

AMENDED AND RESTATED MEDICAL STAFF BYLAWS

***COMMUNITY MEMORIAL HOSPITAL
OF MENOMONEE FALLS, INC.***

Effective October 1, 2012

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ARTICLE 1.

Definitions

The name of this organization shall be "Medical Staff of Community Memorial Hospital." When used herein, the following terms shall have the following meanings:

"Applicant" means either a Practitioner who has completed an application for appointment or reappointment to the Medical Staff, or a Practitioner or an Independent Allied Health Professional who has completed an application for clinical privileges to provide patient care at the Hospital.

"Bylaws" means these Medical Staff Bylaws of Community Memorial Hospital.

"Clinical Services Unit" means any clinical grouping designated by the Medical Executive Council for which a CSU Medical Director is assigned as provided in these Bylaws, and may include a department, service, service line, center, program or like designation.

"Contract Practitioner" means a Practitioner who provides services to patients of the Hospital under an exclusive or non-exclusive service agreement between the Hospital and the entity of which the Practitioner is a member, partner or employee.

"CSU Medical Director" means the Member of the Active Medical Staff appointed as chief of a Clinical Services Unit who is responsible for the coordination, supervision and leadership of such Clinical Services Unit in accordance with the duties and responsibilities assigned to CSU Medical Directors under these Bylaws.

"Governing Body" means the Board of Directors of Community Memorial Hospital.

"Hospital" means, unless the context requires otherwise, Community Memorial Hospital.

"Hospital President" means the individual appointed by the Governing Body to act on its behalf in the overall administrative management of the Hospital.

"Independent Allied Health Staff" or "Independent Allied Health Professional" or "IAHP" means any health professional, who is not a Member of the Medical Staff, but who is qualified by academic and clinical training and by prior and continuing experience and current competence in a discipline who the Governing Body has permitted to assist the Medical Staff in the care of patients in the Hospital.

"Medical Executive Council" means the Executive Council of the Medical Staff.

"Medical Staff" or "Staff" means, unless otherwise expressly stated, the Hospital's organized component of all physicians, dentists and podiatrists who are privileged to attend to patients in the Hospital.

"Member" means Practitioners who have satisfied all credential requirements and have been approved to attend patients as part of the Medical Staff at the Hospital.

“Organization Manual” means the manual adopted by the Medical Executive Council and Governing Body establishing the Clinical Services Units and standing councils of the Medical Staff.

“Physician” means all medical physicians and osteopathic physicians holding license to practice in the State of Wisconsin.

“Practitioner” or **“Licensed Independent Practitioner”** means, unless otherwise expressly limited, any physician, dentist or podiatrist holding clinical privileges in the Hospital or who has completed an application for appointment or reappointment to the Medical Staff.

“Special Notice” means written notification sent by certified mail or registered mail, return receipt requested, or hand delivered to the addressee.

“Voting Staff Member” means a Member who is eligible to vote on all matters presented to the Medical Staff.

ARTICLE 2.

Purpose

The purpose of the Medical Staff shall be:

1. To promote quality care for all Hospital patients and to provide leadership for the Hospital's performance review activities.
2. To provide a means whereby problems of medico-administrative nature may be discussed by the Medical Staff with the Governing Body and the Administration.
3. To adopt hospital policies governing medical practice.
4. To provide education and to maintain educational standards.
5. To promote a professional performance of and to oversee the quality of patient care, treatment and services provided by all Practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each Practitioner may exercise in the Hospital and through an ongoing review and evaluation of each Practitioner's performance in the Hospital.
6. To provide a utilization review program to allocate inpatient medical and health services based upon determination of individual medical needs and to improve the appropriate allocation of medical and health service resources.
7. To conduct reviews and evaluate and improve the quality of patient care through patient care audit procedures and other processes.
8. To initiate and pursue corrective action with respect to Members when warranted.

9. To carry out such other responsibilities as may be reasonably delegated by the Governing Body.

ARTICLE 3. **Membership**

3.1. Membership Privileges.

Membership on the Medical Staff of the Hospital is a privilege that shall be extended only to those Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws.

3.2. Criteria for Appointment.

3.2.1. Education. The Applicant for appointment to the Medical Staff shall be a graduate of an approved medical school, approved osteopathic school, approved dental school, or approved podiatric school, legally licensed to practice medicine, dentistry, or podiatry in the State of Wisconsin, and practicing in the community or within a reasonable distance of the Hospital.

3.2.2. Training. Only physicians, dentists, or podiatrists who can document their background, experience, training and demonstrated current competence, their adherence to the ethics of their profession, their good reputation, their adherence to the appropriate utilization of Hospital resources as determined through quality assurance and utilization review activities, and their ability to work with others with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given a high quality of safe medical care, and who can continue to demonstrate and maintain these standards shall be qualified for appointment to the Medical Staff.

3.2.3. Board Certification. Physicians whose initial appointment occurs on or after August 22, 2002 shall be board certified within five (5) years after appointment by a specialty board approved by either the American Board of Medical Specialties or the American Osteopathic Association in the specialty or subspecialty most closely aligned to the requested clinical privileges, and shall meet at least one of the following:

3.2.3.1. Have completed a residency program approved by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the area of practice in which privileges are requested;

3.2.3.2. Have completed a fellowship program in the area of practice in which privileges are requested, provided the fellowship program is approved by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association and has admission standards requiring completion of a residency program either (i) approved by the Accreditation Council for

Graduate Medical Education or the American Osteopathic Association or (ii) with training and education standards that meet or exceed those of the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

3.2.4. Failure to Achieve Board Certification. If a Physician fails to achieve board certification within five (5) years after his or her initial appointment, such Physician's privileges and Medical Staff membership will automatically terminate. Such automatic termination of privileges shall not be deemed the result of a professional review action, shall not entitle such Physician to fair hearing rights under ARTICLE 9, and shall not be reported to the National Practitioner Data Bank or Wisconsin Medical Examining Board unless required by law. Upon achieving board certification, the Physician may re-apply for Medical Staff membership in accordance with these Bylaws.

3.2.5. Board Recertification; Maintenance of Certification. Once board certification is achieved in the specialty or subspecialty most closely aligned to their clinical privileges, all Physicians must maintain their certification throughout their affiliation with the Hospital, except as otherwise provided in any policy adopted in accordance with ARTICLE 14 of these Bylaws. If a Physician loses his or her board certification and fails to achieve recertification or restore maintenance of certification within any time period prescribed therefor in any such policy, such Physician's privileges and Medical Staff membership will automatically terminate unless otherwise provided in such policy. Such automatic termination of privileges shall not be deemed the result of a professional review action, shall not entitle such Physician to fair hearing rights under ARTICLE 9, and shall not be reported to the National Practitioner Data Bank or Wisconsin Medical Examining Board unless required by law. Upon achieving recertification, the Physician may re-apply for Medical Staff membership in accordance with these Bylaws.

3.2.6. General Requirements for Appointment.

3.2.6.1. Applicants assigned to Active or Affiliate Staff agree to actively participate in providing emergency services and other duties as may be designated by the Medical Staff.

3.2.6.2. Applications for appointment to the Medical Staff shall not be granted unless it is determined, under the procedure set forth in Section 3.3.3 below that: (1) there is a sufficient clinical need to justify the appointment of a physician, dentist, or podiatrist with the Applicant's skill and training; and (2) the Hospital is able to provide adequate facilities and supportive services for the Applicant and his/her patients.

3.2.6.3. Applications for appointment to the Medical Staff shall not be granted unless the Applicant completes a background check required by Section 50.065 of the Wisconsin Statutes, or successor statute thereto, the results of which do

not prevent the Hospital from extending Medical Staff membership to the Applicant.

3.2.6.4. Appropriate call coverage arrangements (where one or more practitioners holding appropriate clinical privileges at the Hospital have agreed to attend to the reasonably anticipated needs of the Applicant's patients) must be established in the event of the Applicant's unavailability (planned or unplanned).

3.2.6.5. No Applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid, is eligible or qualified for appointment to the Medical Staff or to exercise clinical privileges at the Hospital. An individual may be excluded from such health care program upon action by a federal or state agency.

3.3. **Basic Obligations of Members of the Medical Staff.** Each Member of the Medical Staff, regardless of membership category, is required to:

3.3.1. Abide by the principles of ethics of the American Medical Association, American Osteopathic Association, American Dental Association, or the American Podiatric Medical Association, as applicable.

3.3.2. Pledge that such Member will not receive from or pay to another physician, dentist, or podiatrist, either directly or indirectly, any part of a fee received for professional services.

3.3.3. Provide for continuous patient care, seek consultation whenever necessary and delegate in such Member's absence the responsibility for care of patients to a qualified practitioner.

3.3.4. Abide by these Bylaws and by all other applicable standards, policies, rules and regulations of the Hospital and the Medical Staff.

3.3.5. Prepare in a timely fashion accurate and complete medical and other required records for all patients such Member admits to, or provides care for in, the Hospital.

3.3.6. For each patient admitted or referred by such Member, comply with the following requirements:

3.3.6.1. that a history and physical examination be completed and documented in the patient's medical record no more than thirty (30) days before or twenty-four (24) hours after admission or registration but prior to surgery or a procedure requiring anesthesia services, consistent with Medical Staff policy and procedure;

3.3.6.2. that medical histories and physical examinations completed within thirty (30) days before admission or registration be updated, including any changes in the patient's condition, and documented within twenty-four (24) hours after

admission or registration, but prior to surgery or a procedure requiring anesthesia services; and

3.3.6.3. that the scope of the medical history and physical examination is defined when required for non-inpatient services.

3.3.7. Perform surgical operations and other medical procedures only with the informed consent of the patient or the patient's legally authorized representative except in emergencies.

3.3.8. Report any financial interest in any business or organization or other conflict of interest that relates to the provision of patient care at the Hospital.

3.3.9. Provide written notice within five (5) business days, or sooner if so required by these Bylaws, to the Hospital President or the Vice President of Medical Affairs of:

3.3.9.1. notice of investigation, revocation, limitation or suspension of his or her professional licensure;

3.3.9.2. any reprimand or other disciplinary action taken by any state or federal government agency;

3.3.9.3. the imposition of probation or any limitation of his or her practice by any state;

3.3.9.4. his or her voluntary or involuntary loss of Staff membership or loss or restriction of privileges at any hospital or health care institution, whether temporary or permanent, including all suspensions;

3.3.9.5. the loss, cancellation or restriction of his or her professional liability coverage;

3.3.9.6. the revocation, suspension or voluntary relinquishment of his or her DEA number;

3.3.9.7. any notification by a quality improvement organization (e.g. Metastar) or a third-party payor reimbursement program concerning any utilization or quality of care review or any proposed intervention or sanctions imposed, other than notification by a non-governmental third party payor reimbursement program of minor utilization issues related to formulary recommendations;

3.3.9.8. receipt of a quality inquiry letter, an initial sanction notice, notice of investigation or sanction, or the filing of criminal charges or criminal conviction against him or her by any law enforcement agency or health regulatory agency of the United States, the State of Wisconsin, or any other state or political subdivision;

- 3.3.9.9. any criminal conviction or pending criminal charge, and any findings by a governmental agency that the Practitioner has been found to have abused or neglected a child or patient, or has misappropriated a patient's property;
- 3.3.9.10. any proposed or actual exclusion from any federally-funded health care program, any notice to the individual or his or her representative of proposed or actual exclusion or any pending investigation of the individual from any federally-funded health care program, including Medicare and Medicaid;
- 3.3.9.11. receipt of notice of the filing of any suit against the Practitioner or submission of adversity to the Wisconsin Patients Compensation Fund alleging professional liability in connection with the treatment of any patient;
- 3.3.9.12. settlement of any claim by payment from an insurance company (or by the Practitioner or any other party) or any other agreement that results in a release being given by a patient to the Practitioner relating to the treatment of any patient in or at the Hospital;
- 3.3.9.13. the revocation, suspension or voluntary relinquishment of his or her driver's license; or
- 3.3.9.14. any circumstance(s) or change in circumstance(s), including, but not limited to health status, that would materially affect his or her ability to perform essential functions of the Medical Staff or to exercise the clinical privileges granted, or that may put patients or Hospital staff at risk.

3.4. Terms of Appointment.

- 3.4.1. **Initial Appointment/Modifications.** All initial appointments shall be for a period not more than twenty-four (24) months.
- 3.4.2. **Reappointments.** Reappointments to any category of the Medical Staff shall be for a period of not more than twenty-four (24) months.
- 3.4.3. **Appointment/Reappointment Authority.**
 - 3.4.3.1. Appointments and reappointments shall be made by the Governing Body after recommendation of the Medical Executive Council.
 - 3.4.3.2. Appointment to the Medical Staff shall confer on the appointed Member only such privileges as may hereinafter be provided.

3.5. Procedure of Appointment and Reappointment.

- 3.5.1. **General Procedure.** The Medical Staff, through its designated councils, Clinical Services Units and officers shall investigate and consider each application for appointment or reappointment to the Staff and each request for modifications of Staff appointment status or privileges and shall adopt and transmit recommendations

thereon to the Governing Body. In all matters concerning Medical Staff appointments and the granting of clinical privileges, the Governing Body retains final authority. The Medical Staff shall perform these same investigation, evaluation, and recommendation functions in connection with any Independent Allied Health Professional or other individual who seeks to exercise clinical privileges or provide specified services in the Hospital.

3.5.2. Application for Initial Appointment.

3.5.2.1. The Applicant shall have the following qualifications:

- 3.5.2.1.1. An unlimited and current license to practice medicine, osteopathy, dentistry, or podiatry in the State of Wisconsin.
- 3.5.2.1.2. Physicians shall hold board certification or shall have completed a residency, or fellowship, which satisfies Section 3.2.3.
- 3.5.2.1.3. Graduation from a medical school, osteopathic school, dental school, or podiatric school accredited in accordance with Section 455.04 of the Wisconsin Statutes.
- 3.5.2.1.4. Current federal DEA certificate, unless the prospective Applicant practices in a specialty in which DEA certification is not necessary and is not customarily maintained.
- 3.5.2.1.5. Current professional liability insurance in the minimum requirements specified by the Wisconsin Department of Regulation and Licensing or for participation in the Wisconsin Injured Patients and Families Compensation Fund under Chapter 655 of the Wisconsin Statutes.
- 3.5.2.1.6. Applicants must not be currently excluded from participating in a federally-funded health care program nor be barred from providing direct patient care under Wisconsin's caregiver misconduct law.
- 3.5.2.1.7. Applicants must attest to freedom from physical or mental illness or incapacity that would in any way restrict his or her ability to care for patients. In accordance with Medical Staff policies and procedures, either the Governing Body or the Hospital President or the President of the Medical Staff may precondition appointment or reappointment, and granting or continued exercise of clinical privileges upon the Applicant undergoing mental or physical examination and/or such test or tests as may be deemed necessary at that time or any intervening time to evaluate the Applicant's ability to provide high quality, safe care and supervision to his or her patients.

- 3.5.2.1.8. Applicants must have a valid driver's license if the Applicant will be providing care for which the Applicant may be called to the Hospital on short notice.
- 3.5.2.1.9. Applicants must have a National Provider Identifier if the Applicant will furnish care, bill and be paid by third-party payers for services.
- 3.5.2.2. **Application Form.** Each application for appointment to the Staff shall be in writing, submitted on the prescribed form, and signed by the Applicant. When a practitioner requests an application form, he/she shall be given a copy of, or access to a copy of, these Bylaws and the Hospital policies relating to medical practice.
- 3.5.2.3. **Content.** The application form shall include:
- 3.5.2.3.1. **Acknowledgement and Agreement:** A statement that the Applicant has received (or has had access to) and read the Bylaws of the Medical Staff and Hospital policies relating to medical practice and that he/she agrees to be bound by the terms thereof if he/she is granted appointment and/or clinical privileges.
- 3.5.2.3.2. **Qualifications:** Detailed information concerning the Applicant's qualifications, including information on satisfaction of the basic qualifications specified in Section 3.2 and of any additional qualifications specified in these Bylaws for the particular Staff category to which the Applicant requests appointment.
- 3.5.2.3.3. **Requests:** Requests stating the scope of clinical privileges for which the Applicant wishes to be considered.
- 3.5.2.3.4. **Reference:** The names of at least two (2) persons who have recently worked with the Applicant and directly observed his/her professional performance over a reasonable period of time and who can and will provide reliable information regarding the Applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, relevant training and/or experience, current competence, fulfillment of obligations as a Member of the Medical Staff, interpersonal skills, communication skills, professionalism, and any effect of health status on the Applicant's ability to practice medicine or the privileges to be recommended. These references must be peers who are Practitioners in the same or a related professional discipline as the Applicant.
- 3.5.2.3.5. **Other Hospitals and Health Care Facilities:** The names of all hospitals and health care facilities at which the Applicant holds and/or has previously held privileges or appointments.

3.5.2.3.6. Professional Sanctions: Information as to whether any of the following have ever been or are in the process of being investigated, denied, revoked, suspended, reduced, limited, not renewed, subjected to probationary conditions, subjected to any other disciplinary action, or voluntarily relinquished:

3.5.2.3.6.1. Staff membership status or clinical privileges at any other hospital, clinic or other health care institution;

3.5.2.3.6.2. Membership/fellowship in local, state or national professional organizations;

3.5.2.3.6.3. Specialty board certification/eligibility;

3.5.2.3.6.4. License to practice any profession in any state or jurisdiction;

3.5.2.3.6.5. Drug Enforcement Agency (DEA) Certificate;

3.5.2.3.6.6. Participation as provider under a federally-funded health care program.

If any of such actions ever occurred or are pending, the particulars thereof shall be included.

3.5.2.3.7. Professional Liability Insurance and History: A statement that the Applicant carries professional liability insurance coverage as required by law and information on his/her malpractice claims history and experience including: a list of all malpractice judgments entered against the Applicant and all malpractice actions and patient compensation panel actions brought against the Applicant; a statement as to whether the Applicant's malpractice insurance has ever been canceled or not renewed, and the reasons therefore; and a consent to the release of information by his/her present and past malpractice insurance carrier(s).

3.5.2.3.8. Notification of Release and Immunity Provisions: Statements notifying the Applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions contained in ARTICLE 11, and an Authorization and Release in the form prescribed by the Hospital signed by the Applicant.

3.5.2.3.9. Administrative Remedies: A statement whereby the practitioner agrees that, when an adverse ruling is made with respect to his/her Staff appointment, Staff status, and/or clinical privileges, he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.

- 3.5.2.3.10. **Health Information:** A statement of the Applicant's mental and physical ability to safely practice in the areas in which privileges are sought, , including information concerning the Applicant's health status if requested. The Medical Executive Council or the Medical/Patient Services Committee of the Governing Body, provided the requirement is not inconsistent with applicable legal standards or the Hospital's regular policies, may require a Medical Staff Member at any time to complete a physical and/or neuropsychological examination by professionals chosen by or acceptable to the Hospital.
- 3.5.2.3.11. **Background Information:** A fully completed Background Information Disclosure form, along with information as to any currently pending or past criminal convictions (other than minor traffic offenses), current federal, state or municipal ordinance violations (other than minor traffic offenses), including their resolution, or any findings by a governmental agency that the Applicant has been found to have abused or neglected a child or patient or has misappropriated the property of a patient. The Applicant also must cooperate in providing any additional information required to comply with the requirements of Chapter DHS 12 of the Wisconsin Administrative Code.
- 3.5.2.3.12. **Health Safety Policies:** A statement that the Applicant will comply with Hospital policies regarding immunizations, TB surveillance and other health safety requirements.
- 3.5.2.3.13. **Orientation:** A statement that Applicant will participate in orientation and in-hospital training requirements as outlined by the Hospital. Completion of this requirement shall be documented.
- 3.5.2.3.14. **Photo Identification:** A valid government-issued photo identification (e.g., driver's license or passport).
- 3.5.2.3.15. **Other Information:** Such other information as the Medical Executive Council or Governing Body may require.
- 3.5.2.4. **Incomplete Applications.** The Hospital retains the right not to process applications for appointment or reappointment until all documents and information required have been provided and until the Applicant has completed his/her orientation and in-hospital training requirements. The Applicant shall be notified of any missing information or verifications and it shall be the responsibility of the Applicant to have any missing information sent to the Medical Staff office. If the Applicant fails to provide any information or verification within thirty (30) calendar days after being requested to do so, the application shall be automatically deemed to be withdrawn, unless the time to obtain the information is extended by the Medical Staff President and the Hospital President or designee, in their sole discretion.

3.5.3. Effect of Application. As a condition of applying for appointment or reappointment to the Medical Staff or for clinical privileges at the Hospital, each Applicant:

3.5.3.1. Signifies his/her willingness to appear for interviews in regard to his/her application.

3.5.3.2. Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications.

3.5.3.3. Consents to Hospital representatives inspecting all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, of his/her physical and mental health status and of his/her professional ethical qualifications.

3.5.3.4. Releases from any liability all Hospital representatives for their acts performed in good faith and without malice in connection with evaluating the Applicant and his/her credentials.

3.5.3.5. Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith and without malice concerning the Applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Staff appointment and clinical privileges.

3.5.3.6. Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning the Applicant, and releases Hospital representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice.

3.5.3.7. Agrees to abide by these Bylaws and the Hospital policies relating to medical practice which are incorporated herein by reference.

3.5.3.8. For purposes of this Section, the term "Hospital representative" includes the Governing Body, its officers, directors and councils, the Hospital President or his/her designee, the Vice President of Medical Affairs, the Medical Staff organization, the Medical Executive Council and all Medical Staff Members, CSU Medical Directors, Clinical Services Units and councils, which have responsibility for collecting or evaluating the Applicant's credentials or acting upon his/her applications; and any authorized representative of any of the foregoing.

3.5.4. Processing the Application.

3.5.4.1. Applicant's Burden. The Applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, ability, and physical and mental health status, and of resolving any doubts about these or any of the other basic criteria specified in Section 3.2.

3.5.4.2. Verification of Information. The Hospital President or his/her designee shall, in timely fashion, seek to collect or verify the references, license, and other qualification evidence submitted, and shall make inquiry of the National Practitioner Data Bank in the manner prescribed by federal law and shall make inquiry of the criminal background databases in the manner prescribed by state law. The Hospital President or his/her designee shall promptly notify the Applicant of any problem in obtaining the information required, and it shall then be the Applicant's obligation to obtain the required information, within the timeframe allotted. When collection and verification is accomplished, the Hospital President or his/her designee shall transmit the application and all supporting materials to the Medical Executive Council, or to a credentials council established by the Medical Executive Committee (the "Credentials Council") for evaluation.

3.5.4.3. Administrative Denial. The Hospital may, upon the approval of the Hospital President or his/her designee, refuse to process an application for appointment or reappointment to the Medical Staff or for clinical privileges without further review, if it determines any of the following about the Applicant: (1) he or she does not hold a valid Wisconsin license and no application is pending; (2) he or she does not have adequate professional liability insurance; (3) he or she is not eligible to receive payment from the Medicare or Medicaid assistance programs or is currently excluded from any federally-funded health care program; (4) he or she is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code; (5) he or she has been denied medical staff membership (or denial has been or is being recommended at the medical executive committee level or higher) at any other facility within the Froedtert Health, Inc. system; (6) the Hospital cannot provide adequate facilities and/or supportive services for the Applicant and his or her patients; (7) there is not a sufficient patient load to justify the appointment of a physician, dentist, or podiatrist with the Applicant's skill and training; or (8) he or she has only requested clinical privileges that have been exclusively granted to another practitioner pursuant to a written contract then in effect, which contract covers all the clinical privileges being requested by the Applicant. Applicants who are administratively denied under this Section do not have a right to a fair hearing under ARTICLE 9, but may submit evidence to the Hospital to refute the basis for the administrative denial.

3.5.4.4. Credentials Council Action. If the Medical Executive Council has established a Credentials Council, the Credentials Council shall have the

following responsibilities. If the Medical Executive Council has not established a Credentials Council, the responsibilities of the Credentials Council shall be performed directly by the Medical Executive Council and the duties of the Credentials Council chair shall be performed by the Medical Staff President or his/her designee member of the Medical Executive Council.

3.5.4.4.1. Upon receipt of properly completed and qualifying application, the Credentials Council chair and appropriate CSU Medical Director shall review the application, the supporting documentation, and such other information available to them that may be relevant to consideration of the Applicant's qualifications for Staff category and clinical privileges requested.

3.5.4.4.2. Specifically, the Credentials Council chair and appropriate CSU Medical Director will assess the Applicant's competence in six (6) core areas:

3.5.4.4.2.1. Patient care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

3.5.4.4.2.2. Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

3.5.4.4.2.3. Patient-based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

3.5.4.4.2.4. Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

3.5.4.4.2.5. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and responsible attitude toward their patients, their profession, and society.

3.5.4.4.2.6. System-based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

- 3.5.4.4.3. The Credentials Council chair and appropriate CSU Medical Director, or their respective designees, may interview Applicants appearing to meet qualifications per Section 3.2, or they may request that such Applicants be interviewed by the Credentials Council.
- 3.5.4.4.4. If the Credentials Council chair and CSU Medical Director are in agreement that the Applicant meets the criteria for Medical Staff membership and clinical privileges following their interview, they may recommend the Applicant to the Credentials Council, and the Credentials Council may adopt that recommendation or choose to require its own interview with the Applicant.
- 3.5.4.4.5. The Credentials Council shall then transmit to the Medical Executive Council a written report and recommendations as to the Staff appointment and, if appointment is recommended, as to Staff category, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Council may also recommend that the Medical Executive Council defer action on the application.
- 3.5.4.4.6. The reasons for any recommendation to deny appointment or requested privileges shall be stated and supported by reference to the completed application and all other documentation considered by the Credentials Council, all of which shall be transmitted with the report. Whether or not appointment is recommended, any minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the Credentials Council's report.
- 3.5.4.5. Medical Executive Council Action.**
- 3.5.4.5.1. The Medical Executive Council shall review the application, the supporting documentation, the Credentials Council's report and recommendations, if any, and such other information available to it that may be relevant to consideration of the Applicant's qualifications for the Staff category and clinical privileges requested. The Medical Executive Council may adopt the recommendation of the Credentials Council or choose to require its own interview with the Applicant.
- 3.5.4.5.2. The Medical Executive Council shall then transmit to the Governing Body by means of the Medical/Patient Services Committee of the Governing Body, which has been delegated authority by the Governing Body to make decisions regarding Medical Staff appointments, a written report and recommendations as to Staff appointment and, if appointment is recommended, as to Staff category, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Medical Executive Council may also recommend that the Governing Body by means of the Medical/Patients Services Committee defer action on the application.

3.5.4.5.3. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the Medical Executive Council, all of which shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the majority report.

3.5.4.6. Governing Body Action.

3.5.4.6.1. The Governing Body by means of the Medical/Patient Services Committee of the Governing Body shall adopt or reject a favorable recommendation of the Medical Executive Council, or refer it back for further consideration stating the reasons for such referral.

3.5.4.6.2. Any such referral back shall state the reasons, therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Governing Body by means of the Medical/Patient Services Committee of the Governing Body shall render its decision.

3.5.4.7. **Conflict Resolution.** Whenever the Governing Body's proposed decision will be contrary to the Medical Executive Council's recommendation, the Governing Body by means of the Medical/Patient Services Committee of the Governing Body shall submit the matter to a joint meeting of equal numbers of Active Medical Staff Members appointed by the Medical Staff President and Governing Body members appointed by the Hospital President for review and recommendation before making its final decision and giving notice of final decision. The ultimate decision regarding whether to appoint an Applicant rests, however, with the Governing Body.

3.5.4.8. Notice of Final Decision.

3.5.4.8.1. Notice of the Governing Body's final decision shall be given, through the Hospital President, to the Medical Staff President and to the Applicant by means of Special Notice.

3.5.4.8.2. A decision and notice to appoint shall include:

3.5.4.8.2.1. The Staff category to which the Applicant is appointed;

3.5.4.8.2.2. The Clinical Services Unit to which the Applicant is appointed;

3.5.4.8.2.3. The clinical privileges the Applicant may exercise; and

3.5.4.8.2.4. Any special conditions attached to the appointment.

3.5.4.9. Reapplication after Adverse Appointment Decision. An Applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the Applicant shall submit such additional information as the Staff or the Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.

3.5.4.10. Time Periods for Processing Applications. All individuals, councils and committees required to act on an application for Staff appointment shall do so in a timely and good faith manner. Each application should be processed within 240 days after the Credentials Council's receipt, or if a Credentials Council has not been established the Medical Executive Council's receipt, of a completed application (the "Review Period"). During the Review Period, each reviewing individual or body should act on the application in accordance with their respective responsibilities (which act may include, as applicable, approval, adoption, rejection, referral back to a preceding reviewer, or other action) within the following time periods after their receipt of the completed application and any recommendation from the immediately preceding reviewer, as applicable:

If a Credentials Council is established:

Credentials Council Chair:	30 days
CSU Medical Director:	30 days
Credentials Council:	Next Regular Meeting
Medical Executive Council:	Next Regular Meeting
Medical/Patient Services Committee:	Next Regular Meeting

If a Credentials Council is not established:

Medical Staff President or designee	30 days
CSU Medical Director:	30 days
Medical Executive Council:	Next Regular Meeting
Medical/Patient Services Committee:	Next Regular Meeting

These time periods are guidelines and not directives and therefore do not create any rights for an Applicant to have an application processed within these precise periods. If the fair hearing provisions of ARTICLE 9 become applicable, the time requirements provided in ARTICLE 9 shall govern the continued processing of the application.

3.5.5. Nondiscrimination. No person who is otherwise qualified shall be denied appointment or reappointment to the Medical Staff, or the exercise of clinical privileges, on the basis of age, sex, race, creed, color, handicap, national origin, disability, or on the basis of any other criterion unrelated to the delivery of good patient care, to professional qualifications, to the purposes, needs and capabilities of

the Medical Staff, to community need, or to any requirements set forth in these Bylaws.

3.5.6. Reappointment Process.

3.5.6.1. General Information for Reappointment. The Credentials Council chair, or the Medical Staff President if a Credentials Council has not been established, shall, at least seventy-five (75) days prior to the expiration date of the present Staff appointment of each Medical Staff Member, provide such Member with an interval information form for use in considering his/her reappointment. Each Member who desires reappointment shall, at least sixty (60) days prior to such expiration date, complete and return his/her interval information form. Failure, without good cause, to so return a completed interval information form may be deemed a voluntary resignation from the Staff and may result in automatic termination of appointment at the expiration of the Member's current term.

3.5.6.2. Content of Interval Information Form. The interval information form shall request data necessary to update the Medical Staff file. This form shall include information about the following:

3.5.6.2.1. Staff category;

3.5.6.2.2. Documented participation in relevant continuing education as required for licensure by the State of Wisconsin;

3.5.6.2.3. Current mental and physical health status;

3.5.6.2.4. Membership, awards or other recognition conferred by any professional health care societies, institutions or organizations;

3.5.6.2.5. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

3.5.6.2.6. Involvement in any professional liability action or patient compensation panel action, or changes in malpractice insurance coverage effected since last appointment;

3.5.6.2.7. Changes in specialty board certification or membership in professional organizations;

3.5.6.2.8. Previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration;

3.5.6.2.9. Proposed or actual exclusion from any federally-funded health care program, any notice to the individual or his representative of proposed or actual exclusion and/or any or pending investigation of the individual by any health care program, funded in whole or in part by the federal government, including Medicare or Medicaid; and

3.5.6.2.10. Such other information as the Medical Staff or Governing Body may require.

3.5.6.3. Review of Application for Reappointment. The Credentials Council or Medical Executive Council, as applicable, and respective CSU Medical Directors shall review all pertinent information on each Member prior to reappointment. The review shall consist of:

3.5.6.3.1. Professional and clinical performance, including patterns of care, based at least in part on the findings of medical quality assurance studies, utilization review, infection control activities, tissue review and medical record review;

3.5.6.3.2. Current privileges and the basis for any requested modifications;

3.5.6.3.3. Current licensure;

3.5.6.3.4. Health status;

3.5.6.3.5. Documented participation in relevant continuing education as required for licensure by the State of Wisconsin;

3.5.6.3.6. Service on Medical Staff councils and Hospital committees;

3.5.6.3.7. Timely completion of medical records;

3.5.6.3.8. Compliance with applicable hospital policies and with Medical Staff Bylaws;

3.5.6.3.9. Status of board certification;

3.5.6.3.10. Any relevant information provided by the National Practitioner Data Bank in the manner prescribed by federal law and any relevant information provided by criminal background databases in the manner prescribed by state law. Such inquiries shall be made by the Hospital President or his/her designee with respect to each Applicant for reappointment, and results of such inquiry shall be reported to the Credentials Council or Medical Executive Council, as applicable.

If the foregoing review was performed by the Credentials Council, it shall transmit its recommendations to the Medical Executive Council.

3.5.6.4. Basis for Recommendations. Each recommendation concerning the reappointment of a Medical Staff Member and the clinical privileges to be granted upon reappointment shall be based upon documented evidence of such Member's professional ability and clinical judgment in the treatment of patients, his/her professional ethics, his/her discharge of Staff obligations, his/her compliance with these Bylaws, and Hospital policies relating to medical practice, his/her cooperation with Hospital personnel and other practitioners and with patients, and other matters bearing on his/her ability and willingness to contribute to good patient care in the Hospital. Non-compliance may result in reduction of Staff category by at least one step, a reduced period of reappointment, or non-reappointment.

3.5.6.5. Medical Executive Council Action. The Medical Executive Council shall then transmit to the Governing Body by means of the Medical/Patient Services Committee of the Governing Body, which has been delegated authority by the Governing Body to make decisions regarding Medical Staff appointments, a written report and recommendations as to Staff appointment and, if appointment is recommended, as to Staff category, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Medical Executive Council may also recommend that the Governing Body by means of the Medical/Patients Services Committee defer action on the application.

3.5.6.6. Time Periods for Processing Applications for Reappointment. Transmittal of an interval information form to the Member and the Member's submission of updated information are to be carried out in accordance with Section 3.5.6.1 and Section 3.5.6.2. Thereafter, all individuals and bodies required to act on the application for reappointment should complete such action so that all reappointment reports and recommendations are transmitted to the Medical Executive Council and in turn to the Medical/Patient Services Committee of the Governing Body prior to the expiration date of the Member's Medical Staff membership. The time periods specified are to guide the acting parties in accomplishing their tasks.

3.5.6.7. Right to Notice and Hearing. The notice and hearing rights of Applicants for appointment and reappointment to the Medical Staff who have received an adverse recommendation or action shall be as set forth in ARTICLE 9 of these Bylaws.

ARTICLE 4. **Categories of the Medical Staff**

4.1. The Medical Staff.

4.1.1. The Medical Staff shall be divided into emeritus, active, affiliate, refer and follow, and telemedicine groups.

4.1.2. Members of the Medical Staff other than Emeritus Staff shall be assigned to a Clinical Services Unit.

4.2. The Emeritus Medical Staff.

4.2.1. The Emeritus Medical Staff shall consist of Medical Staff Members who are not active in the Hospital, and who have retired from active hospital service; or Members of outstanding reputation who are not necessarily residents in the community.

4.2.2. The Emeritus Medical Staff Members are not eligible to hold office, do not admit patients, and shall have no assigned duties, but are eligible to serve on standing or special councils and committees, including the Medical Executive Council. Emeritus Medical Staff Members are not eligible to vote unless such Members serve on the Medical Executive Council or other standing council of the Medical Staff, in which case such Member shall be a Voting Staff Member during the period of such service; provided, however, that after the first anniversary of the effective date of these Bylaws, such Member's status as a Voting Staff Member shall automatically terminate as of the date immediately preceding the annual September meeting of the Medical Staff if such Member has not attended a minimum of fifty percent (50%) of the council meetings held during the twelve (12) month period immediately preceding such meeting. A Member whose Voting Staff Member status has been terminated shall be automatically reinstated as a Voting Staff Member as of the date immediately preceding any subsequent annual September meeting of the Medical Staff if such Member has attended a minimum of fifty percent (50%) of the council meetings held during the twelve (12) month period immediately preceding such meeting.

4.2.3. Members are appointed to the Emeritus Medical Staff by the Governing Body upon the recommendation of the Medical Executive Council, do not serve for any specified term, and are not required to apply for such status.

4.2.4. In recognition of a Medical Staff Member's outstanding contribution and service to the Hospital and community, the Medical Executive Council may designate such Member as an Honorary Member of the Emeritus Medical Staff, which designation may be made posthumously.

4.3. The Active Medical Staff.

4.3.1. The Active Medical Staff shall consist of Members who (a) maintain an active clinical practice in the community and provide patient care or inpatient consultative services for twenty-four (24) or more inpatients or day surgery patients per year and are not Contract Practitioners; or (b) are Contract Practitioners who are identified by the medical director of the contracted physician group as the core Practitioners for the clinical service.

- 4.3.2. Active Medical Staff Members shall be Voting Staff Members and shall be eligible to participate on and chair councils, and hold office at any level within the Medical Staff organization.
- 4.3.3. Members of the Active Medical Staff shall be required to participate in the emergency services back-up coverage and provide, within their scope of privileges, emergency care without regard to source of payment or ability to pay. Medical Staff Members who are age sixty (60) or beyond shall be excused from this requirement at their option.
- 4.3.4. Only individuals who are currently licensed to practice medicine, podiatric medicine or dentistry are eligible to be Members of the Active Medical Staff.
- 4.4. The Affiliate Medical Staff.**
- 4.4.1. The Affiliate Medical Staff shall consist of those Medical Staff Members who are qualified for Medical Staff membership, accept the responsibilities of membership, maintain an active medical practice in the community served by the Hospital, and refer their patients to the Hospital for inpatient or outpatient services, but who do not have a level of activity at the Hospital commensurate with Active Medical Staff status.
- 4.4.2. Affiliate Staff Members shall not be eligible to vote or hold office.
- 4.4.3. Affiliate Staff Members are eligible for appointment to certain Medical Staff councils, as further set forth in these Bylaws. Additionally, those Members moving from Active to Affiliate status at the time of reappointment remain eligible to serve out their current term on any Medical Staff councils, despite their change in membership status. If an Affiliate Staff Member serves on one or more Medical Staff councils annually, he or she may be advanced to Active Medical Staff at the time of reappointment or sooner, if requested by the Member; provided, however, that after the first anniversary of the effective date of these Bylaws, such Member shall be automatically transferred from Active Staff to Affiliate Staff as of the date immediately preceding the annual September meeting of the Medical Staff if such Member (i) has not attended a minimum of fifty percent (50%) of the council meetings held during the twelve (12) month period immediately preceding such meeting and (ii) is not otherwise entitled to Active Staff membership under Section 4.4.4, below. A Member who has been automatically transferred from Active Staff to Affiliate Staff pursuant to the preceding sentence may, at the Member's request, be advanced to the Active Staff as of the date immediately preceding any subsequent annual September meeting of the Medical Staff if such Member has attended a minimum of fifty percent (50%) of the council meetings held during the twelve (12) month period immediately preceding such meeting.
- 4.4.4. Members of the Affiliate Medical Staff (other than Contract Practitioners) shall be limited to providing care (admitting, consulting, performing procedures or attending) for less than twenty-four (24) inpatients or day surgery patients per year.

A Contract Practitioner is determined to be a Member of the Affiliate Medical Staff if not designated by the medical director of the contracted physician group as a core physician for the clinical service. If the Member has twenty-four (24) or more patient contacts per year, or if a Contract Practitioner Member becomes designated as a core physician, the Member is advanced to Active Medical Staff at the time of reappointment or sooner if requested by the Member.

4.5. Refer and Follow Staff.

4.5.1. The Refer and Follow Staff consists of those physicians, dentists, oral surgeons, and podiatrists who desire to be associated with the Hospital but who do not wish to exercise clinical privileges on an inpatient basis. The primary purpose of the Refer and Follow Staff is to permit these members access to inpatient Hospital services for their patients by referral to members of the Active Staff.

