical staff policies, review proposed amendments, and submit recommendations to MEC.

VI.7.2 This committee will be appointed by MEC for terms as it deems necessary.

Section VI. 8 Nominating Committee

VI.8.1 Appointed annually by the President. See Article IV, Section 3.1

Section VI. 9 Professional Wellness Committee

VI.9.1 Composition – This committee will consist of at least three (3) members of the Active staff. Committee members will be appointed annually by the President of the Medical Staff and approved by the MEC. Consultation with other staff members may be requested as the committee deems necessary.

Members of this committee may not concurrently be a member of the Clinical Performance Committee, Credentials Committee, MEC, physician member of the Board, Quality of Care Committee of the Board or department chair.

VI.9.2

Responsibilities:

- a. Accept referral of members, LIPs or AHPs holding clinical privileges needing or likely to need assistance for any mental, emotional or physical situation, regardless of cause or duration, that may affect the member's, LIP's or AHP's ability to practice.
- b. Work as needed with the Chief Medical Officer and the President of the Medical Staff to assist those who are undergoing stressful circumstances of such significance that may lead to impairment, even though partial or temporary in nature;
- c. Develop and maintain referral information for evaluation and counseling programs for members or AHPs holding clinical privileges who appear to be in need;
- d. Accept self referrals from members or AHPs holding clinical privileges;
- e. Coordinate educational efforts regarding promotion of overall professional wellness to members or AHPs holding clinical privileges;
- f. Maintain confidentiality;
- g. Offer advice and counsel to individual members or AHPs holding clinical privileges referred by the MEC; and
- h. Notify the MEC of failure of the member to comply with previously accepted treatment and monitoring program.

VI.9.3

Meetings will be held at least annually or as deemed necessary by the chairman of the committee.

Section VI.10 Oncology Committee

VI.10.1

Composition: The committee shall consist of at least the following Medical Staff members appointed annually by the President of the Medical Staff: a radiation oncologist, a diagnostic radiologist, a pathologist, a medical oncologist and a general surgeon. The Oncology Committee chair may also be the cancer liaison physician. Other members include representation from the certified tumor registrar, oncology nursing, social worker, quality management, clinical research, pain control and palliative care, and the cancer program administrator.

VI.10.2

Responsibilities

- a. Develop and evaluate the annual goals and objectives for clinical,

community outreach, quality improvement , and programmatic endeavors related to cancer.

- b. Promote a coordinated, multidisciplinary approach to patient management.
- c. Supervise the cancer registry and ensure accurate and timely abstracting, staging and follow-up reporting.
- d. Ensure the educational and consultative cancer conferences cover all major sites and related issues.
- e. Ensure that an active supportive care system is in place for patients, families and staff.
- f. Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.
- g. Promote clinical research.
- h. Promote quality control of registry data.
- i. Encourage data usage and regular reporting.
- j. Ensure content of the annual report meets requirements.
- k. Publish an annual report.
- l. Uphold medical-ethical standards.

VI.10.3 Meetings: The Oncology Committee shall meet at least quarterly with more frequent meetings as called by the chairperson.

VI.10.4 Reporting: The committee shall submit minutes to the Clinical Performance Committee.

ARTICLE VII: MEDICAL STAFF MEETINGS

Section VII.1 Meetings of the Entire Medical Staff

VII.1.1 An annual meeting of the Medical Staff shall be held at least once a year at a time determined by the Medical Staff Executive Committee (MEC). Notice of the meeting shall be at least twenty-one (21) days in advance to all Medical Staff members via appropriate media and posted conspicuously.

VII.1.2 Except as otherwise specified in these Bylaws, the actions of a majority of the members present and voting at a meeting of the Medical Staff at which a quorum is present is the action of the group. Action may be taken without a meeting of the staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or electronic means, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as a quorum responds to the question that is voted upon receives a majority of the votes cast.

VII.1.3 Special Meetings of the Medical Staff

VII.1.3.1 The President of the Medical Staff or majority of MEC, or Hospital Board of Directors, or 15% of Active staff may call a special meeting of the Medical Staff at any time. Such request or resolution shall state the purpose of the meeting. The President of the Medical Staff shall designate the time and place of any special meeting.

VII.1.3.2 Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least seven (7) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

Section VII.2 Regular Meetings of Medical Staff Committees and Departments

VII.2.1 Committees and departments may, by resolution, provide the time for holding regular meetings without notice other than by such resolution.

Section VII.3 Special Meetings of Committees and Departments

VII.3.1 A special meeting of any committee or Department may be called by, or at the request of the chairperson or Department Chair thereof, by the President of the Medical Staff, or by members as delineated in Article II, Section 7.3.

Section VII.4 Quorum

- VII.4.1 For Medical Staff meetings when a vote is requested, a quorum will exist when twenty percent (20%) of Active members are present.
- VII.4.2 For MEC, Credentials Committee, and Clinical Performance Committee, a quorum will exist when fifty percent (50%) of the members are present.
- VII.4.3. Department meetings or Medical Staff committees other than those listed above are not subject to quorum requirements.

Section VII. 5 Attendance Requirements

- VII.5.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff and its committees to which the member is appointed.
 - VII.5.1.1 MEC may establish an incentive program to encourage attendance at Medical Staff meetings.
 - VII.5.1.2 MEC, Credentials Committee, and Clinical Performance Committee meetings: Members of these committees are expected to attend at least seventy-five percent (75%) of the meetings held.
 - VII.5.1.3 Special appearance: An individual Medical Staff member may be required to attend a meeting with a standing or ad hoc medical staff committee concerning suspected deviation from standard clinical practice or professional behavior. The President or the applicable department or committee chair may require the Medical Staff member to confer with him or with a standing or ad hoc medical staff committee that is considering the matter. The Medical Staff member will be given special notice of the meeting at least five (5) days prior to the meeting, including the date, time, place, a statement of the issue involved and that the Medical Staff member's appearance is mandatory. Failure of the Medical Staff member to appear at any such conference after two notices, unless excused by the MEC upon showing good cause, will result in an automatic suspension of Medical Staff privileges. Such suspension will be rescinded upon the Medical Staff member's participation in the previously referenced meeting. The Chief Medical Officer may attend at the invitation of the Medical Staff President.

Section VII.6 Executive Session

- VII.6.1 At the call of its chairman, any Medical Staff committee or department may meet in executive session, with attendance restricted to Medical Staff members, a recording secretary, and such advisors or other attendees as the chairman may specifically request to attend.

Section VII. 7 Robert's Rules of Order

VII.7.1 Medical Staff, department, and committee meetings shall be run in a manner determined by the individual who is the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest edition of *Robert's Rules of Order* shall determine procedure, to the extent they do not conflict with these Bylaws.

Section VII.8 Notice of Meetings

VII.8.1 Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the department or committee not less than five (5) business days (Monday-Friday) before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section VII.9 Action of Department or Committee

VII.9.1 The recommendation of a majority of its members present at a meeting with quorum present shall be the action of a committee or Department. Such recommendation will then be forwarded to the MEC for action.

Section VII.10 Rights of Ex-Officio Members

VII.10.1 Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members thereof, except that they shall not vote or be counted in determining the existence of a quorum. An ex officio member may be excused from an executive session if requested by the department or committee chairman.

Section VII.11 Minutes

VII.11.1 Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and decisions and actions on each matter. The presiding officer shall sign the minutes and copies thereof shall be submitted to the MEC or other designated committee within thirty (30) days. A permanent file of the minutes of each meeting shall be maintained.

ARTICLE VIII: CREDENTIALING

Section VIII. 1 Basis for Credentialing

VIII.1.1 No practitioner shall be entitled to membership on the Medical Staff or to clinical privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, managed care entity, Hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this Hospital.

VIII.1.2 Exceptions:

VIII.1.3.1 All practitioners who were current active staff members as of 1/1/1991 and have met prior qualifications for membership shall be exempt from Board certification and residency requirements.

VIII.1.3.2 Only the MEC may create additional exceptions to the membership qualifications after a joint conference with the Board.

VIII.1.3 Medical Staff membership and clinical privileges shall only be granted to and maintained by individuals who continuously meet the following criteria:

VIII.1.3.1 Fulfill the membership qualification criteria as identified in these bylaws

VIII.1.3.2 Provide evidence of both adequate physical and mental health necessary to fulfill the responsibilities of Medical Staff membership and the specific privileges granted to the applicant.

VIII.1.3.3 Demonstrate evidence of sound personal character by consistently complying with acceptable ethical and professional standards. These standards include, at a minimum:

- a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and
- b. A history of consistently acting in a professional, appropriate, and collegial manner in clinical and professional settings.

- VIII.1.3.4 Appropriate written, electronic and verbal communication skills.
- VIII.1.3.5 Any member of the Medical Staff who provides services to a St. John's Hospital patient or Hospital based skilled nursing facility must demonstrate the capability to provide continuous care. The applicant must provide evidence of acceptable patient coverage that meets the Medical Staff Bylaws, Rules and Regulations and policies of the Medical Staff as approved by MEC.

Section VIII.2 Application Request Procedure

All requests for applications for appointment to the Medical Staff must be in writing. Upon receipt of this request, the Medical Staff Office will provide the potential applicant with

An application packet containing:

- a. The most current State of Illinois Health Care Professional Credentialing and Business Data Gathering Form.
- b. St. John's Hospital Attestation, Agreement and Release Form (which requests information covering practice coverage and anticipated start date)
- c. A copy of the Medical Staff Bylaws, Rules and Regulations and excerpts from Hospital Bylaws that are pertinent to medical practice. The Medical Staff Bylaws contains expectations of behavioral and clinical performance as well as describing responsibilities for Medical Staff members;
- d. A copy of the Ethical and Religious Directives for Catholic Healthcare facilities then in effect at St John's;
- e. A detailed letter listing additional information and items required by the Medical Staff Bylaws, Rules and Regulations and policies.

Section VIII.3 Initial Appointment Procedure

VIII.3.1 Procedure for processing applicants for initial staff appointment:

VIII.3.1.1 A completed application includes:

- a. a signed and dated State of Illinois Health Care Professional Credentialing and Business Data Gathering Form;
- b. the supporting documents required under the Medical Staff Bylaws, Rules and Regulations, and policies;
- c. verification of information necessary to confirm applicant meets criteria for membership and privileges;
- d. all fees or dues as required under the Medical Staff Bylaws, Rules and Regulations, and policies;
- e. receipt of all references;
- f. a plan for continuous care of patients

VIII.3.1.2 An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed.

VIII.3.1.3 The burden is on the applicant to provide all required information.

- a. It is the applicant's responsibility to ensure that the Medical Staff Office receives all required supporting documents verifying information on the application and providing sufficient evidence that the applicant meets the requirements for Medical Staff membership and the privileges requested.
- b. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant, in the most expedient manner (written or electronic means).
- c. If the requested information is not returned to the Medical Staff Office within forty-five (45) days of the request, this will be deemed a voluntary withdrawal of the application.

VIII.3.1.4 Upon review of the application, the Chief Medical Officer

(or his designee) will determine if the application is complete and meets requirements of Section VIII.3.1.1. In the event the requirements of Section VII.3.1.1 are not met, the potential applicant will be notified that he is ineligible for membership on the St. John's Hospital Medical Staff, and the application will not be processed. If the requirements of Section 3.1.1 are met, the application will be accepted for further processing.

VIII.3.1.5

The Medical Staff Office will verify the contents of the application from acceptable sources and collect additional information such as:

- a. Information from current liability insurance carrier(s) and prior carriers concerning claims, suits, settlements and judgments, (if any) during the past ten (10) years;
- b. Documentation of the applicant's past clinical work experience;
- c. Licensure status in all current or past states of licensure;
- d. Available databanks such as the AMA or AOA Physician Profile, the National Practitioner Data Bank, Federation of State Medical Board, HIPDB (Healthcare Integrity and Protection Database), HHS/OIG list of excluded individuals, FACIS (Fraud and Abuse Control Information System), or other data banks including criminal background check;
- e. Completion of professional training programs including residency and fellowship programs;
- f. Other information about adverse credentialing and privileging decisions;
- g. Additional recommendations as necessary to address the applicant's current clinical competence, ethical character and ability to work with others;
- h. The results of any drug testing and/or other health testing required by another health care institution or licensing Board.
- i. Additional Information as may be requested to ensure applicant meets the criteria for Medical Staff membership; and
- j. Only when the information called for under these Bylaws is collected and verified will the application be processed further as a verified application.

- VIII.3.1.6 In the event there is undue delay in obtaining required verifications, the Medical Staff Office will request assistance from the applicant. During this time period, the time for processing the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after thirty (30) days will be deemed a voluntary withdrawal of the application.
- VIII.3.1.7 The Chief Medical Officer or designee shall arrange for an initial orientation interview, and review the file for completeness and accuracy.
- VIII.3.1.8 When the items identified above have been obtained and the interview completed, the file will then be reviewed by the Chief Medical Officer, Department Chair as described in Section 3.2, and the Chair of Medical Staff Credentials Committee, or their designees. The Chair of the Medical Staff Credentials Committee will categorize the application as follows:

Category 1: A verified application that does not raise concerns as identified in the criteria for category 2.

Category 2: One or more of the following criteria are identified in the course of review of a file:

- a. The application is found to be incomplete.
- b. The applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization.
- c. Applicant is, or has been, under investigation by a state medical Board or has prior disciplinary actions or legal sanctions.
- d. Applicant has had any malpractice cases;
- e. Applicant changed medical schools or residency programs or has gaps in training or practice.
- f. Applicant has changed practice locations more than three times in the past ten (10) years.
- g. Applicant has practiced or been licensed in three (3) or more states.
- h. Applicant has one or more reference responses that raise concerns or questions.

