

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
GOTTLIEB MEMORIAL HOSPITAL**

MEDICAL STAFF BYLAWS

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TABLE OF CONTENTS

	<u>PAGE</u>
PREAMBLE	1
1. GENERAL	2
1.A. DEFINITIONS	2
1.B. DELEGATION OF FUNCTIONS	2
1.C. MEDICAL STAFF DUES	2
1.D. ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES	2
2. CATEGORIES OF THE MEDICAL STAFF	3
2.A. ACTIVE STAFF	3
2.A.1. Qualifications	3
2.A.2. Prerogatives	4
2.A.3. Responsibilities	4
2.B. COURTESY STAFF	5
2.B.1. Qualifications	5
2.B.2. Prerogatives and Responsibilities	6
2.C. CONSULTING STAFF	7
2.C.1. Qualifications	7
2.C.2. Prerogatives and Responsibilities	7
2.D. AMBULATORY CARE STAFF	8
2.D.1. Qualifications	8
2.D.2. Prerogatives and Responsibilities	8

	<u>PAGE</u>
2.E. COVERAGE STAFF	9
2.E.1. Qualifications	9
2.E.2. Prerogatives and Responsibilities.....	10
2.F. HONORARY STAFF	11
2.F.1. Qualifications	11
2.F.2. Prerogatives and Responsibilities.....	11
3. OFFICERS	12
3.A. DESIGNATION	12
3.B. ELIGIBILITY CRITERIA	12
3.C. DUTIES.....	13
3.C.1. President of the Medical Staff.....	13
3.C.2. President-Elect of the Medical Staff.....	14
3.C.3. Secretary-Treasurer	14
3.C.4. Immediate Past President of the Medical Staff.....	15
3.D. NOMINATIONS	15
3.E. ELECTION.....	15
3.F. TERM OF OFFICE.....	16
3.G. REMOVAL	16
3.H. VACANCIES	17

	<u>PAGE</u>
4. CLINICAL DEPARTMENTS	18
4.A. ORGANIZATION	18
4.B. ASSIGNMENT TO DEPARTMENT.....	18
4.C. FUNCTIONS OF DEPARTMENTS	18
4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS.....	18
4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS	19
4.F. DUTIES OF DEPARTMENT CHAIRS.....	19
4.G. FUNCTIONS OF SECTIONS.....	21
4.H. QUALIFICATIONS OF SECTION CHIEFS	22
4.I. APPOINTMENT AND REMOVAL OF SECTION CHIEFS.....	22
4.F. DUTIES OF SECTION CHIEFS	23
5. MEDICAL STAFF COMMITTEES	24
5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS.....	24
5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS	24
5.C. MEETINGS, REPORTS, AND RECOMMENDATIONS.....	24
5.D. MEDICAL EXECUTIVE COMMITTEE.....	25
5.D.1. Composition	25
5.D.2. Duties.....	25
5.D.3. Meetings.....	27
5.E. PERFORMANCE IMPROVEMENT FUNCTIONS	27

	<u>PAGE</u>
5.F. CREATION OF STANDING COMMITTEES	29
5.G. SPECIAL COMMITTEES	29
6. MEETINGS	30
6.A. MEDICAL STAFF YEAR	30
6.B. MEDICAL STAFF MEETINGS	30
6.B.1. Regular Meetings	30
6.B.2. Special Meetings	30
6.C. DEPARTMENT AND COMMITTEE MEETINGS	30
6.C.1. Regular Meetings	30
6.C.2. Special Meetings	30
6.D. PROVISIONS COMMON TO ALL MEETINGS	31
6.D.1. Notice of Meetings	31
6.D.2. Quorums and Voting	31
6.D.3. Agenda	33
6.D.4. Minutes, Reports, and Recommendations	33
6.D.5. Confidentiality	33
6.D.6. Attendance Requirements	34
7. INDEMNIFICATION	35
8. BASIC STEPS AND DETAILS (SUMMARY OF APPOINTMENT, PRIVILEGES, AND MEDICAL STAFF MEMBER RIGHTS)	36
8.A. QUALIFICATIONS FOR APPOINTMENT	36
8.B. PROCESS FOR PRIVILEGING	36
8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)	36

	<u>PAGE</u>
8.D. DISASTER PRIVILEGING.....	37
8.E. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES.....	37
8.F. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION.....	38
8.G. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES.....	38
8.H. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL.....	38
9. AMENDMENTS.....	40
9.A. MEDICAL STAFF BYLAWS	40
9.B. OTHER MEDICAL STAFF DOCUMENTS.....	41
9.C. CONFLICT MANAGEMENT PROCESS	41
9.D. UNIFIED MEDICAL STAFF PROVISIONS	42
10. ADOPTION	44