4.5.2. Refer and Follow Staff Members:

4.5.2.1. may attend meetings of the Medical Staff and applicable Clinical Services Unit (without vote except as otherwise provided in Section 5.4.3);

4.5.2.2. shall generally have no Staff council responsibilities, but are eligible to serve (with vote) on standing or special councils (other than the Medical Executive Council);

4.5.2.3. may attend educational activities sponsored by the Medical Staff and the Hospital;

4.5.2.4. may refer patients to the Hospital for admission and/or care;

4.5.2.5. are encouraged to communicate directly with the Staff members about the care of any patients referred, as well as to visit any such patients;

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

4.5.2.7. may refer patients to the Hospital's diagnostic facilities;

4.5.2.8. shall pay applicable fees, dues, and assessments;

4.5.2.9. may not: admit patients, attend patients, exercise inpatient clinical privileges, write inpatient orders or progress notes, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to inpatients at the Hospital.

4.5.3. If a Refer and Follow Staff Member serves on one or more Medical Staff councils annually, he or she shall be a Voting Staff Member during the period of such; provided, however, that after the first anniversary of the effective date of these Bylaws, such Member's status as a Voting Staff Member shall automatically

terminate as of the date immediately preceding the annual September meeting of the Medical Staff if such Member has not attended a minimum of fifty percent (50%) of the council meetings held during the twelve (12) month period immediately preceding such meeting. A Member whose Voting Staff Member status has been terminated shall be automatically reinstated as a Voting Staff Member as of the date immediately preceding any subsequent annual September meeting of the Medical Staff if such Member has attended a minimum of fifty percent (50%) of the council meetings held during the twelve (12) month period immediately preceding such meeting.

- 4.6. **Telemedicine Medical Staff.** Telemedicine Staff members shall be limited to those Practitioners who are contracted by the Hospital to provide diagnosis and treatment to patients in the Hospital remotely solely through telecommunications links. Telemedicine Staff members will be assigned to a Clinical Services Unit, but may not vote, hold office or serve as departmental or council chairs. They may be required by contract to assume responsibilities and functions such as emergency care and consultation, participation in peer review activities and other functions. Telemedicine Staff membership shall automatically terminate upon termination of the member's contractual relationship with the Hospital. Telemedicine Staff may be required to pay fees, dues or assessments in connection with their membership to the Telemedicine Staff in such amount as may be determined by the Medical Executive Council.

ARTICLE 5.

Clinical Services Units

5.1. Organization.

5.1.1. The Medical Staff shall be organized into the Clinical Services Units as listed from time to time in the Organization Manual. Clinical Services Units may be established on any model or combination of models as adopted by the Governing Body upon the recommendation of the Medical Executive Council in accordance with ARTICLE 14, including by way of illustration and not limitation:

5.1.1.1. a clinical department model which defines the Clinical Services Unit as dedicated to a particular specialty clinical service (such as orthopaedics, radiology, anesthesia, obstetrics, etc.);

5.1.1.2. a multi-specialty/multi-disciplinary model which defines the Clinical Services Unit as incorporating various designated clinical specialties, subspecialties and/or disciplines organized for the purpose of providing a continuum of coordinated care within a category of diagnosis (such as heart disease, cancer, etc.), a category of patient types (such as women and children's care, geriatric care, etc.), a category of service (such as emergency and critical care, surgery, etc.), a category of anatomical area (such as neuromusculoskeletal care), or other organizing factor.

5.1.2. Each Clinical Services Unit shall have a CSU Medical Director who has the qualifications, duties and responsibilities, and is appointed, as provided in the Bylaws.

5.2. Creation and Dissolution of Clinical Services Units.

5.2.1. The Medical Executive Council will periodically assess the Medical Staff's Clinical Services Unit structure and recommend to the Governing Body any changes to improve organizational efficiency and patient care (i.e., creating new or combining Clinical Services Units and eliminating Clinical Services Units, or adding specialties to or removing specialties from multi-specialty Clinical Services Units). Action taken by the Governing Body pursuant to this section shall be effective on the date of Governing Body action and shall not require formal amendment of these Bylaws.

5.2.2. The factors that the Medical Executive Council and the Governing Body may consider in determining whether the creation of a new, or modification of an existing, Clinical Services Unit is warranted include, but are not limited to, the following:

5.2.2.1. the existence of a sufficiently large number of Medical Staff members who are available for appointment to and are reasonably expected to actively participate in the proposed new Clinical Services Unit. This number should be sufficiently large to enable the Clinical Services Unit to accomplish its functions as set forth in these Bylaws;

5.2.2.2. a substantial level of clinical activity by the new Clinical Services Unit to warrant imposing the responsibility to accomplish Clinical Services Unit functions on a routine basis;

5.2.2.3. any regulatory or accreditation requirement necessitating the creation or modification of a particular Clinical Services Unit.

5.2.3. The factors that the Medical Executive Council and the Governing Body may consider in determining whether the elimination of a Clinical Services Unit is warranted include, but are not limited to, the following:

5.2.3.1. an adequate number of Medical Staff Members in the Clinical Services Unit is no longer available to accomplish the functions set forth in these Bylaws;

5.2.3.2. the number of patients or the amount of clinical activity is insufficient to warrant the imposition of the designated duties on the Members in the Clinical Services Unit;

5.2.3.3. the Clinical Services Unit fails to meet often enough to accomplish the functions set forth in these Bylaws or assigned to the Clinical Services Unit by the Medical Executive Council;

5.2.3.4. the Clinical Services Unit fails to fulfill all Clinical Services Unit responsibilities and functions;

5.2.3.5. any regulatory or accreditation requirement necessitating the elimination of a particular Clinical Services Unit; or

5.2.3.6. no qualified individual is willing to serve as CSU Medical Director.

5.3. Assignment to Clinical Services Unit.

5.3.1. Upon initial appointment to the Medical Staff, the Governing Body, upon recommendation of the Medical Executive Council, shall assign each Member to a Clinical Services Unit. A Member may be assigned to more than one Clinical Services Unit, provided that only one Clinical Services Unit shall be designated as the Member's home Clinical Services Unit. Voting Staff Members assigned to more than one Clinical Services Unit may vote for the nomination and approval of a CSU Medical Director, or for any other matters brought to a vote of Members of the Clinical Services Unit, only within such Member's home Clinical Services Unit.

5.3.2. An individual may request a change in Clinical Services Unit assignment to reflect a change in the individual's clinical practice. Any such request shall be reviewed by the Credentials Council (if established) and the Medical Executive Council, which shall forward its recommendations to the Governing Body for action.

5.4. Function of Clinical Services Units. The functions of Clinical Services Units shall include, by way of illustration and not limitation, implementing processes (i) to monitor and evaluate the quality, appropriateness and outcomes of the care of patients served by the Clinical Services Unit; (ii) to monitor the practice of all those with clinical privileges in a given Clinical Services Unit; (iii) to provide appropriate specialty coverage in the emergency department, consistent with the provisions in these Bylaws and related documents; and (iv) to monitor care delivery processes used by Medical Staff members and Hospital staff, research opportunities for improvement, and recommend improvements when appropriate.

5.5. Qualifications of CSU Medical Directors. Each CSU Medical Director shall:

5.5.1. be an Active Medical Staff Member and a member of the Clinical Services Unit for which he or she shall serve as CSU Medical Director;

5.5.2. be board certified in a specialty included within his/her Clinical Services Unit, or establish comparable competence through the privilege delineation process;

5.5.3. be deemed by the Medical Executive Council to have the experience and administrative ability and qualifications for the position, including demonstrated leadership ability, demonstrated competence and credibility among

medical staff members, desire and ability to devote time to meet the defined responsibilities, and belief in the patient-centered care model of healthcare.

5.6. Appointment and Term of CSU Medical Directors.

5.6.1. Appointment. CSU Medical Directors shall be appointed in accordance with the following procedure:

5.6.1.1. The Active Staff Members of the Clinical Services Unit shall nominate one or more candidates for CSU Medical Director. In addition, any Active Staff Member of the Clinical Services Unit may nominate himself or herself as a candidate.

5.6.1.2. An Interview Council shall interview the candidates so nominated by the Clinical Services Unit, rank the candidates in the order of most to least qualified to serve as CSU Medical Director, and submit the ranked list of candidates to the Medical Executive Council. Prior to submitting the list of candidates to the Medical Executive Council, any candidates shall be removed from the list who are not approved by both the Medical Staff President and the Hospital President. The Interview Council shall consist of the Hospital President, Vice President of Medical Affairs, Chief Nursing Officer or designee, Medical Staff President or designee, Medical Staff President-Elect or designee, and the past Medical Staff President or designee.

5.6.1.3. The Medical Executive Council shall select a person to serve as CSU Medical Director of the Clinical Services Unit from among the candidates presented by the Interview Council.

5.6.1.4. The Medical Executive Council's selection shall be submitted for approval to all members of the Clinical Services Unit who are Voting Staff Members. Approval shall be obtained by any of the following methods in the discretion of the then acting CSU Medical Director (or in the absence of a then acting CSU Medical Director, the Medical Staff President):

5.6.1.4.1. Approval by a majority of the Voting Staff Members who vote by written ballot at a duly called meeting of the Voting Staff Members of the Clinical Services Unit at which a quorum is present. For purposes hereof, a quorum shall be ten percent (10%) of the Voting Staff Members of the Clinical Services Unit.

5.6.1.4.2. Approval by written consent resolution signed by a majority of the Voting Staff Members of the Clinical Services Unit.

5.6.1.4.3. Approval by a majority of the Voting Staff Members who vote by electronic ballot returned via email or secure website within the

time period prescribed by the notice of such electronic balloting given to all Voting Staff Members of the Clinical Services Unit.

5.6.1.5. If the person selected by the Medical Executive Council is not approved in accordance with Section 5.6.1.4, the selection procedure described in this Section 5.6.1 shall be repeated until a CSU Medical Director is selected and approved as provided herein.

5.6.2. **Term.** CSU Medical Directors shall serve two-year terms or until a successor is appointed, except that the Organization Manual shall designate an initial one-year term for the CSU Medical Directors of three Clinical Services Units. After the expiration of such initial one-year terms all subsequent terms of the CSU Medical Directors for such Clinical Services Units shall be two-year terms. CSU Medical Directors may be reappointed to serve additional terms.

5.6.3. **Stipend.** CSU Medical Directors may be paid a stipend as determined by the Governing Body upon the recommendation of Medical Executive Council. Any financial arrangement for payment of CSU Medical Directors shall comply with applicable law as reasonably determined by the Hospital.

5.6.4. **Vacancies.** If a CSU Medical Director resigns, dies or becomes incapacitated, or is removed as provided in Section 5.7, he or she shall be replaced for the remainder of his or her term by a person qualified under Section 5.5 and selected by the Medical Executive Council. Immediately after the effective date of these Bylaws, persons qualified under Section 5.5 and selected by the Medical Executive Council shall serve as the CSU Medical Directors of the Clinical Services Units until CSU Medical Directors are appointed for such Clinical Services Units in accordance with Section 5.6.1.

5.7. Removal of CSU Medical Directors.

5.7.1. Any CSU Medical Director may be removed by a two-thirds vote of the Voting Staff Members of the Clinical Services Unit; or by a two-thirds vote of the Medical Executive Council; or by the Hospital President, or by the Governing Body. Grounds for removal shall be:

5.7.1.1. failure to comply with applicable policies, Bylaws, or rules and regulations;

5.7.1.2. failure to remain in good standing on the Medical Staff, including being the subject of an adverse recommendation pursuant to the credentials policy, or having automatically relinquished privileges pursuant to that policy;

5.7.1.3. failure to perform the duties of the position held;

5.7.1.4. conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

- 5.7.1.5. an infirmity that renders the individual incapable of fulfilling the duties of that office.
- 5.7.2. 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 shall be taken, at least 10 days prior to the date of the meeting. The individual shall be afforded an opportunity to speak to the members of the Clinical Services Unit, Medical Executive Council, or the Governing Body, as applicable, prior to a vote on such removal.
- 5.8. **Duties of CSU Medical Directors.** Each CSU Medical Director is responsible for the following functions, either personally or in collaboration with Hospital personnel. Each CSU Medical Director's exercise of his/her responsibilities hereunder shall be consistent with the directives, and subject to the overriding authority, of the Medical Executive Council and Governing Body.
- 5.8.1. all clinically related activities of the Clinical Services Unit;
- 5.8.2. all administratively related activities of the Clinical Services Unit, unless otherwise provided for by the Hospital;
- 5.8.3. continuing surveillance of the professional performance of all individuals in the Clinical Services Unit who have delineated clinical privileges;
- 5.8.4. recommending to the Medical Executive Council criteria for clinical privileges that are relevant to the care provided in the Clinical Services Unit;
- 5.8.5. recommending to the Credentials Council, if established, or the Medical Executive Council clinical privileges for each member of the Clinical Services Unit;
- 5.8.6. assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the Clinical Services Unit or the Hospital;
- 5.8.7. the integration of the Clinical Services Unit into the primary functions of the Hospital;
- 5.8.8. the coordination and integration of interdepartmental and intradepartmental services;
- 5.8.9. the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services in the Clinical Services Unit;
- 5.8.10. recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services in the Clinical Services Unit;

- 5.8.11. the determination of the qualifications and competence of Clinical Services Unit personnel who are not licensed independent practitioners and who provide patient care, treatment and services in the Clinical Services Unit;
- 5.8.12. continuous assessment and improvement of the quality of care and services provided in the Clinical Services Unit;
- 5.8.13. maintenance of quality monitoring programs, as appropriate;
- 5.8.14. the orientation and continuing education of all persons in the Clinical Services Unit;
- 5.8.15. recommendations for space, equipment and other resources needed by the Clinical Services Unit;
- 5.8.16. enforcing the Bylaws and rules within the Clinical Services Unit;
- 5.8.17. cooperating with the Hospital's administrative staff on the purchase of supplies and equipment;
- 5.8.18. maintaining the quality of the medical records generated by or maintained within the Clinical Services Unit;
- 5.8.19. representing the Clinical Services Unit in a medical advisory capacity to the Hospital's administrative staff and Governing Body;
- 5.8.20. being a member of and attending meetings of the Medical Executive Council;
- 5.8.21. participating in peer review activities, including but not limited to being an active member of any multi-specialty peer review council established by the Medical Executive Council and the Governing Board;
- 5.8.22. reporting on a regular basis to the Vice President of Medical Affairs;
- 5.8.23. performing such other duties and functions as may be assigned from time to time to CSU Medical Directors by the Governing Body upon the recommendation of the Medical Executive Council.

5.9. Appointment of Chief of Service within Clinical Services Unit.

- 5.9.1. If the Medical Executive Council or Governing Body determines that any service operating within a Clinical Services Unit is required under applicable law or regulations, or under the standards of an Accrediting Body (as defined below), to have a chief of such service, the CSU Medical Director of the Clinical Services Unit in which such service is primarily housed may serve as the chief of the service if eligible to do so. If the CSU Medical Director of the Clinical Services Unit declines to serve as the chief of such service, or is not eligible to serve as the chief of such service under the applicable law, regulation or standard, then the CSU Medical

Director of the Clinical Services Unit, with the approval of the Hospital President, shall appoint a chief of the service who is eligible to so serve, subject to Section 5.9.3, below. For purposes of this Section 5.9.1, an Accrediting Body shall mean The Joint Commission, CMS, or any comparable accrediting body applicable to the Hospital as a whole, and shall not mean accrediting bodies that certify only specific departments, services, practices, specialties or programs functioning within the Hospital.

5.9.2. The term, qualifications, responsibilities and duties of the service chief shall be determined by the Governing Body upon the recommendation of the Medical Executive Council and shall be set forth in a policy maintained with the records of the Medical Executive Council and Clinical Services Unit.

5.9.3. If a chief is determined under Section 5.9.1 to be required for a service that is subject to a service contract with the Hospital that designates a medical director of such service, such medical director shall serve as the chief of the service if the medical director meets the qualifications for such position and is not prevented from doing so by the terms of the service contract.

ARTICLE 6.

Clinical Privileges

6.1. Procedure for Delineating Clinical Privileges.

6.1.1. **Clinical Services Unit Responsibility.** Each Clinical Services Unit shall define the medical procedures that fall within its clinical areas, which shall form the basis for delineating privileges within the Clinical Services Unit. The Medical Executive Council and Medical/Patient Services Committee of the Governing Body, upon the recommendations of the Credentials Council, if such Council has been established, shall periodically review, revise and approve the delineation of clinical privileges.

6.1.2. **Consultation and Other Conditions.** There may be attached to any grant of privileges special requirements for consultation as a condition to the exercise of particular privileges, in addition to requirements for consultation in specified circumstances provided for in the Bylaws or in the rules, regulations and policies, or by the Medical Staff, any of its clinical units, or the Hospital. By requesting clinical privileges, each Applicant agrees that, in dealing with cases outside his or her training and usual area of practice, he or she will seek appropriate consultation or refer to a Medical Staff Member who has expertise in such cases, subject to applicable Medical Staff and Hospital policies.

6.2. Determination of Privileges.

6.2.1. Each application for appointment or reappointment to the Medical Staff must contain a request for the specific privileges desired by the Applicant. Determination of initial privileges shall be based upon an Applicant's education, licensure, training, experience, demonstrated and continuing competence, judgment, health status, physical ability to perform the requested privileges, and level of practice

activity. In processing requests, consideration will also be given as to whether there is sufficient space, equipment, staffing and financial resources to support the requested privileges.

6.2.2. Determination of extension of further privileges shall be based upon an Applicant's education, licensure, training, experience, demonstrated and continuing competence, judgment, health status, physical ability to perform the requested privileges, and level of practice activity, which shall be evaluated by review of the Applicant's credentials, direct observation by the Active Medical Staff, and review of reports of Medical Staff Councils, as provided in Section 7.2 of these Bylaws.

6.3. **Emergency Privileges.** Regardless of his/her Clinical Services Unit or Staff status, in case of emergency, the Medical Staff Member attending the patient shall be expected to do all in his/her ability to save the life of the patient, including the calling of such consultation as may be necessary. When an emergency situation no longer exists, such Member must obtain the privileges necessary to treat the patient. For the purpose of this Section, an emergency is defined as a condition in which serious permanent harm would result to a patient or in which the life of the patient is in immediate danger, and in which any delay in administering treatment would increase the danger.

6.4. **Time-Limited Privileges.**

6.4.1. **Important Patient Care, Treatment or Service Need.** The Hospital President or designee, after conference with the Medical Staff President or designee, shall have the authority to grant temporary privileges to a Practitioner who is not a Member of the Medical Staff and who is not applying for Staff appointment, to permit such Practitioner to care for or consult relative to a specific patient. Before granting such temporary privileges, the Hospital President and Medical Staff President, or their respective designees, shall both examine evidence of current licensure and check with at least one hospital with whom the Applicant for temporary privileges is affiliated. Temporary privileges may be granted for the period of time the specific patient is hospitalized, not to exceed one hundred twenty (120) calendar days, and may be granted no more than four (4) times in any one year, after which the Practitioner to whom temporary privileges have been granted shall be required to become a Member of the Medical Staff before being allowed to attend additional patients.

6.4.2. **Temporary Privileges Pending Staff Appointment.** Temporary privileges may be granted to new Applicants waiting for review by the Medical Executive Council and the Governing Body, provided that the Applicant (i) has no current or previously successful challenge to licensure or registration, (ii) has not been subject to involuntary termination of Medical Staff membership at another organization, and (iii) has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges. The Hospital President, or designee, upon approval of the CSU Medical Director of the applicable Clinical Services Unit or Medical Staff President, shall have the authority to grant temporary privileges, for a period not exceeding one hundred twenty (120) calendar days, to a Medical Staff Applicant who is

applying for Staff appointment, until such time as appointment acceptance is accomplished, provided that the CSU Medical Director of the applicable Clinical Services Unit and/or the Credentials Council (if established) has first received and reviewed all of the same information with respect to such Applicant as is required for initial application to the Staff under Section 3.1.

6.5. Locum Tenens.

6.5.1. The Hospital President, or designee, upon approval by the Medical Staff President, shall have the authority to grant locum tenens privileges to locum tenens Practitioners who are permitted to carry on the practice of a Staff Member who is disabled, vacationing, or otherwise called away from his/her practice. The Medical Staff President shall give an authoritative opinion as to the competence and ethical standing of the Practitioner who desires locum tenens privileges after receiving and reviewing all of the same information with respect to such Practitioner as is required for initial application to the Staff under ARTICLE 3 (including, but not limited to, a currently valid medical, dental, podiatric or other applicable license, a current DEA registration, information concerning professional liability insurance coverage, information regarding work history and experience, information concerning health status, criminal background information, and sanction screening).

6.5.2. In the exercise of such privileges, the locum tenens Practitioner shall be under the supervision of the Medical Staff President or a Member of the Staff designated by him/her. The Practitioner functioning with temporary privileges granted as locum tenens shall exercise these privileges only during those times designated by the Medical Staff President or his/her designee. Privileges as locum tenens may be granted in accordance with these Medical Staff Bylaws for a period not exceeding one hundred twenty (120) days.

6.6. Termination of Emergency/Time-Limited/Locum Tenens Privileges. The Hospital President or designee may at any time, upon the recommendation of the Medical Staff President, terminate a Practitioner's temporary, emergency, or locum tenens privileges. No Practitioner is entitled to emergency, temporary, or locum tenens privileges as a matter of right. A Practitioner shall not be entitled to the procedural rights afforded by the Fair Hearing and Appeal Plan and Procedure because of his/her inability to obtain temporary, emergency, or locum tenens privileges or because of any termination, modification or suspension of temporary, emergency, or locum tenens privileges.

6.7. Dental Staff Privileges.

6.7.1. Privileges granted to dentists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of dental surgical privileges shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the CSU Medical Director of the Clinical Services Unit that includes General/Specialty Surgery. All dental patients shall receive the same basic medical appraisal as all other surgical patients. This shall include having a

physician who is either a Member of the medical staff or is approved by the medical staff to perform an appropriate admission history, physical examination and evaluation of overall medical risk and record the findings in the patient's medical record.

- 6.7.2. A physician Member of the medical staff shall be responsible for the medical care of patients admitted by dentists. Patients admitted for dental care shall have a dental history recorded by the dentist.

6.8. Podiatric Staff Privileges.

- 6.8.1. Privileges granted to podiatrists shall be based on their training, experience, demonstrated competence and judgment. The scope and extent of podiatric surgical privileges shall be specifically delineated and granted in the same manner as all other medical staff privileges. Procedures performed by podiatrists shall be under the overall supervision of the CSU Medical Director of the Clinical Services Unit that includes Orthopaedics. All podiatric surgical patients shall receive the same basic medical appraisal as all other surgical patients. This shall include having a physician, who is either a Member of the Medical Staff or is approved by the Medical Staff, perform an appropriate admission history, physical examination and evaluation of overall medical risk and record the findings in the patient's medical record.

- 6.8.2. A physician Member of the medical staff shall be responsible for the medical care of patients admitted by podiatrists. Patients admitted for podiatric care shall have a podiatric history recorded by the podiatrist.

6.9. Telemedicine Privileges.

- 6.9.1. **Interpretive Telemedicine Privileges.** Practitioners based at distant sites whose practice at the Hospital will be limited to interpretive telemedicine only may apply for telemedicine privileges by submission of the same application required of all other Practitioners for Medical Staff membership or clinical privileges.

- 6.9.2. **Interactive Telemedicine Privileges.** Practitioners based at distant sites requesting any form of interactive telemedicine privileges may apply for privileges by submission of the same application required of all other Practitioners for Medical Staff membership or clinical privileges.

- 6.9.3. **Initial Appointment.** The initial appointment of telemedicine privileges may be based upon:

6.9.3.1. The Practitioner's full compliance with this Hospital's privileging standards; or

6.9.3.2. By using this Hospital's standards but relying on information provided by the distant site hospital or entity at which the Practitioner routinely practices; or

6.9.3.3. By relying entirely on the privileging of the distant site hospital or entity, to make the final privileging decision, but only if all of the following requirements are met:

6.9.3.3.1. This Hospital and the distant site hospital or entity have entered a written telemedicine services agreement that fully complies with the requirements of applicable laws and regulations, including but not limited to 42 CFR §§ 482.22(a)(3) or 482.22(a)(4), as applicable, or any successor regulation thereto;

6.9.3.3.2. The distant site is a Joint Commission-accredited hospital or ambulatory care organization;

6.9.3.3.3. The Practitioner is privileged at the distant site for those services to be provided at this Hospital;

6.9.3.3.4. The distant site provides this Hospital with a current list of licensed independent practitioners' privileges;

6.9.3.3.5. This Hospital maintains evidence of an internal review of the Practitioner's performance of these privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement, including but not limited to all adverse outcomes related to reviewable sentinel events that result from the telemedicine services provided, and complaints about the Practitioner from patients, licensed independent practitioners, or staff at the Hospital.

6.9.4. **Reappointment.** Reappointment of a telemedicine staff member's privileges may be based upon performance at this Hospital, and, if insufficient information is available, upon information from the distant site hospital or entity where the practitioner routinely practices.

6.9.5. **Medical Staff Assignment.** Practitioners with only telemedicine privileges will be assigned to the Telemedicine Staff category.

6.9.6. **Termination of Contract.** The appointment and related privileges of a Telemedicine Staff member shall terminate automatically and immediately upon the termination of his/her telemedicine services agreement, unless he/she continues to provide services under a subsequent telemedicine services agreement with the Hospital. In addition, any Telemedicine Staff member's appointment and privileges shall automatically and immediately terminate if the Hospital exercises a right under the telemedicine services agreement to withdraw its approval of such member to provide services under the agreement.

6.10. **Independent Allied Health Staff Professionals.**

6.10.1. **General Provisions.**

- 6.10.1.1. Independent Allied Health Professionals shall consist of professionally competent licensed and/or certified practitioners and other health professionals who participate in hospital care and are not part of the Medical Staff. Independent Allied Health Professionals shall include the categories of professionals as defined by Hospital policy, which in the Hospital's discretion may include physician's assistants, advanced practice nurses, optometrists, psychologists, clinical social workers, marriage and family therapists, professional counselors and other qualified professionals.
- 6.10.1.2. Independent Allied Health Professionals may practice in relative independence or under the direct supervision of a Medical Staff Member, depending on their training and the supervision required by state law or regulation for licensure or certification.
- 6.10.1.3. Independent Allied Health Professionals shall continuously meet the qualifications, standards and requirements as set forth in these Bylaws and associated policies of the Hospital and the Medical Staff. Independent Allied Health Professionals do not vote at any Medical Staff meeting, or otherwise participate in the benefits of Medical Staff membership.
- 6.10.1.4. Each Applicant will present qualifications for review by the Medical Staff Office in accord with the policies and procedures outlined in ARTICLE 3 of these Bylaws for the appointment of Medical Staff Members. All initial Applicants for Independent Allied Health Professional status will be appointed as Independent Allied Health Professional Staff for a period of not less than one year. Upon successful completion of the Applicant's term, he or she may be considered for regular Independent Allied Health Professional Staff appointment.

6.10.2. Qualifications and Responsibilities.

- 6.10.2.1. Independent Allied Health Professionals may provide patient care services within the limits of their professional skills and abilities and delineated scope of practice, meeting all state licensure and certification requirements and Hospital policies, as applicable. The degree of participation by Independent Allied Health Professionals in patient care shall be determined according to policies recommended by the Medical Staff and approved by the Governing Body.
- 6.10.2.2. An individual applying for appointment as an Independent Allied Health Professional must be continuously sponsored by or collaborating with, a Member of the Medical Staff who will review the adequacy of the individual's performance on a regular basis. The Medical Staff Member sponsor/collaborator will attest to this in writing.
- 6.10.2.3. If an Independent Allied Health Professional is employed by a Medical Staff Member or the same employer as the Medical Staff Member, the Medical

Staff sponsor shall assume full responsibility, and be fully accountable for the conduct of the individual within the hospital. The sponsoring Medical Staff Member shall provide supervision of the Independent Allied Health Professional as required by state licensure and certification requirements. It is further the responsibility of the employer of the Independent Allied Health Professional to acquaint the individual with the applicable policies of the Medical Staff and the hospital, as well as appropriate Members of the Medical Staff and hospital personnel with whom said individual shall have contact with at the hospital.

6.10.3. Psychologists.

6.10.3.1. Privileges granted to psychologists shall be based on their training, experience, demonstrated competence and judgment. The Applicant shall be a graduate of an approved psychology doctoral program, legally licensed to practice psychology in the State of Wisconsin, and practicing in the community or within a reasonable distance of the Hospital. The scope and extent of psychology privileges shall be specifically delineated and granted in the same manner as all other medical staff privileges, except that psychology privileges shall not include admitting patients to the Hospital.

6.10.3.2. Treatment performed by psychologists shall be under the overall supervision of the CSU Medical Director of the Clinical Services Unit which includes psychiatry. All patients of psychologists shall receive the same basic medical appraisal as all other patients. This shall include having a physician who is either a Member of the Medical Staff or is approved by the Medical Staff to perform an appropriate admission history, physical examination and evaluation of overall medical risk and record the findings in the patient's medical record. Patients admitted for psychological care shall have a psychological history recorded by the psychologist.

6.10.4. Application/Appointment Process.

6.10.4.1. Applications for appointment to provide specified services as Independent Allied Health Professionals shall be obtained and processed as follows:

6.10.4.1.1. The Independent Allied Health Professionals shall complete an application.

6.10.4.1.2. The CSU Medical Director of the appropriate Clinical Services Unit shall recommend approval or disapproval after his/her review of the application and any consultation the CSU Medical Director deems appropriate, which may include an interview of the provider by the CSU Medical Director or designee. Requests for approval of Independent Allied Health Professionals and the recommendation of the CSU Medical Director of the Clinical Services Unit shall then be reviewed by the sponsoring or collaborating Medical Staff Member and the Hospital

President or designee; both must approve the request in order for it to be granted. The actions on these requests will be reviewed by the Credentials Council, if established, otherwise by the Medical Executive Council.

6.10.4.1.3. The Independent Allied Health Professional shall comply with Hospital policies regarding immunizations, TB surveillance and other health safety requirements.

6.10.4.1.4. The Independent Allied Health Professional shall participate in orientation and in-hospital training requirements as outlined by the Hospital. Completion of this requirement shall be documented.

6.10.5. Reappointment Process/Termination.

6.10.5.1. Applications for reappointment to provide specified services in the Hospital as an Independent Allied Health Professional shall be obtained and processed in the same manner as applications for Medical Staff reappointment. The Hospital retains the right; either through the Administration or upon recommendation of the Medical Executive Council, to suspend or terminate any or all of the privileges or functions of any category of Independent Allied Health Professional, without recourse on the part of the person in that category to the procedures provided in the Fair Hearing Plan outlined in the Medical Staff Bylaws. Should any such action occur, and result in a reduction or removal of the clinical privileges of the Independent Allied Health Professional, the individual shall be entitled to a hearing conducted by the Hospital President or designee. Such hearing shall be promptly conducted and shall provide the Independent Allied Health Professional with the reasons for the Hospital's actions.

6.10.5.2. An Independent Allied Health Professional's ability to practice at the Hospital shall automatically terminate when: (1) the Independent Allied Health Professional is no longer employed by a Member of the Medical Staff or the same employer as the Medical Staff Member or the Hospital, (2) if the Medical Staff Member sponsor is terminated, or (3) if the Medical Staff Member's clinical privileges are curtailed to the extent that the professional services of said individual within the hospital are no longer necessary or permissible to assist the employer. When privileges are terminated under this Section, the Independent Allied Health Professional shall have no right to a fair hearing or appeal.

6.11. Disaster Privileges.

6.11.1. For purposes of this Section, a "disaster" exists when the Hospital implements its disaster plan and the Hospital is unable to meet patient needs.

6.11.2. During a disaster and in the best interest of immediate patient care, the Hospital President/designee may, at his or her discretion, grant disaster privileges on a case-by-case basis to volunteer physicians upon presentation of the following:

6.11.2.1. A valid government-issued photo identification (i.e., driver's license or passport); and

6.11.2.2. At least one of the following:

6.11.2.2.1. A current picture hospital ID card/badge (a photocopy will be made when possible); or

6.11.2.2.2. A current license to practice (a photocopy will be made when possible); or

6.11.2.2.3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corps ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal response organization or group. Identification indicating that the individual has been granted authority by a federal, state or municipal entity to render patient care in emergency circumstances (a photocopy will be made when possible); or

6.11.2.2.4. Presentation by current Medical Staff Member(s) with personal knowledge regarding the Practitioner's ability to act as a volunteer during a disaster.

6.11.2.3. The Hospital President, or in his/her absence the Vice President of Medical Affairs, will have the overall responsibility for assignment of duties to any volunteer Practitioners that are granted disaster privileges.

6.11.2.4. As soon as possible, additional information will be gathered from the volunteer Practitioners on a "Disaster Privileges" form. Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within seventy-two (72) hours from the time the volunteer begins to provide service at the Hospital. In extraordinary circumstances where primary source verification can not be completed within seventy-two (72) hours, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

6.11.2.5. When possible, all Practitioners granted privileges during a disaster will be identified by a "Voluntary Practitioner: Disaster Privileges Granted" ID

badge. The badges shall be maintained in the Clinical Services Unit that includes Emergency and Critical Care.

6.11.2.6. When the Hospital deems a “disaster or emergency situation to no longer exist or to be under control”:

6.11.2.6.1. The disaster privileges shall expire.

6.11.2.6.2. The Practitioners that were granted disaster privileges must request Medical Staff membership and the clinical privileges necessary to continue to treat patients.

6.11.2.6.3. In the event such privileges are denied or the voluntary Practitioner does not desire such privileges, any patients still receiving care at the Hospital shall be assigned to an appropriate Medical Staff Member.

6.11.2.6.4. After-the-fact/retroactive credentialing for temporary privileges will occur as soon as possible if feasible to cover the time period of the disaster.

6.12. House Staff (Residents and Fellows).

6.12.1. The House Staff is not a category of the Medical Staff and members of the House Staff are not Members of the Medical Staff. House Staff shall include physicians, podiatrists, and dentists in accredited training programs where the Hospital participates in graduate medical education (residents and fellows).

6.12.2. Each resident or fellow, both licensed and unlicensed, participates in patient care under the supervision of a Member of the Medical Staff, who retains responsibility for the actions of the residents and fellows. The extent to which authority and autonomy are delegated is determined by regulatory and accreditation requirements and on an individual basis by the Medical Staff Member responsible for the patient.

6.12.3. Prior to participation, residents and fellows must meet all requirements for patient care under state law and Hospital policies. A resident in the first year of training is not eligible for Wisconsin licensure, but may, under supervision, perform acts such as writing and signing chart notes, patient care orders and prescriptions in accord with applicable law. Supervision of residents and fellows is provided consistent with criteria of the accrediting organizations such as Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or the American Dental Association’s Commission on Dental Accreditations.

6.13. Withdrawal of Privileges.

Any Member of the Medical Staff may voluntarily withdraw any clinical privilege at any time upon written notice to the Medical Executive Council. Such action, unless as a result of disciplinary action or investigation or in lieu thereof, shall not create a right of

hearing under the Fair Hearing Plan nor generate any reporting requirements under Wisconsin Statutes Section 50.36.

6.14. Contract Practitioners.

6.14.1. The Hospital may enter exclusive or nonexclusive clinical services agreements under which duly licensed physicians, podiatrists or dentists ("Contract Practitioners") may provide designated services to patients at the Hospital. Such agreements may be entered on behalf of the Hospital by the Hospital President or designee.

6.14.2. If the Hospital decides to enter an exclusive clinical services agreement that will prevent any existing Medical Staff Members from thereafter exercising their current privileges, such decision shall not give rise to a hearing right on the part of any such Medical Staff Member, nor shall it necessitate any reporting to the National Practitioner Data Bank or Department of Regulation and Licensing.

6.14.3. Contract Practitioners shall apply for appointment to the Medical Staff in accordance with ARTICLE 3, and upon appointment shall be members of the Active Medical Staff or Affiliate Medical Staff as applicable.

6.14.4. Unless expressly provided otherwise in the clinical services agreement or by the Hospital at the time of termination of a clinical services agreement, a Contract Practitioner's appointment and related privileges shall terminate automatically and immediately upon the termination of his/her clinical services agreement, unless such Contract Practitioner continues to provide services under a subsequent clinical services agreement with the Hospital. In addition, any Contract Practitioner's appointment and privileges shall automatically and immediately terminate if the Hospital exercises a right under the clinical services agreement to withdraw its approval of such Practitioner to provide services under the agreement.

6.14.5. A termination of a Contract Practitioner's privileges pursuant to the Hospital's termination of the agreement or exercise of a right to withdraw approval of a Contract Practitioner shall not be deemed a professional review action under ARTICLE 8 creating an entitlement to a hearing or necessitate that a report be filed with the National Practitioner Data Bank unless required by law. If the Hospital determines that such a report is required to be made, the affected Contract Practitioner will be so notified and thereupon be entitled to a hearing and review of the underlying issues in accordance with ARTICLE 9. The hearing and subsequent actions will be restricted to the issues necessitating a report to the National Practitioner Data Bank and the outcome shall not affect any decision regarding the contract termination or withdrawal of approval.

6.14.6. Telemedicine Staff shall not be deemed Contract Practitioners within the meaning of this Section 6.14.

6.15. Orders from Individuals Without Clinical Privileges or Medical Staff Membership.
The Hospital may accept and execute orders per policy for outpatients from Practitioners,

Independent Allied Health Professionals and individuals licensed to practice medicine, podiatry or dentistry in Wisconsin who are not Members of the Medical Staff and who have not been granted any clinical privileges only if all the following conditions are met:

- 6.15.1. The order is within the scope of practice, as established by state law, of the ordering professional.
- 6.15.2. The ordering professional is currently licensed, certified or registered in a State in a field of practice recognized by Wisconsin law and, upon the Hospital's request, provides satisfactory evidence of such current licensure, certification or registration which shall be validated in accordance with Hospital policy.
- 6.15.3. The ordering professional is not excluded from any federally-funded health program (such as Medicare or Medicaid).
- 6.15.4. The order can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering professional.
- 6.15.5. The ordering professional does not hold himself/herself out to be associated with the Hospital or its Medical Staff.

6.16. Focused Professional Practice Evaluation.

- 6.16.1. A period of focused professional practice evaluation shall be implemented:
 - 6.16.1.1. for all initially requested privileges subject to focused professional practice evaluation per Medical Staff policy; and
 - 6.16.1.2. in response to concerns regarding the provision of safe, high quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend.
- 6.16.2. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the Practitioner's current clinical competence, practice behavior and ability to perform the requested privilege.
- 6.16.3. Information for focused professional practice evaluation includes, as appropriate, chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient.

6.17. Ongoing Professional Practice Evaluation.

- 6.17.1. A process of ongoing professional practice evaluation exists to continuously review Medical Staff Members' care and to identify professional practice trends that impact on quality of care and patient safety.

6.17.2. The criteria used in the ongoing professional practice evaluation may include such factors as:

6.17.2.1. The review of operative and other clinical procedures performed and their outcomes;

6.17.2.2. Patterns of blood and pharmaceutical usage;

6.17.2.3. Requests for tests and procedures;

6.17.2.4. Length of stay patterns;

6.17.2.5. Morbidity and mortality data;

6.17.2.6. Practitioner's use of consultants; and

6.17.2.7. Other relevant factors as determined by the Medical Staff.

6.17.3. The information used to review the ongoing professional practice evaluation factors shall include, as appropriate, periodic chart reviews, direct observations, monitoring of diagnostic and treatment techniques and discussions with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing, and administrative personnel.

6.17.4. Relevant information obtained from the ongoing professional practice evaluation shall be integrated into Medical Staff performance improvement activities. Such information shall help determine whether existing privileges should be maintained, revised or revoked. Such information will be used and disclosed to third parties only in accordance with Medical Staff policies.

ARTICLE 7.

Officers and Councils

7.1. Officers.

7.1.1. Terms of Office and Qualifications.

7.1.1.1. The officers of the Medical Staff shall be the Medical Staff President (Chief of Staff), the Medical Staff President-Elect, and the Medical Staff Past-President.