- i. Discrepancy found between information received from the applicant and references or verified information.
- j. Applicant has an adverse National Practitioner Data Bank report.
- k. The request for a clinical privilege is not reasonable based upon applicant's experience, training, and competence, and/or is not in compliance with applicable criteria.
- l. Applicant has been removed from a managed care panel for reasons of professional conduct or quality.
- m. Applicant has potentially relevant physical or mental health problems.
- n. Other as determined by the Department Chair or other representative of the institution.

VIII.3.2

Department Chair Action:

VIII.3.2.1

All completed applications are presented to the Department Chair for review and recommendation. The Department Chair reviews the application to ensure that it fulfills the established standards for membership and all requirements for all requests for clinical privileges. The Department Chair may require an interview with the applicant and may obtain input if necessary from an appropriate subject matter expert. A report must be forwarded to the Medical Staff Credentials Committee within fifteen (15) days. The Department Chair takes action as follows:

- a. Favorable recommendation: The Department Chair must document his findings pertaining to adequacy of education, training, and experience for all privileges requested. Reference to any criteria for clinical privileges must be documented and included in the credentials file. When the Department Chair's recommendation is favorable to the applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, to the Chair of the Medical Staff Credentials Committee.
- b. Adverse recommendation: The Department Chair will document the rationale for all unfavorable findings. Reference to any criteria for clinical privileges not met will be documented and included in the credentials file. The application, along with the Department Chair's adverse recommendation and supporting documentation,

will be forwarded to the Medical Staff Credentials Committee.

- c. Deferral: Department Chair(s) must provide a recommendation on an application. In the event a Department Chair is unable to formulate a report for any reason, the Department Chair must refer the file to the Medical Staff Credentials Committee. The applicant will be notified and reason given by the Medical Staff Office.

VIII.3.3

Medical Staff Credentials Committee Action:

VIII.3.3.1

If the application is designated category 1, it is forwarded to the MEC for review and recommendation. If designated category 2, the Medical Staff Credentials Committee reviews the application and votes for one of the following actions:

- a. Favorable recommendation: When the Medical Staff Credentials Committee's recommendation is favorable to the applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, to the MEC with recommendation for appointment until the next reappointment cycle.
- b. Conditional recommendation: The Medical Staff Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior or to clinical issues. The Medical Staff Credentials Committee may also recommend that appointment may be granted for a limited period of time in order to permit closer monitoring of an individual's compliance with any conditions.
- c. Adverse recommendation: When the Medical Staff Credentials Committee's recommendation is adverse to the applicant, the application shall be forwarded to the MEC.
- d. Deferral: Action by the Medical Staff Credentials Committee to defer the application for further consideration or for gathering of information from the applicant or other sources must be followed within thirty (30) days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department affiliations, and scope of clinical privileges.

VIII.3.3.2

Applicant Interview:

- a. All applicants may be required to participate in an

interview as part of the application for appointment to the Medical Staff at the discretion of the Medical Staff Credentials Committee. The interview is to be conducted by one or more individuals selected by the Medical Staff Credentials Committee for this purpose. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. A written record of the interview will be maintained in the Credentials file.

- b. Procedure for interview: the applicant will be notified when the verification process is complete and that he should contact the responsible individual, via the Medical Staff Office, to schedule an interview. It is the responsibility of the applicant to contact this individual to arrange the interview. Failure of the applicant to schedule an interview with the designated Medical Staff member within thirty (30) days will be deemed a withdrawal of the application.

VIII.3.4 Medical Staff Executive Committee (MEC) Action:

VIII.3.4.1 Category 1 and 2 applications are referred to MEC for review. MEC reviews the application and recommends one of the following actions:

- a. Favorable recommendation: When the MEC's recommendation is favorable to the applicant in all respects, the application shall be forwarded, together with all supporting documentation, to the Board.
- b. Conditional recommendation: The MEC may agree with prior Credentials Committee recommendation or recommend the imposition of specific conditions. These conditions may relate to behavior or to clinical issues. The MEC may also recommend that appointment may be granted for a limited period of time in order to permit closer monitoring of an individual's compliance with any conditions.

When MEC imposes conditional recommendation(s) the applicant will be notified and must accept the condition(s) for membership and privilege in writing within sixty (60) days, prior to the application being recommended to the Board. If the applicant does not accept the conditions he can exercise his rights to a hearing.

- c. Adverse recommendation: When the MEC's recommendation is adverse to the applicant, a special notice shall be sent to the applicant from the Medical Staff President or designee. No such adverse recommendation will be acted upon by the Board until after the practitioner has exercised or has waived his right to a hearing as provided in these Bylaws, Article XI.
- d. Deferral: Action by the MEC to defer the application for further consideration must be followed within sixty (60) days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department affiliations, and clinical privileges. The Chief Executive Officer shall promptly notify the applicant by special, written notice of the action to defer.

VIII.3.4.2 Only those applications on which the MEC took favorable action are eligible for expedited processing by the Board.

VIII.3.5

Board Action:

VIII.3.5.1 Whether the application is recommended by MEC as favorable, conditional or adverse, it is presented to the Board or an appropriate Board subcommittee where the application is reviewed.

- a. Favorable recommendation: the Board may adopt or reject in whole or in part a favorable recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Favorable action by the Board is effective as its final decision.
- b. Conditional recommendation: The Board may adopt or reject in whole or in part a conditional recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Conditional action by the Board is effective as its final decision.
- c. Adverse recommendation: if the Board's action is adverse to the applicant, a special notice will be sent by the CEO or designee to him and he shall then be entitled to the procedural rights provided in the Article XI.

d. All appointments to Medical Staff membership and the

granting of privileges are for a period not to exceed twenty-four (24) months.

VIII.3.6 Basis for recommendation and action: The report of each individual or group required to act on an application, including the Board, must state in writing the reasons for any adverse recommendation or action taken, with specific reference to the completed application and all other documentation considered.

VIII.3.7 Notice of final decision: Notice of Board's final decision shall be given, through the Chief Executive Officer to the MEC and to the chair of each department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions. A decision and notice of appointment includes the staff category to which the applicant is appointed, the department to which he is assigned, the clinical privileges he may exercise, and any special conditions attached to the appointment.

VIII.3.8 Time periods for processing: All individual and groups required to act on an application for staff appointment must do so in a timely and good faith manner, and, except for good cause, each application will be processed within the following time periods:

- | | |
|--|----------|
| a. Medical Staff Office
(to collect, verify, and summarize) | 2 months |
| b. Department Chairs
(to review and report) | 15 days |
| c. Medical Staff Credentials Committee
(analyze and recommend) | 1 month |
| d. Medical Staff Executive Committee (MEC)
(to reach final recommendation and refer to Board) | 1 month |

VIII.3.8.1 These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of the Hearing Procedure in Article XI are activated, the time requirements provided therein govern the continued processing of the application.

Section VIII. 5 Reappointment

VIII.5.1 Reappointment Cycle

- a. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. When the Medical Staff or the Board reappointment process has not resulted in a final action on a pending complete reappointment application within the membership term, the Medical Staff President shall, to meet important patient care needs such as on-call coverage and community access to medical services, grant the individual Temporary Clinical Privileges until such time as the Board

acts on the application. Prior to granting Temporary Privileges, the President shall consult with the relevant department chairperson and the Credentials Committee Chairperson. Only those privileges currently held (and not under restriction or suspension) by the Member seeking reappointment can be granted on a temporary basis.

- b. The granting of new clinical privileges to existing Medical Staff members will be considered independently from the reappointment process and will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 4 above concerning provisional status for those privileges. A suitable peer appointed by the

Medical Staff President shall substitute for the Department Chairperson in the evaluation of current competency of the Department Chairperson, and recommend appropriate action to the Medical Staff Credentials Committee.

- c. Necessary interval information may be requested from Medical Staff and AHPs in the years between the usual two-year reappointment cycles.

VIII.5.2

Information collection and verification:

VIII.5.2.1 The Medical Staff Office will provide all Medical Staff members whose Medical Staff appointment will expire in the current Medical Staff year an application for re-appointment at least one hundred and twenty (120) days prior to that year's last scheduled regular meeting of the Board. The completed reappointment application form and all required documentation must be returned to the Medical Staff Office within thirty (30) days after receipt by the Medical Staff member.

Exceptions:

- a. Upon request of the MEC, reappointment of individual staff members may be conducted more frequently than every two years.
- b. Honorary Staff members are not required to reappoint.

VIII.5.2.2 Information requested includes, but is not limited to the following:

- a. A signed and dated State of Illinois Health Care Professional Re-Credentialing and Business Data Gathering Form to update credentials file on items listed in the initial or most recent reappointment application; any required new, additional, or clarifying information, and any required fees or dues.
- b. St. John's Hospital Attestation, Agreement and Release Form (which requests information regarding practice coverage)
- c. Documentation concerning continued training and continuing medical education during the preceding appointment period.
- d. Specific new requests for clinical privileges sought at reappointment as per 5.1 above. These requests will be

considered separately from the reappointment process. The request must provide information about training, experience and competence.

- e. By signing the re-credentialing form the appointee agrees to the same terms as identified in sections pertaining to the application process.
- f. Any other documents deemed necessary by the MEC for processing the re-credentialing application.
- g. Completed departmental privilege guidelines as requested by the medical Staff Credentials Committee.

VIII.5.2.3

The following information is routinely collected by the Medical Staff Office:

- a. A summary of clinical activity at this Hospital for each appointee due for reappointment.
- b. Performance and conduct in this Hospital and other healthcare organizations in which the practitioner has provided clinical care since the last reappointment, including, without limitation, patterns of care as demonstrated in findings of quality assessment and clinical performance improvement activities, clinical judgment and skills in the treatment of patients, and behavior and cooperation with Hospital personnel, patients, and visitors.
- c. Service on Medical Staff, department, and Hospital committees.
- d. Timely and accurate completion of medical records, with adherence to documentation requirements.
- e. Compliance with all applicable Bylaws, Rules and Regulations and policies of the Medical Staff.
- f. Information regarding gaps in employment or practice since the previous appointment or reappointment.
- g. National Practitioner Data Bank query.
- h. A peer recommendation when insufficient peer review data are available to evaluate current competence, ethical character, and ability to work with others.
- i. Malpractice history for the past two (2) years.
- j. Information on member's professional ethics, current

clinical competence, conduct, skills, and clinical judgment in treatment of patients as indicated by evaluation of patient care provided and review of records of patients treated in this or any other Hospital as necessary.

- k. Progress toward Board certification and recertification as required by applicable department.
- l. Evaluation of performance by the applicable Department Chairperson and by the Credentials Committee and MEC.

VIII.5.3 Procedure for processing applications for staff reappointment: When the items identified in 5.2 above have been obtained and verified, the file will then be reviewed by the Chief Medical Officer or designee and Department Chair (or his designee), who will categorize the application for reappointment as follows:

VIII.5.3.1 Category 1 is assigned for completed applications for reappointment with no concerns as identified in the criteria for category 2. Re-applicants in category 1 will be processed in the same manner as category 1 initial applicants.

VIII.5.3.2 Category 2 is assigned if one or more of the following criteria is identified in the course of review of a completed application for reappointment. Re-applicants in category 2 will be processed in the same manner as category 2 initial applicants. Criteria for category 2 applications for reappointment include but are not necessarily limited to the following:

- a. The application is deemed to be incomplete.
- b. Applicant is found to have experienced an involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization.
- c. Applicant is, or has been, under investigation by a state medical Board or has had prior disciplinary actions or legal sanctions.
- d. Applicant has had malpractice cases filed or final adverse judgments that have not been previously reported.
- e. Applicant has gaps in practice since the most recent re-credentialing.
- f. Applicant has one or more reference responses which

raise concern or questions.

- g. Any significant discrepancy found between information received from the applicant and references or verified information.
- h. Applicant has a National Practitioner Data Bank report, or other mandated inquiries, with adverse information entered since the time of the applicant's previous appointment or reappointment.
- i. The request for clinical privileges is not reasonably based upon applicant's experience, training, and competence, and/or is not in compliance with applicable criteria.
- j. Removal from managed care panel for reasons of professional conduct or quality.
- k. Relevant physical or mental health problems.
- l. Information from the quality monitoring and improvement program at St. John's Hospital or other healthcare facilities which raises possible concerns with the applicant's quality of care or capacity to fulfill the responsibilities of Medical Staff membership and the requested privileges.

VIII.5.4 All applications for reappointment will be processed through the same procedure described in Section 3. Initial Appointment Process. In addition, as part of the assessment of the appointee's performance, the Department Chair or one or more subject matter experts may be asked to provide relevant information concerning provider's clinical and professional qualifications for reappointment for staff category and clinical privileges and to re-evaluate the credentials information. Such evaluation will include providing information of any conduct which indicates significant present or potential physical or behavioral problems affecting the practitioner's ability to perform professional and Medical Staff duties appropriately.

VIII.5.5 Board Action: For the purpose of reappointment an "adverse decision" by the Board as used in Section 3. Initial Appointment Process, means, a) a recommendation or action to deny reappointment, b) to deny or restrict requested clinical privileges or, c) any action which would entitle the applicant for reappointment to a fair hearing under these Bylaws.

Section VIII.6 Clinical Privileges

VIII.6.1 Privileges for which criteria has been established:

VIII.6.1.1 Exercise of privileges: A Medical Staff member providing clinical services at St. John's Hospital may exercise only those privileges granted by the Board as requested by the

member or emergency and disaster privileges as described herein.