APPENDIX A – MEDICAL STAFF CATEGORIES SUMMARY

APPENDIX B – HISTORY AND PHYSICAL EXAMINATIONS

PREAMBLE

- (1) Gottlieb Memorial Hospital is a not-for-profit corporation organized under the laws of the State of Illinois to serve as a general community hospital providing patient care and education with all of its activities subject to the ultimate authority of its Board of Directors; and
- (2) The laws, regulations, customs and generally recognized professional standards that govern hospitals require that all practitioners practicing at a hospital be formally organized into a collegial body of professionals, providing for its members mutual education, consultation and clinical support, constituting the hospital's Medical Staff; and
- (3) A hospital's Medical Staff is the organizational component to which a hospital's Board must delegate responsibilities relating to, and exact accountability for, the quality and appropriateness of professional performance; and
- (4) A hospital's Board and management require a source of collective advice from the professionals practicing at the hospital in aid of institutional policy formulation and enforcement, planning, coordination of services and governance; and
- (5) A purpose of the Hospital is to provide quality patient care and otherwise fulfill professional and institutional obligations to patients, students, and the community; and
- (6) Dedication to this purpose requires a cooperative effort among the professional peers practicing in the Hospital and between them and the Hospital Board and management, with well-defined lines of communication, responsibility and authority throughout the organizational structure.

THEREFORE, the practitioners practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws, and associated manuals, and the charter, policies, rules and regulations of the Hospital.

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy.

1.B. DELEGATION OF FUNCTIONS

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

1.C. MEDICAL STAFF DUES

- (1) Annual Medical Staff dues shall be as recommended by the MEC and may vary by category.
- (2) Members of the MEC shall be exempt from dues throughout the duration of their service on the Committee.
- (3) Dues shall be annually upon request. Failure to pay dues may result in privilege suspension and ineligibility to apply for Medical Staff reappointment.
- (4) Signatories to the Hospital's Medical Staff account shall be the President of the Medical Staff, the Secretary Treasurer, and the CMO.

1.D. ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES

The Medical Staff shall comply with *The Ethical and Religious Directives for Catholic Health Care Services*, as promulgated and revised from time to time by the United States Conference of Catholic Bishops. ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

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

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

- (a) are involved in at least 24 patient contacts per two-year appointment term; and
- (b) have expressed a willingness to contribute to 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 his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

- * Any member who has fewer than 24 patient contacts during his/her two-year appointment term, as verified by the Medical Staff Office, shall not be eligible to request Active Staff status at the time of his/her reappointment.
- ** Another appropriate staff category will be assigned that best reflects his/her relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, Ambulatory Care, or Coverage).

2.A.2. Prerogatives:

Active Staff members may:

- (a) admit patients without limitation as allowed on their clinical privilege form, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;
- (b) vote in all general and special meetings of the Medical Staff and applicable department and committee meetings so long as they meet the definition of Voting Member(s) of the Medical Staff as defined in Part 2: Credentials Policy, Article 1.A (30); provided however, that, upon initial appointment, no Active Staff member shall be eligible to vote for a period of 12 months.
- (c) hold office, serve as department chairs, serve on Medical Staff committees, and serve as chairs of committees; and
- (d) exercise such clinical privileges as are granted to them.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on 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 as may be requested or required by Hospital and/or Medical Staff policies and procedures;
- (c) providing care for unassigned patients;
- (d) participating in the evaluation of new members of the Medical Staff;
- (e) 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 medical specialties);
- (f) accepting inpatient consultations, when requested;

- (g) paying application fees, dues, and assessments; and
- (h) performing assigned duties.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

- (a) are involved in more than six, but fewer than 24, patient contacts per two-year appointment term;
- (b) meet all the same threshold eligibility criteria as other Medical Staff members, including specifically those relating to availability and response times with respect to the care of their patients; and
- (c) upon request, including but not limited to time of each reappointment, provide such 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 his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

- * Any member who has fewer than six patient contacts during his/her two-year appointment term, as verified by the Medical Staff Office, will be assigned to another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Consulting, Ambulatory Care, or Coverage).

- ** Any member who has more than 24 patient contacts during his/her two-year appointment term will be assigned to Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

- (a) admit patients without limitation as allowed on their clinical privilege form, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;
- (b) may attend and participate in Medical Staff and department meetings (without vote);
- (c) may not hold office or serve as department chairs;
- (d) may be invited to serve as chairs and/or members of committees (with vote);
- (e) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:
 - (1) 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, and
 - (2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and
 - (3) will be required to provide specialty coverage if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;
- (e) shall cooperate in the professional practice evaluation and performance improvement processes;
- (f) shall exercise such clinical privileges as are granted to them; and
- (g) shall pay application fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

- (a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff;
- (b) provide services at the Hospital only at the request of other members of the Medical Staff; and
- (c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

- (a) may evaluate and treat patients in conjunction with other members of the Medical Staff;
- (b) may not hold office or serve as department chairs;
- (c) may be invited to serve as chairs and/or members of committees (with vote);
- (d) may attend meetings of the Medical Staff and applicable department meetings (without vote);
- (e) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients, unless the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

- (f) shall cooperate in the professional practice evaluation and performance improvement processes; and
- (g) shall pay application fees, dues, and assessments.