7.1.1.2. The Medical Staff President-Elect shall be elected at the annual meeting of the Medical Staff. The Medical Staff President-Elect shall be elected for a two year term, and shall automatically become Medical Staff President for a term of two years upon completion of his/her term as Medical Staff President-Elect. The Medical Staff President shall automatically become Medical Staff Past-President upon completion of his/her term as Medical Staff President. Terms of office for all officers shall commence October 1.

7.1.1.3. Officers must be Members of the Active Staff at the time of nomination and election and must remain Members in good standing during their term of office. The Medical Staff President, Past-President and President-Elect must be a doctor of medicine or osteopathy, or a doctor of dental surgery or dental medicine.

7.1.2. Medical Staff President.

7.1.2.1. The Medical Staff President shall call and preside at all Medical Staff meetings and shall be a member ex-officio of all councils and committees, except that the Medical Staff President shall not be counted as a Member of Medical Staff councils or committees other than the Medical Executive Council for purposes of determining a quorum.

7.1.2.2. The Medical Staff President will also be responsible for the functioning of the clinical organization of the Clinical Services Units and shall keep or cause to be kept a careful supervision over the clinical work in all Clinical Services Units.

7.1.2.3. Subject to the Bylaws of the Hospital, the Medical Staff President shall serve as a voting member of the Governing Body and shall fulfill all requirements of that position, including preparation of a monthly report to the Governing Body. The Medical Staff President also shall perform any of the duties of any CSU Medical Director or chair of any Medical Staff council or committee, if such individual is unavailable or otherwise fails to perform the necessary duties.

7.1.3. Medical Staff President-Elect. The Medical Staff President-Elect, in the absence of the Medical Staff President, shall assume all his/her duties and have all his/her authority. The Medical Staff President-Elect shall also serve as secretary-treasurer and shall keep accurate and complete minutes of all meetings, call meetings on order of the Medical Staff President, attend to all correspondence, account for all funds entrusted to him/her and perform such other duties as ordinarily pertain to the office of secretary-treasurer. He/she shall also be expected to perform such duties of supervision as may be assigned to him/her by the Medical Staff President.

7.1.4. Medical Staff Past-President. The Medical Staff Past-President shall be expected to perform such duties as provided for such office in these Bylaws and as may be assigned to him/her from time to time by the Medical Staff President.

7.1.5. Removal and Vacancies. An officer shall be automatically removed from office upon the termination, resignation or revocation of such officer's Active Staff status. In addition, an officer may be removed from office by a vote in favor of removal by a two-thirds (2/3) majority of the Voting Staff Members present at any regular meeting of the Medical Staff or at a special meeting of the Medical Staff specifically called for such purpose. In votes taken on removal from office, vote by proxy shall

not be permitted. Vacancies in the office of Medical Staff President shall be temporarily filled by the Medical Staff President-Elect. Vacancies in other Staff offices shall be temporarily filled by appointment by the Medical Staff President, with the approval of the Medical Executive Council. Within sixty (60) days after the occurrence of a vacancy in any Staff office, an election shall be held at a regular or special meeting of the Staff to elect an officer to fill the unexpired term.

7.2. Standing and Special Councils.

7.2.1. Councils. There shall be a Medical Executive Council and such standing and special councils of the Staff as may from time to time be necessary and desirable to perform the functions of the Staff required by these Bylaws or necessarily incidental thereto. The composition, duties and meeting requirements of all councils not specifically set forth in this Article shall be determined by Medical Staff policy adopted in accordance with ARTICLE 14 and set forth in the Organization Manual.

7.2.2. Appointments. All councils (other than the Medical Executive Council) and council chairs shall be appointed by the Medical Staff President, with notice to the Medical Executive Council, except as otherwise provided in these Bylaws. Council appointments shall be for a period of one (1) year. All appointments to special and standing councils shall be formal appointments. All council members shall be voting members unless otherwise provided in these Bylaws and/or the council formats as established by the Medical Executive Council.

7.2.3. Procedure. The standing councils of the Medical Staff shall be those created by Medical Staff policies from time to time in accordance with ARTICLE 14. The Medical Staff Office shall retain a list of all special and standing councils in existence. Any additions to or deletions from the list of standing and special councils, or any material changes in the composition or duties of such councils, shall not be effective until written notice of such changes has been given to the Active Staff and the Active Staff has been given ten (10) days to object thereto in writing, delivered to the Medical Staff President. If ten percent (10%) or more of the Members of the Active Staff so object, a special meeting of the Active Staff shall be called at which such changes shall be considered and voted upon, and in such event, such changes shall not become effective until such vote has been taken.

7.3. Medical Executive Council.

7.3.1. Composition. The Medical Executive Council shall consist of the following members:

7.3.1.1. Medical Staff President, the Medical Staff President-Elect, and the Medical Staff Past-President;

7.3.1.2. four (4) at-large members, each of whom is a Member either of the Active Medical Staff or Emeritus Medical Staff, and who shall be elected at the annual meeting of the Medical Staff to a one-year term commencing on October 1, but may serve successive terms;

- 7.3.1.3. Each CSU Medical Director;
 - 7.3.1.4. Each chief of service appointed under Section 5.9 of these Bylaws;
 - 7.3.1.5. The Hospital President;
 - 7.3.1.6. The Vice President of Medical Affairs;
 - 7.3.1.7. The Chief Nursing Officer.
- 7.3.2. **Voting.** All elected and ex-officio members of the Medical Executive Council shall be voting members, except the Vice President of Medical Affairs and the Chief Nursing Officer. Except as otherwise provided by these Bylaws, an affirmative vote of a majority of the voting members of the Medical Executive Council in any meeting at which a quorum is present shall constitute the action of the Medical Executive Council. Members may not vote by proxy or absentee ballot.
- 7.3.3. **Duties.** The duties of the Medical Executive Council shall be to coordinate the activities and general policies of the various Clinical Services Units, to act for the Staff, to receive and act upon the reports of Medical Staff Councils as the Staff may designate, and to ensure that the Medical Staff is kept abreast of the accreditation program and informed of the Hospital's compliance with the accreditation requirements. In addition, the Medical Executive Council shall:
- 7.3.3.1. act on behalf of the Medical Staff between meetings of the Medical Staff;
 - 7.3.3.2. make recommendations to the Governing Body regarding Medical Staff membership, the Medical Staff's structure, the process used to review credentials and delineate privileges, the delineation of privileges for each Practitioner's privileges through the Medical Staff process, and the Medical Executive Council's review of and actions on reports of Medical Staff councils, departments and other assigned activity groups;
 - 7.3.3.3. adopt Medical Staff policies and procedures on behalf of the Medical Staff and make recommendations to the Governing Body for approval and implementation of such policies and procedures; and
 - 7.3.3.4. regularly receive and review at least semi-annually the Quality and Outcomes and Risk Management reports submitted by each Clinical Services Unit as outlined in the Integrated Performance Improvement Plan and assess the quality of medical care provided in the Hospital.
- 7.3.4. **Meetings.** The Medical Executive Council shall meet at least once a month and maintain a permanent record of its proceedings and actions. The Medical Executive Council shall report at each biannual (March and September) Staff meeting. Failure to meet these requirements, unless excused for just cause, shall be considered grounds for corrective action under ARTICLE 8 of these Bylaws.

7.3.5. Action Without Meeting. Any action required or permitted by these Bylaws to be taken by the Medical Executive Council at a meeting or by resolution, may be taken without a meeting if a consent in writing setting forth the action to be so taken shall be signed by two-thirds (2/3) of the voting members of the Medical Executive Council then in office. A consent under this Section has the same force and effect as a vote of the Medical Executive Council members taken at a meeting. In the event the written consent is not signed by all of the Medical Executive Council members, the members who did not sign the consent must be notified immediately of the text of the written consent and its effective date. The written consent shall be effective either on the date specified in the written consent or on the tenth day after the notice to the non-signing members was given, whichever is later.

7.3.6. Vacancies. Any vacancy of an at large member seat on the Medical Executive Council shall be filled for the remainder of the term by a Member of the Active or Emeritus Medical Staff selected by the Medical Staff President, with the approval of the Hospital President.

7.3.7. Automatic Removal of Medical Executive Council Members. A member of the Medical Executive Council shall be automatically removed:

7.3.7.1. Immediately upon removal from current office or chair position; or

7.3.7.2. Immediately upon loss or suspension of Medical Staff appointment.

7.3.8. Removal of Medical Executive Council Members upon Request of Medical Staff or Certification of Incapacity.

7.3.8.1. A Medical Executive Council member shall be considered for removal from service by the Medical Executive Council upon written request of 20% of the Active Medical Staff directed to the chair of the Medical Executive Council, or the Medical Staff President or Hospital President, or upon certification by two (2) physicians with special qualification in the appropriate medical field(s) that the member cannot be expected to perform his or her duties because of illness for minimum of three (3) months. Such request shall include a list of the allegations or concerns precipitating the request for removal.

7.3.8.2. A member subject to a request for removal from service pursuant to Section 7.3.8.1 shall be so notified in writing by the chair of the Medical Executive Council and advised of his or her rights to a review by the Medical Executive Council, if any. When the Chair of the Medical Executive Council is the member in question, the Medical Staff Past-President shall carry out the duties of the Chair during the removal process until the issue is resolved, at which time the Chair (if not removed) will resume his or her duties or the President-Elect will take over the remaining term of the removed Chair.

7.3.8.3. The member in question will be relieved of his or her Medical Executive Council duties until the question is resolved.

7.3.8.4. Review Procedures.

7.3.8.4.1. A meeting of the Medical Executive Council shall be called within seven (7) working days to consider the matter. A quorum of the Medical Executive Council must be present to act on the matter. The member in question shall have no vote in the matter and may be excluded from the meeting except as in Section 7.3.8.4.2 below.

7.3.8.4.2. The member in question shall be permitted to make an appearance before the Medical Executive Council prior to its taking final action on the request.

7.3.8.4.3. A member may be removed by an affirmative vote of two-thirds of the Medical Executive Council members present at a meeting at which there is a quorum.

7.3.8.4.4. The final decision of the Medical Executive Council shall be given promptly to the member in question in writing by the Chair of the Medical Executive Council.

ARTICLE 8.
Corrective Action

8.1. Procedure.

8.1.1. **Grounds for Corrective Action.** Activities or professional conduct of any Member, or any person for whom such Staff Member is responsible, that is considered not to meet the medical standards of the Medical Staff, to be disruptive to the operations of the Hospital or any Clinical Services Unit, or to be in violation of these Bylaws, shall be grounds for requesting corrective action against such Member. Grounds for corrective action shall also include, but are not limited to, failure to keep adequate records, criminal charges or convictions, significant misstatement in or omission from any application for membership or privileges or any misrepresentation in presenting the Practitioner's credentials, or any other violation of Hospital regulations, rules or policies.

8.1.2. **Requests for Corrective Action.** A request for corrective action may be made by any CSU Medical Director, any officer of the Medical Staff, the chair of any standing council of the Medical Staff, the President of the Medical Staff, the Hospital President, the Vice President of Medical Affairs, or the chair of the Governing Body. All requests for corrective action shall be in writing, shall be made to the Medical Executive Council, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

8.1.3. **Review of Requests for Corrective Action.** The Medical Executive Council shall review each request for corrective action to determine: (i) if sufficient cause exists to take action on the request, (ii) if a formal investigation should be initiated, or (iii) if the request should be dismissed without further investigation. Such review

may include reviewing any reports of witness interviews or other information submitted with the request for corrective action. Such preliminary review shall not be deemed an investigation for purposes of reporting to the National Practitioner Data Bank.

8.1.4. Investigation. If the Medical Executive Council determines that a formal investigation should be initiated, it shall initiate an investigation either on its own or through an ad hoc committee appointed by the CSU Medical Director of the subject Member's Clinical Services Unit (or by the Medical Staff President if the CSU Director is the subject of the investigation). The date of initiation and completion of the investigation shall be noted in the file maintained by the Medical Executive Council with respect to the corrective action request. The subject Member shall be permitted to meet with such ad hoc committee and/or Medical Executive Council to present any information related to the matter before the committee or Council makes any report or recommendation. This appearance shall not constitute a hearing as per ARTICLE 9, and shall be informal in nature.

8.1.5. Action of Medical Executive Council. The action of the Medical Executive Council on a request for corrective action may be: (1) to reject or modify the request; (2) to issue a warning or letter of reprimand; (3) to impose terms of probation; (4) to require daily observation of inpatient care; (5) to require retrospective chart monitoring for a specified time period; (6) to require review of all admissions for a specified time period; (7) to seek an opinion or recommendation on the matter from the State Medical Society's Impaired Physician Program, or other outside consultant, provided that confidential peer review information may not be disclosed in obtaining such opinion or recommendation other than in the manner prescribed by law; (8) to recommend reduction, suspension or revocation of clinical privileges; (9) to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained; or (10) to recommend that Staff appointment be suspended or revoked.

8.1.6. Administrative Staff. Any Member who is engaged by the Hospital in an administrative capacity with related clinical responsibilities is entitled to the same procedural fairness accorded any other Member when his/her Medical Staff privileges are terminated or otherwise affected unless otherwise provided by agreement with the Hospital.

8.2. Summary Suspension.

8.2.1. Grounds. Whenever there are reasonable grounds to believe the conduct or activities of an Member poses a threat to the life, health or safety of any patient, employee or other person at the Hospital and that failure to take prompt action may result in imminent danger to the life, health or safety of any such person, the Medical Staff President, the Hospital President, the Vice President of Medical Affairs, the CSU Medical Director of the applicable Clinical Services Unit, or in their absence, any member of the Medical Executive Council shall have the authority to temporarily suspend an Member's privileges effective immediately.

8.2.2. Procedure. In such a case, the suspended Member shall be entitled to meet with the Medical Executive Council as soon as said meeting can reasonably be convened to review and consider the action taken, the Medical Executive Council may recommend a modification, continuation or termination of terms of the summary suspension. Also, if the Medical Executive Council does not recommend termination of the summary suspension of the affected Practitioner, and the summary suspension lasts longer than 30 days, the adverse action shall be reportable to the National Practitioner Data Bank/PDS.

8.2.3. Fair Hearing Rights. Unless the Medical Executive Council recommends immediate termination of the suspension, the Member shall be entitled to the procedural rights described in ARTICLE 9 of these Bylaws. The terms of the summary suspension as sustained or as modified by the Medical Executive Council shall remain in effect pending a final decision by the Governing Body.

8.3. Automatic Suspension.

8.3.1. If a Member's license to practice his/her profession in the State of Wisconsin is revoked or suspended, such Member shall be immediately and automatically suspended from practicing in the Hospital.

8.3.2. If a Member's license to practice his/her profession in the State of Wisconsin is partially limited or restricted in any way, those clinical privileges granted to the Member that are within the scope of the limitation or restriction shall be similarly and automatically limited or restricted.

8.3.3. If a Member fails to renew his/her license to practice his/her profession in the State of Wisconsin, his/her Staff appointment and clinical privileges shall be immediately and automatically be suspended until the Member's license is renewed.

8.3.4. A Member whose Drug Enforcement Administration (DEA) Certificate or any of the prescribing schedules are revoked, suspended or voluntarily relinquished shall immediately and automatically be divested of the right to prescribe medications covered by such certificate. As soon as reasonably possible after such automatic suspension, the Medical Executive Council shall convene to review and consider the facts under which the DEA certificate or the prescribing schedules were revoked, suspended or relinquished. The Medical Executive Council may then take such further corrective action as is appropriate to the facts disclosed in its investigation.

8.3.5. A Member who fails to complete medical records as required by the Rules and Regulations of the Staff shall immediately and automatically be suspended from all admitting, consultative and surgical privileges until the incomplete medical records are completed, in accordance with the applicable Staff rules regarding completion of medical records.

8.3.6. Upon conviction of a felony of a Member in any federal or state court, the Member's Staff appointment is automatically revoked. Revocation pursuant to this Section of the Bylaws does not preclude the Member from subsequently reapplying

for Staff appointment. The filing of criminal charges or a finding of guilt by a court of record may constitute sufficient basis for invoking some type of corrective action.

- 8.3.7. The action of any government agency or court terminating, suspending or excluding, in whole or in part, a Member from participating in a federally-funded health care program shall effectuate a suspension of the Staff appointment and the clinical privileges.
- 8.3.8. In the event that the policy of professional liability insurance of a Member or Independent Allied Health Professional is canceled, terminated without renewal, or reduced in coverage limits or extension of financial guarantees to below limits required of Medical Staff Members or otherwise required by law, all privileges of that Member or Independent Allied Health Professional shall be automatically suspended.
- 8.3.9. An automatic suspension of all privileges shall occur upon notification received by the Credentials Council or Medical Executive Council of the existence of (a) pending criminal felony charges of an offense affecting caregiver eligibility as identified in the Wisconsin Caregiver Background Check Law ; (b) a criminal felony conviction; (c) pending investigations into or a final administrative finding of patient abuse, neglect or misappropriation of patient property or similar offenses as addressed in the Wisconsin Caregiver Criminal Background Check Law; or (d) a determination under the Children's Code to have abused or neglected a child against a Member. The Member shall promptly provide written notice to the Credentials Council or Medical Executive Council of such pending criminal felony charges or investigation, criminal felony conviction, or final administrative finding of patient abuse, neglect, misappropriation of patient property or similar offenses addressed in the Wisconsin Caregiver Criminal Background Check law or a determination under the Children's Code of child neglect against the Member.
- 8.3.10. An automatic suspension of all privileges may be imposed upon a Member's failure to provide written notification to the Credentials Council or Medical Executive Council within five (5) calendar days of receipt by the Member of an initial sanction notice of a gross and flagrant violation, or of the commencement of a formal investigation, or the filing of charges, or a final determination by a Medicare quality improvement organization, the Department of Health and Human Services, the Wisconsin Department of Health Services, the Office of the Inspector General or any law enforcement or health regulatory agency of the United States or any state.
- 8.3.11. An automatic suspension may be imposed upon a Member's failure, without good cause, to supply information or documentation requested by any of the following: the President of the Medical Staff, the Hospital President, the Vice President of Medical Affairs, the Credentials Council, or the Medical Executive Council. A suspension shall be imposed only if: (a) the request for information or documentation was in writing; (b) the request was related to evaluation of the Member's qualifications for membership or privileges; (c) the Member failed to either comply with the request or to satisfactorily explain his or her inability to

comply; and (d) the Member was notified in writing that failure to supply the requested information or documentation within fifteen (15) days from receipt of the notice would result in automatic suspension. Any automatic suspension imposed pursuant to this Section may be a suspension of any portion or all of the Member's privileges and shall remain in effect until the Member supplies the information or documentation sought or satisfactorily explains his or her failure to supply it.

- 8.4. **Continuity of Patient Care.** Upon the imposition of summary suspension or the occurrence of an automatic suspension, the Medical Staff President or the CSU Medical Director of the Clinical Services Unit to which the suspended Member is assigned shall be responsible to provide for alternative coverage for the Hospital patients of the suspended Member. The wishes of the patient shall be considered, where feasible, in choosing a substitute Member. The suspended Member shall confer with the substitute Member to the extent necessary to safeguard the patient.
- 8.5. **Medical Executive Council Deliberation.** Unless otherwise specified in Section 8.3 above, after a Member's license is suspended, restricted, or placed on probation, the Medical Executive Council shall convene to review and consider the facts under which such action was taken by the licensing authority. The Medical Executive Council may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation, including further limitation of privileges.
- 8.6. **No Right of Hearing.** Automatic suspension activated pursuant to Section 8.3 of this Article shall not be a professional review action and thus not give rise to any right of hearing or appellate review, except as otherwise expressly set forth in ARTICLE 9.
- 8.7. **Enforcement of Automatic Suspensions.** It shall be the duty of the Medical Staff President to cooperate with the Hospital President in enforcing all automatic suspensions.

ARTICLE 9.

Fair Hearing Plan

- 9.1. **Right to Hearing.**
- 9.1.1. **Grounds for Hearing.** Except as otherwise specified in these Bylaws, any one or more of the following actions shall be deemed Adverse and entitle a Practitioner to request a hearing, but only if: (i) the basis for such action is related to clinical competence or professional conduct, and (ii) the action(s) has been recommended by the Medical Executive Council or taken by the Governing Body under circumstances where no prior right to request a hearing existed:
- 9.1.1.1. Denial of Medical Staff appointment or reappointment;
- 9.1.1.2. Suspension of Staff appointment or clinical privileges for longer than 14 days (other than automatic suspensions pursuant to Section 8.3);
- 9.1.1.3. Revocation of Medical Staff appointment;

- 9.1.1.4. Limitation of admitting privileges;
 - 9.1.1.5. Denial or restriction of requested clinical privileges;
 - 9.1.1.6. Reduction or revocation of clinical privileges;
 - 9.1.1.7. Imposition of an individual mandatory prior or concurrent consultation requirement or direct supervision or other form of probationary status that limits the ability to independently exercise clinical privileges;
 - 9.1.1.8. Imposition of modifications of clinical privileges or conditions for reinstatement, if a report to the National Practitioner Data Bank is required.
- 9.1.2. **Actions That Do Not Give Right to a Hearing.** Notwithstanding Section 9.1.1, the following actions shall not entitle a Practitioner to a hearing:
- 9.1.2.1. An oral or written admonition, reprimand or warning, or corrective counseling;
 - 9.1.2.2. The denial, termination, modification, or suspension of temporary, disaster, emergency, locum tenens, or telemedicine privileges unless for demonstrated incompetence or professional misconduct;
 - 9.1.2.3. Imposition of a probationary period with retrospective or concurrent review of cases provided that such probationary period does not otherwise limit the Practitioner's ability to exercise his/her clinical privileges;
 - 9.1.2.4. Termination of clinical privileges and Staff membership due to the Practitioner's failure to achieve board certification or recertification within the time periods prescribed under ARTICLE 3;
 - 9.1.2.5. Denial of requested clinical privileges because the Practitioner failed to satisfy the basic qualifications or criteria of training, education, or experience established for the granting of privileges for a specific procedure or procedures;
 - 9.1.2.6. Denial of requested clinical privileges, or inability to exercise clinical privileges, because a Clinical Services Unit or subspecialty has been eliminated, or the Hospital has elected not to perform or does not provide the service or procedure for which clinical privileges are sought;
 - 9.1.2.7. Denial of requested clinical privileges, or inability to exercise clinical privileges, because an exclusive services agreement does not permit such privileges to be performed by Practitioners who are not Contract Practitioners providing services under the exclusive agreement;

- 9.1.2.8. Termination of the Practitioner's employment or other contract for services with the Hospital or the withdrawal of the Hospital's approval of the Practitioner to provide services under a services agreement;
- 9.1.2.9. An automatic suspension or automatic termination of appointment and/or clinical privileges as defined in the Bylaws;
- 9.1.2.10. A Practitioner's voluntary relinquishment or voluntary resignation of appointment or clinical privileges;
- 9.1.2.11. Rejection of an application for appointment as incomplete or untimely, or due to a misstatement or omission;
- 9.1.2.12. Failure to process a request for a privilege when the Applicant does not meet the eligibility criteria to hold that privilege;
- 9.1.2.13. Conducting an investigation into any matter or the appointment of an ad hoc investigation council;
- 9.1.2.14. Imposition of observation, monitoring, proctoring, educational or training requirements in connection with a focused professional practice evaluation;
- 9.1.2.15. Any recommendation voluntarily accepted by the Practitioner;
- 9.1.2.16. Retrospective chart review;
- 9.1.2.17. Any change in assigned Medical Staff category, or assignment to a different Clinical Services Unit;
- 9.1.2.18. A requirement to complete a health and/or psychiatric/psychological assessment required under these Bylaws or Hospital policy;
- 9.1.2.19. Grant of conditional appointment or appointment for a limited duration;
- 9.1.2.20. Any other action that does not relate to the competence or professional conduct of a Practitioner.

9.2. Procedure for Requesting a Hearing.

- 9.2.1. **Notice.** In all cases in which the Governing Body or the Medical Executive Council shall have made a recommendation or taken an action entitling an Practitioner to a hearing, the Hospital President shall give prompt Special Notice to the Practitioner affected. The notice shall contain the following:
 - 9.2.1.1. That a professional review action has been taken or proposed to be taken against him/her;
 - 9.2.1.2. The reasons for the action or proposed action, including a list of charts being questioned, if any;

- 9.2.1.3. That the Practitioner has a right to request a hearing on the proposed action;
- 9.2.1.4. The time limit (which shall be thirty (30) days) within which he/she must request such a hearing;
- 9.2.1.5. A statement that failure to request a hearing within the specified time, to submit a statement of the case, if required by the Hearing Council, or to personally appear at the scheduled hearing, shall constitute a waiver of the Practitioner's right to the hearing and subsequent appellate review;
- 9.2.1.6. A summary of his/her rights in the hearing, which are: (a) representation by an attorney or other person of his/her choice, provided that, at least three (3) days prior to the date of the hearing, the Practitioner shall submit to the Hearing Council the written agreement of his/her representative to abide by the procedural rules applicable to such hearing; (b) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of a reasonable charge associated with the preparation thereof; (c) to call, examine and cross-examine witnesses; (d) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; (e) to submit a written statement at the close of the hearing; (f) upon completion of the hearing, to receive a copy of the written recommendation of the Hearing Council, including a statement of the basis of the recommendation;
- 9.2.1.7. That a record of the hearing and, if the Practitioner so requests, of the appellate review, will be made and that the Practitioner has a right to receive a copy upon payment of reasonable charges for the preparation of a copy; and
- 9.2.1.8. If the adverse action necessitated a report to the National Practitioner Data Bank.
- 9.2.2. **Request for Hearing.** The request for hearing must be in writing, and delivered in person or by certified mail to the Hospital President.
- 9.2.3. **Waiver.** The failure of a Practitioner to request a hearing to which he or she is entitled by these Bylaws within the time and in the manner provided herein or the failure without good cause of the Practitioner to personally appear at the scheduled hearing shall be deemed a waiver of his/her right to such hearing, and to any appellate review to which he or she might otherwise have been entitled.
- 9.2.4. **Scheduling a Hearing.** Upon receipt of a timely request for hearing, the Hospital President shall deliver such request to the Medical Executive Council. The Medical Executive Council shall, within 15 days after the receipt of such request for hearing, schedule and arrange for such a hearing, and shall send to the affected Practitioner by certified mail, a written notice containing the following:
- 9.2.4.1. The time, place and date of the hearing, which date shall be as soon as practicable, considering the schedules and availability of all concerned, but in

no event earlier than thirty (30) days after the date that the notice of the hearing is provided to the Practitioner, unless the Practitioner, in writing, agrees to an earlier date. The date of the hearing shall be not more than ninety (90) days after the date of receipt of the request for hearing.

9.2.4.2. A list of the witnesses expected to testify at the hearing in support of the adverse recommendation or action.

9.2.4.3. A list by number of the specific or representative patient records in question (if any).

9.2.4.4. A short and plain statement of the basis for the adverse recommendation or action, which shall identify acts, omissions or transactions with which the Practitioner is charged and, when appropriate, other reasons or subject matter that justify the adverse recommendation or action.

9.2.4.5. The names of the hearing officer and members of the Hearing Council appointed in accordance with Sections 9.2.6 and 9.3.2, below.

9.2.5. **Notice of Modifications.** The Practitioner shall be notified in writing of any subsequent modifications to the grounds for the adverse recommendation or action, or the list of expected witnesses, within a reasonable period prior to the hearing date.

9.2.6. **The Hearing Council.** When a hearing is requested, the Hospital President, in consultation with the Medical Staff President, shall appoint a Hearing Council which shall be composed of no fewer than five (5) Members of the Active Staff, none of whom shall have actively participated in the consideration of the matter at the Clinical Services Unit or Medical Executive Council level, and none of whom shall be in direct economic competition with the Practitioner involved. If the matter involves an issue of clinical quality, where feasible, at least one member shall be an individual practicing in the same specialty as the affected Practitioner.

9.2.7. **Hearing Officer.** The Hospital President shall appoint a hearing officer who is qualified by experience and/or professional training and background to conduct administrative hearings and is knowledgeable regarding HCQIA and Wisconsin law. The hearing officer may be a Practitioner or an individual from outside the Hospital, including an attorney. The hearing officer shall preside over the hearing to determine the order of procedure, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. The hearing officer shall not be an advocate for either side at the hearing, and shall not be entitled to vote on the recommendation or findings of the Hearing Council. He/she shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to matters of procedure, including but not limited to the admissibility of evidence, access to information, pre-hearing discovery and exchange of information, requests for postponements or extensions of time, time limits for direct and cross-examination of witnesses, and

limitations on number of witnesses to be called. The hearing officer shall endeavor to ensure that all relevant information is made available to the Hearing Council for its deliberations, report, and recommendation to the Governing Body.

9.2.8. Objections to Hearing Council Members or Hearing Officer. If the affected Practitioner has an objection to any individual named to serve on the Hearing Council or as the hearing officer, the Practitioner shall, within five (5) calendar days after being given the notice of hearing containing such information, give the Hospital President written notice of such objection(s) and the reasons therefore. Failure to give written notice of objection within such five (5) day period shall be deemed a waiver of any objections to the persons so named to serve on the Hearing Council and as the hearing officer. The Hospital President, in consultation with the Medical Staff President, shall consider any timely objection and in his/her discretion shall decide whether to uphold the objection and replace the person regarding whom the objection was made. If a replacement is made, the Hospital President shall inform the affected Practitioner of the name of the replacement, but the Practitioner shall have no right to object to such replacement.

9.2.9. Prehearing Exchange of Witness Lists and Exhibits. At least ten (10) days before the hearing, the Practitioner requesting the hearing shall provide to the Hospital President a written list of the names and addresses of the witnesses that the Practitioner expects to call at the hearing. The parties shall cooperate in the exchange of exhibits reasonably in advance of the hearing date. As a condition of the exchange of exhibits, each party shall agree that all such documents will be maintained as confidential peer review information and not be disclosed or used for any purpose other than the hearing and any appeals related thereto. The introduction at the hearing of exhibits not exchanged, or witnesses not identified, as provided herein shall be at the discretion of the hearing officer.

9.3. Hearing Procedure.

9.3.1. Attendance. The attendance of the Practitioner for whom the hearing has been scheduled shall be required. A Practitioner who fails to appear and proceed at such hearing shall be deemed to have waived his/her right to such hearing, and to any appellate review to which he or she might otherwise have been entitled, unless the Practitioner shows good cause for his/her failure to appear.

9.3.2. Hearing Record. The Hearing Council shall keep an accurate record of the hearing by means of an electronic digital or tape recorder or court reporter, which shall be chosen at the discretion of the Hearing Council, and may, but shall not be required to, mandate that oral evidence be taken on oath or affirmation administered by a person entitled to notarize documents in the State of Wisconsin. A Practitioner desiring an alternate method of recording the hearing shall bear the primary cost thereof.

- 9.3.3. **Testimony of Practitioner.** If the Practitioner does not testify on his/her own behalf, he or she may be called and examined as if under cross-examination, but may not be compelled to testify.
- 9.3.4. **Evidence.** The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matter upon which reasonable 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 evidence inadmissible over objection in a civil or criminal action. The Hearing Council shall also be entitled to consider information and documentation acquired or submitted in connection with applications for appointment to the Staff or for clinical privileges pursuant to these Bylaws. The Practitioner for whom the hearing is being held shall be entitled to submit memoranda concerning any issue of procedure or of fact prior to, during or at the close of the hearing, and such memoranda shall become part of the hearing record.
- 9.3.5. **Taking Official Notice.** In reaching a decision, official notice may be taken by the Hearing Council either before or after submission of the matter for decision of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing, and of any facts which may be judicially noticed by the courts of this state. Participants in the hearing shall be informed of the matters to be noticed, and those matters shall be noted in the hearing record. The Practitioner for whom the hearing is being held shall be given the opportunity on request to refute the officially noticed matters by evidence or by written oral presentation of authority, the manner of such refutation to be determined by the Hearing Council.
- 9.3.6. **Representatives of Medical Executive Council or Governing Body.** The Medical Executive Council, when its action has prompted the hearing, shall appoint one (1) of its members or some other Staff Member to represent it at the hearing, to present the facts in support of its recommendation, and to examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one (1) of its members to represent it at the hearing, to present the facts in support of its decision, and to examine witnesses.
- 9.3.7. **Order of Presentation.** At the hearing, the Medical Executive Council or Governing Body, as applicable, and the affected Practitioner may make opening statements. Following opening statements, the evidence will be presented in the following order:
- 9.3.7.1. The Medical Executive Council or Governing Body, as applicable, shall present evidence in support of its recommendation or action.
- 9.3.7.2. The affected Practitioner shall then come forward with evidence in his/her support.

- 9.3.7.3. The Medical Executive Council or Governing Body, as applicable, may then submit evidence in rebuttal to that presented by the affected Practitioner.
- 9.3.7.4. The Medical Executive Council or Governing Body, as applicable, may then make a closing argument.
- 9.3.7.5. The affected Practitioner may then make a closing argument, even if the Medical Executive Council or Governing Body, as applicable, did not elect to make a closing argument.
- 9.3.7.6. The Medical Executive Council or Governing Body, as applicable, and the affected Practitioner may request to submit written statements after the hearing. If such request is granted by the hearing officer, the hearing officer shall impose a deadline by which such written statements shall be submitted which shall not exceed fourteen days after the close of the hearing.
- 9.3.8. **Burden of Proof.** In order to prevail, the affected Practitioner must establish by clear and convincing evidence (substantially more likely than not) that the recommendation or action that prompted the hearing was unreasonable, not supported by the evidence, or otherwise unfounded.
- 9.3.9. **Deliberations.** The Hearing Council may, without Special Notice, recess the hearing and reconvene the same 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. The Hearing Council may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened.
- 9.3.10. **Report and Recommendation.** Within fifteen (15) days after (i) the close of the hearing (if no written statements were requested or allowed under Section 9.3.7.6) , or (ii) expiration of the time period for submitting written statements (if written statements were requested and allowed under Section 9.3.7.6), the Hearing Council shall make a written report and recommendation, and shall forward same together with the hearing record to the Medical Executive Council. The report may recommend confirmation, modification or rejection of the original recommendation or action of the Medical Executive Council or the Governing Body. A copy of the report and recommendations, which shall include a statement of the basis for the recommendations, shall at the same time be delivered to the Practitioner involved by Special Notice.
- 9.3.11. **Medical Executive Council Decision.** If, after the Medical Executive Council has considered the report and recommendation of the Hearing Council and the hearing record, its reconsidered recommendation is favorable to the Practitioner, it shall be forwarded to the Governing Body for action at its next regularly scheduled meeting. If such recommendation continues to be adverse, the Hospital President shall promptly notify the Practitioner by Special Notice. This notice shall also state

that he/she has a right to an appellate review to the Governing Body, that he/she has fifteen (15) days following receipt of the Special Notice to file a written request for appellate review, and that failure to properly request review shall constitute a waiver of the right to review and a summary of the appellate review procedures. The Hospital President shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action on the matter until after the Practitioner has exercised or has been deemed to have waived his or her rights to an appellate review as provided in Section 9.4.

9.3.12. Governing Body Decision. A reconsidered decision of the Governing Body that is favorable to the Practitioner shall be final and effective immediately upon transmittal of such reconsidered decision to the Practitioner. If the Governing Body's decision following a hearing is adverse to the Practitioner in respect to either appointment or clinical privileges, the Hospital President shall promptly send him/her a copy of such adverse decision by Special Notice. This notice shall also state that he or she has a right to an appellate review, that he or she has fifteen (15) days following receipt of the Special Notice to file a written request for appellate review, and that failure to properly request review shall constitute a waiver of the right to review and a summary of the appellate review procedures. The adverse decision shall then be held in abeyance until the Practitioner has exercised or been deemed to have waived his or her rights to appellate review under Section 9.4. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

9.4. Appeal to the Governing Body.

9.4.1. Written Notice/Appellate Review. Within fifteen (15) days after receipt of the Medical Executive Council's decision under Section 9.3.11 or the Governing Body's decision under Section 9.3.12, as the case may be, the affected Practitioner may, by written notice to the Governing Body delivered through the Hospital President by Special Notice, request an appellate review by the Governing Body. If such appellate review is not requested within such fifteen (15) day period, the affected Practitioner shall be deemed to have waived his/her right to the same.

9.4.2. Appellate Hearing. Within fifteen (15) days after receipt of a request for appellate review, the Governing Body shall schedule and arrange for an appellate hearing. The Governing Body shall cause the affected Practitioner to be notified, by Special Notice, of the time, place and date of the appellate hearing. The date thereof shall be as soon as is mutually agreeable, but not less than twenty (20) days, nor more than forty-five (45) days from the date of receipt of the request for appellate review, except that when a request for appellate review is received from a Practitioner who is then under suspension, the appellate hearing shall be held as soon as the arrangements may reasonably be made, but not more than ten (10) days from the date of receipt of the request.

9.4.3. Appellate Review. The proceedings by the Governing Body shall be in the nature of an appellate review, based upon the record of the proceedings before the

Hearing Council, without the taking of additional evidence. However, the Governing Body may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination and confrontation applicable to the proceedings before the Hearing Council. However, new or additional matters not raised during the original hearing or in the Hearing Council report and not otherwise reflected in the record shall only be introduced at the appellate review under unusual circumstances, and the Governing Body shall, in its sole discretion, determine whether such new matters shall be accepted. Following the appellate hearing, the Governing Body may refer the matter for further review and recommendation, but this shall not extend the time within which the Governing Body shall render its final decision.

9.4.4. Written Decision. Within thirty (30) days after the conclusion of the proceedings before the Governing Body, the Governing Body shall render a final decision in writing and shall deliver copies thereof to the Practitioner and to the Medical Executive Council by Special Notice.

9.4.5. Final Decision. The final decision of the Governing Body following the appeals procedure set forth in this Article shall be effective immediately and shall not be subject to further appeal.

9.4.6. No Additional Hearing. No Practitioner shall be entitled as a matter of right to more than one hearing before the Governing Body on any single matter which may be the subject of an appeal without regard to whether such subject is the result of action by the Medical Executive Council or the Governing Body, or both.

9.4.7. Record and Audio Files. All records, audio files and/or tapes of the proceedings provided for in this ARTICLE 9 shall be kept on file in the Hospital in accordance with Hospital policies, or if a judicial appeal is then pending, until the final determination of such appeal.

9.4.8. Final Decision of the Governing Body. Whether or not a hearing or appellate review has been requested or granted, the final decision of the Governing Body on the matter shall be sent to the affected Practitioner by the Medical Staff President by Special Notice, and shall include a statement of the basis for the decision.

9.4.9. Time Limits. Failure by the Governing Body, Medical Executive Council or any Hearing Council under this ARTICLE 9 to comply with a time limit specified herein shall not be deemed to invalidate their actions.

9.5. General Provisions.

9.5.1. Attorneys.

9.5.1.1. At Hearing. The Practitioner's request for the hearing should indicate whether or not he/she intends to be represented by an attorney at the hearing. The Practitioner may be represented by an attorney at the hearing only if his/her request for the hearing states his/her intent to be so represented. Failure

to do so shall result in the Practitioner's not being permitted to be represented by an attorney at the hearing.

9.5.1.2. At Appellate Review. The Practitioner may be represented by an attorney at an appellate review appearance, but only if the request for appellate review so declares.

9.5.1.3. Equal Representation and Preparation Assistance. If, and only if, the Practitioner is represented by an attorney at the hearing or appellate review may the Medical Executive Council or the Governing Body be allowed such representation. The preceding sentence shall not be deemed to deprive any of the parties, committees or councils of the right to legal counsel in connection with preparation for a hearing or an appellate review.

9.5.1.4. Payment of Attorney Fees. If any Practitioner who is the subject of an adverse recommendation or action in connection with the Practitioner's Medical Staff membership or clinical privileges initiates a suit against any entity or person who is in any way involved in any peer review, credentialing, recredentialing, corrective action or other action, recommendation or decision, the Practitioner filing the suit shall be required to pay all costs and expenses incurred by each individual defendant in defending the suit, including reasonable attorneys fees, unless the Practitioner substantially prevails against the individual defendant.