VIII.6.1.2 Requests: Each application for appointment or reappointment to the Medical Staff must contain a request for setting specific clinical privileges desired by the applicant. Setting specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointment. Privileges are setting-specific meaning that privileges granted to an applicant are based not only on the applicant's qualifications, but also in consideration of the procedures and types of care, treatment, and services that can be performed or provided within the proposed setting.

VIII.6.1.3 Basis for privileges determination: Requests for clinical privileges will be evaluated using evidence of training, current competence and adequate volume experience with acceptable results based on data from quality improvement activities and outcome data if available. When no supporting literature exists for adequate volume, the criteria may be determined by a consensus of the applicant's Department chair and the Credentials Committee. In determining adequate volume experience, consideration will be afforded to the transferability of skills in the core privileges and current training. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges.

VIII.6.2 Privileges for which no criteria have been established:

VIII.6.2.1 In the event a request is submitted for a new procedure or treatment which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed ninety (90) days. During this time the MEC will, upon recommendation from the Medical Staff Credentials Committee and appropriate Department Chair and/or subject matter experts, determine whether to recommend to the Board that the privileges should be supported and the services provided. Upon receiving concurrence from the Board, the MEC shall direct the appropriate Department to develop criteria for consideration by the Credential Committee. If the Board determines that the requested privileges should not be supported, the CEO will inform the applicant that the request cannot be considered because the privileges requested cannot be supported at this institution.

VIII.6.2.2 The Medical Staff Office with the assistance of the appropriate Department Chair will compile information relevant to the privilege requested for the development of

criteria. The information compiled may include, but need not be limited to, position and opinion papers from specialty organizations, white papers and others as available, position and opinion statements from interested individuals or groups, and documentation from other Hospitals in the region as appropriate.

VIII.6.2.3 Criteria to be established for the privilege in question include education, training, Board status, or certification (if applicable), experience, and evidence of current competence. Proctoring requirements, if any, will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as equipment, staff training and management will be referred to the appropriate Hospital administrator or director.

VIII.6.2.4 If the privilege requested overlaps two or more specialty disciplines, an ad hoc committee may be appointed by the Chair of the Medical Staff Credentials Committee to recommend criteria for the privilege in question. This committee shall obtain input from members of each involved discipline. The chair of the ad hoc committee will be a member of the Medical Staff Credentials Committee who has no vested interest in the issue. This does not preclude departments from developing and submitting different privilege criteria to the Credentials Committee, MEC, and the Board for consideration and approval.

VIII.6.3 Valid requests for clinical privileges will be evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Patient care needs for the privilege, the Hospital's capability to support the type of privilege being requested, and the availability of qualified coverage in the applicant's absence may be considered in determining privilege criteria. Privilege determinations may also be based on pertinent information from other sources, including institutions and health care settings where a professional exercises clinical privileges.

VIII.6.3.1 The procedure by which requests for clinical privileges are processed is outlined in Article VIII, Section 3 of these Bylaws.

VIII.6.4 History and Physical Privileges: Only those granted privileges to do so conduct history and physicals or update histories and physicals. Privileges to conduct a history and physical or an update to a history and physical are granted only to physicians, oral surgeons, podiatrists or other qualified licensed individual in accordance with state law and hospital policy. All medical history and physician examination are completed and documented in accordance with state law and medical staff policy.

- VIII.6.5 Special conditions for oral and dental surgery privileges: Requests for clinical privileges for oral surgeons and dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by oral surgeons and dentists will require that all dental patients receive preoperative medical evaluation by a physician member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record.
- VIII.6.5.1 Oral surgeons may be granted the privilege of performing preoperative medical evaluation on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence.
- VIII.6.6 Special conditions for Allied Health Professionals (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 Bylaws documents:
- a. "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. . See Appendix A to the Policy on Allied Health Professionals.
 - b. "Advanced Practice Provider " means a type of Allied Health Professionals 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. See Appendix B to the policy on Allied Health Professionals.
 - c. "Surgical Providers" 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/or Hospital to exercise all of those clinical privileges under the direction of a supervising provider pursuant to a written supervision agreement. See Appendix B to the policy on allied health Professionals.

VIII.6.6.2

Prerogatives of AHPs may include:

- a. Permission to perform specific patient care services under guidelines and collaborative or supervisory agreements as appropriate, recommended by MEC and approved by the Board;
- b. Upon invitation of the appropriate department chairperson, may attend educational meetings of the Medical Staff or Hospital;
- c. Recognition of limited hearing rights in response to corrective action or adverse recommendation of MEC. They must understand the Board has total discretion regarding granting and withdrawing of privileges; and
- d. Serve on pertinent Medical Staff committees as observer or consultant if requested by the department chairperson.

VIII.6.6.3

Prerogatives not included for AHPs:

- a. Membership on the Medical Staff, and therefore no rights applicable to Medical Staff membership;
- b. No responsibility to pay Medical Staff dues;
- c. No access to the Fair Hearing section in the Medical Staff Bylaws;
- d. Cannot vote or hold office; and
- e. Cannot independently admit or discharge patients.

VIII.6.6.4

A credentialing manual for AHPs will be maintained and amended as necessary to meet current regulatory requirements and certifying organization(s) standards. The AHP manual includes:

- a. Credentialing, application and reappointment procedures and process;

- b. Guidelines concerning the scope of patient care services, evaluation and sponsorship of AHP patient care services;
- c. Direction regarding department assignment;
- d. Requirement for professional liability insurance coverage;
- e. Direction concerning resignation and Leave of Absence (LOA) requests; and
- f. Other such issues as from time to time are recommended by MEC and approved by the Board.

The above shall be accomplished through a process similar to that utilized to credential and appoint applicants for Medical Staff membership and privilege(s).

VIII.6.6.5

Whenever the MEC or the Board makes a recommendation or proposes to take an action to restrict or deny an Advanced Practice Provider (APP) or Licensed Independent Provider (LIP) 's clinical privileges for more than thirty days or any application therefore, the CEO shall provide the APP or LIP or his employer with written notice of the recommendation, the reasons therefore and the time period within which the allied health professional or employer can request a hearing. If a hearing is requested, the President of the Medical Staff shall name and CEO shall appoint a committee of three (3) unbiased Medical Staff members and APP/LIP with clinical privileges to hear the APP/LIP or employer's objections to the proposed action or recommendation no later than thirty days from the date of the request. A record of the hearing shall be made. The committee's recommendation shall be in writing, shall reflect consideration of the information presented at the hearing, and shall be provided to the allied health professional or employer, the MEC, and the Board. The APP/LIP or employer and the MEC each have the right to appeal the committee's recommendation by submitting written statements to the Board within thirty days of receipt of the recommendation. The Board, or a committee thereof, shall review the parties' written submissions. If the appeal is reviewed by a committee, it shall promptly provide the parties and the Board with its recommendation. Upon consideration of the hearing committee recommendation and the information presented at appeal, the Board shall take final action and shall thereupon provide all parties with its decision, and the reasons therefore, in writing. Final actions regarding allied health professionals' privileges shall be reported as required by any applicable law.

- VIII.6.7 Special conditions for podiatric privileges: Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests.
- VIII.6.8 Special conditions for residents or fellows in training: In their capacity as a resident or fellow in training in the Hospital, the resident and fellow physician shall not hold membership on the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by a professional graduate education committee in conjunction with the Residency Training Program and in accordance with the resident physician agreement. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which residency program directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care.
- The post-graduate education program director or committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.
- VIII.6.9 Telemedicine Privileges: Practitioners providing telemedicine services must be granted privileges at this hospital if, and only if, these services include prescribing care or otherwise treating patients. Practitioners providing official readings of images, tracings or specimens through a telemedicine mechanism must do so under one of the following two arrangements:
- a. The practitioner is granted clinical privileges at the originating site defined as the site which the patient is receiving care.
 - b. The hospital contracts for the provision of these services by the provider. If the hospital contracts for the provision of these services, they must be provided consistent with the terms described in Section 10 of Article VIII addressing contracted services.
- VIII.6.9.1 In order for a practitioner to be eligible to request telemedicine privileges, the following requirements must be met:
- a. The MEC has recommended that the scope of telemedicine services provided at this originating site/hospital and the distant site hospital include the privileges requested by the practitioner. Both the originating site MEC and the distant site MEC must approve this scope of services.

- b. The practitioner must concurrently maintain privileges, at a minimum, for the same scope of services at the distant site hospital as the practitioner is requesting at the originating site hospital.

VIII.6.9.2 Requests for telemedicine privileges at the originating site hospital will be processed through the established procedure for reviewing and granting privileges at the originating site hospital. Information included in the completed practitioner application for telemedicine privileges at the originating site hospital may be collected in the usual manner or may be collected from the distant site hospital.

VIII.6.9.3 In order for the originating site to utilize credentialing and privileging information from the distant site in credentialing and privileging decisions, the following three conditions must be fulfilled:

- a. the distant site hospital is Joint Commission accredited;
- b. the practitioner is privileged at the distant site hospital for those services to be provided at the originating site hospital; and
- c. the originating site hospital has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site hospital information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided and complaints about the distant site hospital from patients, other licensed independent practitioners, and staff at the originating site hospital.

VIII.6.10 Temporary Privileges: Temporary privileges may be granted by the Chief Executive Officer acting on behalf of the Board, upon written recommendation of the chairperson of the department in which the privileges will be exercised and the President of the Medical Staff, provided there is verification of evidence of professional liability coverage of a type and an amount established by the Medical Staff and Board, current Illinois licensure and current competence. Temporary privileges may be granted only in two circumstances: 1) to fulfill an important patient care need, and 2) when a category 1 applicant is awaiting MEC and Board approval.

VIII.6.10.1 Important Patient Care Need: Temporary privileges may be granted on a case by case basis when an important patient

care need exists that mandates an immediate authorization to practice for a limited period of time, not to exceed 120 days. For the purposes of granting temporary privileges, an important patient care need is defined as including the following:

- c. A circumstance in which one or more individual patients will experience care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted.
- d. A circumstance in which the institution will be placed at risk of not adequately meeting the needs of patients who seek care from the institution if the temporary privileges under consideration are not granted

VIII.6.10.2 Category 1 Application Awaiting Approval: Temporary privileges may be granted upon request for up to one hundred and twenty (120) days when the new applicant for Medical Staff membership or privileges is waiting for review and recommendation by the MEC and approval by the Board and after verification of the following: a complete application for medical staff membership and privileges, relevant training or experience current competence ability to perform the clinical privileges requested query and evaluation of National Practitioner Data Bank information absence of current or previously successful challenge to licensure or registration, absence of involuntary termination of medical staff membership at any hospital or other entity, absence of any involuntary limitation, reduction , denial or loss of clinical privileges.

A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial membership application is withdrawn.

VIII.6.10.4 Special requirements:

Special requirements may be imposed as part of the granting of temporary privileges.

Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Bylaws, rules, and regulations and policies of the Medical Staff and St. John's Hospital in all matters relating to his temporary privileges. Whether or not such written agreement is obtained, these Bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

VIII.6.10.5 Rights of the practitioner with temporary privileges: A

practitioner is entitled to the procedural rights afforded by the Investigation, Corrective Action, Hearing and Appeal procedures outlined in the Medical Staff Bylaws.

VIII.6.10.6 Emergency Privileges: In the case of a medical emergency, any Medical Staff appointee with clinical privileges is authorized to do everything possible within the scope of his/her license to save the patient's life or to save the patient from serious harm, to the degree permitted by the appointee's license, but regardless of department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon appropriate consultative assistance and to arrange appropriate follow-up.

VIII.6.10.7 Disaster Privileges:

a. If the institution's Emergency Management Plan has been activated, and the Hospital is unable to meet immediate patient needs, the Chief Executive Officer or designees and such other individuals as identified in the institution's Emergency Management Plan with such authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to provide patient care to selected practitioners who present a valid picture identification issued by a state, federal or regulatory agency, provided at least one of the following requirements has been met by the practitioner:

- Presentation of a current Hospital photo identification (ID) card;
- Presentation of a current medical license with photo identification (ID) card issued by a state, federal or regulatory agency;
- Presentation of a photo identification (ID) card that certifies the practitioner is a Licensed Independent Practitioner (LIP) indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);
- Presentation of an (ID) card that certifies the practitioner is an LIP who has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies; and
- Presentation by a current Hospital or Medical Staff member (s) who can vouch for the practitioner's identity.

a. The medical staff oversees the professional practice of volunteer licensed independent practitioners.

- b. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.
- c. Once the immediate situation has passed and such determination has been made consistent with the institution's Emergency Management Plan, the practitioner's disaster privileges will be terminated.
- d. Any individual identified in the institution's Emergency Management Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the Hospital and will not give rise to a right to a fair hearing or an appeal.

VIII.6.11

Focused Practice Review

- VIII.6.11.1 Focused Practice Review (FPR) is a process by which the medical staff evaluates the privilege-specific competence of the practitioner who does not yet have documented evidence of competently performing the requested privilege at this hospital. FPR may also be utilized when a question arises regarding a practitioner's ability to provide safe, high quality patient care.
- VIII.6.11.2 A period of FPR is implemented for all practitioners during the provisional period or upon the granting of a new privilege. In addition, the FPR is implemented for assessing the performance of practitioners when issues affecting the provision of safe, high quality care are identified. The process of review is privilege specific and time limited.
- VIII.6.11.3 The Credentials Committee initiates the FPR for requested new privileges, develops criteria for extending an evaluation period, communicates the evaluation results and recommendations based on results to the practitioner and the MEC, implements changes to improve practitioner performance, and recommends system, protocol or policy improvements to the MEC for recommendation to the hospital. The MSQC initiates FPR for current medical staff members as identified by peer review.
- VIII.6.11.4 The performance monitoring process is defined by individual departments. At a minimum, the monitoring

includes criteria for performance, monitoring plans specific to a defined privilege and duration of performance monitoring. External source monitoring is utilized when it is determined that all internal sources are compromised or there is no available expertise.