2.D. AMBULATORY CARE STAFF

2.D.1. Qualifications:

The Ambulatory Care Staff consists of those physicians, dentists, oral surgeons, and podiatrists who:

- (a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital and meet the eligibility criteria set forth in the Medical Staff Credentials Policy with the exception of Section 2.A.1 (c), (d), (j), (k), (l), (m), (n), (o), (p), (q), (r), and (s);
- (b) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Ambulatory Care Staff as outlined in Section 2.D.2; and
- (c) upon request, provide such quality data and other information as may be requested to assist in an appropriate assessment of qualifications for appointment (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).

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

2.D.2. Prerogatives and Responsibilities:

Ambulatory Care Staff members:

- (a) may attend meetings of the Medical Staff and applicable departments (without vote);
- (b) may not hold office or serve as department chairs;

- (c) shall generally have no staff committee responsibilities, but may be invited to serve as chairs and/or members of committees (with vote);
- (d) may attend educational activities sponsored by the Medical Staff and the Hospital;
- (e) may refer patients to members of the Active Staff for admission and/or care;
- (f) are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;
- (g) are also encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients and record a courtesy progress note in the medical record containing relevant information from the patients' outpatient care;
- (h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;
- (i) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;
- (j) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient or outpatient orders (except as set forth in (l) below), perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;
- (k) may actively participate in the professional practice evaluation and performance improvement processes;
- (l) may refer patients to the Hospital's diagnostic facilities and order such tests; however, if medical issues arise with such patients while they are receiving the ordered tests, a member of the Medical Staff with appropriate clinical privileges will be consulted to manage the care of the patient (i.e., a hospitalist or the on-call physician); and
- (m) must pay application fees but are not required to pay dues.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

- (a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active 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 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 managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);
- (c) are not required to satisfy the response time requirements set forth in Section 2.A.1(c) of the Credentials Policy, except for those times when they are providing coverage; and
- (d) 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 Active Staff member(s) terminates for any reason or they will transfer to another appropriate staff category.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

- (a) when providing coverage assistance for an Active Staff member, shall be entitled to admit, as allowed on their clinical privilege form, and/or treat patients who are the responsibility of the Active Staff member that is being covered (i.e., the Active Staff member's own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);
- (b) have no independent Medical Staff responsibilities, but are responsible for fulfilling the Active Staff members' Medical Staff functions and responsibilities, including care for unassigned patients, emergency service care, consultation, and teaching assignments when providing coverage for members of their group practice or coverage group;

- (c) shall be entitled to attend Medical Staff and department meetings (without vote);
- (d) may not hold office or serve as department chairs or committee chairs;
- (e) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote); and
- (f) shall pay applicable fees, dues, and assessments.

2.F. HONORARY STAFF

2.F.1. Qualifications:

- (a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years and who are in good standing.
- (b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

2.F.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 be appointed to committees (with vote);
- (d) are entitled to attend educational programs of the Medical Staff and the Hospital;
- (e) may not hold office or serve as department chairs or committee chairs; and
- (f) are not required to pay application fees, dues, or assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

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

3.B. ELIGIBILITY CRITERIA

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

- (1) be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two years;
- (2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process;
- (3) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges;
- (4) not presently be serving as Medical Staff officers, Board members, or department chairs at any other hospital and shall not so serve during their term of office;
- (5) be willing to faithfully discharge the duties and responsibilities of the position;
- (6) have experience in a leadership position, or other involvement in performance improvement functions;
- (7) have demonstrated an ability to work well with others; and
- (8) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner. Any

disclosed financial relationships shall be considered by the Nominating Committee, the MEC and the Board, which shall have the discretion to determine whether the relationship is such that it renders an individual ineligible for the leadership position at issue.

All such individuals are encouraged to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

- (a) act in coordination and cooperation with the CMO and the President in matters of mutual concern involving the care of patients in the Hospital;
- (b) represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the President and the Board;
- (c) be accountable to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the performance improvement/professional practice evaluation/case management program functions delegated to the Medical Staff;
- (d) call and preside at all regular and special meetings of the Medical Staff and the MEC, and assume responsibility for the agenda of all such meetings;
- (e) appoint all committee chairs and members;
- (f) serve as chair of the MEC (with vote, as necessary) and be a member of all other Medical Staff committees, *ex officio* (with vote, as necessary);
- (g) be a signatory on the Hospital's Medical Staff account;
- (h) promote adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;
- (i) recommend Medical Staff representatives to Hospital committees;

- (j) be the spokesperson for the Medical Staff in its external professional and public relations;
- (k) oversee the preparation of accurate and complete minutes of all MEC and general Medical Staff meetings;
- (l) serve as an *ex officio* member of the Board, without vote; and
- (m) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy.

3.C.2. President-Elect of the Medical Staff:

The President-Elect of the Medical Staff shall:

- (a) assume all duties of the President of the Medical Staff and act with full authority as President of the Medical Staff in his or her absence;
- (b) succeed to the office of President of the Medical Staff at the conclusion of the term as President-Elect;
- (c) serve as the vice chair of the MEC; and
- (d) assume all such additional duties as are assigned by the President of the Medical Staff, the MEC, or the Board.