9.5.2. Number of Hearings and Reviews. Notwithstanding any other provision of the Bylaws, no Practitioner is entitled, as a right, to more than one evidentiary hearing and appellate review with respect to an adverse action.

9.5.3. Release. By requesting a hearing or appellate review under this Article, an Practitioner agrees to be bound by the provisions of ARTICLE 11 relating to immunity from liability.

9.5.4. Substantial Compliance. Technical or insignificant deviations from the procedures set forth in this ARTICLE 9 shall not be grounds for invalidating the action taken.

9.5.5. Reporting Requirements. If adverse action is required to be reported to the Wisconsin Medical Examining Board or the National Practitioner Data Bank, the Hospital President/designee shall submit such reports within fifteen (15) days of the final action taken by the Governing Body, unless otherwise required by law to be submitted earlier.

ARTICLE 10.
Meetings

10.1. The Annual Meeting of the Medical Staff.

10.1.1. The annual meeting of the Medical Staff shall be held in September. At this meeting, the retiring officers and councils shall make such reports as may be desirable, officers for the ensuing year shall be elected from the list of nominees prepared by a nominating council if such a council is established by the Medical Executive Council in accordance with Section 7.2 of these Bylaws, otherwise from a list of nominees prepared by the Medical Executive Council. Nominations from the floor shall not be permitted.

10.1.2. Election shall be carried out by secret written ballot. Voting by proxy may be permitted in the discretion of the Medical Executive Council. A nominee shall be elected upon receiving a majority of the votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

10.2. Semiannual Meeting of the Medical Staff.

10.2.1. The Medical Staff shall meet semiannually in March.

10.2.2. In addition to matters of organization, the program of Medical Staff meetings shall include a report of the Medical Executive Council and/or other councils and Clinical Services Units. Executive sessions may be conducted by the Voting Staff Members with other categories of the Staff excluded.

10.3. Special Meetings of the Medical Staff. Special meetings of the Medical Staff may be called at any time by the Medical Staff President. Meetings shall be called at the request of the Governing Body, the Medical Executive Council, or any five Voting Staff Members. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any special meeting shall include any of the following:

10.3.1. Notice posted on the bulletin board in the Staff room at least one (1) week (if possible) before the time set for the meeting;

10.3.2. Notice sent electronically via email or secure website at least one (1) week (if possible) before the time set for the meeting;

10.3.3. Notice sent via U.S. Mail at least one (1) week (if possible) before the time set for the meeting; or

10.3.4. Notice provided by any other method that is reasonably designed to notify the Medical Staff within sufficient time for Staff Members to attend such meeting.

10.4. Clinical Service Unit Meetings.

- 10.4.1. Individual Clinical Service Units shall determine the frequency of meetings based on their business, clinical, quality monitoring and evaluation activities and/or educational needs, provided that such meetings shall be held at least quarterly.
- 10.4.2. The primary objective of the Clinical Services Unit meetings is to improve the care and treatment of patients in the Hospital, and to provide the mechanism for monitoring and evaluating activities, including: identifying important aspects of care, identifying the indicators used to monitor the important aspects of care and evaluating the care provided; as well as to periodically review care to draw conclusions, formulate recommendations and initiate actions based on findings of review activities; and to communicate to appropriate Clinical Services Unit members the findings, conclusions, recommendations and actions taken.

10.5. Attendance at Meetings.

- 10.5.1. Voting Staff Members and non-voting Affiliate Staff Members are expected to annually attend at least one meeting of the Medical Staff. Voting Staff Members of Clinical Services Units are expected to annually attend at least fifty percent (50%) of the meetings held by their respective home Clinical Services Units. Failure to meet such attendance expectations shall be considered in Staff reappointments and advancements. Attendance records shall be kept of all Medical Staff, Clinical Services Unit and council meetings.
- 10.5.2. Participation in meetings of Clinical Services Units and special and standing councils of the Medical Staff may be in person or by any electronic means of communication, provided that (1) all participants may simultaneously hear each other during the meeting, or (2) all communication during the meeting is immediately transmitted to each participant, and each participant is able to immediately send messages to all other participants. The identity of each participant in a meeting conducted electronically must be reasonably verified by the presiding officer of such meeting before a vote. The conduct of meetings by electronic means shall be subject to any applicable Hospital rules, regulations and policies, including but not limited to policies regarding confidentiality of information and any restrictions on the conduct of certain types of business by electronic means.
- 10.5.3. Members of councils and Clinical Services Units are required to complete their work, especially in review of charts. Failure to meet these requirements, unless excused for just cause, shall be considered in Staff reappointments and advancements.
- 10.5.4. A Member of any category of the Staff who has attended a case that is to be presented for discussion at any meeting shall be notified and shall be required to be present. Failure to attend on receipt of such notice unless for just cause shall be grounds for corrective action under ARTICLE 8 of these Bylaws. Should any Member of the Staff be absent from any meeting at which a case that he has

attended is to be discussed, it shall be presented nevertheless unless the Member is unavoidably absent and has requested that discussion be postponed. In no case shall postponement be granted for a period longer than until the next regular meeting.

- 10.6. **Quorum.** There shall be no quorum requirement for the Annual or Semiannual Medical Staff meetings. Those Voting Staff Members present and voting shall constitute a quorum. At the Medical Executive Council and any Credentials Council meetings, fifty percent (50%) of the voting membership shall constitute a quorum. At other council, Clinical Services Unit, and section meetings, three (3) Staff Members who are members of the Clinical Service Unit, section or council shall constitute a quorum.
- 10.7. **Minutes.** Adequate minutes of all meetings of the Medical Staff shall be kept that are sufficient to document for those Members who did not attend the meeting the general nature of the business conducted, the decisions reached, and the findings and recommendations of the Medical Staff.

ARTICLE 11.

Immunity from Liability

The following shall be express conditions to any Practitioner's application for, or exercise of, clinical privileges at the Hospital.

- 11.1. **Immunity Privilege.** Any act, communication, report, recommendation, or disclosure, with respect to any such Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.
- 11.2. **Immune Parties.** Such privilege shall extend to Members of the Hospital's Medical Staff and members of its Governing Body, its other Practitioner's, its officers and representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this ARTICLE 11, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.
- 11.3. **Civil Liability.** There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.
- 11.4. **Applicable Activities.** Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this, or any other health care institution's activities related, but not limited to:
- 11.4.1. Applications for appointment or clinical privileges;
- 11.4.2. Periodic reappraisals for reappointment or clinical privileges;

- 11.4.3. Corrective action, including summary suspension;
- 11.4.4. Hearings and appellate reviews;
- 11.4.5. Medical care evaluations;
- 11.4.6. Utilization review;
- 11.4.7. Other Hospital, Clinical Services Unit, service or council activities related to quality patient care and professional conduct.
- 11.5. **Extent of Privilege.** The acts, communications, reports, recommendations and disclosures referred to in this ARTICLE 11 may relate to a Practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.
- 11.6. **Liability Release.** In furtherance of the foregoing, each Practitioner shall upon request of the Hospital execute releases in accordance with the tenor and import of this ARTICLE 11 in favor of the individuals and organizations specified in Section 11.2, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.
- 11.7. **Effect on Appointment and Reappointment Procedure.** The consents, authorizations, releases, rights, privileges, and immunities provided by ARTICLE 3 of these Bylaws for the protection of the Hospital's Practitioners, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this ARTICLE 11.

ARTICLE 12.

Staff Dues

- 12.1. **Assessment.**
 - 12.1.1. Staff dues shall be payable on October 31st, the end of the first month of the membership (fiscal) year. Members appointed during a membership year shall have dues prorated for the partial year.
 - 12.1.2. Formal notice of dues shall be sent to each Member by the Medical Staff President-Elect promptly at the beginning of each fiscal year. Failure to remit dues within a period of sixty (60) days after receipt of a notice of dues delinquency sent by certified mail, shall be called to the attention of the Medical Executive Council, and may be grounds for suspension or termination of Staff privileges.
 - 12.1.3. Emeritus Staff Members and Medical Staff Members seventy (70) years of age and over regardless of Staff status are not required to pay dues.

- 12.1.4. Staff dues and special assessments shall be those that are determined by a majority vote of the members of the Medical Executive Council present at a regular meeting of the Medical Executive Council.

ARTICLE 13.

Adoption, Amendment and Repeal of Bylaws

- 13.1. **Medical Staff Responsibility.** The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Governing Body any Medical Staff Bylaws and amendments thereto as needed. The Medical Staff may exercise this responsibility through the Medical Executive Council or through direct action of its voting membership.
- 13.2. **Methods of Amendment of these Bylaws.**
- 13.2.1. **Amendments Proposed by the Medical Executive Council.** The Medical Executive Council may propose amendments of these Bylaws in accordance with the procedure set forth in this Section 13.2.1.
- 13.2.1.1. The Medical Executive Council shall communicate the proposed amendment to the Medical Staff before a vote is taken by the Medical Executive Council. Voting Staff Members may submit written comments on the proposed amendment to the Medical Executive Council within the time specified for comments in the Medical Executive Council's communication to the Medical Staff. The time specified for comments shall be at least fourteen (14) days.
- 13.2.1.2. After expiration of the time specified for comments by the Medical Staff, the Medical Executive Council, after review and consideration of any comments received from the Voting Staff Members, shall vote on the proposed amendment at a regular meeting, or at a special meeting of the Medical Executive Council called for such purpose.
- 13.2.1.3. After approval of the proposed amendment by the Medical Executive Council, the proposed amendment shall be submitted to the Governing Body, together with any written comments received from the Medical Staff pursuant to Section 13.2.1.1. The Governing Body shall consider such proposed amendment at a regular meeting or at a special meeting of the Governing body called for such purpose.
- 13.2.2. Following approval by the Governing Body, the amendment shall be subject to approval by majority vote of the Voting Staff Members present and voting at the next regular meeting of the Medical Staff or special meeting of the Medical Staff called for such purpose at which a quorum is present. For purposes of such regular or special meeting, a quorum shall be fifty percent (50%) of all Voting Staff Members. The Medical Executive Council may provide in the notice of such meeting that the Voting Staff Members need not be present together at such meeting at the same time, but may attend at any time during the meeting for the purpose of

casting votes on the proposed amendment. In such event, the notice of such meeting provided to the Voting Staff Members shall state the start time and end time of the meeting. Alternatively, the proposed amendment may be communicated to Voting Staff Members for approval by mailed-in written ballot or by electronic vote via email or secure website. The Medical Executive Council shall determine whether to submit the proposed amendments for approval by mail, electronic vote or at a meeting of the Medical Staff. Bylaw amendments submitted for approval by mail or electronic vote shall be subject to approval by a majority of the Voting Staff Members who have returned ballots by mail or electronically, as the case may be, within fourteen (14) calendar days after the ballots are mailed or otherwise communicated to the Voting Staff Members. Any ballots that are not returned within such fourteen (14) day period shall not be counted. Written or electronic ballots shall be prepared and validated in such manner as the Medical Executive Council shall approve. The amendment shall be effective upon approval of a majority of the Voting Staff Members as provided in this Section 13.2.1 and shall apply to all matters currently pending to the extent practical, regardless of whether any individual Medical Staff Member received actual notice of the amendment.

13.2.3. Amendments Proposed by the Medical Staff. The Medical Staff may also propose amendments of these Bylaws directly to the Governing Body in accordance with the procedure set forth in this Section 13.2.2.

13.2.3.1. A Voting Staff Member or Members shall first obtain a petition signed by not less than twenty percent (20%) of the Voting Staff Members of the Medical Staff supporting the proposed amendment, and shall submit the petition to the Medical Executive Council for review and comment.

13.2.3.2. The Medical Executive Council shall have not less than fourteen (14) days to review and comment on the proposed amendment.

13.2.3.3. Following the period for review and comment by the Medical Executive Council, the amendment shall be submitted for approval by majority vote of the Voting Staff Members present and voting at the next regular meeting of the Medical Staff or special meeting of the Medical Staff called for such purpose at which a quorum is present. For purposes of such regular or special meeting, a quorum shall be fifty percent (50%) of all Voting Staff Members. The Medical Executive Council may provide in the notice of such meeting that the Voting Staff Members need not be present together at such meeting at the same time, but may attend at any time during the meeting for the purpose of casting votes on the proposed amendment. In such event, the notice of such meeting provided to the Voting Staff Members shall state the start time and end time of the meeting. Alternatively, the proposed amendment may be communicated to Voting Staff Members for approval by mailed in written ballot or by electronic vote via email or secure website. The Medical Executive Council shall determine whether to submit the proposed amendments for approval by mail, electronic vote or at a meeting of the Voting Staff Members. Bylaw amendments submitted for approval by mail or electronic vote shall be subject

to approval by a majority of the Voting Staff Members who have returned ballots by mail or electronically, as the case may be, within fourteen (14) calendar days after the ballots are mailed or otherwise communicated to the Voting Staff Members. Any ballots that are not returned within such fourteen (14) day period shall not be counted. Written or electronic ballots shall be prepared and validated in such manner as the Medical Executive Council shall approve.

13.2.3.4. Following approval by the Voting Staff Members, the proposed amendment shall be submitted to the Governing Body, together with any written comments received from the Medical Executive Council pursuant to Section 13.2.2.2. The Governing Body shall consider such proposed amendment at a regular meeting or at a special meeting of the Governing body called for such purpose. The amendment shall be effective upon the approval of the Governing Body and shall apply to all matters currently pending to the extent practical, regardless of whether any individual Medical Staff Member received actual notice of the amendment.

13.2.4. No Unilateral Amendments. Neither the Medical Staff nor the Governing Body may unilaterally amend the Medical Staff Bylaws.

13.2.5. Provisional Amendments. The Medical Executive Council may provisionally revise these Bylaws without approval of the full Medical Staff if such revisions do not materially amend any Bylaw provision and are solely for technical modifications or clarifications, reorganization or renumbering, or to correct grammatical, spelling or punctuation errors. Such revisions are not formal amendments, but still require approval by the Governing Body to become effective. In addition, the Medical Executive Council may provisionally adopt any urgent amendments required to comply with any legal, regulatory or accreditation requirements. The need for such urgent amendments shall be documented, and the Governing Body may approve such amendments without further notice to the Medical Staff. The Medical Executive Council shall, however, immediately notify the Medical Staff, and the Medical Staff shall then have an opportunity for retrospective review and comment on the provisional amendment. If no conflict exists between the Medical Staff and the Medical Executive Council, the provisional amendment stands. If conflict does arise between the Medical Staff and the Medical Executive Council, the matter shall be submitted to a joint meeting of equal members of the Medical Staff and the Medical Executive Council for review and recommendation to the Governing Body. If resolution cannot be made through this process, both groups shall submit their position to the Governing Body for final decision. Such amendments shall be effective when approved or decided by the Governing Body. In the event the Medical Staff proposes an amendment that is not approved by the Medical Executive Council, the same process for resolving conflict between the Medical Staff and Medical Executive Council shall be followed.

ARTICLE 14.

Adoption and Amendments to Rules, Regulations and Policies

- 14.1. **Delegation of Authority to Medical Executive Council.** The Medical Staff may adopt additional rules, regulations and policies as necessary to carry out its functions and meet its responsibilities under these Bylaws. The authority over rules, regulations and policies is hereby delegated to the Medical Executive Council. A rules and regulations and policies manual may be used to organize these additional documents.
- 14.2. **Proposals by Medical Executive Council.** Any proposed rule, regulation or policy, or amendment thereto, being considered by the Medical Executive Council shall be distributed to the Voting Staff Members for review and comment, in accordance with such procedures as are approved by the Medical Executive Council, before the proposed rule, regulation or policy, or amendment thereto, is adopted by the Medical Executive Council and submitted to the Governing Body for approval. Any rule, regulation or policy, or amendment thereto, adopted by the Medical Executive Council and approved by the Governing Body shall be promptly communicated to the Medical Staff.
- 14.3. **Proposals by Medical Staff.** Rules, regulations and policies, or amendments thereto, may also be proposed directly to the Governing Body by the Medical Staff (i) by majority vote of the Voting Staff Members, or (ii) by the Medical Staff council, service or Clinical Services Unit that will be governed by that policy. Before adopting such rule, regulation or policy, or amendment thereto, the Medical Staff or Medical Staff council, service or Clinical Services Unit, as the case may be, shall first submit such rule, regulation or policy, or amendment thereto, to the Medical Executive Council for its review and comment. Any rule, regulation or policy, or amendment thereto, adopted by the Medical Staff or Medical Staff council, service or Clinical Services Unit shall be submitted to the Governing Body for approval along with any comments from the Medical Executive Council. Upon approval by the Governing Body, the rule, regulation or policy, or amendment thereto, shall be promptly communicated to the Medical Staff.
- 14.4. **Provisional Amendments.** The Medical Executive Council may provisionally revise any rule, regulation or policy without comment by or approval of the Medical Staff in the same manner and for the same purposes as provided for the provisional amendment of these Bylaws under Section 13.2.4. Neither the Medical Staff nor the Governing Body may unilaterally amend the Medical Staff rules, regulations or policies.

ARTICLE 15.

Conflict Resolution

- 15.1. **Conflicts Between the Medical Executive Council and the Medical Staff.** Except as otherwise provided in these Bylaws with respect to the resolution of conflicts relating to a particular matter, the following process shall be followed to manage conflict between the Medical Executive Council and the Medical Staff on issues including, but not limited to, proposals to adopt a rule, regulation or policy or an amendment thereto:

- 15.1.1. If a Voting Staff Member or Members object to any action or inaction of the Medical Executive Council, including but not limited to the Medical Executive Council's adoption or proposal to adopt any rule, regulation or policy or amendment thereto, such Member or Members shall first submit to the Vice President of Medical Affairs, or in his or her absence the Hospital President, a petition signed by not less than twenty percent (20%) of the Voting Staff Members (the "Objecting Members") setting forth all of the following:
- 15.1.1.1. the nature of the objection;
 - 15.1.1.2. any counterproposal or other action requested by the Objecting Members;
 - 15.1.1.3. the names of one or more (but not exceeding five) of the Objecting Members who will serve as representatives of the Objecting Member group (the "Objecting Member Representatives").
- 15.1.2. After receipt of the petition, the Vice President of Medical Affairs or Hospital President, as the case may be, shall arrange a meeting as soon as the participants' schedules will allow between the Objecting Member Representatives and the Medical Staff President, the Medical Staff President-Elect, and the Vice President of Medical Affairs. At any such meeting the participants may decide to have follow-up meetings to continue discussions towards a resolution of the conflict (the initial and any follow-up meetings, the "Informal Discussions").
- 15.1.3. If the Informal Discussions do not resolve the conflict within thirty (30) days after the date that the petition was first submitted, the Objecting Member Representatives or the Medical Staff President may call a special meeting of the Voting Staff Members for the purpose of resolving the conflict. The proposal of the Objecting Members shall be adopted upon an affirmative vote of 2/3 of the Voting Staff Members present at such special meeting. If such proposal is in regard to a matter that requires approval of the Governing Body, it shall be adopted as a recommendation by the Medical Staff to the Governing Body. If the proposal of the Objecting Members does not receive the required 2/3 affirmative vote of the Voting Staff Members present at such meeting, the conflict shall be deemed resolved in favor of the Medical Executive Council's position on the issue.
- 15.1.4. If the Medical Executive Council or Governing Body determines in its sole discretion that action must be taken related to a conflict in a shorter time period than that allowed through the foregoing conflict resolution process in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the Hospital, the Medical Executive Council or Governing Body may take action which will remain in effect until the conflict resolution process is completed.
- 15.1.5. In addition to the formal conflict resolution process herein described, the Medical Staff President may call for a meeting of the Medical Staff at any time for any

reason in order to seek direct input from the Medical Staff Members, clarify any issue, or relay information directly to Medical Staff Members.

- 15.2. Conflicts Between the Governing Body and the Medical Executive Council.** Except as otherwise provided in these Bylaws with respect to the resolution of conflicts relating to a particular matter, the following process shall be followed to manage conflict between the Medical Executive Council and the Governing Body.

15.2.1. The Medical Staff and the Governing Body will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, the communities the Hospital serves, and the Members of the Medical Staff.

15.2.2. If the Governing Body plans to act in a manner contrary to a recommendation of the Medical Executive Council, at the request of the Medical Staff President, the Medical Staff President-Elect, and the Vice President of Medical Affairs shall meet with the Governing Body, the Medical/Patient Services Committee or other designated committee of the Governing Body and seek to resolve the conflict through informal discussions. The Hospital President or his designee shall also attend such meeting(s).

15.2.3. If these informal discussions fail to resolve the conflict, the Medical Staff President or the chairperson of the Governing Body may request initiation of a formal mediation process. After such request, the Medical Executive Council and the Governing Body shall proceed to select a mutually agreeable third party mediator.

15.2.4. The Medical Executive Council and the Governing Body shall each select at least three of their respective members to participate in the mediation. Any resolution arrived at through mediation shall be subject to any approvals of the Medical Executive Council and Governing Body required under these Bylaws and the Article of Incorporation and Bylaws of the Hospital.

15.2.5. If after sixty (60) days from the date of the initial request for mediation the Medical Executive Council and the Governing Body have not resolved the conflict in a manner agreeable to all parties, the Governing Body shall have the authority to act unilaterally on the issue that gave rise to the conflict.

15.2.6. If the Governing Body determines in its sole discretion that action must be taken related to a conflict in a shorter time period than that allowed through the foregoing conflict resolution process in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the Hospital, the Governing Body may take action which will remain in effect until the conflict resolution process is completed.


ARTICLE 16.

Adoption

16.1. These Bylaws may be adopted at any regular or special meeting of the Medical Staff, shall replace any previous Bylaws and rules and regulations, and shall become effective when approved by the Governing Body. Errors, alterations, or additions to these Bylaws shall be effected through the due process outlined in ARTICLE 13 of these Bylaws. These changes, if correction of error, shall be added as errata or, if additions or changes, as supplemental to these Bylaws as an appendage, or by issuance of a revision of the page in question.

16.2. All Medical Staff Members shall be informed of updates to these Bylaws as they occur.

The foregoing Amended and Restated Medical Staff Bylaws were duly adopted by the Community Memorial Hospital Medical Staff effective as of October 1, 2012, except that upon the approval of these Amended and Restated Medical Staff Bylaws by the Medical Staff, the Medical Executive Council and Governing Body shall be authorized to take such actions under the provisions of these Amended and Restated Medical Staff Bylaws as deemed necessary or advisable to ensure that as of October 1, 2012, or as soon thereafter as practical, the Clinical Services Units are established, the CSU Medical Directors and officers of the Medical Staff as defined herein are elected and in place, and other changes effectuated by these Amended and Restated Medical Staff Bylaws are implemented. Such actions may include, by way of illustration and not limitation, assigning Members to Clinical Services Units, nominating, interviewing and selecting CSU Medical Directors, electing officers of the Medical Staff and at-large members of the Medical Executive Council, and such other actions as deemed necessary or advisable to provide a smooth transition to these Amended and Restated Medical Staff Bylaws.



President of the Medical Staff

The foregoing Amended and Restated Medical Staff Bylaws were duly adopted by the Community Memorial Hospital Board of Directors effective as of October 1, 2012, except that upon the approval of these Amended and Restated Medical Staff Bylaws by the Medical Staff, the Medical Executive Council and Governing Body shall be authorized to take such actions under the provisions of these Amended and Restated Medical Staff Bylaws as deemed necessary or advisable to ensure that as of October 1, 2012, or as soon thereafter as practical, the Clinical Services Units are established, the CSU Medical Directors and officers of the Medical Staff as defined herein are elected and in place, and other changes effectuated by these Amended and Restated Medical Staff Bylaws are implemented. Such actions may include, by way of illustration and not limitation, assigning Members to Clinical Services Units, nominating, interviewing and selecting CSU Medical Directors, electing officers of the Medical Staff and at-large members of the Medical Executive Council, and such other actions as deemed necessary or advisable to provide a smooth transition to these Amended and Restated Medical Staff Bylaws.



Chairman, Board of Directors

MEDICAL STAFF ORGANIZATION MANUAL

***COMMUNITY MEMORIAL HOSPITAL OF
MENOMONEE FALLS, INC.***

Effective October 1, 2012

ARTICLE 1

INTRODUCTION

1.1 Purpose. This Organization Manual is adopted pursuant to the Amended and Restated Medical Staff Bylaws (the "Medical Staff Bylaws") of Community Memorial Hospital of Menomonee Falls, Inc. (the "Hospital") and describes the Clinical Services Units and Standing Councils (other than the Medical Executive Council) of the Medical Staff.

1.2 Definitions. Except as otherwise defined herein, or as capitalized in ordinary usage, all capitalized terms used herein shall have the same meaning as set forth for such terms in the Medical Staff Bylaws.

ARTICLE 2

CLINICAL SERVICES UNITS

2.1 General Purpose of Clinical Services Units. Each Clinical Services Unit ("CSU") is established to provide a continuum of coordinated care for patients of the Hospital. A CSU is a group of services that are centered on the patient and are related to each other by such factors as type of clinical need they satisfy, a category of diagnosis (such as heart disease, cancer, etc.), a category of patient types (such as women and children's care, geriatric care, etc.), a category of service (such as emergency and critical care, surgery, etc.), a category of anatomical area (such as neuro-musculoskeletal care), or other organizing factor.

2.2 List of Clinical Services Units. The following CSUs are established pursuant to the Medical Staff Bylaws:

Emergency and Critical Services

Cancer Care

Cardiovascular and Pulmonary Care

Neuro-Musculoskeletal Care

Medical Care

Surgical Care

Women & Children's Care

2.3 Functions and Clinical Privileges of CSUs. The functions and clinical privileges of each CSU are as follows:

2.3.1 Emergency and Critical Services. The Emergency and Critical Services CSU is organized for the purpose of providing a continuum of coordinated care in emergency and critical services, including the emergency and intensive care units of the Hospital. Privileges of providers within this CSU include:

Intensivists

Emergency Medicine

Trauma

eICU

2.3.2 Cancer Care. The Cancer Care CSU is organized for the purpose of providing a continuum of coordinated care for the prevention, diagnosis and treatment of cancer related disease. Privileges of providers within this CSU include:

Radiation Oncology

Medical Oncology

Pathology

2.3.3 Cardiovascular and Pulmonary Care. The Cardiovascular and Pulmonary Care CSU is organized for the purpose of providing a continuum of coordinated care for the prevention, diagnosis and treatment of cardiovascular and pulmonary disease. Privileges of providers within this CSU include:

Cardiology

Cardiothoracic Surgery

Pulmonology

2.3.4 Neuro-Musculoskeletal Care. The Neuro-Musculoskeletal Care CSU is organized for the purpose of providing a continuum of coordinated care for the diagnosis, prevention and treatment of neuro-musculoskeletal disease and disorders. Privileges of providers within this CSU include:

Orthopaedics

Physical Medicine & Rehabilitation

Podiatry

Neurosurgery

Radiology

2.3.5 Medical Care. The Medical Care CSU is organized for the purpose of providing a continuum of coordinated care in the area of general medicine. Privileges of providers within this CSU include:

Internal Medicine

Medical Specialties including Gastroenterology, Nephrology, Neurology, Allergy/Immunology, Dermatology, Endocrinology, Infectious Disease, Occupational Medicine, Rheumatology

Family Practice

Hospitalist

Psychiatry

2.3.6 Surgical Care. The Surgical Care CSU is organized for the purpose of providing a continuum of coordinated care in the area of general and special surgery. Privileges of providers within this CSU include:

General Surgery

Surgical Specialties including Dental/Oral Surgery, Ophthalmology, Urology, Otolaryngology, Plastic, Thoracic, Vascular

Anesthesia

2.3.7 Women & Children's Care. The Women & Children's Care CSU is organized for the purpose of providing a continuum of coordinated care in the area of women's and children's health. Privileges of providers within this CSU include:

Obstetrics

Gynecology

Perinatology

Pediatrics

Neonatology

2.4 Initial Terms of CSU Medical Directors. Pursuant to Section 5.6.2 of the Medical Staff Bylaws, the initial term of CSU Medical Directors for the following three CSUs shall be one year:

Cancer Care

Cardiovascular and Pulmonary Care

Neuro-Musculoskeletal Care

After the expiration of such initial one-year terms, all subsequent terms of the CSU Medical Directors for these three Clinical Services Units shall be two years. The initial term of CSU Medical Directors for all other CSUs shall be two years.

ARTICLE 3

STANDING COUNCILS OF THE MEDICAL STAFF

3.1 List of Standing Councils. The Medical Executive Council and Governing Body of the Hospital have established the following standing councils of the Medical Staff pursuant to the Medical Staff Bylaws:

Quality and Performance Improvement Council

Multi-Specialty Peer Review Council

Medical Staff Health Council

Medical Ethics Advisory Council

Operating Room Steering Council

Utilization Review Council

Pharmacy Council

3.2 Outline of Council Functions. The general functions of the standing councils are as follows. The specific composition, meeting schedules, duties and other details shall be set forth in the Council Manual.

3.2.1 Quality and Performance Improvement Council. The Quality and Performance Improvement Council shall consist of Members of the Active and/or Affiliate Medical Staff and appropriate administrative personnel. The Quality and Performance Improvement Council shall supervise the maintenance of medical records and the required standard of completeness, and shall monitor the quality of medical histories and physical examinations, and delinquencies in medical recordkeeping. On the basis of documented evidence, the Quality and Performance Improvement Council shall evaluate the quality of medical care given patients. The Quality and Performance Improvement Council shall meet as frequently as necessary, at least annually.

3.2.2 Multi-Specialty Peer Review Council. Each CSU Medical Director shall be an ex-officio member of the Multi-Specialty Peer Review Council. The primary function of the Multi-Specialty Peer Review Council shall be to review specific cases brought to its attention through the peer review process policy of the Hospital. The Multi-Specialty Peer Review Council shall meet as often as reasonably necessary to expeditiously review cases and make recommendations to the appropriate council or officer of the Hospital based upon such review. Multi-Specialty Peer Review Council may request the assistance of Members of the Medical

Staff qualified in relevant specialties to assist in reviewing cases, and may submit cases for external review in accordance with the Hospitals' peer review procedures.

3.2.3 Medical Staff Health Council. The Medical Staff Health Council shall evaluate issues related to the health, well being or impairment of Medical Staff Members. The Council shall be the identified point within the Hospital where information and concern about the health of an individual Medical Staff Member can be delivered for consideration and evaluation. It shall be advisory to the Medical Executive Council and to other appropriate Medical Staff committees as the Medical Executive Council designates. The Medical Staff Health Council shall consist of no fewer than three (3) Members of the Active Medical Staff and other personnel, all of whom shall be selected for specific expertise, experience and willingness to serve. The Medical Staff Health Council shall meet no less than annually and as frequently as required to fulfill its responsibilities.

3.2.4 Medical Ethics Advisory Council. The Medical Ethics Advisory Council shall provide guidance, counsel, and support to the medical and nursing staff to facilitate the decision making process in matters relating to the moral and ethical issues of medical care. The Medical Ethics Advisory Council shall consist of Members of the Medical Staff, appropriate administrative personnel, representatives of nursing, social services and the clergy. The Medical Ethics Advisory Council will meet as appropriate and submit a report in writing to the Medical Executive Council.

3.2.5 Operating Room Steering Council. The Operating Room Steering Council is a collaborative group which will provide multidisciplinary coordination, problem solving and make decisions regarding care of the surgical patient population, both inpatient and outpatient. It is the strategic and goal planning body for surgery services, based upon input from its constituent CSUs. This group also reports these goals, strategies and decisions to their constituents.

3.2.6 Utilization Review Council. The Utilization Review Council is a joint medical staff/hospital administration council which develops and amends annually a utilization review plan ("RU Plan") for approval by the Medical Executive Council and Board of Directors. The RU Plan shall comply with applicable requirements of Wisconsin Administrative Code § DHS 124.11 and 42 C.F.R. § 482.30. The Utilization Review Council shall be composed of two or more physicians and assisted by other professional personnel. No Utilization Review Council member shall participate in the review of any case in which he/she was professionally involved in the care of the patient. No person who has a financial interest in the Hospital may serve on the Utilization Review Council. The Utilization Review Council shall keep records of hospital utilization review activities and findings and shall make reports to the Medical Executive Council and Board of Directors. Recommendations relevant to hospital operations and administration shall be reported to the administration.

3.2.7 Pharmacy Council. The Pharmacy Council is responsible for the development and supervision of all drug utilization policies and practices within the Hospital to ensure optimum clinical results and a minimum potential for hazard. The

Pharmacy Council shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital.

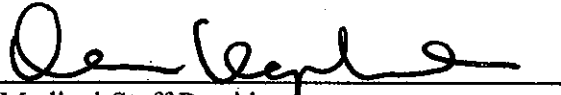
ARTICLE 4

AMENDMENTS AND ADOPTION

4.1 An amendment to this Manual may be made in accordance with the procedures set forth in Article 14 of the Medical Staff Bylaws.

4.2 This Medical Staff Organization Manual is adopted and made effective as of October 1, 2012, and shall supersede and replace any and all previous policies pertaining to the subject matter herein.

Adopted by the Medical Executive Committee on _____, 2012:



Medical Staff President

Approved by the Governing Body on May 24, 2012:



Chair, Board of Directors

FROEDTERT MEMORIAL LUTHERAN HOSPITAL

AMENDED AND RESTATED MEDICAL STAFF BYLAWS

October 2013

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FROEDTERT MEMORIAL LUTHERAN HOSPITAL
RESTATED MEDICAL STAFF BYLAWS

Article I

General

Section 1. Name. The name of this self-governing organization is the Froedtert Memorial Lutheran Hospital Medical Staff.

Section 2. Definitions. The following definitions apply throughout these Bylaws:

- (A) “Appointment” means the process described in these Bylaws by which an applicant becomes a member of the Hospital’s Medical Staff. An appointment shall last for a period of two (2) years at which time the member may be re-appointed.
- (B) “Board of Directors” or “Board” means the Board of Directors of Froedtert Memorial Lutheran Hospital, Inc.
- (C) “Clinical privileges” or “privileges” mean the permission granted a member of the Froedtert Medical Staff to render specific diagnostic, therapeutic, medical, or surgical services.
- (D) “Ex officio” means by virtue of office, without any appointment other than that resulting from the holding of a particular office. Unless otherwise indicated, a person serving on a committee or other body ex officio has both voice, the right to speak regarding all matters before the committee or other body, and vote.
- (E) “Hospital” means Froedtert Memorial Lutheran Hospital, Inc.
- (F) “Investigation” means a referral of a request for corrective action to a Department or an ad hoc committee in accordance with Article VII, Section 1 of these Bylaws.
- (G) “Medical College” or “College” means the Medical College of Wisconsin.
- (H) “Medical Staff”, “organized medical staff,” or “Staff” means the formal self-governing organization of all Licensed Independent Practitioners and other clinicians who have been appointed to a category of the Medical Staff or granted clinical privileges by the Hospital. Except as set forth in these Bylaws, or as may be specifically required by law or accreditation requirements, all activities required to be done by the “Medical Staff” are and shall be the responsibility of the Medical Executive Committee, unless indicated otherwise by means of specific action approved by the organized medical staff and by the Board.
- (I) “Notice” and “notify”, as used in Article VI, Article VII, and Article VIII, mean written notice. The notice may be given personally delivered or sent by email or facsimile and is

deemed given upon delivery. The notice may also be given by mailing through the U.S. Mail. Unless otherwise specified in these Bylaws, and provided the notice is properly addressed and has the correct postage, a notice that is mailed is deemed given on mailing if the period of time for giving the notice is longer than 72 hours and is deemed given on receipt if such period of time is 72 hours or less. The use of certified or registered mail for mailed notices is authorized but not required. In cases where a Medical Staff member is represented by an attorney, any notice given to the attorney is considered notice given to the Medical Staff member.

- (J) “Policy” or “policies” means written statement(s) approved by the Medical Executive Committee or the Board of Directors, and communicated to the Medical Staff which implement responsibilities of the Medical Staff.
- (K) “Licensed Independent Practitioner” or “LIP” means a licensed practitioner as defined by the State of Wisconsin; a Doctor of Allopathic or Osteopathic Medicine, Optometrist, Oral Surgeon, Dentist, Chiropractor, Podiatrist or Clinical Psychologist who is appointed to the Hospital’s Medical Staff; who possesses a current license, certification, or registration; and who is permitted by law to provide care, treatment, teaching or research services in the Hospital without direction, supervision or requirement for a collaborative practice agreement.
- (L) “Allied Health Professional” (“AHP”) means an individual other than a LIP who is qualified by academic and clinical training and by prior and continuing experience and current competence in a discipline which the Board has determined to allow to practice in the Hospital and who:
 - (1) is licensed by the state or possesses professional certification to perform patient care services under the direction of a LIP and within mutually agreed upon guidelines (referred to in these Bylaws as a “Dependent AHP” or “DAHP”);
 - (2) is licensed and permitted by the state and the Hospital to provide patient services in the Hospital with a collaborative practice agreement but without the direct involvement of a LIP (referred to in these Bylaws as an “Independent AHP” or “IAHP”); or
 - (3) is a non-licensed clinical practitioner such as certified surgical assistant who is recognized and appointed by the Hospital as a member of the Medical Staff.
- (M) “President” means the President of Froedtert Memorial Lutheran Hospital, Inc.
- (N) Medical Staff Clinical Leader means the LIP leader(s) responsible for coordinating each of the clinical departments as defined by the Medical Executive Committee.
- (O) “Clinical Department” means any clinical grouping designated by the Medical Executive Committee for which Medical Staff Clinical Leadership is provided, and governed by the Bylaws and may be designated as a department, service, center, program or like designation.

- (P) “Chief Medical Officer” means the Chief Medical Officer (CMO) of Froedtert Memorial Lutheran Hospital, Inc.
- (Q) A “peer” is an individual from the same professional discipline and licensure or certification category who is familiar with the individual’s actual performance. The peer may be, but is not required to be, a member of Hospital’s Medical Staff. For any Medical Staff applicant or member where there is no peer who could provide a peer reference, the Credentials Committee can accept as peer an LIP with essentially equal or greater qualifications who is familiar with the Medical Staff applicant’s or member’s performance.
- (R) A “peer recommendation” includes the following information: medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism, relevant training and experience, current competence, and any effects of health status on privileges being requested. A peer recommendation may include a report from a hospital performance improvement committee when the majority of members are the applicant’s peers; a reference letter, written documentation, or documented telephone conversation about the applicant from a peer who is knowledgeable about the applicant’s professional performance and competence; a department chair or designated clinical service chief who is a peer; or a medical executive committee.

Section 3. Interpretation.

- (A) Unless otherwise specified, citations to Articles, Sections, and Subsections appearing in these Bylaws refer to provisions of these Bylaws.
- (B) The titles and headings in these Bylaws are used only for convenience of description or reference and are not to be interpreted to limit, restrict, or define the scope or effect of any particular provision.
- (C) Unless otherwise specified, references to departments, centers, programs, divisions, and services are to the departments, centers, programs, divisions, and services of the Hospital, not the Medical College.
- (D) All time periods referred to in these Bylaws for action by committees or panels of the Medical Staff, the Board, the President, the Chief Medical Officer, and other officials and references to meetings at which action should be taken by them are advisory only and not mandatory. While no such actions will be required to be accomplished in less time than that specified, extensions should be granted or permitted for reasonable cause or the convenience of participants. Time periods within which Medical Staff members are permitted to request a hearing or appellate review or to take other action are intended to impose mandatory limitations and will be strictly construed.
- (E) A reference to any official, such as the President, Chief Medical Officer, Chief of Staff, Department Chair, or Service Chief, includes any other person who has been designated

to act in behalf of such official, and action by such official's designee has the same effect as if taken by the official.

- (F) If any provision of these Bylaws or its application to any person or circumstance is determined to be invalid, the remaining provisions of these Bylaws or the application of the provision to other persons or circumstances will not be affected by such determination.
- (G) The construction or implementation of any provision of these Bylaws can be the subject of appropriately adopted Policies of the Board or the Medical Executive Committee.