VIII.6.12

External Peer Review: External peer review may take place in the context of focused practice review, investigation and, application processing or at any other time only if deemed appropriate by the Medical Staff department or the MEC or Board; under the following circumstances:

- a. Ambiguity when dealing with vague or conflicting recommendations from committee review(s) where conclusions from this review could directly impact an individual's membership or privileges.
- b. Lack of internal expertise, when no one on the Medical Staff as adequate expertise in the clinical procedure or area under review.
- c. When the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing benchmark for quality monitoring.
- d. To promote impartiality in peer review
- e. Upon the reasonable request of a practitioner.

Any external review report shall be shared with the subject of the review, with any peer review committee, and with the Board or any of its committees involved in considering action on the subject of the review. Any response to the external peer review report prepared by the subject or by the medical staff committee reviewing the matter shall be shared with the subject and the medical staff committee and Board or committee of the Board considering action on the subject of the review, prior to such action.

Section VIII.7

Proctoring

VIII.7.1

A member who has not provided patient care for an extended period of time and who requests clinical privileges may be required to arrange for proctorship, at the discretion of the department chair in consultation with the Medical Staff Credentials Committee and approved by MEC. Proctoring can be arranged with either a current member in good standing of the Medical Staff who practices in the same specialty or with a training program outside of the Hospital. The proctor would be mutually agreed upon by the practitioner, the Chief Medical Officer and the Credentials Committee. The practitioner must assume responsibility for any financial costs incurred to fulfill proctoring requirements.

At a minimum, the proctorship requirements include the following:

- VIII.7.1.1 The scope and intensity of required proctorship activities; including details of monitoring and consultation;

- VIII.7.1.2 The requirement for submission of a written report from the proctor prior to termination of the proctorship period assessing, at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical records documentation, ability to perform the privileges requested, and professional ethics and conduct.
- VIII.7.1.3 Upon completion of the proctorship, the proctor(s) reports will be forwarded to the Department Chair, Medical Staff Credentials Committee and MEC for review and appropriate action.

Section VIII.8 Reapplication and Modifications of Membership Status or Privileges

- VIII.8.1 Reapplication after adverse credentials decision: Except as otherwise determined by the MEC or Board in light of exceptional circumstances, a practitioner who has received a final adverse decision is not eligible to reapply to the Medical Staff for a period of two (2) years from the date of the notice of the final adverse decision, or the effective date of the resignation or application withdrawal. If a practitioner reapplies after two (2) years, the application is subject to the same procedural process as an initial application under these Bylaws. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete, voluntarily withdrawn and will not be processed any further.
- VIII.8.2 Reinstatement after administrative revocation: A practitioner who has had his appointment or clinical privileges administratively revoked for failure to maintain current professional liability insurance in the specified amount or failure to maintain and complete medical records will be reinstated for appointment and appropriate privileges upon submission of documentation that he has resolved the reason for the revocation.
- VIII.8.3 Request for modification of appointment status or privileges: A staff appointee, either in connection with reappointment or at any other time, may request modification of staff category, department assignment, or clinical privileges by submitting a written request to the Medical Staff Office. The written request must contain all pertinent supportive information of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification request is processed in the same manner as a reappointment. A practitioner who determines that he no longer exercises or wishes to restrict or limit the exercise of particular privileges previously granted shall send written notice, through the Medical Staff Office, to the department chairman, Medical Staff Credentials Committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file. Modifications to clinical privileges may be

requested at reappointment; however, the request will be acted upon independently from the reappointment process.

VIII.8.4 Voluntary resignation of staff appointment: A practitioner shall resign his staff appointment or clinical privileges by providing at least a thirty (30) day written notice to the President of the Medical Staff by way of the Medical Staff Office. The resignation shall specify the reason for the resignation and the effective date.

VIII.8.4.1 Automatic resignation of staff appointment: In the absence of a written notice from the Medical Staff member or AHP requesting termination of membership, a written inquiry will be sent to the Medical Staff or AHP member who has not provided care or participated in medical staff activities in 12 months regarding necessity to continue Medical Staff or AHP membership. If there is no reply within sixty (60) days providing information to the contrary, a process of automatic resignation of membership will commence. Upon review by the department chairperson, Credentials Committee, and appropriate recommendation by the Executive Committee to the Board, and upon concurrence by the Board, Medical Staff or AHP membership shall be automatically resigned.

VIII.8.4.2 Any practitioners whose staff appointment or clinical privileges are resigned either voluntarily or automatically is obligated to fully and accurately complete all portions of all medical records for which he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation or termination and indicating that medical records were not completed as required.

Section VIII.9 Leave of Absence

VIII.9.1 Leave request: A staff appointee may obtain a voluntary leave of absence by providing written notice to the President of the Medical Staff by way of Medical Staff Office. The notice must state the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service. During the period of time of the leave, the staff appointee may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities at this hospital.

VIII.9.2 Termination of leave: At least sixty (60) days prior to the termination of the leave, or at any earlier time, the staff appointee may request reinstatement by sending a written notice to the President of the Medical Staff by way of the Medical Staff Office. The staff appointee must submit a written summary of relevant activities during the leave if the MEC or Board so requests. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed.

VIII.9.3 Failure to request reinstatement in a timely manner shall be deemed a voluntary resignation of Medical Staff membership and privileges as of the scheduled expiration date of the leave and shall result in automatic termination of membership and privileges. A request for medical Staff membership subsequently received from the former members shall be treated as an application for initial appointment.

Section VIII.10 Practitioners Providing Contracted Services

VIII.10.1 When the Hospital contracts for patient care services with licensed independent practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are under the control of a Joint Commission accredited organization, one of the following mechanisms will be implemented:

The Hospital will specify in a contract that the entity providing these services by contract (the contracting entity) will ensure that all services provided under this contract by individuals who are licensed independent practitioners (LIP) will be within the scope of those individual's privileges at the contracting entity; or the Hospital will verify that all individuals who are LIPs and providing services under the contract have privileges that include the services provided under the contract.

VIII.10.2 When the Hospital contracts for care services with licensed independent practitioners who provide official readings of images, tracings or specimens through a telemedicine mechanism, and these practitioner's services are not under the control of a Joint Commission accredited organization, all LIPs who will be providing services under this contract will be permitted to do so only after being granted privileges at the Hospital through the mechanisms established in these Bylaws.

VIII.10.3 **Exclusive Contracts:** If the Hospital exercises its option to enter into an exclusive contract and that contract results in the total or partial termination or reduction of Medical Staff membership or clinical privileges of a current Medical Staff member, the Hospital shall provide the effected Medical Staff member 60 days prior notice of the effect on his membership or privileges. The Hospital shall consult with the Medical Staff prior to closing membership in the entire or any portion of the Medical Staff or a department. If the Hospital closes membership in the Medical Staff, any portion of the Medical Staff, or the department over the objections of the Medical Staff then, the Hospital shall provide a detailed written explanation to the Medical Staff 10 days prior to the effective date of any closure. No applications need to be provided when membership in the Medical Staff or any relevant portion on the staff is closed.

VIII.10.4 **Qualifications:** A practitioner who is or will be providing specified professional services pursuant to a contract, or a letter of agreement or any employment arrangement with the Hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his appointment category as any other applicant or staff appointee.

- VIII.10.5 Effect of disciplinary or corrective action recommended by the MEC: The terms of the Medical Staff Bylaws will govern disciplinary action taken or recommended by the MEC involving all applicants, privileges holders or Medical Staff members, including those serving under contract, letter of agreement or any employment arrangement.
- VIII.10.6 Effect of contract or employment expiration or termination: A Medical Staff member providing professional services under a contract with the Hospital shall not have his or her Medical Staff membership or privileges terminated for reasons pertaining to the quality of care provided by the Medical Staff member without the same rights of hearing and appeal as are available to all members of the Medical Staff. These provisions will take precedence over any inconsistent terms in a contract between a member of the Medical Staff and the Hospital purporting to waive all rights of hearing and appeal provided in these Bylaws. The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will otherwise be governed solely by the terms of the practitioner's contract with St. John's 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 clinical privileges.
- VIII.10.7 The Medical Staff member(s) whose privileges or membership may be adversely affected by the Board's final decision to impose exclusivity is entitled to at least sixty days notice prior to any adverse affect on privileges or membership. The affected member may request a hearing pursuant to these Bylaws, which hearing shall commence within 30 days after the date of such request, unless the parties agree to a longer time period before commencing the hearing.

Section VIII.11 Medical Administrative Officers

- VIII.11.1 A medical administrative officer is a practitioner engaged by the Hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the medical administrative officer's direction. In the selection of a medical administrative officer, the MEC shall have an opportunity to review and comment on all candidates. These duties and responsibilities shall not usurp those of the Officers of the Medical Staff.
- VIII.11.2 Each medical administrative officer must achieve and maintain Medical Staff appointment and may obtain clinical privileges appropriate to clinical responsibilities and discharge staff obligations appropriate to staff category in the same manner applicable to all other staff members.
- VIII.11.3 Effect of removal from office or adverse change in appointment status or clinical privileges:

- a. Where a contract exists between the officer and the Hospital, its terms govern the effect of removal from the medical administrative office on the officer's staff appointment and privileges and the effect of an adverse change in the officer's staff appointment or clinical privileges remaining in office; however, such adverse actions shall be subject to the hearing rights provided all members under these Bylaws.
- b. In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be determined by the Board
- c. A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract, a consequence of removal from office.

ARTICLE IX: CONDUCT

Section IX.1 Definition and Severity of Actionable Behavior

Appropriate Behavior

The following behaviors are **not** considered disruptive or actionable and are appropriate and encouraged:

- a. Constructive suggestions or complaints intended to improve patient care, hospital operations or practice environment directed to staff, managers, directors or administration in a respectful manner.
- b. Submission of verbal or written reports of behaviors that increase risk of patient or staff harm.
- c. Legitimate business activities that may or may not compete with the hospital.

Behavior of the following types undermine the medical staff culture of safety and may be actionable:

- a. Verbal attacks leveled at other members of the medical staff, residents, fellows and students, hospital personnel, patients, or patients' families that are beyond the bounds of fair and appropriate professional conduct.
- b. Physical attacks leveled at other members of the medical staff, residents, fellows and students, hospital personnel, patients, or patients' families in the patient care context are always actionable.
- c. Comments or illustrations made in patient medical records or other official hospital or medical staff documents that maliciously impugn the quality of care in the hospital or attack particular physicians, nurses, or hospital or medical staff policies.
- d. Harassment, sexual harassment or other forms of inappropriate behavior by a medical staff member that jeopardizes quality patient care or the ability of others to provide quality patient care at the Hospital;
- e. Verbal, visual or physical abuse directed against any individual (medical staff member, resident, fellow, student, hospital staff, patient or visitor) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, gender or sexual orientation
- f. Unwelcome sexual advances, requests for sexual favors, or verbal, visual or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions,
- g. Unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating or otherwise hostile work environment

IX.1.2 Consequences of Actionable Behavior

Behavior by Medical Staff members while on Hospital property that generates a complaint by another Medical Staff member, a member of the

Hospital clinical or administrative staff, or individuals in contact with the Medical Staff member at the Hospital other than patients, will be responded to exclusively according to these Bylaws.

IX.1.3 Behavior Resulting from Impairment

Behavior that results from a physical, mental or emotional impairment will lead to referral to the Professional Wellness Committee to assist the Medical Staff member while protecting others.

IX.1.4 Graded response to Complaints

To aid in responding appropriately to a complaint, actionable behavior is classified here into three levels of severity. Any corrective action will be commensurate with the nature and severity of the actionable behavior.

Level I: Physical violence or other physical abuse which is directed at people; sexual harassment or harassment involving physical contact; carrying a gun or other threatening weapon, resulting generally in immediate summary suspension pending due process as outlined in Article X of these bylaws.

Level II: Verbal abuse such as unwarranted yelling, swearing or cursing; threatening, berating, intimidating, humiliating, sexual or otherwise inappropriate comments directed at a person or persons verbally; visual abuse such as threatening, humiliating, sexual or otherwise inappropriate writing or picture(s) directed at a person or person, or physical violence or abuse directed in anger at an inanimate object, resulting in counseling for first offense with more severe consequences from written warnings up to suspension of medical staff membership and privileges for repeated offenses. Referral to the Physician Wellness Committee may be part of this process with referral for treatment as recommended by the committee.

Level III: Verbal abuse which is directed at-large, but has been reasonably perceived by a witness to be actionable behavior as defined above resulting in counseling progressing to written warnings up to referral to the Physician Wellness Committee for referral for professional treatment or counseling.

Section IX.2 Corrective Action for Actionable Behavior

IX.2.1 Actionable behavior by members of the Medical Staff that affects or may affect patient care, or refusal of members to cooperate with these behavior procedures, may result in corrective action, which shall be carried out according to the Medical Staff Bylaws. Response may range from a written warning to a written corrective action plan to suspension of privileges. A pattern of incidents of actionable behavior should, in general, result in consistently more severe consequences for each subsequent incident.