3.C.3. Secretary-Treasurer:

The Secretary-Treasurer shall:

- (a) serve as a member of the MEC;
- (b) attend to all appropriate correspondence and notices on behalf of the Medical Staff, as may be requested;
- (c) be a signatory on the Hospital's Medical Staff account; and
- (d) perform such additional duties as are assigned by the President of the Medical Staff, the MEC, or the Board.

3.C.4. Immediate Past President of the Medical Staff:

The Immediate Past President of the Medical Staff shall:

- (a) serve as an advisor and mentor to the President of the Medical Staff and the other officers;
- (b) serve as a voting member of the MEC; and
- (c) perform such additional duties as are assigned by the President of the Medical Staff, the MEC, or the Board.

3.D. NOMINATIONS

- (1) The Nominating Committee shall consist of the President of the Medical Staff (who shall serve as Chair), the Immediate Past President of the Medical Staff, and the President-Elect of the Medical Staff. The CMO and President shall also be members of the Committee, *ex officio*, without vote.
- (2) The Committee shall convene at least 90 days prior to the election and shall select the names of one or more qualified nominees for the offices of President-Elect of the Medical Staff and Secretary-Treasurer. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees shall then be provided to the Medical Staff at least 30 days prior to the election.
- (3) Additional nominations may be submitted to the Nominating Committee by written petition signed by at least 20 voting staff members at least fifteen days prior to the election. In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 3.B, in the judgment of the Nominating Committee, and be willing to serve.
- (4) Nominations from the floor shall not be accepted.

3.E. ELECTION

- (1) The election shall be held solely by written ballot returned to the Medical Staff Office. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Office by the day of the

election. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation.

- (2) In the alternative, at the discretion of the MEC, candidates receiving a majority of written votes cast at an official meeting shall be elected, subject to Board confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected. Officers must be out of office for one year before being eligible to be nominated for another term in the same office. This does not preclude the nomination of such individuals for a different office at the conclusion of their current terms.

3.G. REMOVAL

- (1) Removal of an elected officer or member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Active Staff, or by the Board. Grounds for removal shall be:
 - (a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;
 - (b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws;
 - (c) failure to perform the duties of the position held;
 - (d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or
 - (e) an infirmity that renders the individual incapable of fulfilling the duties of that office.
- (2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC,

the Active Staff, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.

3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the President-Elect of the Medical Staff. A vacancy in the office of President-Elect of the Medical Staff shall be filled by the Secretary-Treasurer. In the event there is a vacancy in the office of Secretary-Treasurer, the President of the Medical Staff shall appoint an individual to fill that office for the remainder of the term or until a special election can be held, in the discretion of the MEC.

ARTICLE 4

CLINICAL DEPARTMENTS AND SECTIONS

4.A. ORGANIZATION

The Medical Staff shall be organized into departments and sections as listed in the Medical Staff Organization Manual. Subject to the approval of the Board, the MEC may create new departments, eliminate departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENT

- (1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department and, if applicable, to a section within the department. Assignment to a particular department does not preclude an individual from seeking and being granted clinical privileges typically associated with another department.
- (2) An individual may request a change in department assignment to reflect a change in the individual's clinical practice.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments, (ii) to monitor the practice of all those with clinical privileges or a scope of practice in a given department, and (iii) to provide appropriate specialty coverage in the Emergency Department, consistent with the provisions in these Bylaws and related documents.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS

Each department chair shall satisfy all the eligibility criteria outlined in Section 3.B, unless waived by the Board after considering the recommendation of the President of the Medical Staff.

4.E. APPOINTMENT AND REMOVAL OF DEPARTMENT CHAIRS

- (1) Except as otherwise provided by contract, department chairs shall be selected by the voting members of the department, subject to approval by the MEC and the Board.
- (2) Any department chair may be removed by a two-thirds vote of the department members, subject to Board confirmation; or by a two-thirds vote of the MEC, subject to Board confirmation; or by the Board. Grounds for removal shall be:
 - (a) failure to comply with applicable policies and Bylaws;
 - (b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws (unless a waiver has been granted in accordance with Section 4.D);
 - (c) failure to perform the duties of the position held;
 - (d) suspected conduct detrimental to the interests of the Hospital and/or its Medical Staff; or
 - (e) an infirmity that renders the individual incapable of fulfilling the duties of that office.
- (3) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to speak to the department, the MEC, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.
- (4) Department chairs shall serve for a term of two years and may be re-selected.