Article II

Purposes and Responsibilities

Section 1. Purposes. The purposes of the Medical Staff are as follows:

- (A) To constitute a professional collegial body that will provide for its members' mutual education, consultation, and professional support.
- (B) To serve as the collegial body through which individual Medical Staff members may obtain membership prerogatives or clinical privileges at the Hospital in order to provide clinical services to patients and to engage in teaching and research. The Medical Staff designates individual Medical Staff members to provide oversight of care, treatment and services through clinical privileges and defines a process for supervision of residents and Allied Health Professionals.
- (C) To develop an organizational structure that provides for a uniform standard of quality of patient care, treatment, and services and defines the responsibility and concomitant authority and accountability of every organizational component.
- (D) To integrate those community-based Medical Staff members serving as faculty members of the Medical College into the Medical Staff's organizational structure to enable them to exercise responsibility and authority commensurate with their contribution to patient care and to the teaching and research needs of the Hospital.
- (E) To provide for accountability to the Board, through defined Medical Staff components, for each Medical Staff member's patient care, professional and ethical conduct, and teaching and research activities.
- (F) To provide a framework whereby the Medical Staff may make recommendations for the Hospital's policy-making and planning processes and through which the Hospital's policies and plans are communicated to and observed by all members of the Medical Staff.

Section 2. Responsibilities. To carry out the purposes listed in Section 1 of this Article, the Medical Staff has the following responsibilities:

- (A) Participating in the Hospital's quality assessment and improvement program by conducting all necessary and required activities for assessing and improving the quality and efficiency of medical care provided in the Hospital, including without limitation:
 - (1) Evaluating Medical Staff members' performance through valid and reliable measurement systems based on objective, clinically sound criteria.
 - (2) Engaging in the ongoing monitoring of patient care practices and enforcing Medical Staff and Hospital policies.

- (3) Evaluating the competency of Medical Staff members for appointment and reappointment to membership in the Medical Staff and the delineating the scope of recommended clinical privileges for each Medical Staff member in the Hospital.
 - (4) Prioritizing and arranging for Medical Staff participation in programs designed to meet the educational needs of its members.
 - (5) Working toward the appropriate medical and health care services at the Hospital for meeting the medical, social, and emotional needs of the Hospital's patients in accordance with sound health care resource utilization practices.
 - (6) Communicating quality assessment and improvement findings, conclusions, recommendations, and action to the appropriate Medical Staff members and the Board.
 - (7) Participating in organization-wide performance improvement activities;
 - (8) Reviewing findings of the assessment process that are relevant to an individual Medical Staff member's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a Medical Staff member's competence.
- (B) Ensuring Medical Staff members practice only within the scope of their privileges as determined through mechanisms defined by the organized Medical Staff.
 - (C) Making recommendations to the Board concerning appointments and reappointments to the Medical Staff, membership category if any, Department and Service assignments, clinical privileges, and corrective action.
 - (D) Maintaining sound professional practices, an atmosphere conducive to the diagnosis and treatment of the sick and injured, and an environment that accommodates teaching and research.
 - (E) Setting continuing education requirement for the Medical Staff members, evaluating hospital-sponsored educational activities, and documenting each individual Medical Staff member's participation in continuing education.
 - (F) Assisting in the development, management and evaluation of the Hospital's educational programs, clinical services and laboratory research activities involving Medical Staff members.
 - (G) Enforcing compliance with these Bylaws, the rules, regulations and policies of the Medical Staff and of its administrative and clinical components, and the Hospital's corporate bylaws and policies.

- (H) Assisting in the identification of community health needs, suggesting to the Board appropriate institutional policies and programs to meet those needs, and participating, as requested, in the Board's long-range planning activities.
- (I) Providing leadership in quality assessment and improvement activities within the organization, including but not limited to issues associated with:
 - (1) education of patients and families;
 - (2) coordination of care, treatment and services with other Medical Staff members and hospital personnel;
 - (3) accurate, timely, and legible completion of patient's medical records;
 - (4) individual Medical Staff member's performance and competence
 - (5) patient safety;
 - (6) medical assessment and treatment of patients;
 - (7) use of information about adverse privileging decisions for any Medical Staff member privileged through the medical staff processes;
 - (8) use of medications;
 - (9) use of blood and blood components;
 - (10) operative and other procedure(s);
 - (11) appropriateness of clinical practice patterns;
 - (12) significant departures from established patterns of clinical practice; and
 - (13) use of developed criteria for autopsies.
- (J) Providing oversight of quality of care, treatment, and services delivered by Medical Staff members in order to provide for a uniform quality of patient care, treatment, and services.
- (K) Providing leadership in activities related to patient safety.
- (L) Providing oversight in the process of analyzing and improving patient satisfaction.
- (M) Maintaining a valid and active email address in order to receive official medical staff communications.
- (N) Through its designated mechanism, determining the circumstances under which consultation or management by a LIP or other Medical Staff member is acquired.

- (O) Defining the circumstances requiring monitoring and evaluation of a Medical Staff member's professional performance.
- (P) Developing criteria to be used for evaluating the performance of Medical Staff members when issues affecting the provision of safe, high quality patient care are identified; to consistently implement focused professional practice in accordance with the criteria and requirements defined; to clearly define the triggers that indicate the need for performance monitoring; and to include the following in the performance monitoring process: criteria for conducting performance monitoring, method for establishing a monitoring plan specific to the requested privilege, method for determining the duration of performance monitoring, and circumstances under which monitoring by an external source is required.
- (Q) Implementing a process for the ongoing professional practice evaluation that includes the following:
 - (1) A defined process that facilitates the evaluation of each Medical Staff member's professional practice.
 - (2) The type of data to be collected at the departmental level and reviewed by the organized medical staff.
 - (3) Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).
 - (4) The measures employed to resolve performance issues are defined and consistently implemented.
- (R) Implementing a process to identify and manage matters of individual health for Medical Staff members which is separate from action taken for purposes of corrective action that addresses the following issues:
 - (1) Education of Medical Staff members and other organization staff about illness and impairment recognition issues specific to Medical Staff.
 - (2) Provision of a self referral mechanism by a Medical Staff member.
 - (3) Maintenance of informant confidentiality when referrals are made by others.
 - (4) Referral of the Medical Staff member to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.
 - (5) Maintenance of confidentiality of the Medical Staff member seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health or safety of a patient is threatened.
 - (6) Evaluation of the credibility of a complaint, allegation, or concern concerning a Medical Staff member.

- (7) Monitor the Medical Staff member and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.
- (8) Report to the organized medical staff leadership instances in which a Medical Staff member is providing unsafe treatment.
- (9) Initiation of appropriate actions when a Medical Staff member fails to complete the required rehabilitation program.
- (S) Implementing its process to identify and manage matters of individual health for Medical Staff members.
- (T) Evaluating, investigating and addressing reported concerns regarding a privileged Medical Staff member's clinical practice and/or competence using a defined process.
- (U) Approving and complying with the medical staff bylaws.

Section 3. Immunity from Liability.

- (A) **General Rule.** As a condition of applying for clinical privileges at the Hospital, Medical Staff members agree not to sue the Hospital or other individuals involved in quality assessment and improvement, peer review, credentialing, and similar activities.
- (B) **Confidentiality of Information.** Any act, communication, report, recommendation, or disclosure with respect to a Medical Staff member for the purpose of achieving and maintaining quality patient care in the Hospital or in any other facility operated by the Hospital is absolutely confidential and privileged from disclosure. To the fullest extent permitted by law, Medical Staff members acknowledge that there shall be immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even when the information involved would otherwise be deemed defamatory.
- (C) **Persons Protected.** The immunity provisions agreed to by Medical Staff members under this Section extend to the Medical Staff, the Board, and the Hospital; to their respective members, agents, employees, and representatives; and to all third parties (both individuals and organizations) who supply information to any of the foregoing authorized to receive, release, or act on such information.
- (D) **Actions Protected.** The immunity protections of this Section extend to all acts, communications, reports, recommendations, and disclosures performed or made in connection with the Hospital's or any other healthcare organization's activities relating to a Medical Staff member's professional or personal qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care. By way of illustration rather than limitation, the immunity protections of this Section apply to:
 - (1) Applications for appointment to Medical Staff membership or seeking clinical privileges at the Hospital;

- (2) Periodic reappraisals for reappointment or clinical privileges;
- (3) Corrective action, including summary suspension;
- (4) Patient care and professional conduct interviews, hearings, and appellate reviews;
- (5) Clinical quality and medical care evaluations;
- (6) Utilization management; and
- (7) Other Hospital or Medical Staff committee activities.

- (E) **Conditions of Staff Membership.** To implement the requirements of this Section, each Medical Staff applicant applying for Medical Staff membership or clinical privileges is required to execute releases in accordance with the tenor or import of this Section in favor of the individuals and organizations specified in this Section; provided, however, that even in the absence of such executed release or releases, all of the consents, authorizations, releases, rights, privileges, and immunities provided by these Bylaws in general and by this Section in particular will be deemed conclusively to have been given and accepted as conditions of any Medical Staff applicant's request or application for, or exercise of, clinical privileges at the Hospital or any other health care facilities operated by the Hospital. The consents, authorizations, releases, rights, privileges, and immunities provided by this Section in connection with applications for initial appointment are also fully applicable to the additional activities and procedures covered by this Section.
- (F) **Immunity Not Exclusive.** The provisions in this Section and in application forms relating to authorizations, confidentiality of information, and waivers, releases, and immunities from liability are cumulative of other protections provided by law and are not intended to limit such other protections or to be limited by such other protections.

Article III

Membership

Background

In all matters concerning medical staff appointments, faculty appointment requirements, and the granting of clinical privileges, the Board of Directors retains final authority. As such, the Board may consider hospital and community resources and needs, such as the Hospital's current and projected patient care, teaching, and research needs and the Hospital's ability to provide the facilities, beds, and support services that will be required in the granting of medical staff membership or specific clinical privileges.

Section 1. General Qualifications and Criteria. Every Medical Staff applicant or member who seeks or enjoys Medical Staff Membership must, at the time of appointment, re-appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board the following qualifications and criteria designed to assure that patients will receive quality care, treatment, and services:

- (A) **Licensure.** Unless waived by the Board in accordance with applicable law or as otherwise specified in these Bylaws, a currently valid and unrestricted license or certification issued by the State of Wisconsin.
- (B) **Faculty Appointment.** For AHPs who are not employed by the Hospital and any LIPs, appointment as an employee and/or full-time faculty member of the Medical College or a member of the voluntary clinical faculty of the Medical College with a specific acknowledgment in his or her faculty appointment letter or through written communication to the Hospital by the Dean of the Medical College or designate that exercising clinical privileges at the Hospital is an essential expectation of the voluntary clinical faculty appointment, except as set forth in (3), below. The Hospital requires that the MCW Department granting the faculty appointment must be the Medical Staff member's primary clinical discipline, i.e., the Clinical Department that most closely reflects his or her professional training and experience and the clinical area in which his or her practice is concentrated and that the Medical Staff member have membership in such Clinical Department. The requirements of this Subsection (B) are in recognition of the unique relationship of the Hospital with the Medical College and the Hospital's mission as an academic medical center. The requirements do not apply to Medical Staff members performing contracted services not available through the Medical College as determined solely by the Hospital, and to LIPs exercising limited clinical privileges but who are not members of the Medical Staff.
 - (1) The Medical College and its clinical departments shall not be unreasonable in the granting of voluntary clinical faculty status and in good faith admit to voluntary clinical faculty status qualified LIPs recommended by the Chief Medical Officer or the President of the Hospital.

- (2) In the event that any individual whom the Hospital desires to have on its medical staff is denied faculty membership, the Chief Medical Officer and the President of the Hospital shall consult with the Dean of the Medical College to seek a satisfactory resolution of that matter.
 - (3) In acknowledgement of the Hospital requiring all LIP medical staff members to have a faculty appointment, the Medical College has agreed to assist in providing the Hospital with a medical staff that is able to generate sufficient clinical volumes to meet financial and community service requirements of the Hospital. In the event the Medical College is unable to meet these requirements as defined by the Hospital, the Hospital maintains the right to take the appropriate action by means of actions of its Board of Directors, including but not limited to the appointment of non-faculty LIPs and non-LIP clinical practitioners to the Hospital's Medical Staff after notification of the Medical College.
- (C) **Performance.** Professional education, relevant training and experience, current competence, and clinical results documenting a continuing ability to perform the essential functions of the Medical Staff member's privileges or category of Staff membership, including, without limitation, the provision of appropriate quality patient care.
- (D) **Professional Responsibilities.** Each member of the Hospital's Medical staff is expected:
- (1) To work with and relate to other Medical Staff members, residents, students, other health professionals, Hospital administration, other employees of the Hospital, Hospital visitors, and the community in general in a cooperative and professional manner.
 - (2) To participate equitably in the discharge of Medical Staff obligations appropriate to the Medical Staff member's membership category.
 - (3) To adhere to requirements of regulatory and accreditation bodies and generally recognized standards of professional ethics, including, without limitation, prohibitions against fee-splitting, performing "ghost" surgery, and delegating the responsibility for diagnosis or care of patients to a LIP or other clinician not qualified to undertake that responsibility; and failure or refusal to obtain the necessary informed consent for care and treatment.
- (E) **Health Status.** To the extent permitted by law, the applicant must submit a statement that his or her current health status will permit him or her to safely practice in the areas in which privileges are sought. The Medical Executive Committee or the Board, provided the requirement is not inconsistent with applicable legal standards or the Hospital's regular policies, may require a Medical Staff member at any time to complete a physical and/or neuropsychological examination by professionals chosen by or acceptable to the Hospital.
- (F) **Professional Liability Insurance.** Professional liability insurance in not less than the minimum amount, if any, specified by a resolution of the Board adopted after

consultation with the Medical Executive Committee, or such other evidence of financial responsibility as the Board may establish.

- (G) **National Provider Identifier (NPI).** A NPI if the applicant will furnish care, bill, and be paid by third-party payers for services.
- (H) **No Bar from Service.** No bar under the Caregiver Background Check law (Chapter DHS 12 of the Wisconsin Administrative Code) to providing services in the Hospital.
- (I) **Exclusion from Federal Health Care Programs.** No exclusion from any health care program funded in whole or in part by the federal government, including Medicare, Medicaid, and Tricare.

Section 2. Effect of Other Affiliations. No Medical Staff applicant is automatically entitled to membership on the Medical Staff or to the exercise of particular clinical privileges merely because he or she is licensed or certified to practice in this or any other state, is a member of a particular professional organization, is certified by a particular clinical board, is a member of the Medical College faculty, serves in an administrative position of the Hospital or Medical Staff, or because he or she had, or presently has, staff membership or privileges at another health care facility or in another practice setting. Nor shall any Medical Staff member be automatically entitled to appointment, reappointment, or particular clinical privileges because he or she had, or presently has, Medical Staff membership or those particular privileges at the Hospital.

Section 3. Nondiscrimination. No aspect of Medical Staff membership or particular clinical privileges may be denied or restricted on the basis of age, sex, race, creed, color, national origin, disability, or any other criterion that is not related to the delivery of quality patient care or the qualifications described in this Article. These nondiscrimination requirements will be interpreted and applied in accordance with federal, state, or local laws and regulations to the extent any such law or regulation may be applicable.

Section 4. Basic Obligations of Individual Staff Membership. Each member of the Medical Staff, regardless of membership category, and each LIP exercising any clinical privileges without Medical Staff membership under these Bylaws, is required to:

- (A) Provide his or her patients with care at the generally recognized professional level of quality and efficiency.
- (B) Perform high quality medical histories and physical examinations including defining the scope for non-patient services and terms for countersignature; and including specifically, a history and physical examination must be completed and documented in the patient's medical record no more than thirty (30) days before or twenty-four (24) hours after admission or registration but prior to surgery or a procedure requiring anesthesia services, consistent with Medical Staff policy and procedure.
- (C) Provide adequate call coverage to ensure continuous care to patients and, in their absence, delegate the responsibility for that care only to qualified Medical Staff members with equivalent privileges at the Hospital.

- (D) Abide by these Bylaws and by all other applicable standards, policies, rules, and regulations of the Hospital or the Medical Staff.
- (E) Discharge the Staff, committee, Service, Department, and Hospital functions for which he or she is responsible, whether by membership category, appointment, election, or otherwise.
- (F) Prepare and complete in timely fashion the medical and other required records for all patients he or she admits to, or provides care for in, the Hospital.
- (G) Abide by generally recognized standards of professional ethics.
- (H) Promptly notify the President or Chief Medical Officer of, and to provide such additional information as may be requested regarding each of the following:
 - (1) Revocation, limitation, or suspension of the Medical Staff member's professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to the professional license, or the imposition of terms of probation by any state;
 - (2) Loss of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;
 - (3) Cancellation or change of professional liability insurance coverage;
 - (4) Receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction, or of the commencement of a formal investigation, or the filing of charges relating to health care matters by a Medicare peer review organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin;
 - (5) Receipt of notice of the filing of any suit against the Medical Staff member alleging professional liability in connection with the treatment of any patient;
 - (6) Arrest under or conviction of a criminal charge or any findings by a governmental agency that the applicant has abused or neglected a child or patient, or has misappropriated a patient's property;
 - (7) Proposed or actual exclusion from any federally funded health care program, any notice to the individual or his representative of proposed or actual exclusion and/or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.
 - (8) Leave of absence for any reason of more than 30 days; and
 - (9) Medical/psychiatric or other circumstances that could be reasonably expected to impact one's ability to practice under one's current granted privileges.

- (I) Participate in the Hospital's organized health care arrangement under the privacy requirements of the Health Information Portability and Accountability Act of 1996, as amended, and abide by the terms of the Hospital's and the Medical College's Joint Notice of Privacy Practices.
- (J) Report any financial interest in any business or organization or other conflict of interest that relates to the provision of patient care at the Hospital.

Section 5. Membership Categories. There are two categories of the Medical Staff: Licensed Independent Practitioners (LIPs) and Allied Health Practitioners (AHPs). The statuses of Medical Staff LIP category membership are Active, Affiliate and Refer and Follow. The Hospital may extend limited practice privileges to LIPs who are not members of the Medical Staff (privileges without membership), as provided in Section 8 of this Article. The prerogatives set forth below under each LIP Staff category status are general in nature and may be subject to limitation by special conditions attached to a Medical Staff member's Staff membership, by other sections of these Bylaws, by rules and regulations adopted by the Medical Staff, and by other policies of the Hospital. All Medical Staff members are expected to maintain a level of practice activity at the Hospital consistent with their Medical Staff category or privileges. Failure to maintain practice activity at the Hospital consistent with expectations as determined by the clinical departments or the Medical Executive Committee may permit the Board to not renew a membership or extend clinical privileges of the Medical Staff member after notice is provided to the affected Medical Staff member.

(A) LIP Category, Active Status.

(1) **Qualifications.** A member of the Active LIP Medical Staff status must:

- (a) Be located close enough to the Hospital to provide continuous care to his or her patients or demonstrate suitable alternative coverage arrangements;
- (b) Regularly participate in the care of Hospital patients (admit, consult or provide outpatient services) or otherwise be regularly involved in the Hospital's teaching or administrative programs or in the care of patients in the Hospital. Regular participation means clinical, teaching, or administrative activity greater than an estimated 10% of a median FTE in that discipline as determined by the Medical Executive Committee (using commonly accepted benchmarks) over an appointment cycle.
- (c) Be primarily associated with one of the Services based at the Hospital; and

(2) **Prerogatives.** A member of the Active LIP Medical Staff status may:

- (a) Care for patients as defined by the Medical Staff member's clinical privileges, without limitation, except as otherwise provided in these Bylaws or in rules and regulations adopted by the Medical Staff;

- (b) Vote on all matters presented at general and special meetings of the Medical Staff and of the Department, Service, and committees of which he or she is a member;
 - (c) Hold office at any level in the Staff organization and serve as chair of any committee; except the Medical Executive Committee, unless elected as the Chief of Staff;
 - (d) Exercise such clinical privileges as are granted to him or her in accordance with these Bylaws and utilize the Hospital as defined in the Medical Staff member's privileges; and
 - (e) Hold or serve as the Medical Staff Clinical Leadership of clinical departments as defined by the Hospital.
- (3) **Obligations.** In addition to satisfying the basic obligations set forth in Section 4 of this Article, a member of the Active LIP Medical Staff status must:
- (a) Contribute to the organizational and administrative affairs of the Medical Staff, including service in Medical Staff, Department, and Service offices and on Hospital and Medical Staff committees, faithfully performing the duties of any office or position to which he or she is elected or appointed;
 - (b) Participate in all required quality assessment and improvement activities;
 - (c) Discharge the recognized functions of Medical Staff membership by engaging in the Hospital's teaching programs, caring for charity patients as required, providing consultation to other Medical Staff members consistent with his or her delineated privileges, supervising Medical Staff members during the provisional period, and fulfilling such other Medical Staff functions as may be reasonably required of Medical Staff members; and
 - (d) Attend regular and special meetings of the Medical Staff and of the clinical department and committees of which he or she is a member.

(B) LIP Category, Affiliate Status.

(1) Qualifications.

- (a) The Affiliate status applies to LIP members of the Medical Staff if the consultations, procedures, other patient care contacts, teaching, or administrative activities will be less than an estimated 10% of a median FTE in that discipline as determined by the Medical Executive Committee (using commonly accepted benchmarks) over an appointment cycle.
- (b) A LIP applicant for membership must apply for Affiliate status rather than Active status if he or she possesses skills needed at the Hospital on a specific project, for call coverage, or on an occasional basis as defined below.

(2) Prerogatives.

- (a) A member of the LIP Affiliate Staff status may exercise such clinical privileges as are granted to him or her in accordance with these Bylaws.
- (b) A member of the LIP Affiliate Staff status is not eligible to hold office in the Staff organization or to vote at meetings of the Staff or of any Department, Service, or committee.

(3) Obligations.

- (a) A member of the LIP Affiliate Staff status must apply for LIP Active Staff status at re-appointment if the consultations, procedures, other patient care contacts, teaching or administrative activities of such member of the Affiliate Staff status were more than an estimated 10% a median clinical FTE in that discipline as determined by the Medical Executive Committee in the prior appointment cycle.
- (b) A member of the LIP Affiliate Staff status has no other specific obligations beyond the basic obligations set forth in Section 4 of this Article.

(C) LIP Category, Refer and Follow Status.

- (1) **Qualifications.** The Refer and Follow Staff consists of those LIPs who desire to be associated with the Hospital but who do not wish to exercise clinical privileges on an inpatient basis. The primary purpose of the Refer and Follow Staff is to permit these members access to inpatient Hospital services for their patients by referral to members of the LIP Active Staff.
- (2) **Prerogatives.** Refer and Follow Staff Members:

- (a) May attend meetings of the Medical Staff (without vote).
 - (b) Shall generally have no Staff committee responsibilities, but are eligible to serve (with vote) on standing or special committees (other than the Medical Executive Committee).
 - (c) May attend educational activities sponsored by the Medical Staff and the Hospital.
 - (d) May refer patients to the Hospital for admission and/or care.
 - (e) Are encouraged to communicate directly with the Staff members about the care of any patients referred, as well as to visit any such patients.
 - (f) May review the medical records and test results (via paper or electronic access) for any patients who are referred.
 - (g) May refer patients to the Hospital's diagnostic facilities.
 - (h) May not admit patients, attend patients, exercise inpatient clinical privileges, write inpatient order or progress notes, perform consultations, assist in surgery or otherwise participate in the provision or management of clinical care to inpatients at the Hospital.
- (3) **Obligations.** Each LIP Refer and Follow Staff must pay applicable fees, dues and assessments.

(D) **Allied Health Professionals Category.**

- (1) **Qualifications.** Only those Allied Health Professionals (AHPs) who meet the definition of AHP contained in Article I, Section 2(L) and who satisfy the basic qualifications contained in Article III, Section 1, except for a Medical College faculty appointment or employment, are eligible to provide specified services in the Hospital. The Medical Executive Committee may, in consultation with the Chief Medical Officer, establish additional qualifications required of AHP members.
- (2) **Prerogatives.** An AHP may perform the history and physical examination or update any history and physician examination, in accordance with Article III, Section 4(B) of these Bylaws and Medical Staff policy,
- (3) **Obligations.** Each AHP must:
 - (a) Retain appropriate responsibility within his or her area of professional competence for the care and supervision of each patient in the Hospital for whom he or she is providing services, or arrange a suitable alternative for such care and supervision.

- (b) Participate as appropriate in the Hospital's quality assessment and improvement program activities, in the supervision of new appointees of his or her AHP category during the provisional period, and in the discharge of such other Staff functions as may be required from time to time.
 - (c) Attend clinical meetings of the Staff, Department, Service, and committees of which he or she is a member.
 - (d) Participate in continuing education to maintain clinical skills and current competence.
- (4) **Removal Procedures and Status.** The Hospital retains the right, either through the Administration or upon recommendation of the Medical Executive Committee, to suspend, terminate, or limit any or all of the privileges or functions of any AHP. Should any such action occur, and result in a reduction or removal of the clinical privileges of an AHP, the AHP shall be entitled to a hearing conducted as provided in Article VIII, Section 8.

Section 6. House Staff (Residents and Fellows). The house staff, which shall not be a category of Staff membership, shall include LIPs and non-LIPs in accredited graduate medical, osteopathic or dental training programs conducted within the Hospital. House staff are not members of the Medical Staff. Each member of the house staff, both licensed and unlicensed, participates in patient care under the supervision of an LIP member of the Medical Staff, who retains responsibility for the actions of the house staff member. The extent to which authority and autonomy are delegated to the house staff member are determined by regulatory and accreditation requirements and on an individual basis by the LIP Medical Staff member responsible for the patient. A member of the house staff in the first year of training is not eligible for Wisconsin licensure but may, under supervision, perform acts such as writing and signing chart notes, patient care orders, and prescriptions in accord with applicable law. Supervision of House Staff is provided consistent with criteria of the Accreditation Council on Graduate Medical Education.

Section 7. Delineation of Privileges.

- (A) **Exercise of Privileges.** LIPs and AHPs may exercise only those clinical privileges specifically granted by the Board. Regardless of the level of privileges granted, each LIP or AHP must obtain consultation when necessary for patient safety or when required by the rules, regulations, or other policies of the Staff, any of its clinical units, or the Hospital.
- (B) **Bases for Determination of Privileges.** Clinical privileges are granted in accordance with prior and continuing education, training, experience, and demonstrated current competence, judgment, and clinical activity as documented and verified in each Medical Staff member's credentials file. The bases for determination of privileges for current Staff members in connection with reappointment, renewal of privileges, or a requested

change in privileges must include clinical performance and documented results of the Staff's quality assessment and improvement activities.

- (C) **System and Procedure for Delineating Privileges.** The procedures by which requests for privileges are processed are set forth in Article VI.
- (D) **Special Conditions for Oral Surgery.** Requests for clinical privileges from oral surgeons are processed in the same manner as requests for clinical privileges of other LIPs. Surgical procedures performed by oral surgeons are under the overall supervision of the Medical Staff Clinical Leader of the Department of Surgery. A LIP member of the Medical Staff who is a Doctor of Allopathic or Osteopathic medicine ("LIP consultant") shall also be responsible for the care of any significant medical problem that may be present at admission or that may arise during hospitalization and shall determine the risk and effect of any proposed surgical or special procedure on the total health status of the patient. When significant medical abnormality is present, the final decision on whether to proceed with the proposed surgery must be agreed upon by the oral surgeon and the LIP consultant. The Medical Staff Clinical Leader of the Department of Surgery will decide the issue in case of disagreement.

Section 8. LIPs Providing Services Without Staff Membership. A LIP who is, or who will be, providing specified professional services pursuant to a contract with the Hospital or who is permitted to exercise designated clinical privileges without a Medical Staff membership appointment, must meet the basic membership qualifications except he or she may not be required to meet the conditions of Section 1(B) of this Article, and must be processed for clinical privileges in the same manner as any other applicant. LIPs exercising clinical privileges without a medical staff appointment shall do so under the general supervision of the specialty department or service appropriate to the privileges. Residents licensed as LIPs working pursuant to such contracts and not as members of the House Staff shall not be members of the Medical Staff and shall not be granted admitting privileges. The Medical Executive Committee may also recommend the extending of Clinical Privileges to LIPs who provide clinical services remotely by means of electronic consultation or other form of telemedicine as such is permitted and set forth in policies approved by the Medical Executive Committee and the Board.

Section 9. Meetings of Members. The following applies to meetings of the Medical Staff, Departments, and Services. Meetings of committees shall be governed by the procedures set forth in the Medical Staff Policies and Procedures.

- (A) **Medical Staff Year.** For purposes of the business of the Medical Staff, the business year will commence on July 1 and expire on the following June 30.
- (B) **Medical Staff Meetings.**
 - (1) **Regular Meetings.** The Medical Executive Committee may authorize the holding of a general Staff meeting by resolution. The resolution authorizing any such meeting must require notice specifying the place, date, and time for the meeting, and that the meeting can transact any business that may come before it.

- (2) **Special Meetings.** A special meeting of the Medical Staff may be called by the Chief of Staff, and must be called by the Chief of Staff at the written request of the Board, the Medical Executive Committee, or one-third of the members of the LIP Active Staff status.
- (C) **Order of Business at a Regular Staff Meeting.** The order of business at a regular Staff meeting is determined by the Chief of Staff, but the agenda should include at least the following:
- (1) Acceptance of the minutes of the last regular and all special meetings held since the last regular meeting.
 - (2) Administrative reports from the President, the Chief Medical Officer, and the Chief of Staff.
 - (3) The election of officers and of representatives to Staff and Hospital committees, when required by these Bylaws.
 - (4) Reports by responsible officers, Services, and committees and discussion regarding the overall quality assessment and improvement activities of the Staff and regarding the fulfillment of the other required Staff responsibilities and functions.
 - (5) New business.
- (D) **Clinical Department Meetings.**
- (1) **Regular Meetings.** Clinical Departments should hold regular meetings of LIP Active Staff status and/or AHP Medical Staff members. Clinical departments may, by resolution, provide for the places, times, and dates for regular meetings and no notice other than such resolution is required.
 - (2) **Special Meetings.** A special meeting of any clinical department may be called by the Medical Staff Clinical Leader thereof, and must be called by the Medical Staff Clinical Leader at the written request of the Board, the Chief Medical Officer, the Chief of Staff, or one-third of the current LIP Active Staff status members (but not less than two) of the Clinical Department.
- (E) **Notice of Meetings.** Written notice of any regular general Medical Staff meeting, or of any regular Clinical Department meeting, not held pursuant to resolution, must be delivered personally or by regular or electronic mail to each person entitled to be present at the meeting not less than 5 nor more than 15 days before the date of the meeting. Notice of any special meeting of the Staff or of a Clinical Department must be given orally, in writing or electronically at least 72 hours prior to the meeting. Personal attendance at a meeting constitutes a waiver of notice of such meeting, except when a person attends for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because the meeting was not duly called or convened. No

business shall be transacted at any special meeting except that stated in the meeting notice.

(F) **Quorum.**

- (1) The presence of any number of the members of the LIP Active Staff status at any regular or special general staff meeting constitutes a quorum for the transaction of any business under these Bylaws.
- (2) The presence of two or more of the qualified voting members of a Department or Service plus the Department Chair or Service Chief, or his or her delegate, constitutes a quorum at any meeting of such Department or Service.

(G) **Minutes.** Minutes of all meetings are prepared by the secretary of the meeting and will include a record of attendance and the vote taken on each matter. Copies of the minutes must be forwarded to the Medical Executive Committee.

(H) **Attendance Requirements.** Unless excused by reason of illness, absence from the city, or a medical or personal emergency, each member of the Staff is expected to attend the Medical Staff and Clinical Department meetings required for members in his or her Staff category and status, and the meetings of the committees on which he or she serves. Any member of the Medical Staff may attend a general Medical Staff meeting.

Section 10. Review of Clinical Matters.

- (A) A Medical Staff member whose patient's clinical course of treatment is scheduled for discussion at a Clinical Department or committee meeting should be so advised and invited to present the case.
- (B) Whenever a Medical Staff, Clinical Department, or committee meeting is prompted by findings of quality assessment and improvement activities, the Medical Staff member whose performance prompted the program will be advised of the time, date, and place of the program, the subject matter to be covered, and its special applicability to the Medical Staff member's practice. Except in unusual circumstances, the Medical Staff member will then be required to be present at the meeting.

Section 11. Exclusive Clinical Services Arrangements.

- (A) The Board may, following discussion with the Medical Executive Committee, determine that designated clinical services are to be provided pursuant to an exclusive clinical services agreement. Such discussions shall take into consideration, the resources of the Hospital, improved patient care, existing affiliation arrangements with the Medical College or others, and the effect upon clinical privileges of current Medical Staff members. If a decision is made to provide such services by means of an exclusive service agreement and such will prevent existing Medical Staff members from thereafter exercising their current privileges, such Medical Staff member shall be afforded an opportunity to meet with the Board to discuss the matter. Such meeting shall not be a hearing as provided in Article VIII, and any subsequent decision by the Board to enter into an exclusive clinical services agreement shall not give rise to a hearing right on the part of any Medical Staff member who is thereafter foreclosed from exercising clinical privileges. Nor shall it necessitate any reporting to the National Practitioner Data Bank or Department of Regulation and Licensing regarding the matter.
- (B) A decision by the Board to discontinue an exclusive clinical services agreement and replace it with a subsequent exclusive agreement shall terminate the clinical privileges of Medical Staff members covered by the initial agreement unless they are to continue services under the subsequent agreement. A termination of affected privileges pursuant to termination of the agreement shall not be a professional review action under Article VIII creating an entitlement to a hearing unless the reasons for the termination necessitates a report being filed with the National Practitioner Data Bank. If such a report is required to be made, the LIP or AHP involved will be so notified and thereupon be entitled to a hearing and review on the underlying issues in accordance with Article VIII. The hearing and subsequent actions will be restricted to the issues necessitating a report to the National Practitioner Data Bank and the outcome shall not directly affect any decision regarding the contract termination.

Article IV

Organizational Structure of the Medical Staff

Section 1. Officers. The general officers of the Staff are the Chief of Staff and the Chief of Staff-Elect. Each general officer must be a LIP member of the Active Staff at the time of nomination and election or appointment, and, during his or her term of office, must remain a member in good standing, and must be willing and able faithfully to discharge the duties of the office held. The Chief of Staff and the Chief of Staff-Elect must also have demonstrated executive ability and be recognized for their high level of clinical competence. No individual may hold two general staff offices concurrently.

(A) **Term of Office; Eligibility for Re-election or Reappointment.** The term of office of the Chief of Staff is three Medical Staff years. The term of office for the Chief of Staff-Elect is one Medical Staff year. Officers assume office on the first day of the Medical Staff year following their election or appointment, except that an officer elected to fill a vacancy assumes office immediately upon election.

(B) **Attainment of Office.**

(1) **Chief of Staff.** The Chief of Staff attains office by automatic succession from the office of Chief of Staff-Elect.

(2) **Chief of Staff-Elect.**

(a) **Election.** The Chief of Staff-Elect is elected by a majority vote cast by secret ballot by the members of the Medical Staff eligible and qualified to vote for general officers. All candidates must have been nominated in accordance with Subsection (b) below. If no candidate for Chief of Staff-Elect receives a majority vote of the ballots cast on the first ballot, a runoff election is held promptly between the two candidates receiving the highest number of votes.

(b) **Nomination.** Upon recommendation of the President, Chief Medical Officer and the Chief of Staff, the Medical Executive Committee nominates one or more qualified candidates for the office of Chief of Staff-Elect at least three months preceding the beginning of the Chief of Staff's last year of office. Immediately thereafter, the list of nominees is mailed to all Medical Staff members then eligible and qualified to vote for general Staff officers. Additional nominations may be made by petition signed by at least 20 of such eligible and qualified members and submitted to the Chair of the Medical Executive Committee within 15 days of mailing the notice of nomination to the Medical Staff. Each petition must be accompanied by evidence of the candidate's qualifications and willingness to be nominated. The Committee prepares the final list of candidates and transmits the list to the Board for its approval prior to

presentation to the Staff for election. Voting shall be by either electronic or mail ballot. If the Board does not approve one or more of the nominees, the Medical Executive Committee may submit additional names to the Board for approval prior to the Medical Staff's mail ballot election.

(C) **Vacancies.**

- (1) **Chief of Staff.** A vacancy in the office of Chief of Staff is filled by succession of the Chief of Staff-Elect. If the unexpired term has 12 or more months to run, such service by succession is only for the balance of the unexpired term. If the unexpired term has fewer than 12 unexpired months to run, the Chief of Staff-Elect both completes the unexpired term and serves an additional full three-year term as Chief of Staff. If the vacancy occurs at the time there is no Chief of Staff-Elect, the Medical Executive Committee meets within one week to select one of its members to act as Interim Chief of Staff. The election process for Chief of Staff begins immediately as defined in Section 1(B)(1).
- (2) **Chief of Staff-Elect.** A vacancy occurring in the office of Chief of Staff-Elect will be filled by the process outlined in Section 1(B)(2).

- (D) **Resignation.** A Medical Staff officer may resign at any time by giving written notice to the Medical Executive Committee. The resignation takes effect at the time specified therein or, if no time is specified, then upon receipt of the resignation by the Medical Executive Committee. Unless otherwise specified, acceptance of the resignation is not necessary to make it effective.

- (E) **Removal.** A Medical Staff officer may be removed from office by the Board acting on its own initiative, whenever in the Board's judgment the best interests of the Hospital will be served thereby, or by a two-thirds vote by secret ballot of the members of the Medical Staff eligible and qualified to vote for Medical Staff officers taken at a special meeting called for that purpose. Permissible bases for removal of a general Medical Staff officer include, without limitation, the failure of such officer to perform the duties of his or her office in a timely and appropriate manner and/or the failure continuously to satisfy the qualifications for the office.

- (F) **Duties of the Chief of Staff.** The Chief of Staff is the primary Medical Staff officer, the chief administrative officer of the Medical Staff, and the Staff's representative in its relationship to others within the Hospital. In fulfillment of that role, and by way of illustration, not of limitation, the Chief of Staff:

- (1) Transmits to the Board, a committee of the Board, or the President, as appropriate, the views and recommendations of the Medical Staff and the Medical Executive Committee on matters of Hospital policy, planning, operations, governance, and relationships with external agencies, and transmits the views and decisions of the Board and the President to the Medical Executive Committee and the Medical Staff.

- (2) Except as otherwise provided in these Bylaws or the Hospital's corporate bylaws, appoints Medical Staff members to and the chairs of Medical Staff committees formed to accomplish Staff administrative or representation functions.
 - (3) Serves ex officio as Chair of the Medical Executive Committee and as Vice Chair of the Hospital Advisory Committee and, with voice but without vote, as a member of the Board and all other standing Medical Staff committees.
 - (4) Presides at and is responsible for the agendas of all general and special meetings of the Medical Staff and of the Medical Executive Committee.
 - (5) Directs the efficient operation and self-governance of the administrative, policy-making, and representative aspects of the Medical Staff organization by enforcing compliance with the Bylaws, rules, regulations, policies, and procedures of the Medical Staff and of the Hospital and with the requirements of regulatory and accrediting agencies, and by periodically evaluating the effectiveness of the organization.
 - (6) Oversees compliance on the part of the Medical Staff with the procedural safeguards and rights of individual Medical Staff members in all stages of the Hospital's credentialing process.
 - (7) Reviews and enforces compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relationships with each other, the Board, Hospital Administration, other professional and support staff, and the community the Hospital serves.
 - (8) Communicates and represents to the Board and the President the opinions and concerns of the Medical Staff and its individual members regarding organizational and individual matters affecting the Hospital's operations.
- (G) **Duties of the Chief of Staff-Elect.** As the second-ranking Medical Staff officer, the Chief of Staff-Elect:
- (1) Assumes all of the duties and responsibilities and exercises all of the authority of the Chief of Staff when the Chief of Staff is unable—temporarily or permanently—to accomplish the same because of illness, absence, disability, or other incapacity.
 - (2) Serves ex officio as a voting member of the Medical Executive Committee and as a nonvoting member of the Board.
 - (3) Performs such additional duties as may be assigned by the Chief of Staff, the Medical Executive Committee, or the Board.