IX.2.2 Behavior by members of the Medical Staff that has no impact on patient care, and therefore does not meet the threshold requirements for resolution under

these Bylaws but constitutes violence or harassment as described under Hospital policy, may be resolved by administrative action. The Medical Executive Committee will be apprised of the Hospital policy and all changes.

Section IX.3 Medical Staff Disruptive Behavior Complaint Process

- IX.3.1 Complaints about a Medical Staff member's conduct alleging actionable behavior must be submitted in writing, signed and directed to the President of the Medical Staff or Chief Medical Officer. The President of the Medical Staff and Chief Medical Officer or designee(s) must review the complaint as soon as feasible, and provide the complainant with a written acknowledgment of receipt of the complaint and copies of the sections of the Bylaws addressing conduct. The President of the Medical Staff or designee shall make an initial determination of authenticity and severity, and act accordingly. In all cases, the member involved shall be provided with a copy of these Bylaws and a copy of the complaint. If no corrective action is taken, a confidential memorandum summarizing the disposition of the complaint shall be retained in the member's credentials file.
- IX.3.2 At the discretion of the President of the Medical Staff or at the discretion of the Medical Staff Executive Committee (MEC), the duties here assigned to the President of the Medical Staff may be delegated to a different officer of the Medical Staff, on a case-by-case basis or for the President's term of office.
- IX.3.3 Behavior that, in the judgment of the Medical Staff President, warrants summary suspension consistent with Article X shall result in immediate suspension of privileges. The Medical Staff member shall be interviewed within 24 hours and encouraged to respond in writing within 72 hours to ensure the interpretation of events is properly considered.
- IX.3.4 Behavior of concern that, in the judgment of the Medical Staff President or his/her designee, does not immediately pose a threat to patients or staff shall result in a meeting as quickly as possible with the Medical Staff President, CMO or members of the MEC selected by the medical staff president to determine appropriate steps. The Medical Staff member and any witnesses shall be interviewed, if possible, within 5 working days for level 2 incidents and within 10 days for level 3 incidents. In all cases, the medical staff member shall be encouraged to respond in writing within 72 hours to ensure the interpretation of events is properly considered.
- IX.3.5 After initial interview and response is received, the President of the Medical Staff, Chief Medical Officer, MEC member(s) or appropriate designees may do one or more of the following:
- i. determine that no action is warranted.
 - ii. issue a written warning.
 - iii. require a written apology to the complainant.
 - iv. refer the member to the Professional Wellness Committee.

v. initiate corrective action pursuant to the Medical Staff Bylaws.

IX.3.6 The affected Medical Staff member and complainant will receive written notification from the Medical Staff President regarding all recommended action(s) within seven (7) days after interviews are completed. All information regarding the matter will be reviewed by the MEC within 31 days or at its next regular meeting. The MEC may recommend investigative and correction action as delineated under Article X.

Section IX.4 Conduct Complaints Not Governed By Medical Staff Complaint Process

IX.4.1 Actionable behavior which is directed against a Medical Staff member by a Hospital employee, Board member, contractor, or other member of the Hospital community who is not a Medical Staff member shall be reported by the member to the Hospital pursuant to Hospital policy governing conduct of its employees or agents.

Section IX.5 Abuse of Process

IX.5.1 Threats or actions directed against the complainant by the subject of the complaint is inappropriate and will not be tolerated under any circumstance. Retaliation or attempted retaliation by members against complainants will give rise to corrective action pursuant to the Medical Staff Bylaws. Individuals who submit a complaint or complaints that are determined to be knowingly false is inappropriate and shall be subject to corrective action under the Medical Staff Bylaws or Hospital employment policies, whichever applies to the individual.

Section IX.6 Behavioral Conduct Awareness Efforts

IX.6.1 The Medical Staff shall promote continuing awareness of actionable behavior among the Medical Staff and the Hospital community, including the following efforts:

- a. Sponsor or support educational programs on actionable behavior to be offered to Medical Staff members and Hospital employees;
- b. Disseminate this Bylaws section to all current members upon its adoption and to all new members of the Medical Staff upon joining the staff;
- c. Facilitate assistance by the Professional Wellness Committee for members of the Medical Staff exhibiting disruptive behavior to obtain education, behavior modification, or other treatment to prevent further violations.

Section IX.7 Record of Action

IX.7.1 All records will be maintained in peer review confidential files in the Medical Staff Office, and made available for the corrective action process.

ARTICLE X: INVESTIGATIVE, CORRECTIVE ACTION, and SUSPENSIONS

Section X.1 Investigation and Corrective Action

X.1.1 Initiation Process: Any person, or committee of the hospital or Medical Staff, may provide written, specific, signed and dated information in order to request investigation or corrective action regarding conduct, performance, or competence of any Medical Staff member, applicant or individual with clinical privileges at St. John's Hospital. For the purpose of these procedures regarding investigation, corrective action, hearing, and appeals, the term "member" shall include applicants to the Medical Staff and those holding or applying for clinical privileges.

This information or request for investigation or corrective action may be directed to the Medical Staff President, any Department Chairman or any Medical Staff Executive Committee (MEC) member, the Chief Medical Officer (CMO), Chief Executive Officer (CEO), or any Hospital Board of Director member, and will be immediately transmitted to the Medical Staff President (or designee).

X.1.2 Preliminary Review Process: The Medical Staff President and Chief Medical Officer (CMO)(or their designees) will promptly review the received information or request for investigation or corrective action for apparent credibility and the possibility that the matter relates to the following actions:

- a. Detrimental to patient safety;
- b. Detrimental to the delivery of quality patient care within St. John's Hospital;
- c. Unethical;
- d. Contrary to the Medical Staff Bylaws, Medical Staff policies or any Rules and Regulations;
- e. Harassing or intimidating to colleagues, patients and their families, or staff
- f. Disruptive of the hospital mission or Medical Staff operations; or
- g. Below applicable professional standards, or
- h. Felony conviction.

X.1.3 Preliminary Action: A prompt determination will be made by the Medical Staff President and Chief Medical Officer (or designees) regarding the matter as follows:

- a. The request is serious enough to require immediate corrective action (with or without additional investigation) in accordance with these Bylaws and notification requirements.
- b. The request needs additional prompt investigation by the MEC, or by an investigative committee.
- c. The request may need referral to the Professional Wellness Committee with periodic confidential reports to the MEC.
- d. The request has no apparent validity and no immediate action appears warranted.

X.1.4 Preliminary Notification: Upon completion of this preliminary review and determination, the Medical Staff President (or designee) shall inform the involved Medical Staff member promptly, verbally and subsequently in writing, of the request for investigation or corrective action. The member will be provided general information regarding the request for investigation or corrective action and the preliminary actions taken. If circumstances warrant, to protect against retribution or harassment, attribution or identification of witnesses may be withheld at this stage at the discretion of the CMO and Medical Staff President. The member will be informed that the MEC will review the matter at a special meeting or the next regularly scheduled meeting of the MEC.

X.1.5 MEC Initial Review, Action and Notification:

X.1.5.1 All preliminary determinations and recommendations of the Medical Staff President and CMO will be reviewed by the MEC.

- a. Recommendations resulting in a summary suspension will be reviewed by the MEC within three (3) days in accordance with the Bylaws section on summary suspension. If the MEC continues or imposes a summary suspension, notification will be in accordance with the Bylaws section on summary suspension.
- b. All other categories of recommendations will be reviewed at the next regularly scheduled or special meeting of the MEC. The MEC shall act on the matter at that time by continuing, modifying, or terminating the preliminary actions initiated by the Medical Staff President and CMO.

X.1.5.2 Notification of Initial Medical Staff Executive Committee (MEC) Investigation and Action

X.1.5.2.1 If no summary suspension has been imposed, then within three (3) business days the Medical Staff President or designee will again notify the involved member, this time in

writing, of the general information regarding the matter and initial MEC recommendation(s) and action(s).

- X.1.5.2.2 If the MEC has terminated the preliminary action, the member will be so notified and no further action is needed. All information (adverse and exonerating) regarding this matter will be placed in the confidential peer review file.
- X.1.5.2.3 If the MEC continues or modifies the preliminary action, the member will be provided the following information:
- a. General information regarding the request for investigation or corrective action and if warranted without attribution or identification of witnesses.
 - b. The action taken by the MEC after their initial review.
 - c. A copy of the Bylaws.
 - d. Invitation to the next regularly scheduled meeting of the MEC or to any MEC meeting during an Investigative Committee process, to discuss, explain, or refute the information in the initial request for investigation or corrective action. This meeting shall not constitute a hearing and none of the procedural rights and rules provided in these Bylaws with respect to hearing shall apply. A record of this meeting shall be included in the minutes of the MEC.
- X.1.5.2.4 If the MEC recommends an investigative committee to evaluate and make further recommendations regarding the matter the member will be so notified, and the Bylaws section on investigative committee shall apply.

X.1.6 Investigative Committee

The Investigative Committee will function in the following manner:

This committee, appointed by the Medical Staff President, shall consist of at least three (3) persons, any of whom may or may not hold appointments to the St. John's Hospital Medical Staff. This committee shall not include partners, associates, relatives, or any person in direct economic competition with the involved Medical Staff member. The Investigative Committee shall have available to them the full resources of the Medical Staff and hospital to assist in their work, and may request outside consultants with Medical Staff President (or designee) and Chief Medical Officer approval. The committee also is designated the authority to require the involved Medical Staff member to have a physical and/or mental examination by Medical Staff member(s) or other physician(s) satisfactory to the Investigative Committee, and require that the results of such additional examination(s) be made available for the investigation and consideration of subsequent review committees. The

involved Medical Staff member being investigated shall have an opportunity to meet with and be interviewed by the Investigative Committee before it makes its report and to submit the results of any additional physical or mental examination performed by any consultants selected by the involved Medical Staff member.

- a. This informal interview shall not constitute a hearing and none of the procedural rules with respect to these Bylaws shall apply.
- b. A written summary of the Investigative Committee interview shall be made and included along with its report to the MEC. This investigation and report should be made within a reasonable time, generally not to exceed ninety (90) days.

X.1.7 Meeting with Medical Staff Executive Committee (MEC) after Investigative Committee Report

At least five (5) days prior to the MEC meeting when the report of the Investigative Committee will be reviewed and acted upon, the Medical Staff member against whom the investigative or corrective action had been requested shall be notified of and invited to this meeting of the MEC. The member shall be provided the Investigative Committee report without attribution or identification of witnesses (if in the reasonable opinion of the Committee this is necessary to protect against harassment) and informed, again, of the nature of the investigative or corrective action requested. The member may discuss, explain, or refute the request for corrective action or the Investigative Committee's recommendations. If necessary the member may request a continuance to the subsequent MEC meeting. The meeting will be conducted without the involved Medical Staff member if the member fails to appear. This meeting, as all other such meetings in this process, shall not constitute a hearing and shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply hereto. A record of such meeting shall be made by the MEC and included in its meeting minutes.

X.1.8 Medical Staff Executive Committee Action: Within forty-five (45) days following receipt of the report from the Investigative Committee or within 45 days after receiving a request from the President to review a complaint that would not appear to entitle the Medical Staff member to request a hearing, the MEC shall meet and take action on the request for investigative or corrective action. The MEC may take action on the Investigative Report at the same meeting at which it is received.

This action may include, but is not limited to:

- X.1.8.1 Determining that no corrective action is to be taken. Documentation of the proceedings shall be maintained in the member's confidential peer review file.
- X.1.8.2 Deferring action for a reasonable time where circumstances warrant.

- X.1.8.3 Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected Medical Staff member may make a written response, which shall be attached to the MEC letter and placed in the member's file.
- X.1.8.4 Recommending for the sole purpose of evaluating credentials or performance, the immediate imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, proctoring, or monitoring.
- X.1.8.5 Recommending denial, restriction, modification, reduction, suspension or revocation of clinical privileges.
- X.1.8.6 Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care.
- X.1.8.7 Recommending suspension, revocation, or probation of Medical Staff membership.
- X.1.8.8 Recommending reassignment of any member from one category of the Medical Staff to another category of the Medical Staff or other appropriate action for failure to adhere to Medical staff member responsibilities, Article II, Section 6.
- X.1.8.9 Taking other actions deemed appropriate under the circumstances, including referral to the Professional Wellness Committee.

X.1.9 Subsequent Actions

- X.1.9.1 If the MEC recommends corrective action that entitles the Medical Staff member to request a hearing, the Notice and Hearing provisions of these Bylaws shall be initiated. Suspensions are effective immediately and continued pending final action by the Board unless terminated pursuant to these Bylaws. If a hearing is not requested, the recommendation is transmitted to the Board for final decision.
- X.1.9.2 If MEC decides upon corrective action that does not entitle the Medical Staff member to request a hearing, the

action is effective immediately and is communicated within seven (7) days to the member and to the Board.

X.1.9.3 In the event the Board reaches a conclusion based on established facts that the MEC has incorrectly determined an investigation is not necessary or has recommended an inappropriate action, it may direct the MEC to proceed with an investigative process or further consider the matter.

X.1.9.4 The Chief Executive Officer or designee shall notify the affected Medical Staff member within seven (7) days by certified mail, return receipt requested or hand-delivery, of the Board decision.

Section X.2 Automatic Suspension or Limitation

X.2.1 Medical Staff member's obligation. It is the obligation of the Medical Staff member to notify the Medical Staff Office:

- a. Immediately of any loss or change of liability insurance or carrier, and
- b. Promptly (within five (5) business days) of any action taken or occurring in regards to licensure, DEA certification, participation in State or Federal medical programs.