4.F. DUTIES OF DEPARTMENT CHAIRS

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

- (1) coordinating all clinically-related activities of the department;

- (2) coordinating all administratively-related activities of the department;
- (3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE), as outlined in the Professional Practice Evaluation Policy;
- (4) recommending criteria for clinical privileges that are relevant to the care provided in the department;
- (5) evaluating requests for clinical privileges for each member of the department;
- (6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;
- (7) integrating the department into the primary functions of the Hospital;
- (8) coordinating and integrating interdepartmental and intradepartmental services;
- (9) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the department;
- (10) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- (11) determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- (12) continuously assessing and improving the quality of care, treatment, and services provided within the department;
- (13) maintaining quality monitoring programs, as appropriate;
- (14) providing for the orientation and continuing education of all persons in the department;
- (15) making recommendations for space and other resources needed by the department;

- (16) cooperating with the preparation of Emergency Department on-call rosters to ensure appropriate coverage; and
- (17) performing all functions authorized in the Credentials Policy, including collegial intervention efforts.

4.G. FUNCTIONS OF SECTIONS

Due to the diversity of medical or surgical specialties within a department, and the number of physicians in a department, a department chair may recommend to the MEC, after consultation with the Voting Medical Staff section members, that Sections be established under the department to assist with the administrative duties as delineated in Article 4.

- (1) Sections may perform any of the following activities:
 - (a) Continuing education;
 - (b) Discussion of policy;
 - (c) Discussion of equipment needs;
 - (d) Development of recommendations to the department chair or the MEC;
 - (e) Participation in the development of criteria for clinical privileges, focused professional practice evaluation, and ongoing professional practice evaluation (when requested by the department chair); and
 - (f) Discussion of a specific issue at the request of a department chair or the MEC.
- (2) No minutes or reports will be required reflecting the activities of sections, except when they are making formal recommendations to a department, department chair, the Credentials Committee or the MEC.
- (3) Sections shall be required to hold at least one annual meeting (with official minutes of the meeting), and Voting Medical Staff section members may request a meeting at any time.
- (4) All section chief recommendations and actions are subject to review and approval by the department chair.

4.H. QUALIFICATIONS OF SECTION CHIEFS

Each section chief must be a Voting Medical Staff member for at least two years, which requirement may not be waived. Each such section chief must also satisfy all of the eligibility criteria outlined in Section 3.B(2) through (8) unless waived by the MEC.

4.I. APPOINTMENT AND REMOVAL OF SECTION CHIEFS

- (1) Section chiefs shall be selected by the department chair, subject to approval by the MEC.
- (2) Section chiefs may be removed at the discretion of the department chair after receiving input from section members and upon approval of the MEC and the Board. Grounds for removal shall be:
 - (a) failure to comply with applicable policies and Bylaws;
 - (b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws (unless a waiver has been granted in accordance with Section 4.D);
 - (c) failure to perform the duties of the position held;
 - (d) suspected conduct detrimental to the interests of the Hospital and/or its Medical Staff; or
 - (e) an infirmity that renders the individual incapable of fulfilling the duties of that office.
- (3) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to speak to the department, the MEC, or the Board, as applicable, prior to a vote on removal. No removal shall be effective until approved by the Board.
- (4) Section chiefs shall serve for a term of two years and may be re-selected.

4.J DUTIES OF SECTION CHIEFS

The section chief shall carry out those functions delegated by the department chair, which may include the following:

- (1) Review and report on applications for initial appointment and clinical privileges;
- (2) Review and report on applications for reappointment and renewal of clinical privileges;
- (3) Review and report on requests for the expansion of clinical privileges;
- (4) Evaluate individuals during the focused professional practice evaluation process to confirm competence for all initial-granted clinical privileges, whether at the time of initial appointment, reappointment or during the term of appointment;
- (5) Participate in the development of criteria for clinical privileges within the section;
- (6) Review and report regarding the ongoing professional performance of individuals practicing within the section;
- (7) Support the department chair in making recommendations regarding the coordination of the department, as well as the Hospital resources necessary for the section to function effectively; and
- (8) Perform all functions authorized in the Credentials Policy, including collegial intervention efforts.

ARTICLE 5

MEDICAL STAFF COMMITTEES

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

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

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

- (1) Unless otherwise indicated, all committee chairs and members shall be appointed by the President of the Medical Staff. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws.
- (2) Committee chairs and members shall be appointed for initial terms of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the President of the Medical Staff at his/her discretion.
- (3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the President. All such representatives shall serve on the committees, without vote.
- (4) Unless otherwise indicated, the President of the Medical Staff, the CMO, CQO, and the President (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

5.C. MEETINGS, REPORTS, AND RECOMMENDATIONS

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

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

- (a) The MEC shall consist of:
- President of the Medical Staff,
 - President-Elect of the Medical Staff,
 - Secretary-Treasurer,
 - Immediate Past President of the Medical Staff, and
 - department chairs, Credentials Chair and other Service Medical Directors as determined by the Medical Staff President.
- (b) The President of the Medical Staff will chair the MEC.
- (c) The Hospital President, the CMO, CQO, the Director of the Quality Management Resources Department, the Chief Health Informatics Officer and a representative of the Nursing Department shall be *ex officio* members of the MEC, without vote.
- (d) Other Medical Staff members or Hospital personnel may be invited to attend a particular MEC meeting (as guests, without vote) in order to assist the MEC in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the MEC.

5.D.2. Duties:

- (a) The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws and related policies.