Section 2. Committees. The principal committee of the Medical Staff is the Medical Executive Committee. In addition, there shall be such other committees as may be established from time to time by Medical Staff policy.

Section 3. Medical Executive Committee.

(A) The majority of voting members must be fully licensed LIP Medical Staff members in the Active Staff category practicing in the Hospital; however, all members of the organized medical staff, of any discipline or specialty, are eligible for membership on the Medical Executive Committee except as otherwise provided in these Bylaws.

(B) The following are standing members of the Medical Executive Committee:

- (1) The Chief of Staff, who also serves as Chair of the committee;
- (2) The Chief of Staff-Elect;
- (3) The President who serves ex officio, may designate the Chief Medical Officer to serve in his or her absence;
- (4) The Chief Medical Officer;
- (5) The Chairs of the Departments of Emergency Medicine, Medicine, and Surgery *
- (6) The MCW Designated Institutional Officer (DIO) or designate recommended by the DIO and approved by the Medical Executive Committee;
- (7) The Chief Medical Officer of the Medical College Physicians.
- (8) The Hospital's Vice Presidents, of Clinical and Support Services, Patient Care Services (Chief Nursing Officer), Perioperative Services, and Ambulatory Services.
- (9) The Senior Medical Directors of Inpatient and Hospital Services, Surgical Services, Ambulatory Services and Quality.
- (10) The Chair of the Credentials Committee.

* The positions may be filled by a designate recommended by the Chair and approved by the Medical Executive Committee on a triennial schedule.

(C) The following are selected members of the Medical Executive Committee:

- (1) One other Department Chair or Service Line Director selected triennially by the Medical Executive Committee;

- (2) A Chair from one of the Hospital-based services of the Departments of Anesthesiology, Pathology or Radiology to be selected by the Medical Executive Committee on a triennial schedule*.
- (D) An officer who is removed from his or her position in accordance with Article IV, Section 1(E) will automatically lose his or her membership on the Medical Executive Committee. Where a standing or selected member is removed or resigns this position, his or her replacement will serve on the Medical Executive Committee
- (E) The Medical Executive Committee meets at least bimonthly. Minutes will be kept of all deliberations of the Medical Executive Committee. The Medical Executive Committee is empowered to act for the Medical Staff on all matters not reserved to the Medical Staff by these Bylaws or otherwise and to coordinate all activities and policies of the Medical Staff and its Clinical Departments and committees. Without limiting the generality of the preceding sentence, the Medical Executive Committee is responsible for:
 - (1) Making recommendations regarding the medical staff structure including the designation of Clinical Departments and approval of Medical Staff Clinical Leaders;
 - (2) Assessing the quality of medical care provided in the Hospital;
 - (3) Reviewing and acting on reports of Medical Staff committees, Departments, and other assigned activity groups;
 - (4) Making recommendations regarding the mechanisms designed to prepare appointment and reappointment recommendations as well as individual clinical privileges;
 - (5) Reviewing the credentials of applicants for Medical Staff membership and delineated clinical privileges, upon recommendation of the Credentials Committee of the Medical Staff, including requesting evaluations of applicant as provided in Article III, Section 1(E);
 - (6) Making recommendations for Medical Staff membership and delineated clinical privileges for each Medical Staff member privileged through the medical staff process to the Board;
 - (7) Overseeing the Medical Staff's quality assessment and improvement activities and establishing a mechanism designed to conduct, evaluate, and revise such activities;
 - (8) Reviewing and approving medical staff policies and procedures;
 - (9) Complying with all applicable accreditation requirements;

- (10) Nominating officers of the Medical Staff, at-large members of the Medical Executive Committee, and Chairs of Medical Staff committees and subcommittees;
- (11) Developing the mechanism by which Medical Staff membership may be terminated and creating the mechanism designed for use in fair hearing procedures under Article VIII;
- (12) Adjudicating clinical practice conflicts;
- (13) Members of the Medical Executive Committee are expected to be diligent in attending meetings. Members, except those serving ex officio, must attend at least 75% of scheduled meetings annually. If a member, except one serving ex officio, is not present at 75% of regularly scheduled meetings without cause acceptable to the Committee, the Committee may recommend to the Board that the member be removed and be declared ineligible to serve on the Committee for a period not to exceed three years. In the event a member is so removed, the Committee may elect a new member to fill the vacancy.

Section 4. Clinical Departments. Each Clinical Department as designated by the Medical Executive Committee is a separate organizational component of the Medical Staff. Each Clinical Department shall provide opportunities for its members to contribute their professional views and insights to the formulation of policies and plans on the part of the Medical Staff and the Hospital, communicate formulated policies and plans to its members for implementation, and coordinate the professional services of its members with the professional services of other Clinical Departments and with support services provided by the Medical Staff and the Hospital. Each Clinical Department will have a Medical Staff Clinical Leader who must be or become a LIP member of the Active Staff and possess a faculty appointment from the College. Selection and responsibilities of Medical Staff Clinical Leaders will be in accordance with Medical Staff rules and regulations. The Medical Staff will periodically review the structure of Clinical Departments.

Section 5. Role and Responsibilities of Medical Staff Clinical Leaders.

- (A) Medical Staff Clinical Leaders must be qualified by an appropriate specialty board through the credentialing process.
- (B) Medical Staff Clinical Leaders have the following roles and responsibilities:
 - (1) Clinically related activities of the clinical department including adherence to all clinical policies and clinical care pathways approved by the Hospital;
 - (2) Administrative related activities of the clinical department, unless otherwise provided by the Hospital;
 - (3) Assisting the Hospital to be in compliance with all regulatory and accreditation standards.

- (4) Continuing surveillance and evaluation of the professional performance of all individuals in the clinical department who have delineated clinical privileges;
- (5) Recommending to the Medical Staff, the criteria for clinical privileges that are relevant to the care provided in the clinical department;
- (6) Recommending clinical privileges for each member of the clinical department;
- (7) Assessing and recommending to the relevant Hospital authority, off-site sources for needed patient care, treatment, and services, not provided by the clinical department or the organization;
- (8) The integration of the clinical department or service into the primary functions of the organization;
- (9) The coordination and integration of interdepartmental and intradepartmental services;
- (10) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
- (11) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
- (12) The determination of the qualifications and competence of department personnel who are not LIPs and who provide patient care, treatment, and services;
- (13) The continuous assessment and improvement of the quality of care, treatment, and services;
- (14) The maintenance of quality control programs, as appropriate;
- (15) The orientation and continuing education of all persons in the department or service;
- (16) Recommending space and other resources needed by the clinical department.

Article V

Procedure for Appointment and Reappointment

Background

The credentials process involves obtaining, verifying, and assessing the qualifications of an applicant to provide patient care, treatment, and services. The purpose of verifying credentials data is to ensure that the individual requesting privileges is the same individual who is identified in the credentialing documents, the applicant has attested to the credentials as stated, the credentials are current, and there are no challenges to the credentials.

Section 1. Application for Appointment.

- (A) **Content and Form of Application.** The content and form of the application for Staff membership shall be as established by policy or by the Medical Executive Committee or Board. The applicant must sign the application, and, in so doing, the applicant:
- (1) Attests to the correctness and completeness of all information;
 - (2) Signifies his or her willingness to appear for interviews in connection with the application;
 - (3) Agrees to abide by the terms of the Bylaws, rules and regulations, policies, and procedure manuals of the Medical Staff and of the Hospital if granted membership and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application, whether or not membership and/or privileges are granted;
 - (4) Agrees to maintain an ethical practice and to provide continuous care to his or her patients;
 - (5) Authorizes and consents to representatives of the Hospital and/or Medical Staff consulting with the applicant's employer and exchanging information with the applicant's employer related to quality data, peer review, and other matters bearing on the professional or ethical qualifications and competence of the applicant;
 - (6) Authorizes and consents to representatives of the Hospital and/or Medical Staff consulting peers, prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to evaluation of such qualifications and competence; and
 - (7) Releases from any liability all those who, in good faith and without malice, review, act on, or provide information regarding the applicant's competence,

professional ethics, character, health status, and other qualifications for Staff appointment and clinical privileges.

(B) Processing the Application.

- (1) **Applicant's Burden.** The applicant has the burden of producing adequate information for a proper evaluation of his or her experience, training, competence, demonstrated ability to perform the privileges requested, and (to the extent legally appropriate) health status, and of resolving any doubts about these or any of the qualifications required for Staff membership or the requested Medical Staff category, Clinical Department assignment, or clinical privileges and of satisfying any reasonable requests for information or clarification (including health examinations if required under Section 1(E) of Article III or Hospital policy) made by appropriate Staff or Board authorities.
- (2) **Verification of Information.** The office of the Chief Medical Officer collects or verifies the references, current licensure, training, experience, and board certifications, and other qualification evidence submitted and makes the necessary queries to the National Practitioner Data Bank in accordance with the Health Care Quality Improvement Act and the appropriate regulations, and the Department of Justice in any state where the applicant is or was a resident during the past three years. Licensure is verified by the primary source from the licensing board(s) of the appropriate state(s). Relevant training and experience is verified from the primary source whenever feasible. Current competence is verified in writing by peers in the same professional discipline as the applicant that are knowledgeable about the applicant's professional performance. An applicant needs (i) a complete application, (ii) no current or, within the last three (3) years, previously successful challenge to licensure or registration, (ii) no subjection, within the last three (3) years, to involuntary termination of medical staff membership at another organization, (ii) and, within the last three (3) years, no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.
- (3) **Clinical Department Action.**

 - (a) The Medical Staff Clinical Leader of each Clinical Department in which the applicant seeks privileges reviews the application and its supporting documentation and forwards to the Medical Executive Committee or its delegate a signed written report evaluating the evidence of the Medical Staff member's training, experience, and demonstrated ability and stating how the Medical Staff member's skills are expected to contribute to the clinical and educational activities of the Clinical Department. This report must state the Medical Staff Clinical Leader's recommendation as to approval or denial of, and any special limitations on, Medical Staff appointment, category of Medical Staff membership, Clinical Department affiliation, and scope of clinical privileges.

- (b) A Medical Staff Clinical Leader may also, at his or her discretion, conduct an interview with the Medical Staff applicant. If a Medical Staff Clinical Leader requires further information about a Medical Staff applicant, he or she may defer transmitting a report, but their combined deferral time must not exceed 30 days. In case of a deferral, the applicable Chief must notify the Medical Staff applicant and the Chief Medical Officer of the deferral and the reason(s) for the deferral.
- (4) **Medical Executive Committee Action.** A Medical Executive Committee-appointed Credentials Committee, hereinafter referred to as the Credentials Committee, at its next regular meeting, reviews the application, the supporting documentation, the reports and recommendations from the Medical Staff Clinical Leader, and any other available and relevant information. Before recommending privileges, the organized Medical Staff also evaluates the following: challenges to any licensure or registration; voluntary and involuntary relinquishment of any license or registration; voluntary and involuntary termination of medical staff membership; voluntary and involuntary limitation, reduction, or loss of clinical privileges; any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant; documentation as to the applicant's health status; relevant practitioner-specific data as compared to aggregate data, when available; and morbidity and mortality data, when available. On the recommendation of the Credentials Committee, the Medical Executive Committee acts upon the application or prepares a written report with recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Medical Staff membership, Clinical Department affiliation, and scope of clinical privileges. The Medical Executive Committee can authorize the Chief of Staff or Chief Medical Officer to approve and sign off on credentials documents between meetings of the Committee in the absence of any issues or adverse matters identified by the Credentials Committee. The Medical Executive Committee may request evaluations of any Medical Staff applicant when there is doubt about an applicant's ability to perform the privileges requested.
- (5) **Effect of Medical Executive Committee Action.**
 - (a) **Deferral.** Action by the Medical Executive Committee to defer the application of a Medical Staff applicant for further consideration must be followed within 30 days with subsequent recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Medical Staff membership, Clinical Department affiliation, and scope of clinical privileges. The Chief Medical Officer promptly sends the Medical Staff applicant notice of an action to defer.
 - (b) **Favorable Recommendation.** When the Medical Executive Committee's recommendation is favorable to the Medical Staff applicant in all respects, the Chief Medical Officer promptly forwards it to the Board.

- (c) **Adverse Recommendation.** When the Medical Executive Committee's recommendation is adverse to the Medical Staff applicant, the Chief Medical Officer will immediately so notify the Medical Staff applicant. The Medical Staff applicant is then entitled to the procedural rights provided in Article VIII. An "adverse recommendation" by the Medical Executive Committee is defined as a recommendation for taking such actions as are set forth in Article VIII, Section 1(A).
- (6) **Board Action.**
 - (a) **Procedural Rights.** The Board may adopt or reject, in whole or in part, a favorable recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made. Action favorable to the Medical Staff applicant by the Board is effective as its final decision. If the Board's action, after compliance with the requirements of Section 1(B)(9) of this Article, is adverse to the Medical Staff applicant in any respect, the Chief Medical Officer promptly notifies the applicant, and the applicant is then entitled to the procedural rights provided in Article VIII.
 - (b) **Without Benefit of Medical Executive Committee Recommendation.** If, in its determination, the Board does not receive a recommendation from the Medical Executive Committee in a timely fashion, it may, after notifying the Medical Executive Committee of its intent, including a reasonable period of time for response, take action on its own initiative, employing the same type of information usually considered by the Medical Executive Committee. Any favorable action is effective as its final decision. If the Board action is adverse in any respect, the Chief Medical Officer promptly notifies the Medical Staff applicant, and the Medical Staff applicant is entitled to the procedural rights provided in Article VIII.
 - (c) **After Procedural Rights.** In the case of an adverse recommendation by the Medical Executive Committee, the Board takes final action on the matter as provided in Article VIII.
- (7) **Bases for Recommendations and Actions.** Each individual or group acting on an application, including the Board, is required to prepare a report stating the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered. Any dissenting views at any point in the process must also be reduced to writing, supported by reasons and references, and transmitted with the majority report.
- (8) **Conflict Resolution.** Whenever the Board determines that it will decide a matter contrary to the Medical Executive Committee's recommendation, the matter will

be submitted to a joint conference, composed of three members from the Medical Staff appointed by the Chief of Staff and three members from the Board appointed by the Chairman of the Board, for review and recommendation before the Board makes its decision.

(9) **Notice of Final Decision.**

- (a) Notice of the Board's final decision is communicated through the Chief Medical Officer to the Medical Executive Committee, to the Medical Staff Clinical Leader of each Clinical Department, and the appropriate Hospital staff concerned, and to the Medical Staff applicant.
- (b) The decision and notice to appoint includes the Medical Staff category to which the Medical Staff applicant is appointed; the Clinical Department to which the Medical Staff applicant is assigned; the clinical privileges the Medical Staff applicant may exercise; and any special conditions attached to the appointment.

(10) **Reapplication after Adverse Appointment Decision.** A Medical Staff applicant who has received a final adverse decision regarding appointment, Staff category, Department assignment, or clinical privileges is not eligible to reapply to the Medical Staff or for the denied category, Department, or privileges for a period of six months. Any such reapplication is processed as an initial application, and the applicant must submit such additional information as the Staff or the Board may require demonstrating that all bases for the earlier adverse action no longer apply.

(11) **Time Periods for Processing.** All individuals and groups required to act on an application for Staff appointment must do so in a timely and good faith manner. Except for good cause, each application should be processed within 120 days of receipt of a completed application and in accordance with the following time periods:

Individual or Group	Time
Chief Medical Officer	30 days
Department Evaluation	30 days
Credentials Committee	Next regular meeting
Medical Executive Committee	Next regular meeting
Board	Next regular meeting or by Consent Action

These time periods are guidelines and not directives and therefore do not create any rights for a Medical Staff applicant to have an application processed within these precise periods. If the provisions of Article VIII become applicable, the time requirements provided there govern the continued processing of the application.

- (12) **Term of Appointment and/or Privileges.** Appointments to the Medical Staff and/or privileges granted are for a period of two years, except that the Medical Executive Committee, with the approval of the Board, may set a more frequent reappraisal period for the exercise of particular privileges, either in general or as may be necessary or appropriate in particular circumstances. Such a different reappraisal period is not adverse action entitling the applicant to the procedural rights provided in Article VIII.
- (13) **Effect of Expiration or Termination of Staff Membership.** Because professional practice at the Hospital is contingent upon continued Medical Staff membership and is also constrained by the extent of the clinical privileges granted, a Medical Staff member's right to use Hospital facilities is automatically terminated when his or her Staff membership expires or is terminated.
- (14) **Medical Resignation.** Any member of the Medical Staff may resign at any time. Resignation may be in writing or may be deemed to have occurred when the member no longer meets eligibility criteria, has not requested a Leave of Absence from the Medical Staff or fails to complete his/her application for reappointment within required time frames. A Staff member is expected to have completed clinical and record-keeping responsibilities at the time of resignation. A Medical Staff member who resigns from the Medical Staff without having completed and signed medical records and fulfilled other clinical responsibilities is considered to have resigned, not in good standing.

Section 2. Expedited Process for Applicants Meeting Predetermined Criteria.

- (A) When there is documentation that an applicant for membership or clinical privileges unquestionably meets all professional criteria set forth in these Bylaws, including criteria defined in Section 2(B) below, those applications can be processed using a "expedited" credentialing process defined in this Section 2.
- (B) **Criteria.** The criteria for applications to qualify for the expedited process are:
 - (1) All applicant information is complete and verified;
 - (2) There is no evidence that the Medical Staff applicant would be barred from providing services in the Hospital under the Caregiver Background Check Law (Chapter DHS 12 of the Wisconsin Administrative Code.)
 - (3) The final recommendation of the Medical Executive Committee is not adverse or does not have limitations.

The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:

- (4) Replies have not been received from all reference requests and all recommendations favorable;

- (5) Unexplained period of time in the applicant's professional career;
 - (6) The applicant is more than five years out of medical school;
 - (7) Past or pending malpractice cases;
 - (8) Loss, denial, involuntary reduction, or restrictions of privileges;
 - (9) Pending challenges to or revocation of licensure or registration;
 - (10) The Medical Staff applicant does not meet the health status required under Article III, Section 1(E); and
 - (11) Requested privileges are not consistent with Hospital need, available resources, and professional development plans.
 - (12) The applicant has received an involuntary termination of medical staff membership at another organization.
 - (13) The applicant submits an incomplete application.
- (C) **Expedited Review.** If all the above criteria are met, the application will be processed through the relevant Clinical Department Medical Staff Leader, the Chair of the Credentials Committee, and the Chief Medical Officer, or the Chief of Staff. Review of an application shall generally proceed sequentially through the aforementioned individuals who may confer with each other regarding the application. Each reviewer will submit a summary of his or her recommendations regarding the decision to grant Medical Staff membership and/or privileges to the next reviewing individual. The application will not be forwarded to the Board Chair for review unless all of the reviewers issue favorable recommendations. Any reviewer may decide for any reason to refer the application to either the Credentials Committee or to the Medical Executive Committee to be processed in accordance with Section 1 of this Article. Such referral is not adverse action entitling the applicant to the procedural rights provided in Article VIII.
- (D) **Board Chair Action.** If all individuals identified in Section 2(C) above issue favorable recommendations, the Chair of the Board or, if unavailable, another voting member of the Board will review the application and submit a summary of his or her recommendations regarding the decision to grant Medical Staff membership and/or privileges.
- (E) **Notice of Decision.** After receipt by the Chair of the Board of a favorable report from the other voting member of the Board, and such Chair's own review of the application, the Chair will notify the Medical Executive Committee and Board, listing the applicants that have been processed and approved under this procedure. The Board Chair may refer any application to the full Medical Executive Committee to be processed in accordance with Section 1 of this Article.

- (F) **Full Committee Review.** In the event a question is raised by the Medical Executive Committee or Board within 45 days of notice from the Board Chair under Section 2(E) above, concerning an applicant's qualifications, competence, or health status after an applicant has been granted privileges through this expedited process, the question will be submitted to the Medical Executive Committee for review and a report will be sent back within 30 days. If there is sufficient cause as determined either by the Medical Executive Committee or Board, the appointment or privileges decision will be withdrawn and promptly processed in accordance with Section 1 of this Article. Such withdrawal of the decision and referral is not adverse action entitling the applicant to the procedural rights provided in Article VIII.
- (G) **Final Decision.** Any expedited review action not withdrawn by the Board within 45 days of the notice to the Board under Section 2(E) above is deemed final.

Section 3. Reappointment Procedures.

(A) Processing the Application.

(1) Information Collection and Verification.

- (a) **From Medical Staff Member.** Not later than 90 days prior to the date of expiration of a Medical Staff member's appointment, the office of the Chief Medical Officer notifies him or her of the date of expiration. At least 60 days prior to the date of expiration of his or her appointment, the Medical Staff member furnishes, in writing: (a) complete information updating the information in the member's file described in Section 1(B) of this Article; (b) evidence of continuing training and education external to the Hospital during the preceding period; (c) a specific request for the clinical privileges sought on reappointment, with any basis for changes; (d) any requests for changes in Medical Staff category or Clinical Department assignment; (e) authorizations, consents, and releases in the form outlines in Section 1(A) of this Article; and (f) a statement confirming that the member has no health problems that could adversely affect his or her ability to perform the privileges requested or adversely affect his or her practice (or that any such problems can be dealt with through reasonable accommodation), countersigned by the member's Clinical Department Medical Staff Leader. The office of the Chief Medical Officer notifies the Medical Staff member of any information inadequacies or verification problems. The Medical Staff member then has the burden of producing adequate information and resolving any doubts about the data. To the extent permitted by law, the member is required to submit any reasonable evidence of current health status that may be requested under policies established by the Medical Executive Committee. If the Hospital contracts with a third party to provide assistance in the credentialing process, references to the Chief Medical Officer in connection with the collection and verification of information

necessary for reappointment will be deemed to include the third-party contractor.

- (b) Failure, without good cause, to provide any of the information referred to above is deemed a voluntary resignation from the Medical Staff and results in automatic termination of membership at the expiration of the current term unless explicitly extended for not more than two 30-day periods by action of the Medical Executive Committee.
- (c) A LIP whose membership is terminated under Section 3(A)(1)(b) above is entitled to the procedural rights provided in Article VIII for the sole purpose of determining the issue of good cause.

(2) **From Internal Sources.** The Chief Medical Officer collects for each Medical Staff member's credentials file all relevant criteria regarding the applicant's continued ability to provide quality care, treatment, and services in the settings the applicant has been practicing in the organization. Such ability will be assessed by evaluating professional performance, including clinical and technical skills, physical ability, and conduct in the Hospital. Such information includes, without limitation: patterns of care as demonstrated in the findings of quality assessment and improvement data and peer review data and activities; attendance at required Medical Staff, Clinical Department meetings; service on Medical Staff, Clinical Department and Hospital committees; timely and accurate completion of medical records; participation in continuing medical education; and compliance with all applicable Bylaws, rules, regulations, policies, and procedures of the Hospital and Staff. If sufficient peer review data are not available, verified written recommendations by peers in the same professional discipline as the applicant, who are knowledgeable about the applicant's professional performance, may be used to recommend the applicant for the renewal of clinical privileges.

(3) **Verification of Information.** The office of the Chief Medical Officer collects or verifies the current licensure and other qualification evidence submitted and makes the necessary queries to the National Practitioner Data Bank in accordance with the Health Care Quality Improvement Act and the appropriate regulations, and the Department of Justice in any state where the applicant is or was a resident during the past three years. Licensure is verified by the primary source from the licensing board(s) of the appropriate state(s).

(B) **Clinical Department Action.** Each Clinical Department Medical Staff Leader in which the Medical Staff member requests or has exercised privileges reappraises the applicant to evaluate his or her continued ability to provide quality care, treatment, and services for the privileges requested and forwards to the Credentials Committee a signed written report, including a statement as to whether or not the Clinical Department Medical Staff Leader has observed or been informed of any conduct that indicates significant present or potential physical or behavioral problems affecting the Medical Staff member's ability to perform professional and Medical Staff duties appropriately, with recommendations for

reappointment or non-reappointment, and, as appropriate, for Medical Staff category, Clinical Department assignment, and clinical privileges.

- (C) **Additional Review.** In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by someone other than the applicant's Clinical Department Medical Staff Leader may be necessary to resolve the issue. The Medical Executive Committee is responsible for requesting such an evaluation.
- (D) **Medical Executive Committee Action.** The Credentials Committee reviews the member's file, Department, and Service reports, and any other available relevant information available. On the recommendation of the Credentials Committee, the Medical Executive Committee acts upon the reappointment or prepares a written report with recommendations for reappointment or non-reappointment and for Medical Staff category, Clinical Department assignment, and clinical privileges.
- (E) **Final Processing and Board Action.** Final processing of reappointments follows the procedure set forth in Section 1(B) of this Article. For purposes of reappointment, an "adverse recommendation" by the Medical Executive Committee or an "adverse action" by the Board as used in those Sections means recommendation or action set forth in Article VIII, Section 1(A).
- (F) **Bases for Recommendations and Action.** The report of each individual or group, including the Board, required to act on a reappointment must state the reasons for each recommendation made or action taken, with specific reference to the Medical Staff member's credentials file and all other documentation considered. Any dissenting views at any point in the process must also be expressed in writing, supported by reasons and references, and transmitted with the majority report.
- (G) **Time Periods for Processing.** Transmittal of the notice to a Medical Staff member and the member's provision of updated information are to be carried out in accordance with Section 2(B)(1) of this Article. Thereafter, and except for good cause, all persons and groups required to act must complete such action so that all reappointment reports and recommendations are transmitted to the Medical Executive Committee and in turn to the Board prior to the expiration date of the member's Medical Staff membership. The time periods specified are to guide the acting parties in accomplishing their tasks. If reappointment processing has not been completed by such expiration date through no fault of the Medical Staff member, the member maintains his or her current membership status and clinical privileges until the time that processing is completed, unless corrective action is taken with respect to all or any part of such status or privileges. Such an extension, however, does not create a right of automatic reappointment for another term. If a delay is attributable to the member's failure to provide information required by Section 2(B)(1) of this Article, the member is subject to the provisions of Section 3(A)(1)(b) of this Article.
- (H) **Requests for Modifications of Membership Status.** A Medical Staff member may, either in connection with reappointment or at any other time, request modification of his or her Medical Staff category, of Clinical Department assignment, or clinical privileges

by submitting a written application to the Chief Medical Officer on the prescribed form. An application for such a modification is processed in the same manner as a reappointment.

Article VI

Delineation of Clinical Privileges

Section 1. Board Certification for Licensed Independent Practitioners (LIPs).

- (A) LIPs applying for initial privileges at Froedtert Hospital must be certified by one of the following recognized specialty boards: the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), or the Royal College of Physicians and Surgeons of Canada (RCPS-C).
- (B) A LIP who is board eligible may be granted privileges but must achieve board certification within four years of the date privileges were initially granted. If board certification is not achieved within that time span, the LIP's privileges will automatically lapse.
- (C) An international medical graduate LIP who is participating in an ABMS-sponsored alternative pathway into specialty board certification program approved by the Hospital Board may be granted privileges but must achieve board certification within five years of the date the alternative pathway program is completed. If board certification is not achieved within that timeframe, the international medical graduate LIP's privileges will automatically lapse.
- (D) All LIPs must maintain current board certification in the specialty or subspecialty most closely aligned to their clinical privileges throughout their affiliation with the Hospital.
- (E) In the event a LIP Medical Staff member loses his or her board certification, he or she has one full reappointment cycle to achieve recertification (in the specialty or subspecialty most closely aligned to his or her clinical privileges). Failure to achieve recertification in that time period will cause the member's privileges to lapse.
- (F) An automatic lapse of privileges under this Section 1 is not an adverse determination that gives the LIP appeal rights nor is it an action reportable to the National Practitioner Data Bank.

Section 2. System and Procedures for Delineating Clinical Privileges.

- (A) **Clinical Department Responsibility.** Each Clinical Department must define the procedures that fall within its clinical area. These definitions form the bases for delineating privileges within the Clinical Department and setting, and must be periodically reviewed, revised, and approved by the Medical Executive Committee and the Board upon recommendations from the Credentials Committee. Special procedures that may be performed in the Hospital must also be defined and privileges specifically requested for them. Information regarding each Staff Member's scope of privileges is updated as changes in clinical privileges for each practitioner are made. Prior to granting a privilege, the resources necessary to support the requested privilege are determined to

be currently available, or available within a specified time frame. The Hospital consistently determines the resources needed for each requested privilege, and there is a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege.

- (B) **Consultation and Other Conditions.** There may be attached to any grant of privileges special requirements for consultation as a condition to the exercise of particular privileges, in addition to requirements for consultation in specified circumstances provided for in the Bylaws or in the rules, regulations, and policies, or by the Medical Staff, any of its clinical units, or the Hospital. As part of a request for clinical privileges, each Medical Staff member pledges that, in dealing with cases outside his or her training and usual area of practice, he or she will seek appropriate consultation or refer to a Medical Staff member who has expertise in such cases and acknowledges that the request is circumscribed by Hospital and Medical Staff policies concerning the management of patients in intensive care units and on mechanical ventilators, as well as by other applicable policies.
- (C) **Procedure for Delineating Privileges.**
 - (1) **Requests.** Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant or Medical Staff member. Specific requests must also be submitted for modifications of privileges in the interim between appraisals.
 - (2) **Processing Requests.** All requests for clinical privileges will be processed according to the procedures outlined in Article V, Section 1, Section 2 and Section 3, as applicable. In processing requests, consideration will be given as to whether there is sufficient space, equipment, staffing and financial resources to support the requested privilege.
 - (3) **Requests Outside the Appointment Cycle.** New privilege requests made outside of the appointment/reappointment cycle must follow the process outlined in Article VI, Section 2(C)(2).

Section 3. Special Conditions. The initial application or renewal of clinical privileges of a LIP who is, or who will be, providing specified professional services pursuant to a contract with the Hospital or an LIP who is permitted to exercise designated clinical privileges without a membership appointment, as described in Article III, Section 8, is processed in the same manner as all other applications or re-applications.

Section 4. Emergency Privileges. In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or in which the life of a patient is in immediate danger, and any delay in administering treatment could add to that danger, any LIP who has been granted clinical privileges by the Board is authorized to provide any type of patient care, treatment, and services necessary to save the patient's life or to prevent serious bodily harm, to the degree permitted by the scope of the LIP's license, but regardless of Clinical

Department affiliation, Staff category, or level of privileges. A LIP exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

Section 5. Temporary Privileges.

- (A) **Conditions.** Temporary privileges may be granted only in the circumstances described in this Section to an appropriately licensed Medical Staff applicant when the information available reasonably supports a favorable determination regarding the requesting Medical Staff applicant's qualifications, ability, and judgment to exercise the privileges requested. Primary source verification of licensure, current competence, and professional liability insurance coverage, at a minimum, is required prior to the granting of temporary privileges. If necessary, verification may be accomplished by a documented telephone call. Special requirements of consultation and reporting may be imposed by the Medical Staff Clinical Leader of the Clinical Department responsible for supervising the Medical Staff applicant. Except in unusual circumstances, temporary privileges will not be granted unless the Medical Staff applicant has agreed in writing to abide by this policy and by the rules, regulations, and policies of the Medical Staff and the Hospital in all matters relating to such temporary privileges.
- (B) **Circumstances.** Upon the written concurrence of the Medical Staff Clinical Leader of the Clinical Department where the privileges will be exercised and with the recommendation of the Chief Medical Officer or the Chief of Staff, temporary privileges may be granted by the President or his authorized designee, the Chief Medical Officer, under the circumstances specified in (1) and (2) below. In the absence of the President and Chief Medical Officer, temporary privileges may be granted by the Executive Vice President or other appropriate individual identified in the Policy CPA.0004 Order of Succession in Absence of the President:
- (1) To fulfill an important patient care need, treatment, or service that requires an immediate authorization to practice, for example, when a Medical Staff member becomes ill or takes a leave of absence and needs another Medical Staff member to cover his or her practice.
 - (2) When a new applicant with a complete application is awaiting review and approval of the Medical Executive Committee and the Board, in which case primary source verification in accordance with Article V, Section 1(B)(2) reveals no concerns.
- (C) **Length of time.**
- (1) Temporary privileges granted after receipt of a written request for specific temporary privileges for the care of one or more specific patients are restricted to the care of such patient(s) and shall expire when the patients are discharged.
 - (2) Temporary privileges granted prior to Medical Executive Committee action are valid for no more than 120 days.

- (D) **Termination.** The Chief Medical Officer must terminate any or all of an individual's temporary privileges on the discovery of any information or the occurrence of any event of any nature that raises questions about the individual's professional qualifications or ability to exercise any or all of the temporary privileges granted. The Chief Medical Officer may terminate an individual's temporary privileges at any other time upon consultation with the Medical Staff Clinical Leader of the Clinical Department responsible for supervising the Medical Staff member concerned. In cases where the life or well being of a patient is determined to be endangered, an individual's temporary privileges may be terminated by any person entitled to impose summary suspensions. In the event of any termination of temporary privileges described in this Subsection (D), the Medical Staff Clinical Leader of the Clinical Department responsible for supervision of the terminated individual will reassign the terminated individual's patients then in the Hospital to another Medical Staff member after considering, to the extent feasible, the wishes of the affected patients.
- (E) **Rights of an Applicant for Temporary Privileges.** An individual is not entitled to the procedural rights afforded by these Bylaws because his or her request for temporary privileges is refused or because all or any portion of his or her temporary privileges are terminated.
- (F) **Guest Privileges for Visiting Medical Staff.**
- (1) The President or his authorized designee, the Chief Medical Officer, on request of a Medical Staff Clinical Leader of the Clinical Department, may grant guest privileges. Guest privileges may be granted to recognize officially the professional credentials of a visiting LIP who may be invited to participate in the delivery of patient care. Guest privileges may also be granted in situations where the guest professional possesses skills that are required for patient care and cannot be supplied by current privileged members of the Medical Staff. Guest privileges shall be for a period not to exceed 30 days.
 - (2) Guest privileges may not be granted or renewed more than three times in twelve-month period starting on the date the privileges are initially granted. With the approval of the President or his authorized designee, the Chief Medical Officer, exceptions may be made for continuity of care purposes.
 - (3) Guest privileges will be granted only after verification that the applicant's professional license and hospital privileges elsewhere are in good standing, and that malpractice insurance is in place and applicable at the Hospital. Other verifications may be required.
- (G) In each instance, those granted temporary/guest privileges of any kind shall be reported at the next regular meeting of the Medical Executive Committee, and then subsequently to the Board.

Section 6. Disaster Privileges.

- (A) In times of a local, state, or national disaster emergency situation, it may become necessary to grant temporary privileges to LIPs who are not part of or otherwise eligible to be a member of Hospital's Medical Staff ("External LIPs") to help care for an unusually high number of critically ill patients. Disaster privileges are only granted when the Hospital's disaster plan has been activated and the Hospital is unable to handle the immediate patient needs. In order to expedite the processing of LIPs' applications for temporary disaster emergency clinical privileges, the President or Chief Medical Officer or his or her designee has the option to grant disaster privileges. The President or Chief Medical Officer or his or her designee will declare a "state of emergency," and other priorities will cease.
- (B) **Mechanism to Manage External Physicians Who Receive Disaster Privileges.**
- (1) When the Hospital's Disaster Plan has been activated, the President or Chief Medical Officer or his/her designee may, on a case-by-case basis, grant disaster privileges to provide patient care to selected External LIPs, provided the External LIP can present at a minimum a valid government-issued photo ID that has been issued by a U.S. state or federal agency, such as a driver's license or passport, and at least one of the following:
 - (a) A current picture hospital identification card that clearly identifies professional designation;
 - (b) A current license to practice medicine;
 - (c) Identification indicating that the External LIP is a member of a Disaster Medicine Assistance Team (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
 - (d) Identification indicating that the External LIP has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
 - (e) Identification by current Hospital or Medical Staff member(s) who possess personal knowledge regarding the External LIP's ability to professionally provide patient care during a disaster.
 - (2) The Medical Staff oversees the professional practice of External LIP. External LIPs will be assigned to clinical departments for appropriate allocation pursuant to the Hospital's disaster plan.
 - (3) Any items such as a parking card and name tag (or other identification) will be disbursed to the External LIP in as expedient a manner as possible. A copy of a photo identification card will be made at the time the External LIP first comes to the Hospital.

- (4) Medical Staff Office personnel will notify appropriate Hospital staff, e.g., Emergency Room, Surgery, Nursing Administration, Medical Records, Admissions, and Pharmacy, who have a need to know about the privileges of External LIPs.
- (5) 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 External LIP presents to the Hospital.
- (6) The President or Chief Medical Officer or his or her designee 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
- (7) Once the immediate situation has passed and the determination that the disaster is over has been made in accordance with Hospital's disaster plan, the External LIP's disaster privileges will terminate immediately.
- (8) An External LIP is not entitled to the procedural rights afforded by these Bylaws because his or her request for disaster privileges is refused or because all or any portion of his or her disaster privileges are terminated.

Article VII

Corrective Action

Section 1. Routine Corrective Action.

- (A) **Bases for Corrective Action.** Corrective action may be initiated by any officer of the Medical Staff, by the Medical Staff Clinical Leader of the Clinical Department where the affected Medical Staff member holds membership or exercises clinical privileges, by the President, by the Chief Medical Officer, or by the Board whenever a Medical Staff member with privileges engages in, makes, or exhibits acts, statements, demeanor, or professional conduct, either within or outside of the Hospital, that is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care, noncompliance with regulatory or accreditation standards, disruptive to the Hospital's operations, or detrimental to the community's confidence in the Hospital. Conduct or activity upon which the request for corrective action may be based shall include, but not be limited to:
 - (1) Conduct or activity by a Staff member considered to lower the standards or aims of the Medical Staff or to adversely reflect upon the reputation of the Medical Staff or Hospital as a whole in the community or which is disruptive to the operations of the Hospital or where a member's current physical, mental or emotional condition may pose a threat to patient care.

- (2) Conduct involving moral turpitude.
 - (3) Conviction of a crime.
 - (4) Unethical practice.
 - (5) Incompetence.
 - (6) Failure to keep adequate records.
 - (7) Revocation, suspension or limitation of Medical Staff member's license by the applicable State licensing body or voluntarily by the Medical Staff member.
 - (8) Loss or limitation of Medical Staff member's narcotics (DEA) license.
 - (9) Exercising privileges while Medical Staff member's professional ability is impaired, whether through illness, accident, addiction, or from any other source.
 - (10) Significant misstatement in or omission from any application for membership or privileges or any misrepresentation in presenting the Medical Staff member's credentials.
 - (11) Violation of the Bylaws, Rules and Regulations or policies of the Medical Staff, Hospital bylaws, the Code of Ethics of the applicable professional association, State of Wisconsin laws or rules, or the Hospital's mission statement.
 - (12) Commission of an offense that bars the Medical Staff member from providing services in the Hospital under the Caregiver Background Check law (Chapter DHS 12 of the Wisconsin Administrative Code.)
- (B) **Discretionary Interview Prior to Corrective Action.** Before initiating corrective action against a Medical Staff member, the initiating party may, but is not obligated to, afford the Medical Staff member a formal interview at which the circumstances prompting the corrective action are discussed and the Medical Staff member is permitted to present relevant information. The formal interview must be initiated by notice to the Medical Staff member, with copies transmitted to the Chief of Staff, the Chief Medical Officer, and the Board. The Chief of Staff and the Chief Medical Officer, or either of them, may, in their discretion, be present as observers during the formal interview. A written report reflecting the substance of the interview must be made and transmitted to the Medical Staff member, the Chief of Staff, the Chief Medical Officer, and the Board. If the Medical Staff member fails to respond to the notice of the interview or declines to participate in the interview, corrective action must immediately proceed in accordance with the remaining provisions of this Article. The formal interview provided for in this Subsection is not a procedural right and is not subject to the requirements of Article VIII.
- (C) **Requests and Notices.** All requests for corrective action must be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activities or conduct constituting the grounds for the request. Unless the request was initiated by

the Chief Medical Officer, the Chief of Staff promptly notifies the Chief Medical Officer in writing of all requests.