X.2.2 In the following instances, the member's privileges or membership will be suspended or limited as described below. This automatic action shall be subject to the limited hearing procedure described in Article X, Section 2.7.

X.2.2.1 Licensure:

- a. **Revocation and Suspension:** Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
- b. **Restriction:** Whenever a member's license is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at St. John's Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- c. **Probation:** Whenever a member is placed on probation by the applicable licensing or certifying authority, his membership status and clinical privileges shall

automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

X.2.2.2 Controlled Substance Prescribing Authority granted by DEA or State:

- a. Revocation, Limitation or Suspension: Whenever a member's DEA certificate or state controlled substance prescribing license is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate or license, as of the date such action becomes effective and throughout its term.
- b. Probation: Whenever a member's DEA certificate or state controlled substance prescribing license is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

X.2.2.3 Medicare, Medicaid, and/or other State or Federal Programs: Whenever a member is involuntarily excluded from the Medicare, Medicaid, and/or other State or Federal programs, the Medical Staff member's privileges to provide care for Hospital patients in these programs will be automatically revoked or limited in accordance with the actions. Within 31 days the MEC will review all available information regarding the actions with further recommendations in accordance with these Bylaws.

X.2.2.4 Professional Liability Insurance: Failure to maintain professional liability insurance in the amount pursuant to these Bylaws shall result in automatic suspension of members' clinical privileges. If within ninety (90) days after written warning of the delinquency the member does not provide evidence of required professional liability insurance, which may include endorsement for any prior period, the member shall be considered to have voluntarily resigned from the Medical Staff.

X.2.3 Administrative Suspension or Limitation

X.2.3.1 Misstatement in Application: A Medical Staff member's clinical and admitting privileges as well as Medical Staff membership may be automatically suspended upon discovery by the Hospital of any significant misstatements or material omissions of information required in the application for appointment or reappointment to the Medical Staff.

- X.2.3.2 Medical Record Completion Requirements: Penalties for failure to satisfy these requirements shall be delineated in Medical Staff Rules and Regulations, policies and procedures.
- X.2.4 Preliminary Review and Action(s)
- X.2.4.1 Review and determination: Upon receiving information that appears to require an automatic action, the Medical Staff President and CMO will promptly meet to review the received information to assess its credibility and make a determination as to whether the automatic suspension clause of these Bylaws applies or the MEC should make that determination.
- X.2.4.2 Notification: Promptly and at least five (5) days before the next regularly scheduled meeting of the MEC, the affected member will be notified in writing return receipt requested or hand delivery of the following:
- a. The information received that qualifies for an automatic action or suspension.
 - b. The preliminary action taken by the Medical Staff President and CMO.
 - c. The upcoming review by the MEC at either a special meeting or the next regular meeting, and the time, date, and place of such meeting.
 - d. Copy of the Bylaws.
 - e. The right to limited hearing as described in this Article, Section 2.7.
- X.2.5 Medical Staff Executive Committee Deliberation: At the next regularly scheduled meeting or at a special meeting, the MEC shall convene to review and consider the facts. The MEC may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in this Section or deem no further action needed.
- X.2.6 Notification: The Medical Staff President or designee shall notify the affected Medical Staff member by certified mail return receipt requested, or by hand delivery, of the MEC action and the member's right to the limited hearing in Section 2.7, and that the member will not be entitled to any other hearing or appeal rights in these Bylaws.
- X.2.7 Limited Hearing Rights: The Medical Staff member may request a limited hearing by delivering a written request for such hearing to the President of the Medical Staff or designee within five (5) days of receipt of a notice of the

MEC decision to continue automatic suspension. Failure to deliver such written request for a limited hearing within five (5) days shall constitute a waiver of all hearing rights. Upon receipt of such a written request for a limited hearing, the President of the Medical Staff or designee shall appoint a hearing committee in accordance with these Bylaws. A hearing shall be held within fifteen (15) days of receipt of the request for a limited hearing. The hearing procedures set forth in these Bylaws shall govern the conduct of any hearing under this section. The written recommendation of the hearing committee shall be forwarded promptly to the President of the Medical Staff and the Chairman of the Board. The Board shall make a decision regarding the automatic suspension or limitation on or before the date of its next regular meeting after receipt by the Board Chairman of the hearing committee's recommendation. The decision of the Board shall be final and shall not be subject to appeal.

- X.2.8 Care of Suspended Member's Patients: Immediately upon the imposition of an automatic or summary suspension the appropriate department chairman or in their absence the President of the Medical Staff, shall assign the care of the affected member's patients who are still in the hospital, to another Medical Staff member with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of this substitute member, and the care shall continue until discharge.

Section X.3 Summary Suspension

- X.3.1 Criteria and Procedure for Initiation: Whenever there is documentation or reliable information that a member's conduct requires that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any person, it may become necessary to immediately suspend, without a prior hearing, all or any portion of the clinical privileges of a Medical Staff member. First a reasonable effort must be made to obtain the facts of the matter with the resultant belief the action is warranted. This action may be taken by:

- a. A committee of two, one of whom must be the Medical Staff President, President-Elect, or in their absences any other elected MEC member and one of whom must be the Chief Medical Officer, the Chief Executive Officer, or designee; or
- b. The Medical Staff Executive Committee (MEC).

- X.3.2 Notification: The affected Medical Staff member is immediately advised in writing, by the Medical Staff President or designee, verbally and by certified mail return receipt requested, or by hand delivery, of the imposition of and reasons for the suspension. This written notice shall also invite the affected Medical Staff member to attend the Medical Staff Executive Committee meeting that will be held within three (3) days and to respond to any questions directed to him at that meeting, understanding this meeting does not constitute a Hearing as conducted under these Bylaws. The MEC, Chief Medical Officer, and Chief Executive Officer must also be immediately made

aware of the summary suspension.

X.3.3 Medical Staff Executive Committee (MEC) Action: Within three (3) days of the imposition of the summary suspension action, the MEC shall meet to review the documentation and decide whether the summary suspension shall continue. Failure to observe the three (3) days deadline shall not terminate a summary suspension in effect. The MEC may modify, continue, or terminate the suspension, or request additional investigation regarding the suspension. The MEC may act whether the affected Medical Staff member attends or does not attend the meeting. Decisions of the MEC to lift, expunge or modify the suspension shall be reviewed by the Board, or a Board committee, within three days, and shall uphold the MEC decision if it is supported by a preponderance of the evidence. Should the Board's decision restore the suspension, the suspension shall be processed as if the MEC had acted to continue it.

X.3.4 Notice of Right to Request an Expedited Hearing: In the event that the MEC decides that the summary suspension shall remain in effect, then the Medical Staff President or his designee shall immediately notify the affected Medical Staff member of the continuation of the suspension and the member's right to request an expedited hearing. This notification shall be verbally and in writing by certified mail return receipt requested or by hand-delivery.

The notice shall also state:

- a. If the Medical Staff member requests an expedited hearing within three (3) days after the affected Medical Staff member's receipt of the notice, the member can obtain a final decision within thirty (30) days of the imposition of the summary suspension; and
- b. If the Medical Staff member fails to request an expedited hearing within three days, the Hearing and Appellate Review procedures of these Bylaws shall govern and the Medical Staff member shall be supplied the requisite notice pursuant thereto.

X.3.5 Expedited Hearing

X.3.5.1 Rationale for expedited hearing: The Medical Staff provides to a suspended member an expedited process for hearing, appeal, and Hospital Board decision in less than thirty (30) days, so that if the suspension is lifted, no report to the National Practitioner Databank will be required.

X3.5.2 Expedited Hearing Timetable: A requested expedited hearing shall follow the hearing and appellate review procedures described in these Bylaws except that the following expedited timetable shall apply:

- a. The hearing committee members shall be appointed within three (3) days of the request for hearing.

- b. Any challenge for bias or prejudice shall be made by the Medical Staff member within two (2) days of the appointment of the hearing committee.
- c. Beginning of hearing shall be within five (5) days of naming the agreed upon hearing committee.
- d. Report of hearing committee shall be distributed to the MEC, the hearing committee members, the affected member, and the Board within two (2) days of adjournment of hearing.
- e. Request to the Board for appeal shall be received within two (2) days of service of the hearing committee report.
- f. Appeal shall be heard by the Board within five (5) days of request.
- g. Final decision of the Board shall be submitted within thirty (30) days of the imposition of the summary suspension.

X.3.6 Failure to observe these deadlines shall not terminate a summary suspension in effect.

X.3.7 Care of Suspended Member's Patients: Shall be transferred to a Medical Staff member with appropriate clinical privileges as in Article X, Section 2.7.

X.3.8 Exclusive Summary Suspension Process: These procedures delineate the sole method for summary suspension of any privileges or Medical Staff membership at St. John's Hospital.

ARTICLE XI: HEARING PROCEDURE

Section XI.1 Process

XI.1.1 When any Medical Staff member receives notice of a recommendation from the MEC regarding clinical competence or professional conduct that, if ratified by decision of the Board, will adversely affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges, he shall be entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the hearing committee following such a hearing is adverse to the affected Medical Staff member he shall then be entitled to an appellate review before the Board makes its final decision on the matter.

When any Medical staff member receives notice of a decision by the Board that will affect his appointment to or status as a member of the Medical Staff or his exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Medical Staff Executive Committee (MEC) with respect to which he was entitled to a hearing and appellate review, he shall be entitled to a hearing by a committee appointed by the Board. If such hearing does not result in a favorable recommendation, the affected Medical Staff member shall be entitled to an appellate review by the Board, before the Board makes a final decision on the matter.

XI.1.2 Grounds for All Hearings

The following shall constitute grounds for a hearing pursuant to this Section:

- a. Denial of initial medical staff appointment;
- b. Denial of requested advancement in medical staff category;
- c. Denial of medical staff reappointment;
- d. Revocation of medical staff appointment;
- e. Denial of requested initial clinical privileges;
- f. Denial of requested increased clinical privileges;
- g. Involuntary decrease of clinical privileges;
- h. Imposition of mandatory concurring consultation requirement;
- i. Summary Suspension of clinical privileges.

XI.1.3 Exclusive Contract Matters: If the Hospital exercises its option to enter into an exclusive contract and that contract results in the total or partial

termination or reduction of medical staff membership or clinical privileges of a current staff member, the Hospital shall provide the affected medical staff member 60 days prior notice of the effect on his medical staff membership or privileges. An affected staff member desiring a hearing pursuant to this section must request the hearing within 14 days after the date he is so notified. If an exclusive contract is signed by a representative of a group of physicians, a waiver of any rights granted in this section that is contained in the contract shall apply to all members of the group, unless otherwise stated in the contract.

XI.1.4

Notice of Adverse Recommendation to Medical Staff Member: The Chief Executive Officer or designee shall be responsible for giving notice within seven (7) days of an adverse recommendation or decision to any affected medical staff member who is entitled to a hearing pursuant to these Bylaws. For purposes of this Section, "notice" shall mean a written notice delivered by hand or mailed by certified mail, return receipt requested. Refusal of mail delivery by the affected medical staff member or member's representative shall constitute receipt of the notice by the medical staff member. A copy of these Bylaws shall be mailed to the affected medical staff member with such notice. The notice of such adverse recommendation shall state, in concise language, the action proposed to be taken, the acts or omissions with which the medical staff member is charged, and the reasons for the adverse recommendation or decision, including reasons based on the quality of medical care, economic factors, or any other basis.

XI.1.4.1 The notice of adverse recommendation shall specifically advise the medical staff member of his right to a hearing and specify that he shall have thirty (30) days following the date of receipt of such notice in which to provide written request for hearing to the Chief Executive Officer or designee. The notice shall further state that failure to request a hearing within thirty (30) days constitutes a waiver of rights to any hearing or appellate review on the matter that is the subject of the notice. All the Medical Staff member's rights are delineated in the accompanying Medical Staff Bylaws copy.

XI.1.4.2 The notice of adverse recommendation shall also state that upon receipt of his hearing request, the Medical Staff member shall be notified of the date, time and place of hearing. The hearing date shall neither be less than thirty (30) days nor more than fifty (50) days (unless mutually agreed upon otherwise by all involved parties) from the date of the receipt.

XI.1.4.3 The notice of adverse recommendation will state that the 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.

- XI.1.5 Waiver of Hearing: The failure of a Medical Staff member to request a hearing to which the member is entitled by these Bylaws in the manner herein provided within thirty (30) days after receipt of notice thereof shall be deemed a waiver of the right to such hearing and appellate review to which the member might otherwise have been entitled. When the hearing and appellate review waived relates to an adverse recommendation of the Medical Staff Executive Committee or of a hearing committee appointed hereunder, the same shall thereupon become and remain effective pending final action on the matter by the Board. Where the hearing and appellate review waived relates to an adverse decision by the Board, the same shall thereupon become and remain a final decision of the Board. In either of such events, the Chief Executive Officer or designee shall promptly give notice to the affected medical staff member of the final decision of the Board.
- XI.1.6 Notice of Hearing: Within fourteen (14) days after receipt of a request for hearing from a medical staff member entitled to the same, the Medical Staff Executive Committee or the Board, shall through the Chief Executive Officer, notify the medical staff member by certified mail, return receipt requested as follows:
- XI.1.6.1 The time, place and date of the hearing and list of witnesses expected to testify at the hearing on behalf of the Medical Staff Executive Committee or the Board. The hearing date shall not be less than thirty (30) days nor more than fifty (50) days from the date of receipt of the request for hearing.
- XI.1.6.2 The names of the members of the hearing committee and the presiding hearing officer or committee chairman. Any objections to a member of the hearing committee or the presiding officer shall be made in writing within ten (10) days of receipt of notice of the hearing committee. This objection shall be resolved in conjunction with the MEC and the Board.
- XI.1.6.3 The affected medical staff member shall have the right, upon written request to the Chief Executive Officer, to inspect all pertinent information in the Hospital's possession upon which the adverse recommendation or action was based. All investigative materials, evidence, findings, and hearing procedures are to be maintained in confidence and information disseminated only to the involved parties, hearing committees, and/or others permitted access by law.
- XI.1.7 Hearing Committees:
- XI.1.7.1 All hearings related to an adverse recommendation of the MEC shall be conducted by an ad hoc committee of not less than five (5) members of the Medical Staff agreed to and appointed by the Chief Executive Officer on behalf of the Board, on the recommendation of the President of the Medical Staff in consultation with the MEC.