- (b) The MEC is responsible for the following:
- (1) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);
 - (2) recommending directly to the Board on at least the following:
 - (i) the Medical Staff's structure;
 - (ii) the mechanism used to review credentials and to delineate individual clinical privileges;
 - (iii) applicants for Medical Staff appointment and reappointment;
 - (iv) delineation of clinical privileges for each eligible individual;
 - (v) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;
 - (vi) the mechanism by which Medical Staff appointment may be terminated;
 - (vii) hearing procedures; and
 - (viii) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;
 - (3) consulting with administration on quality-related aspects of contracts for patient care services;
 - (4) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;
 - (5) providing leadership in activities related to patient safety;
 - (6) providing oversight in the process of analyzing and improving patient satisfaction;

- (7) ensuring that, at least every five years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;
- (8) providing and promoting effective liaison among the Medical Staff, Administration, and the Board; and
- (9) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, or other applicable policies.

5.D.3. Meetings:

The MEC shall meet at least ten times a year, and shall maintain a permanent record of its proceedings and actions.

5.E. PERFORMANCE IMPROVEMENT FUNCTIONS

- (1) The Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:
 - (a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;
 - (b) the Hospital's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;
 - (c) medical assessment and treatment of patients;
 - (d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;
 - (e) the utilization of blood and blood components, including review of significant transfusion reactions;
 - (f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;
 - (g) appropriateness of clinical practice patterns;

- (h) significant departures from established patterns of clinical practice;
 - (i) use of information about adverse privileging determinations regarding any practitioner;
 - (j) the use of developed criteria for autopsies;
 - (k) sentinel events, including root cause analyses and responses to unanticipated adverse events;
 - (l) nosocomial infections and the potential for infection;
 - (m) unnecessary procedures or treatment;
 - (n) appropriate resource utilization;
 - (o) education of patients and families;
 - (p) coordination of care, treatment, and services with other practitioners and Hospital personnel;
 - (q) accurate, timely, and legible completion of medical records;
 - (r) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix B of these Bylaws;
 - (s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and
 - (t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the Board.
- (2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the Medical Staff Organization Manual.

5.F. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may, by resolution and upon approval of the Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the MEC.

5.G. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the President of the Medical Staff and/or the MEC. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least biannually and at any additional time as determined by the Medical Staff Officers.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, or by a petition signed by at least 20 members of the voting staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

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

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, the MEC, or by a petition signed by not less than one-fourth of the voting staff members of the department or committee (but in no event fewer than two members).

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

- (a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least 14 days in advance of the meetings. Notice may also be provided by posting in a designated location at least two week prior to the meetings. All notices shall state the date, time, and place of the meetings.
- (b) When a special meeting of the Medical Staff or a department is called, the required notice period shall be at least seven days. When a special meeting of a committee is called, the required notice period shall be at least 48 hours (i.e., must be given at least 48 hours prior to the special meeting). In addition, posting may not be the sole mechanism used for providing notice of any special meeting.
- (c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

6.D.2. Quorums and Voting:

(a) Medical Staff Meetings

- (1) Quorum: For any regular or special meeting of the Medical Staff, 20 voting staff members must be present in order to establish a quorum. The exception to this general rule is when amendments to these Medical Staff Bylaws or the related Bylaws Documents will be discussed, in which case at least 10% of the entire voting staff must be present in order to establish a quorum.
- (2) Voting: No voting shall take place at any regular or special meeting of the Medical Staff. Issues shall be discussed and deliberated at such meetings, but voting on all issues shall take place by written or electronic means.

Specifically, the voting members of the Medical Staff shall be presented with matters requiring a vote by mail, facsimile, e-mail, website, hand-delivery, telephone, or other technology approved by the President of the Medical Staff. Votes shall be returned to the President of the Medical Staff via the Medical Staff Office by the method designated in the notice. The question raised shall be determined in the affirmative and shall be

binding if a quorum is achieved and the majority of the responses returned has so indicated.

(b) Department Meetings

- (1) Quorum: For any regular or special meeting of a department, those voting members present (but not fewer than two) shall constitute a quorum.
- (2) Voting: Recommendations and actions taken by departments shall be by consensus of the members present. In the event it is necessary to vote on a particular issue, that issue will be determined by a majority vote of those voting members present at a department meeting.

As an alternative to a formal department meeting, the voting members of the department may be presented with a question by mail, facsimile, e-mail, website, hand-delivery, telephone, or other technology approved by the department chair. Votes shall be returned to the department chair via the Medical Staff Office by the method designated in the notice. A quorum for purposes of written or electronic votes shall be the number of responses returned to the department chair by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(c) Committee Meetings

- (1) Quorum: For any regular or special meeting of a committee, those voting members present (but not fewer than two) shall constitute a quorum. The exception to this general rule is that for meetings of the MEC, Credentials Committee, and the Professional Practice Evaluation Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum.
- (2) Voting: Recommendations and actions taken by committees shall be by consensus of the members present. In the event it is necessary to vote on a particular issue, that issue will be determined by a majority vote of those voting members present at a committee meeting.