- (D) **Investigation.** After deliberation, the Medical Executive Committee may either act on the request for corrective action or direct that an investigation concerning the alleged bases for the request be undertaken. Investigation for all purposes of these Bylaws means formal action undertaken by an officer, Medical Staff leader of a Clinical Department, the Chief Medical Officer or any committee after notice is provided to or the action is approved by the Medical Executive Committee. The Medical Executive Committee may conduct the investigation itself or may have the investigation conducted by a Medical Staff officer or by a Clinical Department, standing or ad hoc committee, or other organizational component. This investigative process is not a “hearing” as that term is used in Article VIII. The investigative process may include a consultation with the Medical Staff member involved, with the individual or group making the request, and with other individuals who may have knowledge of the events involved. If the investigation is accomplished by a group or individual other than the Medical Executive Committee, that group or individual must forward a written report of the investigation to the Medical Executive Committee as soon as practicable after the assignment to investigate has been made. The Medical Executive Committee may, at any time, in its discretion, and must, at the request of the Board, terminate the investigative process with action as provided below.
- (E) **Medical Executive Committee Action.** As soon as practicable after the conclusion of the investigative process, if any, but in any event within 45 days after receipt of the request for corrective action, unless deferred, the Medical Executive Committee acts upon such request. Its action may include, without limitation:
- (1) Recommending rejection of the request for corrective action;
 - (2) Recommending a warning or a formal letter of reprimand;
 - (3) Recommending a probationary period with retrospective review of cases, but without special requirements of prior or concurrent consultation or direct supervision;
 - (4) Recommending suspension of membership prerogatives that do not affect clinical privileges;
 - (5) Recommending individual requirements of consultation or supervision;
 - (6) Recommending reduction, suspension, or revocation of clinical privileges;
 - (7) Recommending reduction of Medical Staff category or limitation of any prerogatives directly affecting the Medical Staff member’s clinical privileges; and
 - (8) Recommending suspension or revocation of Medical Staff membership.

- (9) Requiring a physical or mental examination and report by a LIP chosen by or acceptable to the Medical Executive Committee and compliance with any recommendations issued as a result of such action.
- (F) **Deferral.** If additional time is needed to complete the investigative process, the Medical Executive Committee may defer action on the request for corrective action.
- (G) **Adverse Action.** A recommendation by the Medical Executive Committee for individual consultation or supervision under Section 1(E)(5) of this Article, for reduction, suspension, or revocation of clinical privileges under Section 1(E)(6); for reduction of Staff category or limitation of a prerogative directly affecting clinical privileges under Section 1(E)(7); or for suspension or revocation of Staff membership under Section 1(E)(8) is deemed adverse to the LIP Medical Staff member and entitles the Medical Staff member to the procedural rights set forth in Article VIII.
- (H) **Other Action.**
 - (1) A recommendation by the Medical Executive Committee for rejection of the request for corrective action under Section 1(E)(1) of this Article, for a warning or formal reprimand under Section 1(E)(2), for probation with retrospective monitoring under Section 1(E)(3), or for suspended membership prerogatives that would not affect clinical privileges under Section 1(E)(4) is deemed favorable to the Medical Staff member and is transmitted to the Board together with all supporting documentation. Thereafter, the procedure in Section 1(B)(6)(a) of Article V is applicable. However, if the Board's initial action on any such recommendation represents a substantive change from the Medical Executive Committee's recommendation, the procedure at Section 1(B) of Article V is applicable. A "favorable recommendation" as used in Section 1(B)(6)(a) of Article V is any recommended action other than those that entitle the LIP Medical Staff member to procedural rights.
 - (2) If, in the Board's determination, the Medical Executive Committee fails to act in timely fashion in processing and recommending action on a request for corrective action, the provisions of Section 1(B)(6)(b) of Article V apply and are then to be followed.

Section 2. Summary Suspension.

- (A) **Bases for Summary Suspension.** Summary suspension may be initiated by the Chief of Staff, the President, or the Chief Medical Officer whenever a Medical Staff member with privileges engages in or exhibits demeanor or professional conduct that is, or is reasonably likely to be, detrimental to patient safety or to the delivery of quality patient care, disruptive to the Hospital's operations, or detrimental to the community's confidence in the Hospital, or whenever a Medical Staff member's conduct requires summary suspension to protect the life of any patient or to reduce the likelihood of injury or damage to the health or safety of any patient, employee, or other person present in the Hospital. Summary suspension may relate to the Medical Staff membership status or all

or any portion of the clinical privileges of the affected Medical Staff member. Summary suspension is effective immediately upon imposition and the person imposing suspension must give prompt notice to the affected Medical Staff member. Upon imposition of summary suspension, the Medical Staff Clinical Leader reassigns the suspended Medical Staff member's patients then in the Hospital to another Medical Staff member, taking into account as appropriate the wishes of the affected patients in the selection of a substitute Medical Staff member.

- (B) **Medical Executive Committee Action.** Unless discussed or approved by the Medical Executive Committee in advance, as soon as possible, but in any event within 72 hours after a summary suspension is imposed, the Medical Executive Committee convenes to review and consider the action taken. The Medical Executive Committee may recommend modification, continuation, or termination of the terms of the suspension and may recommend any of the other actions described in Section 1(E) of this Article.
- (C) **Procedural Rights.** Unless the Medical Executive Committee recommends immediate termination of the suspension or modification of the suspension to one of the lesser sanctions provided for in Section 1(E)(1) through (9) of this Article, the Medical Staff member is entitled to the procedural rights contained in Article VIII.
- (D) **Other Action.** A recommendation by the Medical Executive Committee to terminate or modify the suspension to a lesser sanction not involving procedural rights is transmitted immediately, together with all supporting documentation, to the Board, and the procedure in Section 1(H) of this Article is then followed. The terms of the summary suspension as originally imposed remain in effect pending a final decision by the Board.

Section 3. Automatic Suspension.

(A) Wisconsin Licensure.

- (1) Whenever a Medical Staff member's license to practice in the State of Wisconsin is revoked, his or her Medical Staff membership and clinical privileges are immediately and automatically revoked.
- (2) Whenever a Medical Staff member's license to practice in the State of Wisconsin is partially limited or restricted in any way, those clinical privileges granted to the Medical Staff member that are within the scope of the limitation or restriction are similarly and automatically limited or restricted. Further action on the matter proceeds under Section 4 of this Article.
- (3) Whenever a Medical Staff member's license to practice in the State of Wisconsin is suspended, his or her Staff membership or clinical privileges are similarly and automatically suspended effective upon, and for, at least, the term of the suspension. Further action on the matter proceeds under Section 4 of this Article.
- (4) Whenever a Medical Staff member's license to practice in the State of Wisconsin is made probationary, his or her voting and office-holding prerogatives are

automatically suspended, effective upon, and for, at least, the term of the probation. Further action on the matter proceeds under Section 4 of this Article.

- (5) Whenever a Medical Staff member fails to renew his or her license to practice in the State of Wisconsin, his or her Medical Staff membership or clinical privileges are automatically revoked until the Medical Staff member's license is renewed.

(B) Medical College Faculty Appointment.

- (1) Whenever a Medical Staff member's appointment to the faculty of or employment by the Medical College is revoked or terminated, the member's Staff membership and clinical privileges are immediately and automatically revoked.
- (2) Whenever a Medical Staff member's appointment to the faculty of or employment by the Medical College is suspended, the member's Staff membership and clinical privileges are automatically suspended effective upon and for, at least, the term of the suspension imposed by the Medical College. Further action on the matter proceeds under Section 4 of this Article.
- (3) Whenever a Medical Staff member's appointment to the faculty of or employment by the Medical College is made probationary or otherwise restricted or diminished, action on the matter proceeds under Section 4 of this Article.

(C) Drug Enforcement Administration.

- (1) Whenever a Medical Staff member's controlled substances number from the Drug Enforcement Administration or other authority is revoked or voluntarily surrendered, the Medical Staff member is immediately and automatically divested, at least, of the right to prescribe medications covered by such number. Further action on the matter proceeds under Section 4 of this Article.
- (2) Whenever a Medical Staff member's controlled substances number from the Drug Enforcement Administration or other authority is suspended, the Medical Staff member is automatically divested, at least, of the right to prescribe medications covered by such number, effective upon, and for at least the term of, the suspension. Further action on the matter proceeds under Section 4 of this Article.
- (3) Whenever a Medical Staff member's controlled substances number from the Drug Enforcement Administration or other authority is partially restricted or limited in any way, or the Medical Staff member is placed on probation with respect to the use of such number, the Medical Staff member's right to prescribe medications covered by such number is similarly restricted or limited, effective upon, and for at least the term of, and consistent with, any conditions of the restriction, limitation, or probation. Further action on the matter proceeds under Section 4 of this Article.

(D) Caregiver Background Check Suspension.

- (1) Subject to proof of rehabilitation review approval, an automatic suspension of all privileges of a Medical Staff member shall be imposed upon notification received by the Chief of Staff, President, or Chief Medical Officer that the Medical Staff member:
 - (a) Has been convicted of a serious crime, act, or offense or has pending charges for a serious crime, act, or offense as defined in Chapter DHS 12 of the Wisconsin Administrative Code;
 - (b) Has been found by a unit of government to have abused or neglected a client or misappropriated a client's property; or
 - (c) Has been determined under the Children's Code to have abused or neglected a child.
- (2) As soon as possible after an automatic suspension under subsection (D)(1) above, the Medical Executive Committee shall convene to review and consider the facts under which the individual was barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code. The Medical Executive Committee may then take such further corrective action as is appropriate under the circumstances. If the Medical Staff member provides evidence that rehabilitation review approval has been received, the Medical Executive Committee must determine whether the rehabilitation review approval in any way limits the Medical Staff member's ability to practice the privileges granted and if it wishes to retain the Medical Staff member on the Medical Staff. The Medical Executive Committee may then take such further corrective action as is appropriate under the circumstances.
- (3) A suspension of all privileges of a Medical Staff member may be imposed by the Chief of Staff, President or Chief Medical Officer upon notification that a Medical Staff member:
 - (a) Is under investigation for a serious crime, act or offense as defined in Chapter DHS 12 of the Wisconsin Administrative Code;
 - (b) Is being investigated by a unit of government or an entity subject to DHS 12 for abuse or neglect of a client or misappropriation of a client's property; or
 - (c) Is being investigated under the Children's Code or an entity under DHS 12 for abuse or neglect of a child.
- (4) As soon as possible after suspension under Subsection (D)(3) above, the Executive Medical Committee or its designee shall convene to review and consider the facts under which the individual was suspended and determine whether or not to continue the suspension pending the outcome of the investigation, terminate the suspension subject to monitoring or other safeguards

pending the outcome of the investigation, or to take such further corrective action as is appropriate under the circumstances.

(E) **Suspension for Exclusion from Federally Funded Health Care Program.**

- (1) The action of any government agency or court terminating or suspending a Medical Staff member from federal or state payment programs shall effectuate a suspension of membership and privileges as of the date of the government action.
- (2) If the member immediately notifies the Chief Medical Officer of any proposed or actual exclusion from any federally funded health care program as required by these Bylaws, a simultaneous request in writing by the member for a meeting with the President and the Chief Medical Officer, or their designees, to contest the fact of the exclusion and present relevant information shall be granted. If requested, such a meeting shall be held as soon as possible but in no event later than five business days from the date of the written request. The President and the Chief Medical Officer or their designees shall determine within 10 business days following the meeting, and after such follow-up review as they deem appropriate, whether the exclusion had in fact occurred, and whether the member's staff membership and privileges shall be immediately terminated. The determination of the President and the Chief Medical Officer or their designees regarding the matter shall be final, and the member shall have no further procedural rights within the Hospital or its Medical Staff. The member shall be given notice of the termination in the most expeditious manner possible, and shall also promptly receive written notice of the termination.
- (3) A member who does not immediately notify the Chief Medical Officer of any proposed or actual exclusion from any federally funded health care program as required by these Bylaws shall have his or her staff membership and privileges terminated, effective immediately, at such time as the President or his or her designee receives reliable information of the member's exclusion. The member shall be given notice of the termination in the most expeditious manner possible, and shall also promptly receive written notice of the termination.
- (4) Whenever a Medical Staff member's membership and privileges are terminated pursuant to this Section, the Chief Medical Officer and applicable Medical Staff Clinical Leader will assign any patients currently under the member's care in the Hospital to the care of another appropriate Medical Staff member taking the patient's wishes into account when possible.

(F) **Professional Liability Insurance.** For failure to maintain the minimum amount of professional liability insurance, if any, required under Section 1(F) of Article III, a Medical Staff member's Medical Staff membership and privileges are subject to immediate suspension.

(G) **Termination of Sponsoring LIP's Membership and Privileges.** Whenever an LIP Medical Staff member's membership and privileges are terminated, whether voluntarily

or involuntarily, the membership and privileges of any AHP who is sponsored or supervised by such terminated LIP Medical Staff member shall also be immediately terminated. Termination of an AHP Medical Staff member's membership and privileges under this Subsection (G) shall not be subject to review under Section 4 of this Article or to the hearing rights under Article VIII.

Section 4. Medical Executive Committee Deliberation. As soon as practicable after a Medical Staff member's license is suspended, restricted, or placed on probation; after a Medical Staff member's appointment to the faculty of or employment by the Medical College is suspended, made probationary, or otherwise restricted or diminished but not totally revoked; or after a Medical Staff member's controlled substances number is revoked, suspended, restricted, limited, or made probationary, the Medical Executive Committee convenes to review and consider the facts under which such action was taken. The Medical Executive Committee may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation, including limitation of privileges. Thereafter, the procedure in Section 1(G) or Section 1(H) of this Article is followed, as applicable.

Section 5. No Right of Hearing. Automatic suspension activated pursuant to Section 3 of this Article shall not be a professional review action and thus not give rise to any right of hearing or appellate review, except as otherwise expressly set forth in this Section.

Section 6. Enforcement of Automatic Suspensions. It shall be the duty of the Chief Medical Officer to cooperate with the President in enforcing all automatic suspensions.

Article VIII

Fair Hearing and Appellate Review Procedure

Background

This purpose of this Article VIII is to provide mechanisms for fair hearing and appeal processes that are designed to allow an affected Medical Staff member or applicant a fair opportunity to defend herself or himself regarding the adverse decision to an unbiased hearing body of the Medical Staff, and an opportunity to appeal the decision of the hearing body to the governing body. The purpose of the fair hearing and appeal is to assure full consideration and reconsideration of quality and safety issues, and under the current structure of reporting to the National Practitioner Data Bank, allow LIPs to defend themselves. The provisions of this Article VIII apply only under the circumstances as specified in the provisions of these Bylaws. Section 1 through Section 7 apply only to LIP Medical Staff members; Section 8 applies to AHP Medical Staff Members; and Section 9 applies to LIPs who have clinical privileges but who are not applicants for membership or who are not current members of the Medical Staff.

Section 1. Right to a Fair Hearing; Initiation of Proceedings.

(A) **Triggering Events.** The following actions, if deemed adverse under Section 1(B) below, entitle the member of the Medical Staff or an applicant for membership to a fair hearing upon a timely and proper request:

- (1) Denial of initial Medical Staff appointment.
- (2) Denial of reappointment.
- (3) Suspension of Medical Staff membership (other than suspensions pursuant to Article VII, Section 3).
- (4) Revocation of Medical Staff membership.
- (5) Denial of requested appointment to or advancement in Medical Staff category
- (6) Reduction in Medical Staff category.
- (7) Limitation of the right to admit patients.
- (8) Denial of requested Clinical Department affiliation.
- (9) Denial or restriction of requested clinical privileges.
- (10) Reduction in clinical privileges.
- (11) Suspension of clinical privileges (other than suspensions pursuant to Article VII, Section 3).

- (12) Revocation of clinical privileges.
- (13) Individual application of, or individual changes in, mandatory consultation requirement.
- (B) **When Deemed Adverse.** An action listed above is adverse only when it has been:
 - (1) Recommended by the Medical Executive Committee;
 - (2) Taken by the Board under circumstances where no prior right to a hearing existed; or
 - (3) Instituted as a summary suspension under Article VII, Section 2 if the conditions of Article VII, Section 2(C) are met; or
 - (4) Taken by the Board under circumstances where no prior right to a hearing existed.
- (C) **Notice of Adverse Action.** The Chief Medical Officer promptly gives the LIP notice of the action that:
 - (1) Advises the LIP of the reasons for the action and of the right to request a hearing pursuant to the provisions of this Article.
 - (2) Specifies that the LIP has 30 days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Section 1(D) of this Article.
 - (3) States that the LIP's failure to request a hearing within the 30-day time period and in the proper manner constitutes a waiver of rights to a hearing and to an appellate review regarding the matter.
 - (4) States that the LIP will be notified of the date, time, and place of the hearing after making a timely and proper request.
 - (5) Summarizes or sets forth the provisions of Section 2(C) and Section 3(D) of this Article or includes a copy of these Bylaws.
- (D) **Request for Hearing.** The LIP must file a written request for a hearing within 30 days after receipt of the notice described in Subsection (C) above. The LIP's request must be given to the Chief Medical Officer by notice in accordance with Section 2(I) of Article I.
- (E) **Waiver by Failure to Request a Hearing.** A LIP who fails to request a hearing within the time specified in Section 1(D) is deemed to have waived all rights to any hearing or any appellate review to which he or she might otherwise have been entitled.
 - (1) Such waiver in connection with an adverse action by the Board becomes the final decision of the Board.

- (2) Such waiver in connection with an adverse recommendation by the Medical Executive Committee constitutes acceptance of that action, which then becomes and remains effective pending the final decision of the Board. The Board considers the adverse action or recommendation at its next regular meeting following waiver. If the Board's action accords with the Medical Executive Committee's recommendation, it becomes the final decision of the Board. If the Board's action is different from the Medical Executive Committee's recommendation, the matter is submitted to a joint conference as provided in Section 6(J) of this Article. The Chief Medical Officer promptly gives the LIP and the Chief of Staff notice of each action taken under this Section.
- (F) If the adverse action necessitates a report to the National Practitioner Data Bank, that is if it remains in effect for 30 or more days, the notice to the LIP shall so state.

Section 2. Hearing Prerequisites.

- (A) **Arrangements for Hearing.** After receipt of a timely request for a hearing, the Chief of Staff or Chairman of the Board, depending on whose recommendation or action prompted the hearing request, must schedule and arrange for a hearing. The Chief Medical Officer gives the LIP notice of the hearing at least 30 days in advance of the hearing.
- (B) **Notice of Hearing.** The notice of hearing given to the LIP must include the following:
 - (1) The place, time, and date of the hearing;
 - (2) A list of the witnesses (if any) expected to testify at the hearing in support of the adverse action; and
 - (3) The agenda for the hearing, including a summary of the LIP's alleged acts or omissions, a list by number of the specific or representative patient records in question, and/or a summary of the other reasons or subject matter forming the basis for the adverse action that is the subject of the hearing.
- (C) **Appointment of Hearing Officer or Hearing Committee.** As determined by the Hospital, the hearing will be held:
 - (1) Before a hearing officer who is appointed by the Hospital and who is not in direct economic competition with the LIP involved (LIPs in direct economic competition are those actively engaged in the affected LIP's primary medical community and who practice in the same medical specialty or subspecialty); or
 - (2) Before a hearing committee composed of individuals appointed by the Hospital who are not in direct economic competition with the LIP involved, one of whom will be designated by the Hospital as the chair of the hearing committee.

- (D) **Composition of Hearing Committee.** If the Hospital determines that the hearing will be held before a hearing committee pursuant to Subsection (C)(2) above, then the hearing committee will be constituted as follows:
- (1) A hearing occasioned by an adverse recommendation of the Medical Executive Committee is conducted before a hearing committee appointed by the Chief of Staff, approved by the Chairman of the Board, and composed of at least three individuals, all of whom must, if feasible, be LIP members of the Medical Staff.
 - (2) A hearing occasioned by an adverse action of the Board is conducted before a hearing committee appointed by the Chairman of the Board and composed of five individuals, at least two of whom must, if feasible, be LIP members of the Medical Staff.
- (E) **Service as Hearing Officer or Member of Hearing Committee.** A Medical Staff or Board member is not disqualified from serving as a hearing officer or on a hearing committee merely because he or she participated in the investigation of the underlying matter at issue or because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be.
- (F) **Hearing Conducted by Independent Consultant.** If in the judgment of the Hospital, a sufficient number of LIP Medical Staff members not in direct economic competition with the LIP are not available to form a hearing committee, the committee may be composed of other LIPs who are impartial peers (whether or not Medical Staff members).

Section 3. Hearing Procedure.

- (A) **Personal Presence.** The personal presence of the LIP is required. A LIP who fails without good cause to appear and proceed at the hearing is deemed to have waived all rights to any hearing or any appellate review to which he or she might otherwise have been entitled with the same consequences as provided in Section 1(E) of this Article.
- (B) **Duties of Arbitrator, Hearing Officer, or Chair.** Subject to Section 7(A) of this Article, the arbitrator, hearing officer, or chair of the hearing committee, as the case may be, is the presiding officer at the hearing. This officer maintains decorum and assures that all participants have a reasonable opportunity to present relevant oral and documentary evidence. He or she determines the order of procedure during the hearing and makes all rulings on matters of law and procedure and on the admissibility of evidence.
- (C) **Representation.** Subject to Section 7(B) of this Article, the LIP may be accompanied and represented at the hearing by a licensed Wisconsin attorney or other person of the LIP's choice. The Medical Executive Committee or the Board, depending on whose recommendation or action prompted the hearing, will appoint an individual to represent it.

(D) Rights of the Parties.

- (1) During the Hearing.** During the hearing, each party has the right:
 - (a) To have a record made of the proceedings, copies of which may be obtained by the LIP upon payment of any reasonable charges associated with the preparation thereof;
 - (b) To call, examine, and cross-examine witnesses;
 - (c) To present evidence and exhibits determined to be relevant by the arbitrator, hearing officer, or chair of the hearing panel, as the case may be, regardless of the admissibility of such evidence and exhibits in a court of law;
 - (d) To rebut any evidence; and
 - (e) To present a written statement at the close of the hearing.
 - (f) Further, a LIP who does not testify in his or her own behalf may be called and examined as if under cross-examination.
- (2) Following the Hearing.** Upon completion of the hearing, the LIP involved has the right:
 - (a) To receive a copy of the written record of the hearing upon payment of the charges referred to in Subsection (D)(1)(a) above;
 - (b) To receive copies of each report prepared pursuant to Section 4(A) and (B) of this Article, including particularly a copy of the final decision of the Hospital, which must be in writing and include a statement of the bases on which it was made.
 - (c) To request appellate review in accordance with Section 5 and Section 6 of this Article.

(E) Procedure and Evidence. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party is entitled, prior to or during the hearing, to submit memoranda concerning any issues of law or fact, and those memoranda will become part of the hearing record.

(F) Official Notice. In reaching a decision, the hearing officer or hearing committee, as the case may be, may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration and of any facts that may be judicially noticed by the courts of the

state where the hearing is held. Parties present at the hearing must be informed of the matters to be noticed and those matters must be noted in the hearing record. On timely request, any party must be given the opportunity to ask that a matter be officially noticed and to refute the officially noticed matters proposed by the other party, by evidence or by written or oral presentation of authority, in a manner to be determined by the hearing officer or hearing committee, as the case may be. All other information that can be considered under these Medical Staff Bylaws in connection with credentials matters may also be considered.

- (G) **Burden of Proof.** When a hearing relates to the denial of the LIP's request for initial Staff appointment, the denial of a requested appointment to or advancement in Staff status, the denial of a requested Department or Service affiliation, or the denial or restriction of requested clinical privileges under, respectively, Section 1(A)(1), (5), (8) or (9) of this Article, the LIP has the burden of proving that the adverse action or recommendation lacks any substantial factual basis or that the basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious. For the other matters listed in Section 1 of this Article, the body whose adverse action or recommendation occasioned the hearing has the initial obligation to present evidence in support thereof, but the LIP thereafter is responsible for supporting his or her challenge that the adverse action or recommendation lacks any substantial factual basis or that the basis or the conclusions drawn therefrom are either arbitrary, unreasonable, or capricious.
- (H) **Hearing Record.** A record of the hearing will be kept that is of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision on the matter. The hearing officer or hearing committee may select the methods to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings.
- (I) **Postponement.** Requests for postponement of a hearing may be granted only upon a showing of good cause and only if the request is made as soon as is reasonably practical.
- (J) **Presence of Hearing Committee Members and Vote.** In a hearing conducted before a hearing committee, a majority of the hearing committee must be present throughout the hearing and deliberations. A committee member who is absent from any significant part of the proceedings shall not participate in the deliberations or the decision.
- (K) **Recesses and Adjournment.** The hearing may be recessed and reconvened without additional notice 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, subject to the submission of written statements pursuant to Subsection (D)(1)(e) of this Section. The hearing committee (if any) shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing committee shall be adjourned.

Section 4. Hearing Report and Further Action.

- (A) **Hearing Report.** Within 10 days after final adjournment of the hearing, the hearing officer or hearing committee makes a written report and forwards it to the body whose adverse action occasioned the hearing. The report must include recommendations and a statement of the findings constituting the basis for the recommendations, with specific reference to the hearing record and other documentation considered.
- (B) **Action on Hearing Report.** As soon as practical, but within 45 days after receiving the hearing report, the body whose adverse action occasioned the hearing considers the report and prepares its own report affirming, modifying, or reversing its previous action. The report of such body must include a statement of the basis for the decision. The body then transmits its report, together with the hearing record, the hearing report, and all other documentation considered, to the Chief Medical Officer.
- (C) **Notice and Effect of Report.**
- (1) **Notice.** The Chief Medical Officer promptly gives copies of the reports mentioned in Section 4(A) and (B) to the LIP by notice, and also sends copies to the Chief of Staff, the Medical Executive Committee, and the Board.
- (2) **Effect of Favorable Report.**
- (a) **Adopted by the Board.** If the Board's report under Section 4(B) is favorable to the LIP, it becomes the final decision of the Board.
- (b) **Adopted by the Medical Executive Committee.** If the Medical Executive Committee's report under Section 4(B) is favorable to the LIP, the Chief Medical Officer promptly forwards it, together with all supporting documentation, to the Board. The Board may adopt or reject the report in whole or in part or refer the matter back to the Medical Executive Committee for further consideration. Any referral back must set a time limit within which a subsequent recommendation must be made and may include a directive for an additional hearing. After receiving a subsequent recommendation and any new evidence, the Board takes action. Any decision by the Board must be in writing and must include a statement of the bases for the decision. The Chief Medical Officer promptly gives the LIP notice of each action taken under this Subsection, including a copy of the decision. A favorable action by the Board becomes the final decision and the matter proceeds as provided in Section 4(C)(2) above.
- (3) **Effect of Adverse Report.** If the report of the Medical Executive Committee or the Board under Section 4(B) continues to be adverse to the LIP, the notice under Section 4(C)(1) shall inform the LIP of the right to request an appellate review by the Board as provided in Section 5 of this Article.
- (D) **Disqualification from Review of Hearing Report.** A Medical Staff or Board member is not disqualified from participating as a member of the Board or the Medical Executive

Committee in review activities under Section 4 or appellate review activities under Section 5 and Section 6 of this Article merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be. However, a Medical Staff or Board member who served as an arbitrator, hearing officer, member of a hearing committee or who participated in a hearing in a particular case, or who is in direct economic competition with the LIP involved, shall not vote as a member of the Board or the Medical Executive Committee in review activities under Section 4 or appellate review activities under Section 5 and Section 6 of this Article.

Section 5. Initiation and Prerequisites for Appellate Review.

- (A) **Request for Appellate Review.** The LIP must file a written request for an appellate review within 10 days after receipt of a notice of final adverse action to a file a written request for an appellate review. The request for appellate review must be given to the Chief Medical Officer by notice in accordance with Section 2(I) of Article I. The request may include a request for copies of the hearing record and all other materials, favorable or unfavorable, if not previously forwarded, that were considered in taking the adverse action. If the LIP wishes to make an oral statement to the appellate review body, the request must so state.
- (B) **Waiver by Failure to Request Appellate Review.** A LIP who fails to request an appellate review within the 10-day period specified in Subsection (A) is deemed to have waived any right to any appellate review. The waiver has the same force and effect as provided in Section 1(E) of this Article.
- (C) **Notice of Time and Place for Appellate Review.** As soon as practicable after receipt of a timely request for appellate review, the Chief Medical Officer delivers a copy to the Board. As soon as practicable, the Board schedules and arranges for an appellate review, which shall not be less than 10 days nor more than 45 days after the Board's receipt of the request; provided, however, that an appellate review for a LIP who is under suspension then in effect shall be held as soon as the arrangements for it may be reasonably made, but not later than 10 days after the Board's receipt of the request. The Chief Medical Officer gives the LIP notice of the time, place, and date of the appellate review. The appellate review body may extend the time and date of the appellate review for good cause if a request for an extension is made as soon as reasonably practicable.
- (D) **Appellate Review Body.** If a recommendation by the Medical Executive Committee occasions the appellate review, the Board serves as the appellate review body. If an action by the Board occasions the appellate review, the review is conducted by the Board as a whole.

Section 6. Appellate Review Procedure.

- (A) **Nature of the Proceedings.** The proceedings by the appellate review body are a review based upon the hearing record, the hearing report, all subsequent reports and actions, the written statements, if any, provided, and any other material that may be presented and accepted.

- (B) **Written Statements.** The LIP may submit a written statement detailing the findings, recommendations, conclusions, and procedural matters with which he or she disagrees and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement must be submitted to the appellate review body through the Chief Medical Officer by notice at least five days prior to the scheduled date of the review, unless such time limit is waived by the reviewing body. A similar statement may be submitted by the group whose adverse action occasioned the review, and if submitted, the Chief Medical Officer must provide a copy to the LIP by notice at least three days prior to the scheduled date of the appellate review.
- (C) **Presiding Officer.** The chair of the appellate review body is the presiding officer. He or she determines the order of procedure during the review, makes all required rulings, and maintains decorum.
- (D) **Oral Statement.** The appellate review body, in its sole discretion, may allow the parties and/or their representatives to appear personally and to make oral statements in favor of their positions. Any party or representative appearing is required to answer questions put by any member of the reviewing body.
- (E) **Consideration of New or Additional Matters.** New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only at the discretion of the reviewing body and only if the party requesting consideration of the matter or evidence shows that it could not have been discovered in time for the initial hearing. The requesting party must ask for consideration of the matter or evidence at least 72 hours prior to the scheduled date of the review by providing a written, substantive description of the matter or evidence by notice to the appellate review body through the Chief Medical Officer and by notice to the other party.
- (F) **Powers.** The appellate review body has all the powers granted to the arbitrator, hearing officer, or the hearing committee, as the case may be, and any additional powers that are reasonably appropriate to or necessary for the discharge of its responsibilities.
- (G) **Presence of Members and Vote.** A majority of the reviewing body must be present throughout the review and deliberations. A member who is absent from any significant part of the proceedings shall not be permitted to participate in the deliberations or the decision.
- (H) **Recesses and Adjournments.** The reviewing body may recess and reconvene the proceedings without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. At the conclusion of the oral statements, if allowed, the appellate review shall be closed. The reviewing body shall then, at a time convenient to itself, conduct its deliberations outside the presence of the parties. The appellate review shall be adjourned at the conclusion of those deliberations.
- (I) **Action Taken.** The decision of the reviewing body must be in writing and must include a statement of the bases for the decision. A copy shall be given the LIP by notice. The

reviewing body may affirm, modify, or reverse the adverse result or action, or, in its discretion, may refer the matter back to the hearing committee for further review and recommendation, to be returned to the reviewing body within 10 days and in accordance with its instructions. Within 10 days after receipt of such recommendation after referral, the reviewing body shall take action. If the reviewing body's decision is in accord with the Medical Executive Committee's last recommendation in the matter, if any, it shall be immediately effective and final. If the reviewing body's decision has the effect of changing the Medical Executive Committee's last recommendation, if any, the matter shall be referred to a joint conference as provided in Subsection (J) below. The reviewing body's decision on the matter following receipt of the joint conference recommendation shall be immediately effective and final.

- (J) **Joint Conference Review.** Within three days after receiving a matter referred to it under Subsection (I) above, a joint conference composed of three Board members appointed by the Chairman of the Board and three Medical Staff members appointed by the Chief of Staff shall convene to consider the matter and shall submit its recommendations to the reviewing body. A copy of the recommendations shall be provided to the LIP by notice.

Section 7. General Provisions.

- (A) **Hearing Officer Appointment and Duties.** The use of a hearing officer in lieu of a hearing committee or the use of a hearing officer to preside at the evidentiary hearing in lieu of the chair of the hearing committee is optional and is to be determined by the Board after consultation with the Chief of Staff. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings.
- (B) **Attorneys.**
 - (1) **At Hearing.** The LIP may be represented by an attorney at the hearing, but his or her request for the hearing should indicate an intent as to whether or not he or she will be so represented.
 - (2) **At Appellate Review.** If the LIP desires to be represented by an attorney at an appellate review appearance, the request for the review must so declare. The appellate review body determines in its sole discretion whether to permit such representation.
- (C) **Number of Hearings and Reviews.** Notwithstanding any other provision of the Medical Staff Bylaws, no LIP is entitled, as a right, to more than one evidentiary hearing and appellate review with respect to an adverse action.
- (D) **Release.** By requesting a hearing or appellate review under this Article, a LIP agrees to be bound by the provisions of Article II, Section 3 relating to immunity from liability.
- (E) **Substantial Compliance.** Technical or insignificant deviations from the procedures set forth in this Article VIII shall not be grounds for invalidating the action taken.

- (F) **Reporting Requirements.** If adverse action is required to be reported to the Wisconsin Medical Examining Board or the National Practitioner Data Bank, Hospital Chief Medical Officer shall submit such reports within 15 days of the final action taken by the Board of Directors, unless otherwise required by law to be submitted earlier.

Section 8. Fair Hearing and Appeal of Termination of Privileges for AHPs.

The Medical Staff provides a limited fair hearing process with respect to termination, suspension, non-appointment, non-reappointment, or denial or reduction of clinical privileges for Allied Health Professionals. This will be provided in the form of a conference with an Ad Hoc Committee composed of the AHP's Medical Staff Clinical Leader, the sponsoring or supervising LIP(s) if there is a member(s) of the Medical Staff who serves as sponsor, and the Chief of Staff. The Ad Hoc Committee will provide the affected Allied Health Professional written notice of date, time and place of the conference which notice will include the basis for the privilege action. The Allied Health Professional has the right to appear before the Ad Hoc Committee and present information refuting the privilege action.

Within a reasonable time after adjournment of the conference, the Ad Hoc Committee will advise the Allied Health Professional in writing indicating whether it agrees with the privilege action. If the decision is in disagreement with the privilege action, the matter will be referred to the Medical Executive Committee for its consideration and recommendation. If the decision is in agreement with the privilege action, the Allied Health Professional may appeal the decision to the Board who shall have the sole authority to decide the status of the Allied Health Professional's privileges.

Section 9. Fair Hearing and Appeal of Termination of Privileges for Non-member LIPs.

LIPs who have clinical privileges but who are not applicants for membership or who are not current members of the Medical Staff are entitled to a hearing to be conducted by the Chief of Staff, the Chief Medical Officer for Medical Affairs and a designee of the Hospital President if adverse action is taken regarding their privileges. The hearing body shall provide a recommendation to the party whose action was adverse to the LIP and thereafter the decision will be final.

Article IX

Adoption and Amendment of Medical Staff Bylaws

Section 1. Medical Staff Authority and Responsibility. Neither the Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws. However, in the event of a stalemate between the Medical Staff and the Board to resolve disagreements regarding the Bylaws, a Joint Conference Committee, consisting of the Board and the MEC, will be convened to discuss the matter in detail and will follow the same process as set forth under Section 3(B) of this Article. These Bylaws will be reviewed at least every three years by a committee appointed by the Chief of Staff. Proposed amendments to these Bylaws may originate from the appointed committee, the Medical Executive Committee, or a petition signed by 25% of the Active LIP Medical Staff. Because the Board has delegated to the Medical Staff the authority and responsibility to initiate

and recommend to the Board the Bylaws establishing the Staff's organizational structure and governing its processes and manner of acting, subject only to certain limitations detailed in the Hospital's corporate bylaws, the adoption and amendment of these Medical Staff Bylaws require the actions specified in Section 2 and Section 3 of this Article. The adoption and amendment of the rules, regulations and policies set forth in this Article IX require the actions specified in Section 4 of this Article.

Section 2. Medical Staff Action. The Medical Staff may act under either Subsection (A) or (B) of this Section to adopt or amend these Bylaws. The Medical Staff's action is forwarded to the Board for its action.

- (A) **Action by Meeting.** These Bylaws may be adopted or amended by the affirmative vote of two-thirds of the Staff members eligible to vote at a regular or special Staff meeting at which a quorum is present, provided that a copy of the proposed Bylaws or amendments were provided to each voting member in advance of the meeting, or, in the case of a special meeting, with the notice of the meeting.
- (B) **Action by Mail (Electronic or Paper) Ballot.** These Bylaws may also be adopted or amended by the affirmative vote of two-thirds of the ballots received from the Staff members eligible to vote pursuant to a ballot, provided that a copy of the proposed Bylaws or amendments was provided to each voting member 15 calendar days in advance of the vote, and, provided further, that appropriate measures are used limit the voting to eligible Staff members.
- (C) **Action by the Medical Executive Committee.** When the Medical Executive Committee proposes changes and before it votes, it will communicate its proposed amendment to the Medical Staff. The Medical Executive Committee shall have the authority to provisionally revise these Bylaws without approval of the full Medical Staff if such amendments do not materially amend any Bylaw provision and are solely for technical modification or clarification, reorganization or renumbering, or to correct grammatical, spelling or punctuation errors. Such revisions are not formal amendments but still require formal approval by the Board to become effective. In the event the Medical Executive Committee proposes an amendment that is not approved by the Medical Staff, the process for resolving conflict as set forth in Article IX, Section 5 shall be followed.

Section 3. Board Action.

- (A) **When Favorable to Medical Staff Recommendation.** The Bylaws adopted or amended by the action of the Medical Staff are effective upon the affirmative vote of a majority of the Board cast at a regular or special meeting at which a quorum is present. Such information is then communicated to the Board at its next regularly scheduled meeting.
- (B) **When Contrary to a Medical Staff Recommendation.** Following exhaustion of the notice and hearing procedures provided in the Hospital's corporate bylaws for application when the Board and Medical Staff are not in agreement concerning provisions of the Medical Staff Bylaws, the Board may adopt or amend Bylaws notwithstanding the

Medical Staff's action upon the affirmative vote of a majority of the Board cast at a regular or special meeting at which a quorum is present.

Section 4. Adoption and Amendment of Policies. Medical Staff policies are not unilaterally amended. Neither the organized staff nor the governing body may unilaterally amend Medical Staff policies. The Medical Staff may adopt such policies as may be necessary or desirable in the implementation of the matters dealt with in these Bylaws. Medical Staff policies will not conflict with these Bylaws. The Medical Staff hereby delegates such authority to the Medical Executive Committee, as stated in Section 3(C) of Article IV of these Bylaws. Any policy adopted by the Medical Executive Committee and approved by the Board shall be promptly communicated to the Medical Staff. Policies may also be proposed to the Board by majority vote of the members of the Medical Staff entitled to vote. Any such policies proposed by a majority of the Medical Staff shall be submitted to the Medical Executive Committee for review and comment before such policy is forwarded to the Board for approval. The proposed policy shall then be presented to the Board along with any comments from the Medical Executive Committee.