- a. The President may appoint one of the hearing committee members as chairman, who will carry out the responsibilities of presiding officer if none is appointed or when the presiding officer is not available, or may arrange for a presiding officer to serve as chairman.
- b. If a presiding officer is to be appointed, the President of the Medical Staff shall recommend a presiding officer to the Chief Executive Officer to appoint on behalf of the Governing Body. The presiding officer shall be an attorney at law qualified to preside over such administrative hearing, but attorneys from a firm regularly utilized by the Hospital, the medical staff or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as presiding officer. The presiding officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The presiding officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure or the admissibility of evidence. If the presiding officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the presiding officer may take such discretionary action as seems warranted by the circumstances. If requested by the hearing committee, the presiding officer may participate in the deliberations of such committee and be a legal advisor to it, but the presiding officer shall not be entitled to vote.

XI.1.7.2 All hearings relating to an adverse decision of the Board that is contrary to a recommendation of the MEC will be conducted by a five (5) member hearing committee of members of the Medical Staff. These members shall be appointed by the Chief Executive Officer on behalf of the Board, on the recommendation of the President of the Medical Staff in consultation with the MEC. The Board will designate one of the members of the committee to be its chairman, or shall appoint a presiding officer consistent with the provisions above.

XI.1.7.3 In either of the above instances, no medical staff member or other person who has actively participated in the consideration of the adverse recommendation or who is in direct economic competition with the affected medical staff member shall be appointed a member of hearing committees.

XI.1.7.4 The Presiding Officer

The presiding officer shall:

- a. Allow all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
- b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, and abusive or that causes undue delay;
- c. Maintain decorum throughout the hearing;
- d. Determine the order of procedure throughout the hearing;
- e. Have the authority and discretion in accordance with these Bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;
- f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing committee in formulating its recommendations.

XI.1.7.5 Pre-Hearing Conference: The presiding officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall address procedural questions, including any objections to exhibits or witnesses, and may establish guidelines regarding the time to be allotted to each witness's testimony and cross-examination.

XI.1.8 Conduct of Medical Staff Hearing:

XI.1.8.1 Quorum: A majority of the members of the hearing committee shall be present when the hearing takes place.

XI.1.8.2 Hearing Record: An accurate record of the hearing must be kept through the use of a court reporter unless the hearing committee designates otherwise.

- XI.1.8.3 No hearing shall be conducted without the presence in person of the medical staff member for whom the hearing has been scheduled.
- a. If the medical staff member provides a written request for waiver of the hearing at this time, the member shall be deemed to have lost all hearing and appellate review rights, to have voluntarily accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect pending final decision by the Board. No hearing will be held.
 - b. If the medical staff member fails without good cause to appear and proceed with the requested hearing, the hearing committee will review the adverse recommendation or decision, as well as any pertinent available information and recommend that the adverse recommendation or decision involved be considered as voluntarily accepted. The same shall therefore become and remain in effect pending final decision by the Board. Further hearing and appeal rights are waived.
 - c. If the medical staff member requests postponement of the hearing for apparent good cause, said postponement will be made by the hearing committee in its sole discretion.
- XI.1.8.4 The affected medical staff member shall be entitled to be accompanied by up to two (2) persons unless permitted otherwise by hearing committee agreement. Persons that may accompany the medical staff member include attorneys, and other persons of the medical staff member's choice.
- XI.1.8.5 Order of Presentation: The Board or Medical Staff Executive Committee, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.
- XI.1.8.6 Evidence: The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in a civil or criminal action. Where appropriate, the presiding officer of the hearing, in his sole and exclusive discretion, may allow testimony to be heard and taken which is relevant to, but may exceed the scope of, the

particular charges continued in the notice of the hearing. The medical staff member for whom the hearing is being held shall, prior to the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become a part of the hearing record. The hearing committee may also require the medical staff member, where practicable, to reduce testimonial evidence to written statements signed by witnesses. Any such statements shall clearly indicate those matters of which the witness has direct personal knowledge and those matters of which the witness' knowledge is based on hearsay information or belief. Such statements shall also indicate the complete basis of any opinions expressed by the witness.

- XI.1.8.7 Medical Staff Representative: The Board or MEC depending on whose recommendation prompted the hearing initially, shall appoint a member of the Medical Staff or of the Board, respectively, to present facts in support of the adverse decision or recommendation and to examine witnesses, and may also be represented at the hearing by legal counsel. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision, but the affected medical staff member shall thereafter be responsible for supporting his challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or any action based thereon is either arbitrary, unreasonable, or capricious.

As requested by the hearing committee chairman, the Chief Medical Officer or designee or Chief Executive Officer or designee may be present as an observer or advisor during the hearing. This does not in any way deprive the Medical Staff member, the MEC, or the Board of the right to legal counsel advice in connection with preparation for the hearing or for a possible appeal.

- XI.1.8.8 The medical staff representative shall be entitled to be accompanied by up to two (2) persons unless permitted otherwise by hearing committee agreement.

Unless designated otherwise in this section, the medical staff representative shall be entitled to be similarly accompanied as the affected medical staff member. Persons that may accompany the medical staff representative include attorneys, or other persons of the medical staff representative's choice.

- XI.1.8.9 Examination of Witnesses: The parties shall have the following rights; to call and examine witnesses, to introduce written evidence, to cross-examine any witness on any

matter relevant to the issue of the hearing, to challenge any witness, and to rebut any evidence. If the medical staff member does not testify on their own behalf, they may be examined as if under cross-examination. Hearing committee members may also question witnesses and all others involved in the hearing.

The hearing committee may, but shall not be required to, order that all oral evidence shall be taken only on oath or affirmation administered by any person designated to do so by the State of Illinois.

XI.1.8.10 Deliberations: The hearing committee may, without special notice, recess the hearing and reconvene the same within a reasonable time, not to exceed two weeks, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. Both parties shall have the right to submit a written statement at the close of the hearing. The hearing committee may thereupon within a reasonable time, at a time convenient to itself, conduct its deliberations outside the presence of the medical staff member for whom the hearing is convened.

XI.1.9 Hearing Report: Within ten (10) days after final adjournment of the hearing, the hearing committee shall make a written recommendation and report including a statement of the basis for the recommendation and shall forward the same, to the affected medical staff member, the MEC and to the Board. Included with this hearing committee recommendation should be the written report and all other supporting documents, if feasible.

XI.1.9.1 The hearing committee shall have independent authority to recommend action to the Board. The hearing committee's report may recommend affirmation, modification, or rejection of the original adverse recommendation of the MEC or decision of the Board.

XI.1.9.2 If the affected medical staff member requests a copy of the completed hearing record, said record may be furnished upon payment of reasonable charges for the document.

XI.1.10 If the recommended action of the hearing committee is adverse to the affected medical staff member, the member shall be entitled to an appellate review by the Board in accordance with these Bylaws, the Chief Executive Officer or designee shall so notify the affected Medical Staff member by certified mail, return receipt requested, within 10 days after receiving the hearing report.

ARTICLE XII: PROCEDURE FOR APPEALS TO THE HOSPITAL BOARD OF DIRECTORS

Section XII.1 Process

XII.1.1 Grounds for Appeal: The grounds for appeal shall be limited to the following:

XII.1.1.1 There was substantial failure to comply with the Medical Staff Bylaws prior to or during the hearing so as to deny a fair hearing; or

XII.1.1.2 The recommendation of the hearing committee was made arbitrarily, capriciously or with prejudice; or

XII.1.1.3 The recommendation of the hearing committee was not supported by substantial evidence based upon the hearing record.

XII.1.2 Appeal Request: An adverse recommendation of the hearing committee may be appealed by the affected Medical Staff member or the Medical Staff Executive Committee (MEC) by written notice to the Board delivered through the Chief Executive Officer within 30 days after receipt of the notice. Such written notice must be delivered by certified mail or hand-delivered. Any adverse recommendation will remain in effect pending the appellate process and final decision by the Board. The medical staff member or the MEC may request that oral argument be permitted as a part of the appellate review.

XII.1.3 Waiver of Appeal Request: If such appellate review is not requested within thirty (30) days after the receipt of the notice, the affected medical staff member shall be deemed to have waived their rights to the same and to have accepted such adverse recommendation, and the same shall become immediately effective as a final decision of the Board.

XII.1.4 Reply to Request for Appeal to the Board:

XII.1.4.1 Within ten (10) days after receipt of such notice of request for appellate review, the Board shall schedule a date for such review, including a time and place for oral argument if such has been requested, and shall, through the Chief Executive Officer, by written notice sent by certified mail, return receipt requested, notify the parties of same. The date of the appellate review shall not be less than ten (10) nor more than thirty (30) days from the date of receipt of the notice request for appellate review, except when the medical staff member requesting the review is under a suspension which is then in effect, such review shall be scheduled as soon as the arrangements for it may be reasonably made.

XII.1.4.2 This notice must state that this appeal shall be limited to the hearing record and the written statements provided for in these Bylaws unless otherwise permitted by the Board.

XII.1.4.3 The record of the hearing and the report of the hearing committee shall be presented to the Board prior to the appellate review by the chairman of the hearing committee.

XII.1.5 Composition of the Appellate Review Committee: The appellate review shall be conducted by the Board or a duly appointed appellate review committee of the Board of not less than five (5) members, none of whom shall be in economic competition with the member. The Chairman of the Board shall act as, or designate, a chairman for the appellate review.

XII.1.6 Appeal Statements:

XII.1.6.1 Factual Disputes: The parties shall have access to the report and record of the hearing committee and all other materials, favorable or unfavorable, that were considered in making the recommendation. The parties shall have up to twenty (20) days after receipt of the hearing committee's report and recommendation to submit a written statement to the Board, in which those factual and procedural matters with which there is disagreement he disagrees, and his the reasons for such disagreement, shall be specified. This written statement may cover any matters raised at any step in the procedure with which the appeal is related, and legal counsel may assist in its preparation. Such written statements shall be submitted to the Board through the Chief Executive Officer by certified mail, return receipt requested, or by hand delivery. The statements must be received at least five (5) days prior to the scheduled date for the appellate review.

The Chief Executive Officer shall provide a copy thereof to the other parties as soon as possible but at least three (3) days prior to the date of such appellate review by certified mail, return receipt requested, or by hand delivery.

XII.1.6.2 New or Additional Matters: New or additional matters not raised during the original hearing or in the hearing committee report, nor otherwise reflected in the record, shall only be introduced at the appellate review under unusual circumstances. The Board or the Committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

XII.1.7 Appellate Review Committee Procedures

XII.1.7.1. Review of Record and Conduction of the Review: The

review body shall examine the record created in the proceedings and shall consider written statements submitted pursuant to these Bylaws. Consideration shall be for the purpose of determining whether the adverse recommendation against the affected medical staff member was justified and was not arbitrary or capricious. If oral argument has been requested as part of the review procedure, the parties shall be present at such appellate review and shall be permitted to speak regarding the against the adverse recommendation with a thirty (30) minute time limit; and shall answer questions put to them by any member of the appellate review body. The Chief Medical Officer and/or Chief Executive Officer may be present to assist in the review at the request of the chairman of the appellate review body.

XII.1.7.2 Actions: If the appellate review is conducted by the Board, it may affirm, modify, or reverse its prior decision. If the Board determines the recommendation is not supported by the preponderance of the due evidence it may, in its discretion, refer the matter back to the hearing committee of the Medical Staff for further review and recommendation within twenty (20) days.

If the appellate review is conducted by a committee of the Board, such committee shall, within ten (10) days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Board affirm, modify, or reverse its prior decision, or refer the matter back to the hearing committee for further review and recommendation within twenty (20) days.

XII.1.7.3 Conclusion: The appellate review should not be deemed concluded until all of the procedural steps provided in these Bylaws have been completed or waived. Where permitted by the Hospital Bylaws, all action required of the Board may be taken by a committee of the Board duly authorized to so act.

XII.1.8 Final Decision by the Board

XII.1.8.1 Final Decision: No later than thirty (30) days after the conclusion of the appellate review, the Board shall make its final decision in the matter and shall send a written notice thereof to the MEC and, through the Chief Executive Officer, to the affected medical staff member by certified mail, return receipt requested. Said notice must include a statement of the basis for the decision.

XII.1.8.2 No More Than One Hearing: Notwithstanding any other provision of these Bylaws, no medical staff member shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of

action by the MEC of the Medical Staff or by the Board or by a duly authorized committee of the Board or by both.