As an alternative to a formal committee meeting, the voting members of the committee may be presented with a question by mail, facsimile, e-mail, website, hand-delivery, telephone, or other technology approved by

the committee chair. Votes shall be returned to the committee chair via the Medical Staff Office by the method designated in the notice. Except for actions by the MEC, the Credentials Committee, and the Professional Practice Evaluation Committee (which require a response by 50% of the voting members), a quorum for purposes of all other written or electronic votes shall be the number of responses returned to the Committee Chair by the date indicated. The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

- (d) Meetings may be conducted by telephone conference or videoconference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Minutes, Reports, and Recommendations:

- (a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.
- (b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC. The Board shall be kept apprised of the recommendations of the Medical Staff and its clinical departments and committees.
- (c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.5. Confidentiality:

All Medical Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any

individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.D.6. Attendance Requirements:

- (a) Attendance at all meetings of the MEC, the Credentials Committee, and the Professional Practice Evaluation Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.
- (b) Each Active Staff member is expected to attend and participate in Medical Staff meetings and applicable department and committee meetings each year.

ARTICLE 7

INDEMNIFICATION

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

ARTICLE 8

BASIC STEPS AND DETAILS (SUMMARY OF APPOINTMENT, PRIVILEGES, AND MEDICAL STAFF MEMBER RIGHTS)

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Allied Health Professionals in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials and Allied Health Professionals Policies.

8.B. PROCESS FOR PRIVILEGING

Requests for privileges are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the President of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable department chair, who reviews the individual's education, training, and experience and prepares a report (on a form provided by the Medical Staff Office) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair's assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the

Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the President of the right to request a hearing.

8.D. DISASTER PRIVILEGING

When the disaster plan has been implemented, the President or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges after verification of the volunteer's identity and licensure.

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

- (1) Appointment and clinical privileges may be automatically relinquished if an individual:
 - (a) fails to do any of the following:
 - (i) timely complete medical records;
 - (ii) satisfy threshold eligibility criteria;
 - (iii) comply with training or educational requirements;
 - (iv) provide requested information; or
 - (v) attend a special conference to discuss issues or concerns;
 - (b) is involved or alleged to be involved in criminal activity as defined in the Credentials Policy;
 - (c) makes a misstatement or omission on an application form; or
 - (d) remains absent on leave for longer than one year, unless an extension is granted by the President.
- (2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.F. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

- (1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, or any two of the following: the President of the Medical Staff, the CMO, or the President is authorized to suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.
- (2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the President or the MEC.
- (3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.
- (4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.
- (5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MEC.

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

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is inconsistent with the Medical Staff Code of Conduct.

8.H. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

- (1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

- (2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.
- (3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.
- (4) A stenographic reporter will be present to make a record of the hearing.
- (5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to obtain written documents that form the basis for the recommendation(s) at issue; (b) to call and examine witnesses, to the extent they are available and willing to testify; (c) to introduce exhibits; (d) to cross-examine any witness on any matter relevant to the issues; (e) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (f) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.
- (6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.
- (8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

- (1) Neither the MEC, the Medical Staff, nor the Board shall unilaterally amend these Bylaws.
- (2) Amendments to these Bylaws that are in compliance with state and federal law and accreditation standards may be proposed by the Bylaws Committee, the MEC, or by a petition signed by at least 20 voting members of the Medical Staff.
- (3) All proposed amendments to these Bylaws shall be reviewed by the Bylaws Committee which shall report on the amendments to the MEC. Amendments shall also be reviewed by the MEC prior to a vote by the Medical Staff. The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose; however, voting on the amendments shall not occur at such meetings.
- (4) The MEC shall present all proposed amendments to these Bylaws to the voting staff by written ballot or e-mail to be returned to the President of the Medical Staff in care of the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC shall provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 50% of the voting Medical Staff, and (ii) the amendment must receive a majority of the votes cast.
- (5) The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.
- (6) All amendments shall be effective only after approval by the Board.
- (7) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its

contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the President within two weeks after receipt of a request.

9.B. OTHER MEDICAL STAFF DOCUMENTS

- (1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, and shall be amended in accordance with the procedure for amending the Bylaws that is set forth in Section 9.A of these Bylaws. The only exception is for amendments to the Rules and Regulations that are necessary only to comply with state or federal law or accreditation standards which the MEC may act upon without prior review by the Bylaws Committee. In this exceptional circumstance, amendments may be acted upon by the MEC with the assent of the Chair of the Bylaws Committee. These additional documents are the Medical Staff Credentials Policy, the Policy on Allied Health Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.
- (2) All other policies of the Medical Staff (i.e., those not specifically listed in paragraph (1) above), may be adopted and amended by a majority vote of the MEC. No prior notice is required.
- (3) Adoption of, and changes to, the Credentials Policy, Medical Staff Organization Manual, Policy on Allied Health Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.
- (4) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

9.C. CONFLICT MANAGEMENT PROCESS

- (1) When there is a conflict between the Medical Staff and the MEC with regard to:
 - (a) proposed amendments to the Medical Staff Rules and Regulations;

- (b) a new policy proposed or adopted by the MEC; or
- (c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 20 voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

- (2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Board for final action.
- (3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.
- (4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the President, who will forward the request for communication to the Chair of the Board. The President will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

9.D. UNIFIED MEDICAL STAFF PROVISIONS

- (1) Adoption of a Unified Medical Staff:

If Loyola University Health System elects to adopt a single unified Medical Staff that includes the Hospital's Medical Staff, the voting members of the Hospital's Medical Staff may approve or disapprove a unified Medical Staff structure by conducting a vote in accordance with the process outlined in Section 9.A for amending these Medical Staff Bylaws.

- (2) Bylaws, Policies, and Rules and Regulations of the Unified Medical Staff:

Upon approval of a unified Medical Staff structure, the unified Medical Staff will adopt Medical Staff bylaws, policies, and rules and regulations that:

- (a) describe the process for self-governance, appointment, credentialing, privileging and oversight, as well as its peer review policies and due process guarantees, including a process for the Hospital Medical Staff members eligible to vote to be advised of their rights to opt-out of the unified Medical Staff structure after a vote conducted pursuant to Section 9.D.3 below;
- (b) take into account the unique circumstances of each participating hospital, including any significant differences in the patient populations that are served and the clinical services that are offered; and
- (c) address the localized needs and concerns of Medical Staff members at each of the participating hospitals, and the unified Medical Staff shall conduct meetings at least twice a year to ensure such needs and concerns are being addressed.

(3) Opt-Out Procedures:

If a unified Medical Staff structure is approved, the current members of the Hospital Medical Staff eligible to vote may later vote to opt out of the unified Medical Staff. Any such vote will be conducted in accordance with the process outlined in the unified Medical Staff Bylaws in force at the time of the vote. Upon disunification, the Hospital's Medical Staff Bylaws in effect as of the date of unification shall return to full force and effect.

Medical Staff members eligible to vote may vote no more than every two years whether to remain or discontinue as a unified Medical Staff.

ARTICLE 10

ADOPTION

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

Adopted by the Medical Staff: September 23, 2014

Approved by the GMH Credentialing
Committee of the Board: September 29, 2014

Approved by the Board of Directors: October 3, 2014

GOTTLIEB MEMORIAL HOSPITAL – MEDICAL STAFF BYLAWS

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Courtesy	Consulting	Ambulatory Care	Coverage	Honorary
Basic Requirements						
Number of hospital contacts/2-year	≥ 24	> 6 & < 24	NA	N	NA	N
Rights						
Admit	Y	> 6 & < 24	Y	N	P	N
Exercise clinical privileges	Y	Y	Y	N	P	N
May attend meetings	Y	Y	Y	Y	Y	Y
Voting privileges	Y	P	P	P	P	P
Hold office	Y	N	N	N	N	N
Responsibilities						
Serve on committees	Y	Y	Y	Y	Y	Y
Emergency call coverage	Y	FUC	N	FUC	P	N
Meeting requirements	Y	N	N	N	N	N
Dues	Y	Y	Y	N	Y	N
Comply w/ guidelines	Y	Y	Y	Y	Y	N
OPPE/FPPE	Y	Y	Y	N	Y	N

Y = Yes

N = No

P = Partial (with respect to voting, the individual may only vote at committee meetings for the committee(s) to which the individual has been appointed)

FUC = Follow-up care

GOTTLIEB MEMORIAL HOSPITAL – MEDICAL STAFF BYLAWS

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

(1) General Documentation Requirements

- (a) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.
- (b) The scope of the medical history and physical examination will include, as pertinent:
- patient identification;
 - chief complaint;
 - history of present illness;
 - review of systems;
 - personal medical history, including medications and allergies;
 - family medical history;
 - social history, including any abuse or neglect;
 - physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
 - data reviewed;
 - assessments, including problem list;
 - plan of treatment; and

- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.
- (c) In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.
- (d) History and physical examinations performed by physician assistants and non-credentialed practitioners, such as housestaff, must be countersigned by the attending physician/preceptor within 24 hours.
- (2) H&Ps Performed Prior to Admission
- (a) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.
- (b) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.
- (c) The update of the history and physical examination shall be based upon an examination of the patient and must reflect (i) any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.
- (3) Cancellations, Delays, and Emergency Situations
- (a) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operative suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is

recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

- (b) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

(4) Short Stay Documentation Requirements

For ambulatory or same day procedures, a Short Stay History and Physical Form, approved by the MEC, may be utilized. These forms shall document, at a minimum, the patient's chief complaint or reason for the procedure, relevant history of the present illness or injury, current clinical condition, general appearance, vital signs, and an assessment of the heart and lungs.

(5) Prenatal Records for Obstetric Patients in the Emergency Department

The current Emergency Department record will include prenatal documentation for any obstetric patient. The initial prenatal documentation will contain relevant obstetric history if the patient's obstetric history cannot be ascertained from the Hospital's medical record. An interval progress note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.