- XII.1.8.3 Exhaustion of administrative remedies: Every practitioner agrees that he will exhaust all the administrative remedies afforded in the various sections of the Bylaws before initiating legal action against the Hospital or its agents.
- XII.1.8.4 Advance Notice of Implementing Economic Credentialing Decisions: Written notice shall be given fifteen (15) days before implementation of an adverse medical staff membership or clinical privileges decision based substantially on economic factors. This notice shall be given after the medical staff member exhausts all applicable hearing and appeal procedures under the Bylaws in order to allow sufficient time for the orderly provision of patient care.
- XII.1.8.5 Reporting requirements: The Chief Executive Officer or his designee shall be responsible for assuring that the Hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes. Reportable actions that must be reported shall be only upon adoption as final actions by the Board following completion or waiver of the hearing process. Where no hearing was requested or granted, the member shall be granted the opportunity to meet with the President of the Medical Staff and the Chief Executive Officer or his designee to review and discuss the proposed reports before they are filed.

ARTICLE XIII: INDEMNIFICATION

Section 1 Indemnification

- XIII.1.1 Members of the medical staff of St. John's Hospital are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the Hospital and medical staff.
- XIII.1.2 Subject to applicable law, the Hospital shall indemnify against actual and necessary expenses, costs, and liabilities incurred by a medical staff member in connection with the defense of any pending or threatened action, suit or proceeding to which the member is made a party by reason of his having acted in an official capacity in good faith on behalf of the Hospital or medical staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

ARTICLE XIV: CONFLICT RESOLUTION

Section XIV. 1 Conflict Resolution Between the Medical Staff and Board of Directors

XIV.1.1 In the event the Board of Directors acts in a manner contrary to a recommendation by the Medical Staff Executive Committee (MEC) or other disputes arise between the Board and the Medical Staff, the matter may (at the request of the MEC or the Board) be submitted for an ad hoc committee composed of the officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full Board. The committee shall serve as the exclusive body to handle Medical Staff and Board conflicts, gathering information as warranted and meeting with involved parties as soon as possible to identify and manage any conflict. The committee will submit its recommendation to the Board and the MEC within thirty (30) days of its meeting.

XIV.1.2 The Chairperson of the Board or the Medical Staff President may call for an ad hoc committee as described above at any time and for any reason in order to seek direct input from the Medical Staff leaders, clarify any issue, or relay information directly to Medical Staff leaders.

Section XIV. 2 Conflict Resolution Between the Medical Staff and Medical Executive Committee

At any meeting of the medical staff, its members may or shall, if the medical staff votes to do so, address and as feasible manage or arrange for the management of conflicts between the Executive Committee and the Medical Staff, or otherwise within the Medical Staff. Conflicts may also be resolved by a simple majority vote of the medical staff on the issue causing conflict.

ARTICLE XV: MEDICAL STAFF BYLAWS, RULES AND REGULATIONS AND POLICY REVIEW, REVISION, ADOPTION AND AMENDMENT

Section XV.1 Medical Staff Responsibility

- XV.1.1 The Medical Staff shall have the responsibility to review, at least biennially, and recommend amendments to the Medical Staff Bylaws, Rules and Regulations which shall be effective when approved by the Hospital Board of Directors, which approval shall not be unreasonably withheld. The Medical Staff can exercise this responsibility through the Medical Staff Executive Committee (MEC) utilizing the Bylaw Review Committee as needed, or by direct submission to the Board.
- XV.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the review, adoption, and amendment of the related rules and policies developed to implement the various sections of these Bylaws.

Section XV.2 Methods of Bylaws Adoption and Amendment

- XV.2.1 Amendments proposed to these Medical Staff Bylaws, whether originated by the MEC, another standing committee, a member of the Active category of the staff, or the Board, must be reviewed by the medical staff and Board attorney and approved by the MEC.
- XV.2.2 The MEC shall vote on proposed amendments at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, each Active Medical Staff member will be eligible to vote on the proposed amendments to these Bylaws via printed ballot, distributed at a meeting of the medical staff, or in lieu of a meeting via electronic ballot. The President of the Medical Staff shall also make provisions for absentee ballots to be available and counted. All Active members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes and the respective legal counsel recommendations. To be adopted, such changes must receive a two-thirds (2/3) of the votes, with quorum present cast by the eligible members of the Medical Staff. If a quorum is not reached at that meeting, action may be taken without a meeting of the staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or electronic means, and their vote recorded in accordance with procedures approved by the MEC. A two-thirds (2/3) of the votes so cast shall be required to adopt the amendment. Amendments so adopted shall be effective when approved by the Board.
- XV.2.3 Amendments to these Bylaws proposed by the Medical Staff and stipulated to not be subject to MEC review must be reviewed by both Medical Staff and

Board attorneys. These amendments will be subject to all requirements in Section 2.2 excluding MEC review and will be submitted to the Board after affirmative two-thirds (2/3) Medical Staff vote.

- XV.2.4 The MEC may independently adopt such amendments to these Bylaws as are, in the committee's judgment, due to technical modifications or clarifications; reorganization or renumbering or those needed due to punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the Chief Executive Officer. At the request of any active member, such an adoption shall be reviewed by the medical staff at its next meeting and can be deleted or revised by a majority of those voting. If so deleted by the medical staff, the amendment can only be made through the full Bylaws amendment process.

Section XV.3. Effect of Bylaws Adoption

- XV.3.1 Upon adoption and approval of these Bylaws, the Hospital and the Medical Staff intending to comply with the Bylaws, agree that these Bylaws shall be binding upon the Medical Staff, its members, and upon the Hospital, and upon any successor in interest in this Hospital. Affiliations between the Hospital and other Hospitals, healthcare systems or other entities shall not, of themselves, affect these Bylaws.
- XV.3.2 Upon approval of these Bylaws by the Medical Staff and the Board, the MEC is authorized to develop appropriate policies to ensure a smooth transition.

Section XV.4 Rules and Regulations

- XV.4.1 The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. The Rules and Regulations shall be amended, added to, or repealed at a regular or special meeting of the Medical Staff at which a quorum is present, by a majority vote of the Active Staff members. If a quorum is not reached at the meeting, action may subsequently be taken without a meeting of the staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or electronic means, and the vote recorded by the Medical Staff Office. 1 Amendments, additions, or recommendations for Rule and Regulations repeal must be approved by MEC and presented to the Medical Staff at least fifteen (15) days prior to the meeting at which they are to be acted upon unless designated otherwise. Rules and Regulations changes shall become effective when approved by the Board, which shall not be unreasonably withheld.
- XV.4.2 Medical Staff Rules and regulation amendments stipulated to not be reviewed by MEC will be subject to all requirements in Section XV.4.1 excluding MEC approval, and will be submitted to the Board after appropriate affirmative Medical Staff vote.
- XV.4.3 Departmental rules and regulations shall be adopted, repealed, or amended,

under the guidance of the applicable Department Chairman, by a majority vote of those members of the department present at any meeting at which a quorum exists. Nothing in such department rules and regulations or proposed amendments thereto shall conflict with these Bylaws. All departmental rules and regulations shall be submitted to the MEC for final review and approval prior to their implementation.

Section XV. 5 Medical Staff Policy

XV.5.1 The MEC shall review, develop and adopt policies which will be binding upon the medical staff and its members and those otherwise holding clinical privileges. Such policies must be consistent with the Medical Staff Bylaws and Rules and Regulations. Only policies adopted by the MEC and Hospital policies pertinent to medical practice are binding upon the Medical Staff and its members. Amendments to Medical Staff policies are to be distributed in writing to Medical Staff members and those otherwise holding clinical privileges in a timely and effective manner. At any general Medical Staff meeting or any special Medical Staff meeting called for that purpose, policy adopted by the MEC shall, at the request of any active member, be reviewed by the medical staff and may be revised by a majority of those voting.

XV.5.2 Each member of the Medical Staff in the Active category may request a general staff meeting to discuss a matter relevant to MEC decision about policy. Upon presentation of a petition signed by 15% of the members of the active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

ADOPTION

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

Originally adopted by the Medical Staff:	
Originally approved by the Board:	
Revisions adopted by the Medical Staff:	10/10/2013, 01/27/2014, 07/08/2025
Revisions approved by the Board:	02/05/2014, 08/20/2025

DEFINITIONS

For the purpose of these Bylaws, Rules and Regulations, the following terms shall have the following meanings:

1. "Adverse Decision" means decision reducing, restricting, suspending, revoking, denying, or not renewing medical staff membership or clinical privileges.
2. "Allied Health Professional" ("AHP") means individuals, other than a members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. Allied Health professionals are described as Licensed Independent Providers, Advanced Practice Providers or Surgical Providers in the Medical Staff Bylaw documents.
 - Advanced Practice Provider (APP) 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 Practitioner" means an individual permitted by law and the Hospital to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with clinical privileges individually granted consistent with these Bylaws.
 - "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" means the Board of Directors of the Hospital, which is the governing body having overall responsibility for the conduct of the affairs of the Hospital, including those of the Medical Staff, by virtue of the authority vested in it by law and charter and by its Bylaws.
4. "Bylaws" mean the Bylaws of the Medical Staff.
5. "Chairman" means a member recommended by a department, approved by the MEC, as the professional head of a department of the Medical Staff.
6. "Chief Executive Officer (CEO)" means the individual or designee(s) appointed by the Board to act on its behalf in the overall administrative management of the Hospital.

The title of this office or the designee or designees is the option of the Board.

7. "Chief Medical Officer" means a practitioner appointed by the Hospital's Administration and Board as the administrative and professional coordinator of medical staff affairs. The CMO shall report to the CEO. The CMO's responsibility shall not conflict with the responsibilities of officers or department Chairmen as described in these Bylaws. In the selection of a CMO, the MEC shall have an opportunity to review and comment regarding possible candidates.
8. "Economic Factor" means any information or reasons for decisions unrelated to quality of care or professional competency.
9. "Ex officio" means service by virtue of an office or position held and, unless otherwise expressly provided, means without voting right.
10. "He" or "Him" as used herein means the masculine, feminine, or neuter gender, as the context may require.
11. "Hospital" means all the health facilities owned and operated by St. John's Hospital at which Hospital inpatients and/or outpatients are treated.
12. "House Staff" mean all physicians who are assigned within departments for graduate medical education who will ordinarily carry the title of resident or fellow.
13. "Investigation" means a process specifically initiated by the MEC to determine the validity, if any, to a concern or complaint raised against a Medical Staff member or individual holding clinical privileges, and does not include activity of the Professional Wellness Committee
14. "Licensed Independent Provider" (LIP) 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.
15. "MEC" means the Medical Staff Executive Committee or Medical Executive Committee of the Medical Staff.
16. "Medical Staff" or "Staff" members means all licensed practitioners serving the Hospital who have delineated clinical privileges to attend patients or provide other diagnostic, therapeutic, teaching or research services in the Hospital.
17. "Medical Coordinator" or "Medical Director" of a specific service means a practitioner appointed by the Hospital's Administration and Board, with opportunity for review and comment by the MEC, as the Administrative and professional Coordinator of a medical program/service within the Hospital. Medical Coordinators shall report to the CMO

and/or CEO. Medical Coordinator's responsibilities shall not conflict with responsibilities of Officers or Department Chairmen as described in these Bylaws.

18. "Organized Medical Staff" The organized medical staff is a self-governing entity accountable to the governing body that operates under a set of bylaws and rules and regulations and policies developed and adopted by the medical staff and approved by the governing body. The medical staff is composed of Doctor of Medicine, osteopathy, and, in accordance with the medical staff bylaws, may also be composed of other practitioners. The medical staff is responsible for overseeing the quality of care provided by all physicians, and other licensed independent practitioners, and for overseeing the quality of care provided by all other practitioners who are privileged through the medical staff. To discharge this responsibility, the medical staff engages in a number of structured activities, including at a minimum: the privileging of all licensed independent practitioners, engaging in performance improvement activities; and working collaboratively with the hospital administration and governing body.
19. 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.
20. "Physician" for these Bylaws means a graduate of a college or school approved or recognized by the Department who is currently licensed by the Department to practice medicine in all its branches. "Physician" shall also include a visiting professor on the faculty of SIU who holds a valid visiting professor permit issued by the Department regardless of status of approval by the Department of the college or school from which the physician graduated.
21. "Practitioner" means a person who is a graduate of a college or school approved or recognized by the Illinois Department of Financial and Professional Regulation ("IDFPR" or "Department"), who is currently licensed by the Department to practice medicine in all its branches, podiatry, or dentistry in Illinois; and who applies for or has been granted delineated clinical privileges, or provides other diagnostic, therapeutic, teaching or research services in the Hospital.
22. "Practitioner" shall also include a visiting professor on the faculty of SIU who holds a valid visiting professor permit issued by the Department regardless of status of approval by the Department of the college or school from which the practitioner graduated.
23. "President" means the President of the Medical Staff.
24. "President-elect" means the President-elect of the Medical Staff.
25. "Privilege" means permission to provide medical or other patient care services and permission to use Hospital resources, including equipment, facilities and personnel

that are necessary to effectively provide medical or other patient care services. This definition shall not be construed to require a Hospital to acquire additional equipment, facilities, or personnel to accommodate the granting of privileges.

26. "Secretary" means the Secretary of the Medical Staff.

27. "SIU" means Southern Illinois University School of Medicine

28. "Telemedicine" The use of health care information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider, and for the purpose of improving patient care, treatment, and services.

APPENDIX A

Those individuals currently or have the potential to practicing as Licensed Independent Providers at HSHS St. John'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. John'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. John'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.