Section 5. Conflict Resolution. In the event of a conflict between members of the Medical Staff and the Medical Executive Committee regarding the adoption of any Bylaw, Rule, Regulation, policy or any amendment thereto, the matters shall be submitted to a joint meeting of equal members of the Medical Staff and the Medical Executive Committee for review and recommendation to the Board. If resolution cannot be made through this process, both groups shall submit their position to the Board for final decision. Such amendments shall be effective when approved as decided by the Governing Body.

* * * * *

The foregoing Amended and Restated Medical Staff Bylaws were duly adopted by the Froedtert Memorial Lutheran Hospital Medical Staff effective as of October 23, 2013.



Chief of Staff

The foregoing Amended and Restated Medical Staff Bylaws were duly adopted by the Froedtert Memorial Lutheran Hospital Board of Directors effective as of October 23, 2013.



Chairman, Board of Directors

MEDICAL STAFF

BYLAWS

APPROVED BY GOVERNING BODY APRIL 5, 2012

FROEDTERT SURGERY CENTER, LLC
Milwaukee, Wisconsin

**FROEDTERT SURGERY CENTER
MEDICAL STAFF BYLAWS**

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ARTICLE I. DEFINITIONS

For purpose of these Bylaws, the following definitions shall apply:

1. The term “Management Committee” means the governing body responsible for conducting the ordinary business affairs of the Facility.
2. The term “Executive Director or their designee” means the individual appointed by the Management Committee to serve as the chief executive officer of the Facility or their designee. The Executive Director or their designee is responsible to the Management Committee for supervising the management of the Facility and its employees.
3. The term “Facility” means Froedtert Surgery Center, LLC.
4. The term “Medical Advisory Committee” means the advisory committee of the Medical Staff consisting of active Medical Staff and consulting Medical Staff members appointed by the Management Committee.
5. The term “Allied Health Staff” means those individuals who are qualified to render health care services at the Facility under the supervision of a member of the Medical Staff, in accordance with the terms and conditions of the Medical Staff Rules and Regulations, and who are not members of the Medical Staff.
6. The term “Medical Director” means the Medical Staff member appointed by the Management Committee to serve as the chairperson of the Medical Advisory Committee.
7. The term “Medical Staff” means all physicians, dentists, and podiatrists who are privileged to attend patients in the Facility.
8. The term “physician” means an appropriately licensed medical physician or osteopathic physician.
9. The term “practitioner” means an appropriately licensed medical physician, osteopathic physician, dentist or Doctor of Podiatric Medicine.

ARTICLE II. CATEGORIES OF MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into active, consulting and provisional categories.

Section 2. Active Medical Staff

Active Medical Staff shall consist of practitioners qualified for Medical Staff membership who are regularly involved in the care of patients at the Facility, at minimum, one (1) case per annum of their appointment cycle, and who assume the functions and responsibilities of the active Medical Staff. Members of the active Medical Staff must have completed at least one (1) term as a member of the provisional Medical Staff. Members of the active Medical Staff shall be entitled to vote and shall be eligible to hold office and serve on Medical Staff committees.

Section 3. Consulting Medical Staff

Consulting Medical Staff shall consist of practitioners qualified for Medical Staff membership who provide consultation in the diagnosis and treatment of patients in the Facility at the request of an active Medical Staff member. Members of the consulting Medical Staff shall be entitled to vote, and shall be eligible to hold office and serve on Medical Staff committees.

Section 4. Provisional Medical Staff

Provisional Medical Staff shall consist of practitioners new to the Medical Staff who are seeking appointment as a member of the active Medical Staff. Members of the provisional Medical Staff shall not vote, hold office or serve on Medical Staff committees. All initial appointments to the provisional Medical Staff shall be for a period of up to two (2) years. During the provisional appointment, a provisional staff member shall perform a minimum of ten (10) cases to advance to active staff status. If a practitioner does not meet this requirement during the initial two (2) year period, the Medical Advisory Committee may, by written notice to the provisional Medical Staff member, extend the provisional period for an additional two (2) years, after which time failure to advance a practitioner to active Medical Staff status shall terminate such practitioner's staff appointment. The provisional Medical Staff member will be observed by the Medical Advisory Committee representative from the appropriate clinical department to assess clinical and professional performance and eligibility for advancement to the active Medical Staff.

Section 5. Allied Health Staff

- a. Allied Health Staff include, but are not limited to the following categories of professionals: physician's assistants, advanced practice nurses, optometrists, clinical social workers, marriage and family therapists, and certain professional counselors as defined by policy. Allied Health Staff may be either: (1) employed by the Facility, or (2) employed by Members of the Medical Staff or legal organizations of Members of the Medical Staff. Allied Health Staff may practice in relative independence or under the direct supervision of a Medical Staff member, depending on their training and the supervision required by state law or regulation for licensure or certification. Allied Health Staff shall continuously meet the qualifications, standards and requirements as set forth in these Bylaws and associated Medical Staff Rules and Regulations. Allied Health Staff do not vote at any Medical Staff meeting, or otherwise participate in the benefits of Medical Staff membership.

Each individual will present qualifications for review by the Medical Advisory Committee in accord with the policies and procedures outlined in Article III of these Bylaws for the appointment of Medical Staff members.

All initial applicants for Allied Health Staff status will be appointed as Allied Health Staff for a provisional period of not less than two (2) years. Upon successful completion of the applicant's provisional term, he or she may be considered for regular Allied Health Staff appointment.

- b. **Qualifications and Responsibilities.** Allied Health Staff may provide patient care services within the limits of their professional skills and abilities and delineated scope of practice,

meeting all state licensure and certification requirements, as applicable. The degree of participation by Allied Health Staff in patient care shall be determined according to policies recommended by the Medical Staff and approved by the Management Committee.

An individual applying for appointment as an Allied Health Staff member must be continuously sponsored by or collaborating with, a member of the Medical Staff who will review the adequacy of the individual's performance on a regular basis. The Medical Staff member sponsor/collaborator will attest to this in writing.

If an Allied Health Staff member is employed by a Medical Staff member or the same employer as the Medical Staff member, the Medical Staff sponsor shall assume full responsibility, and be fully accountable for the conduct of the individual within the Facility. The sponsoring Medical Staff member shall provide supervision of the Allied Health Staff member as required by state licensure and certification requirements. It is further the responsibility of the employer of the Allied Health Staff member to acquaint the individual with the applicable policies of the Medical Staff and the Facility, as well as appropriate members of the Medical Staff and Facility personnel with whom said individual shall have contact with at the Facility.

- c. Application/Appointment Process. Applications for appointment to provide specified services as Allied Health Staff shall be obtained and processed as follows:
 - 1) The Allied Health Staff shall complete an application;
 - 2) Requests for approval of Allied Health Staff members shall be reviewed by the sponsoring collaborating Medical Staff member and the Executive Director or their designee; both must approve the request in order for it to be granted. The actions on these requests will be then reviewed by the Medical Advisory Committee and sent to the Board for final approval;
 - 3) The Allied Health Staff member shall comply with Occupational Health policy regarding immunizations and TB surveillance;
 - 4) The Allied Health Staff member shall participate in orientation and in-Facility training requirements as outlined by the Facility. Completion of this requirement shall be documented.
- d. Reappointment Process/Termination. Applications for reappointment to provide specified services in the Facility as an Allied Health Staff member shall be obtained and processed in the same manner as applications for Medical Staff reappointment. The Facility retains the right; either through the administration or upon recommendation of the Medical Advisory Committee, to suspend or terminate any or all of the privileges or functions of any category of Allied Health Staff member, without recourse on the part of the person in that category to the procedures provided in the Fair Hearing Plan outlined in the Medical Staff Bylaws. Should any such action occur, and result in a reduction or removal of the clinical privileges of the Allied Health Staff member, the individual shall be entitled to a hearing conducted by the Medical Director. Such hearing shall be

promptly conducted and shall provide the Allied Health Staff member with the reasons for the Facility's actions.

An Allied Health Staff member's ability to practice at the Facility shall automatically terminate when: (1) the Allied Health Staff member is no longer employed by a member of the Medical Staff or the same employer as the Medical Staff member or the Facility, (2) if the Medical Staff member sponsor is terminated and replaced with another Medical Staff member sponsor for the Allied Health Staff member, or (3) if the Medical Staff member's clinical privileges are curtailed to the extent that the professional services of said individual are no longer necessary or permissible to assist the employer and there is not a Medical Staff member sponsor for the Allied Health Staff member. When privileges are terminated under this Section, the Allied Health Staff member shall have no right to an appeal, unless provided under the Facility's Human Resource policy.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 1. Qualifications for Membership

- a. Membership on the Medical Staff of the Facility shall be a privilege available only to those professionally competent practitioners within the Facility's primary service area who consistently meet the qualifications, standards and requirements set forth in these Bylaws and the Medical Staff Rules and Regulations. Only practitioners who satisfy the following conditions shall be qualified for appointment to the Medical Staff:
 - 1) Are able to document their background, experience, training, competence, their adherence to the ethics of their profession, and their good reputation and ability to work with other practitioners and staff with sufficient adequacy to assure the Medical Staff and the Management Committee that any patient treated by them in the Facility will receive high quality medical care;
 - 2) Have an unlimited license to practice medicine, osteopathy, dentistry or podiatry in the State of Wisconsin;
 - 3) Are board certified, or board eligible or board qualified and receive board certification within five (5) years, and maintain such board certification by the applicable specialty for the duration of practitioner's Medical Staff membership; except that this requirement is waived:
 - a. if the practitioner is a podiatrist who has completed a residency program approved by an appropriate specialty board recognized by the Council of Podiatric Medical Education of the American Podiatric Medical Association;
 - b. if the practitioner is a dentist; or
 - c. if the practitioner was approved for clinical privileges at Froedtert Memorial Lutheran Hospital prior to 3/1/2005 and has maintained clinical privileges continuously since that date.

- 4) Graduated from a medical school, osteopathic school, dental school or podiatric school program accredited in accordance with Wisconsin law;
 - 5) Possess a current federal Drug Enforcement Agency (“DEA”) certificate, unless the practitioner practices in a specialty in which DEA certification is not necessary and is not customarily mandated;
 - 6) Annually submit evidence of current professional malpractice insurance coverage with limits not less than those specified in Wis. Stat. §655.23 or successor statutes thereto; and each practitioner must maintain compliance with the provisions of Wis. Stat. §655.27, or successor statutes thereto, regarding participation in the Injured Patients and Families Compensation Fund;
 - 7) Are not excluded from any healthcare program funded in whole or in part by the federal government;
 - 8) Have completed a background check required by Wis. Stat. §50.065 or successor statute thereto, the results of which do not prevent the Facility from extending Medical Staff membership to the practitioner;
 - 9) Obtain or have the Facility obtain, a report from the National Practitioner Data Bank, the results of which do not prevent the Facility from extending Medical Staff membership to the practitioner;
 - 10) Provide documentation of Hepatitis B vaccination status consistent with OSHA requirements and agree to comply with the Facility’s Exposure Control Plan for compliance with the OSHA Standard on Occupational Exposure to Bloodborne Pathogens as modified from time to time, and provide documentation of Tuberculosis and Rubella vaccination status;
 - 11) Have signed an acknowledgment that the practitioner has received and read copies of these Bylaws, the Medical Staff Rules and Regulations, and associated policies, and agrees to be bound by and comply with the same.
- b. In addition, the practitioner shall be required to provide the Facility the following information:
- 1) The practitioner’s professional liability claims history;
 - 2) Any revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations on the practitioner’s license to practice any profession in any jurisdiction;
 - 3) Any denial, revocation, suspension, limitation, reduction, termination, nonrenewal, investigation or voluntary relinquishment of any specialty board certification or eligibility;
 - 4) Any complaints or adverse action reports filed against the practitioner with a local, state, or national professional society or licensure board;

- 5) Any refusal or cancellation of professional liability coverage;
 - 6) Any denial, revocation, suspension, limitation, reduction, termination, nonrenewal, investigation or voluntary relinquishment of the practitioner's professional privileges at any clinic, hospital, health plan or other institution;
 - 7) Any DEA and state license action;
 - 8) Any Medicare/Medicaid sanctions;
 - 9) Any conviction of a criminal offense (other than minor traffic violations);
 - 10) A current and valid picture identification issued by a state or federal agency;
 - 11) Certification that the practitioner is free from a physical, a mental health or an alcohol dependency condition or incapacity which would in any way restrict the practitioner's ability to care for patients. The Management Committee may precondition appointment or reappointment, and granting or continued exercise of clinical privileges, upon the practitioner undergoing mental or physical examinations and/or such test or tests as it may deem necessary at that time or at any intervening time, to evaluate the practitioner's ability to provide or continue to provide quality care and supervision to the practitioner's patients; and
 - 12) Signed statement releasing the Facility from liability and attesting to the correctness and completeness of the submitted information.
- c. The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications, in the appointment, reappointment and privileging process.
 - d. No practitioner shall be entitled to membership on the Medical Staff or to the exercise of clinical privileges merely by virtue of the fact that he or she is licensed to practice medicine, podiatry or dentistry in this or any other state, or that he or she is a member of any professional organization, or that he or she had or presently has such privileges at another hospital or similar facility.
 - e. No practitioner who is otherwise qualified shall be denied appointment or reappointment to the Medical Staff, or the exercise of clinical privileges, by reason of race, color, creed, age, sexual orientation, disability, sex or national origin, except as may be permitted by law.

Section 2. Conditions and Duration of Appointment

- a. Appointments to the Medical Staff shall be made by the Management Committee upon recommendation by the Medical Advisory Committee. Initial appointment for practitioners new to the Medical Staff who are seeking appointment as a member of the active Medical Staff shall be for a provisional period of up to two (2) years. Initial active or consulting Medical Staff appointments are for a period of up to two (2) years, and

thereafter renewal is for two (2) years. For the purpose of these Bylaws, the Medical Staff year commences on the first day of January and ends on the thirty-first day of December of each year.

- b. The codes of ethics as adopted or amended by the American Medical Association and the American College of Surgeons, the American Podiatric Medical Association, Inc., the American Dental Association, or the American Osteopathic Society, respectively, shall govern the professional conduct of the members of the Medical Staff.
- c. Upon application for appointment or reappointment to the Medical Staff, each applicant or Medical Staff member shall agree not to engage in the practice of the division of fees under any guise whatsoever, and shall agree to abide by these Bylaws, the Medical Staff Rules and Regulations and by such bylaws, rules and regulations as may be, from time to time, enacted. Along with the application for appointment or reappointment, practitioner must execute and submit authorization for the release of information and release from liability as required by the Facility in order to verify and evaluate the application.
- d. All Medical Staff members shall promptly notify the Executive Director or their designee of any condition affecting his or her continued right to Medical Staff membership.
- e. Activity Threshold. An activity threshold has been established at ten (10) cases per appointment period as discussed in Article III, Section 5 below, which must be performed at the Facility. Any practitioner not meeting this threshold may be considered to be voluntarily relinquishing his or her privileges, but may re-apply at any time.
- f. Leave of Absence. A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written notice to the Medical Director stating the exact period of time of the leave, which may not exceed one (1) calendar year for reasons related to illness, continuing and/or further formal education. During such period of absence, the Medical Staff member's privileges shall be suspended. At least thirty (30) days prior to the termination of leave, or at any earlier time, the staff member may request the reinstatement of privileges by submitting a written notice to the Medical Director. The Medical Staff member shall submit a summary of his or her relevant activities during the leave.

Section 3. Application Procedure

- a. An applicant for the Medical Staff of the Facility shall present written application for appointment and privileges for specific procedures to the Medical Director utilizing the form prescribed by the Facility. The application shall include all of the Medical Staff qualifications outlined in Section 1 of this Article.
- b. Upon receipt of the application, the Medical Director or his or her designee shall verify the application and transmit it to the Medical Advisory Committee for evaluation. If requested, the applicant shall appear for interviews in regard to his or her application. The Medical Advisory Committee shall review the character, qualifications, professional standing and suitability of the applicant and shall submit a written recommendation to the

Management Committee within ninety (90) days of receipt of application, including recommendations regarding specific procedures to be granted.

- c. The Management Committee shall either accept or reject the recommendations of the Medical Advisory Committee, or refer them back for further consideration, stating the reasons for such action. This shall be done at the next regularly scheduled meeting of the Management Committee not to occur later than one hundred twenty (120) days after receipt of the Medical Advisory Committee recommendation by the Management Committee. In the event the application is referred back to the Medical Advisory Committee, the applicant shall be notified and the Medical Advisory Committee shall submit a report to the Management Committee within ninety (90) days of the referral by the Management Committee. The Management Committee shall take action within ninety (90) days of the Medical Advisory Committee's second report. Failure of the Medical Advisory Committee or the Management Committee to meet the time deadlines contained in this Section, unless extended by mutual agreement of the applicant and either the Medical Director or the Executive Director or their designee, shall result in the denial of the application. When final action has been taken by the Management Committee, the Executive Director or their designee will transmit this information to the applicant.
- d. If the Management Committee's action with respect to an application for appointment or reappointment to the Medical Staff is adverse to the applicant or Medical Staff member, as the case may be, as further described in Article V hereof, the Executive Director or their designee shall promptly so inform the applicant or Medical Staff member by certified mail, return receipt requested, and the applicant or Medical Staff member shall be entitled to the procedural rights as provided in Article V.

Section 4. Clinical Privileges

- a. Every practitioner practicing at the Facility shall be entitled to exercise only those clinical privileges specifically granted by the Management Committee.
- b. Except as set forth in Section 1.a.3) (a & b) of this Article, all applicants requesting surgical admitting privileges must have admitting or co-admitting privileges in a local licensed and accredited hospital and must, in accordance with the requirements of the appropriate board, be (i) either board certified, or (ii) board eligible or board qualified and receive board certification within five (5) years.
- c. Upon receipt of a complete application for Medical Staff appointment and clinical privileges, temporary privileges may be granted on the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, with the written approval of the Medical Director and the Executive Director or their designee or his or her designee. This request shall be made in writing by the applicant and directed to the Medical Director. In exercising such temporary privileges, the applicant shall act under the supervision of the Medical Director. These privileges may be granted for a period of thirty (30) to one hundred twenty (120) days total. Temporary privileges may be immediately suspended or terminated by the Medical Director or his or her designee upon the occurrence of any event of a professional or

personal nature which casts doubt on the applicant's qualifications or ability to exercise the temporary privileges granted. An applicant will have no right to a hearing, appeal or appellate review of any kind because of inability to obtain temporary privileges, failure or renewal of such privileges, or termination of such privileges.

- d. Case-specific privileges may be granted for the care of a specific patient for a period of one (1) to five (5) days to practitioners who are potential staff applicants but who have not submitted a complete application for appointment to the Medical Staff, upon written approval by the Medical Director and the Executive Director or their designee. Prior approval for each surgical case performed in the Facility by the potential applicant with case-specific privileges shall be required, and the practitioner shall act under the supervision of the Medical Director.
- e. Privileges granted to Allied Health Staff shall be based upon their training, licensure, experience, ability to work with others, demonstrated competence and judgment, applicable state and federal laws, and such other requirements as may be set forth in these Bylaws and the Medical Staff Rules and Regulations.
- f. Disaster Privileges and Emergency Preparedness.
 - 1) For purposes of this Section, a "disaster" exists when the Facility implements its disaster plan and the Facility is unable to meet patient needs.
 - 2) During a disaster and in the best interest of immediate patient care, the Executive Director or their designee may, at their discretion, grant disaster privileges on a case-by-case basis to volunteer physicians upon presentation of the following:
 - a. A valid government-issued photo identification (i.e., driver's license or passport); and
 - b. At least one of the following:
 - (i) A current picture hospital ID card/badge (a photocopy will be made when possible); or
 - (ii) A current license to practice (a photocopy will be made when possible); or
 - (iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corps ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal response organization or group. Identification indicating that the individual has been granted authority by a federal, state or municipal entity to render patient care in emergency circumstances (a photocopy will be made when possible); or

- (iv) Presentation by current Medical Staff member(s) with personal knowledge regarding the practitioner's ability to act as a volunteer during a disaster.
- c. The Executive Director or his or her designee will have the overall responsibility for assignment of duties to any volunteer practitioners that are granted disaster privileges.
- d. As soon as possible, additional information will be gathered from the volunteer practitioners on a "Disaster Privileges" form. Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within seventy-two (72) hours from the time the volunteer begins to provide services at the Facility. In extraordinary circumstances where primary source verification can not be completed within seventy-two (72) hours, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- e. When possible, all practitioners granted disaster privileges during a disaster will be identified by a "Voluntary Practitioner: Disaster Privileges Granted" ID badge.
- f. When the Facility deems a "disaster or emergency situation to no longer exist or to be under control":
 - (i) The disaster privileges shall expire.
 - (ii) The practitioners that were granted disaster privileges must request Medical Staff membership and the clinical privileges necessary to continue to treat patients.
 - (iii) In the event such privileges are denied or the voluntary practitioner does not desire such privileges, any patients still receiving care at the Facility shall be assigned to an appropriate Medical Staff member.
 - (iv) After-the-fact/retroactive recredentialing for temporary privileges will occur as soon as possible if feasible to cover the time period of the disaster.

Section 5. Reappointment

- a. All appointments and privileges shall be reviewed for reappointment during the year of their two (2) year anniversary after appointment to the active or consulting Medical Staff and every two (2) years thereafter.
- b. Each applicant for reappointment to the Medical Staff shall submit to the Medical Advisory Committee and the Executive Director or their designee all information necessary to update the Medical Staff file on the Medical Staff member's health care related activities which shall include, but not be limited to, a specific request for privileges and, upon the request of the Medical Advisory Committee or the Executive Director or their designee, any or all of the Medical Staff qualifications required for initial appointment discussed in Article III, Section 1. No Medical Staff member shall be reappointed without specific review of the individual's performance and qualifications by the Medical Advisory Committee which will make specific recommendations to the Management Committee, setting forth its recommendations for renewal of staff privileges for each Medical Staff member.
- c. Each recommendation concerning the reappointment for a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgment in the treatment of patients, his or her professional ethics and conduct, physician and mental capabilities, his or her ability to perform the essential functions of his or her professional, with or without accommodation, according to accepted standards of professional performance and without posing a threat to the safety of patients, his or her attendance at Medical Staff meetings and participation in Medical Staff affairs, his or her compliance with the Facility's corporate bylaws and these Medical Staff Bylaws, cooperation with personnel, efficient and economical use of the organization's facility for patients, relations with other staff members, and general attitude toward patients, the organization and the public.
- d. If the practitioner has submitted a reappointment application, but the reappointment process has not been fully completed by the end of the current appointment, the applicant's privileges will be suspended until such time as the application has been processed as outlined herein. A practitioner who fails to submit a reappointment application by the end of his or her current appointment will be considered resigned from the staff and the resignation will be accepted by the Medical Advisory Committee and the Executive Committee. Should the resigned practitioner wish to again join the staff, it will be necessary for him to submit an initial application for staff membership.

Section 6. Exercise of Privileges

Members of the Medical Staff are strongly discouraged from acting as physician to their family members who are treated at the Facility and should do so only when no viable alternative treatment is available in the area, in accordance with AMA policy #E-8.19, entitled "Self Treatment or Treatment of Immediate Family Members."

ARTICLE IV. DISCIPLINARY MEASURES

Section 1. Corrective Action

- a. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Facility, corrective action against such practitioner may be initiated by the Medical Director, the Medical Advisory Committee representative from the affected practitioner's clinical department, the Executive Director or their designee or the Management Committee.
- b. All requests for corrective action shall be in writing, submitted to the Medical Advisory Committee, and supported by reference to the specific activities or conduct which constitute the grounds for request. The Medical Director shall promptly notify the Executive Director or their designee in writing of all requests for corrective action received by the Medical Advisory Committee and shall continue to keep the Executive Director or their designee fully informed of all action taken in conjunction therewith. The Medical Director shall inform the affected practitioner in writing of the request for corrective action and the reported grounds for the request.
- c. The Medical Advisory Committee shall forward the request for corrective action to an ad hoc committee, which shall immediately investigate the matter. The Medical Director shall designate the members of the ad hoc committee. The affected practitioner shall be afforded an opportunity for an interview with the ad hoc committee. At such interview, the practitioner shall again be notified of the general nature of the charges against him or her, and the practitioner shall be invited to explain the activities or conduct involved or to refute the charges. The interview shall not constitute a hearing, and it need not be conducted according to the procedural rules provided in these Bylaws with respect to hearings. A record by mechanical device or minutes of such interview shall be made by the ad hoc committee and included with its written report to the Medical Advisory Committee. Within thirty (30) days after the receipt of the request for investigation, the ad hoc committee shall forward a written report of the investigation to the Medical Advisory Committee.
- d. Within thirty (30) days after the receipt of the ad hoc committee's report, the Medical Advisory Committee shall take action upon the request for corrective action. Such action may include without limitation: rejecting the request for corrective action; issuing a warning, a letter of admonition, or a letter of reprimand; recommending terms of probation or individual requirements of consultation; recommending reduction, suspension or revocation of clinical privileges; recommending reduction of staff category or limitation of any staff prerogatives directly related to patient care; or recommending suspension or revocation of Medical Staff membership;
- e. Any action by the Medical Advisory Committee that is adverse to the practitioner, as defined in Article V, shall entitle the practitioner to the procedural rights as provided in Article V, and shall not become effective until the procedural rights in Article V are either waived or exhausted.

Section 2. Summary Suspension

- a. Whenever a practitioner's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Facility, either the Medical Director, the Executive Director or their designee, the Medical Advisory Committee or the Management Committee shall have the authority to summarily suspend the Medical Staff membership, status, and all or any portion of the clinical privileges of such practitioner. Such summary suspension shall become effective immediately upon imposition, and the Executive Director or their designee shall promptly give notice of the suspension to the practitioner in person, or via certified mail, return receipt requested.
- b. As soon as possible after such summary suspension, but in no event more than ten (10) days after the imposition of the summary suspension, a meeting of the Medical Advisory Committee shall be convened to review and consider the appropriateness of the action taken. The Medical Advisory Committee may modify, continue or terminate the terms of the summary suspension.
- c. Unless the Medical Advisory Committee immediately terminates the suspension and ceases all further corrective action, any summary suspension that is adverse to the practitioner as defined in Article V shall entitle the practitioner to the procedural rights as provided in Article V.
- d. If the Medical Advisory Committee's action pursuant to Section 2.b of this Article is to terminate the suspension and to cease all further corrective action, notice of such action shall be transmitted immediately, together with all supporting documentation, to the Management Committee. At its next regular meeting after receipt of such a recommendation, the Management Committee shall adopt or reject, in whole or in part, the recommendation of the Medical Advisory Committee. If the Management Committee's action is adverse to the practitioner as defined in Article V hereof, the Executive Director or their designee shall promptly so inform the practitioner by certified mail, return receipt requested, and the practitioner shall be entitled to the procedural rights as set forth in Article V hereof. The Management Committee shall take final action in the matter only after the practitioner has exhausted or has waived his or her procedural rights as provided in Article V. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Management Committee.

Section 3. Automatic Suspension, Termination and Resignation

- a. A Medical Staff member whose license authorizing him or her to practice in the State of Wisconsin is revoked or suspended shall immediately and automatically be suspended from practicing in the Facility. In the event of action by the pertinent licensing agency placing a practitioner on probation, limitations and restrictions shall automatically be placed on the practitioner's Medical Staff membership and clinical privileges under the same terms and conditions as contained in the agency's order.

- b. A Medical Staff member whose DEA number is revoked, suspended, voluntarily relinquished, or subject to probation, shall immediately and automatically be suspended from prescribing medications covered by the number. As soon as possible after such automatic suspension, the Medical Advisory Committee shall convene to review and consider the facts under which the DEA number was revoked, suspended, relinquished or subject to probation. The Medical Advisory Committee may then take such further corrective action as is appropriate to the facts disclosed in its investigation.
- c. An automatic suspension shall be imposed, effective thirty (30) days after written warning, for failure to complete and sign or authenticate medical records within thirty (30) days following the patient's discharge. Such suspension may take the form of withdrawal of a practitioner's surgical, admitting, or consulting privileges and shall be effective until all delinquent medical records are completed.
- d. An automatic suspension shall be imposed for failure to complete an application for reappointment as required. Failure to complete an application for reappointment within thirty (30) days after written notice of suspension shall be deemed to be a resignation of the practitioner's Medical Staff membership.
- e. An automatic suspension of all privileges at the Facility shall be imposed if the Medical Staff member, at any time, fails to maintain adequate professional liability insurance as required by the Facility. If within thirty (30) days after written notice of the suspension, the Medical Staff member does not provide evidence of required professional liability insurance coverage, the practitioner's Medical Staff membership shall be automatically terminated.
- f. The Medical Staff member shall be entitled to reinstatement of Medical Staff privileges only upon written request to the Medical Advisory Committee with documentation of having cured or satisfied the delinquency resulting in automatic suspension. Upon receipt of the request and documentation, unless the Medical Advisory Committee immediately terminates the automatic suspension and ceases all further corrective action, any automatic suspension that is adverse to the practitioner as defined in Article V shall entitle the practitioner to the procedural rights as provided in Article V. The terms of the automatic suspension shall remain in effect pending a final decision of the Management Committee.

Section 4. Continuity of Patient Care

Upon the imposition of summary suspension or the occurrence of an automatic suspension or limitation or restriction of privilege of a Medical Staff member, the Medical Director shall be responsible to provide for alternative coverage for the patients of the subject Medical Staff member. The wishes of the patient shall be considered, where feasible, in choosing a substitute physician/dentist/podiatrist. The Medical Staff member involved shall confer with the substitute physician/dentist/podiatrist to the extent necessary to safeguard the patient.

Section 5. Voluntary Relinquishment of Clinical Privileges or Medical Staff Appointment

A Medical Staff member may voluntarily relinquish any or all of his or her clinical privileges at any time, so long as the relinquishment is not found by the Medical Advisory Committee to be for the purpose of avoiding a suspension of clinical staff privileges. Any voluntary relinquishment of clinical privileges that extends beyond ninety (90) days will require the practitioner, should he or she wish to reinstate clinical privileges, to reapply for Medical Staff membership and clinical privileges through the initial appointment process.

Section 6. Reporting Requirements

The Executive Director or their designee shall notify the National Practitioner Data Bank when the clinical privileges of any Medical Staff member are adversely affected for a period in excess of thirty (30) days or the Facility accepts the surrender of clinical privileges of a practitioner (i) while the practitioner is under investigation by the Facility relating to possible incompetence or improper professional conduct or (ii) in return for not conducting such investigation or proceeding. Such report shall be filed within fifteen (15) days of the time such action becomes final.

Section 7. Enforcement

It shall be the duty of the Medical Director to cooperate with the Executive Director or their designee in the enforcement of all suspensions of members of the Medical Staff.

ARTICLE V. HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Initiation of Hearing

- a. One or more of the following actions without limitation, shall, if deemed adverse pursuant to Section 1.b of this Article V, entitle the practitioner affected thereby to a hearing:
 - 1) Denial of initial staff appointment;
 - 2) Denial of staff reappointment;
 - 3) Suspension of staff membership if such suspension or restriction is for more than fourteen (14) days;
 - 4) Revocation of staff membership;
 - 5) Denial of requested advancement in staff category;
 - 6) Reduction in staff category;
 - 7) Limitation or suspension of admitting privileges if such limitation or suspension is for more than fourteen (14) days;
 - 8) Denial of requested clinical privileges;

- 9) Reduction in clinical privileges;
 - 10) Suspension of clinical privileges if such suspension or reduction is for more than fourteen (14) days;
 - 11) Revocation of clinical privileges; and/or,
 - 12) Individual requirement of consultation.
- b. An action enumerated in Section 1.a of this Article V shall be deemed adverse only when it has been:
- 1) taken by the Medical Advisory Committee;
 - 2) taken by the Management Committee contrary to a favorable recommendation by the Medical Advisory Committee; or
 - 3) taken by the Management Committee on its own initiative without benefit of a prior recommendation by the Medical Advisory Committee. Notwithstanding anything herein to the contrary, the Management Committee shall have this power.
- c. A practitioner against whom an adverse action has been taken which constitutes grounds for a hearing pursuant to Section 1.a and Section 1.b of this Article V shall promptly be given notice of such action by certified or registered mail, return receipt requested. Such notice shall include a statement of the reasons for such action and shall advise the practitioner of his or her right to request a hearing and a summary of his or her rights in the hearing. Such notice shall specify that the practitioner has thirty (30) days following the date of receipt of notice within which a written request for a hearing by the judicial review committee as described in Section 2.c must be submitted to the Executive Director or their designee.
- d. A practitioner shall have thirty (30) days following the receipt of notice of adverse action to file a written request for a hearing. Such request shall be delivered to the Executive Director or their designee either in person or by certified or registered mail. A practitioner who fails to request a hearing within the time and in the manner specified hereof waives any right to such hearing and to any appellate review to which he or she might otherwise have been entitled. In the event the applicant or Medical Staff member does not request a hearing within the time and in the manner set forth above, he or she shall be deemed to have accepted the action involved. Such action shall thereupon immediately become the final decision in the matter.

Section 2. Hearing Requirements

- a. Upon receipt of a proper and timely request for hearing, the Executive Director or their designee shall deliver such request to the Medical Director and shall notify the Management Committee of such request. Within ten (10) days after receipt of such request, the Medical Director shall schedule and arrange for a hearing by a judicial

review committee. At least thirty (30) days prior to the hearing, the Executive Director or their designee shall send the practitioner notice of the time, place, date of hearing and a list of the witnesses expected to testify at the hearing on behalf of the Facility. The hearing date shall be not less than thirty (30) nor more than forty-five (45) days from the date of receipt of the notice of hearing.

- b. The practitioner shall, within ten (10) days of receiving the Facility's witness list, furnish to the Executive Director or their designee a written list of the names and addresses of the witnesses, if any, expected to testify at the hearing on behalf of the practitioner. The witness lists of either party shall be amended when additional witnesses are identified.
- c. When a hearing is properly requested, the Medical Director shall appoint a judicial review committee composed of five (5) members of the Medical Staff who have not actively participated in the consideration of the matter involved at any previous level and who are not in direct economic competition with the practitioner. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the judicial review committee.

Section 3. Hearing Procedure

- a. The personal presence of the practitioner who requested the hearing shall be required at the hearing. A practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have forfeited his or her right to a hearing and appellate review.
- b. The affected practitioner shall be entitled to be accompanied and represented at the hearing by an attorney or other person of the practitioner's choice. If the practitioner is to be represented by an attorney at the hearing, the affected practitioner shall notify the Executive Director or their designee at least fifteen (15) days prior to the hearing. The Facility shall at all times be entitled to be represented at the hearing by legal counsel.
- c. During the hearing, each of the parties shall have the right to call, examine and cross-examine witnesses, and to introduce evidence on any matter relevant to the issues. If the affected practitioner does not testify on his or her own behalf, he or she may be called as if under cross-examination.
- d. The hearing shall not be conducted according to rules of courts of law relating to the examination of witnesses or presentation of evidence. Information upon which reasonable persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled to submit written memoranda and such documents shall become part of the hearing record. The chairperson of the judicial review committee shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present oral and documentary evidence. The chairperson of the judicial review committee shall determine the order of procedure during the hearing, the admissibility of evidence and may limit evidence that is cumulative or irrelevant. The chairperson may order that oral evidence be taken only on oath or affirmation administered by any person who is entitled to notarize documents in Wisconsin and who has been designated by the

chairperson to administer such oath or affirmation. The judicial review committee may examine the witnesses or call additional witnesses if the committee deems such action appropriate.

- e. During the hearing, the chairperson of the judicial review committee may take official notice of any generally accepted technical or scientific matter relating to the issues under consideration. Parties to the hearing shall be informed of the matters to be officially noticed and those matters shall be noted in the hearing record.
- f. Unless otherwise determined for good cause, the Facility shall have the initial duty to present evidence in support of its action or recommendation for each ground or issue. The practitioner shall be obligated to present evidence in response. Throughout the hearing, the Facility shall have the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.
- g. A record of the proceedings shall be made by a court reporter. The Facility shall bear the cost of the reporter's appearance. Either party may request a copy of the record made of the proceedings upon payment of any reasonable charges associated with the preparation thereof.
- h. A majority of the members of the judicial review committee may act as and for the judicial review committee. No committee member may vote by proxy. A majority of the judicial review committee members must be present throughout the hearing and deliberations. If a committee member is absent from any part of the proceedings, the member shall not be permitted to participate in the deliberations or the decision.
- i. The judicial review committee may recess the hearing and reconvene the same without additional notice 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. The judicial review committee shall thereupon, within the time specified in Section 4.a hereof, outside the presence of the parties or their representatives or any other persons, conduct its deliberations and render a recommendation and the hearing shall be declared finally adjourned.

Section 4. Judicial Review Committee Recommendation and Further Action

- a. Within thirty (30) days after closing of the hearing (except that the time shall be ten (10) days in the case of a Medical Staff member currently under suspension), the judicial review committee shall render a written recommendation in the matter, based on the evidence produced at the hearing, and shall forward the same, together with the hearing records and all other documentation considered by the committee, to the Executive Director or their designee. The judicial review committee's recommendation shall be supported by reference to the hearing records and the other documentation considered by the committee. The Executive Director or their designee shall promptly send a copy of the judicial review committee's recommendation to the practitioner by registered or certified mail, to the Medical Director, to the Medical Advisory Committee, and to the Management Committee.

- b. If the hearing was the result of Article V, Section 1.b.1), then the Medical Advisory Committee shall consider the judicial review committee's recommendation and issue a decision. If the decision is favorable to the practitioner it shall be forwarded to the Management Committee for action. If the hearing was a result of Article V, Sections Section 1.b.2) or Section 1.b.3), then the Management Committee shall consider the judicial review committee's recommendation and issue a decision. If the Management Committee's decision is favorable to the practitioner it shall be final and effective immediately. The Executive Director or their designee shall notify the practitioner by certified mail of the favorable decision of either the Medical Advisory Committee or the Management Committee.
- c. If the decision of the Medical Advisory Committee or Management Committee, pursuant to Article V, Section 4.b, continues to be adverse, the Executive Director or their designee shall notify the practitioner by certified mail of the decision. The notice shall inform the practitioner of the basis of the decision and the practitioner's right to request appellate review. If the practitioner fails to request appellate review within the time and in the manner specified in Section 5.a and Section 5.b of this Article, the practitioner waives any right to such review.

Section 5. Initiation and Requirements of Appellate Review

- a. Within ten (10) days following receipt of the notice of the adverse decision of the Medical Advisory Committee or Management Committee, the practitioner may file a written request for an appellate review by the Management Committee. Such request shall be delivered to the Executive Director or their designee either in person or by certified or registered mail.
- b. The request for appellate review shall include an identification of the grounds for appeal and a statement of facts in support of the appeal. Grounds for appeal shall be:
 - 1) substantial non-compliance with the procedures required by these Bylaws; or
 - 2) the decision was not supported by a preponderance of the evidence based upon the hearing record or such other additional information as may be permitted pursuant to Section 6.e of this Article.
- c. Upon receipt of a proper and timely request for appellate review, the Executive Director or their designee shall deliver such request to the Management Committee. As soon as practicable, the Management Committee shall schedule and arrange for an appellate review which shall be conducted not less than twenty (20) days nor more than forty-five (45) days from the date of receipt of the appellate review request; provided, however, that an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as arrangements for it may reasonably be made. At least ten (10) days prior to the appellate review, the Executive Director or their designee shall deliver to the practitioner notice of the time, place and date of the review. The chairman of the Management Committee or chairman of the Management Committee's designated appellate review committee shall permit postponements or extensions of the appellate review only on good cause and if the request therefore is made as soon as is reasonably

practicable. In all cases, the appellate review shall be postponed until the transcript of the judicial review committee hearing is available.

- d. The Management Committee shall determine whether the appellate review shall be conducted by the Management Committee as a whole or by an appellate review committee of three (3) members of the Management Committee appointed by the chairman of the Management Committee. If an appellate review committee is appointed, one of its members shall be designated as chairman. Knowledge of the matter involved shall not preclude any person from serving as a member of the appellate review committee or the Management Committee, so long as that person did not take part in a prior hearing on the same matter. The appellate review committee or the Management Committee shall have all the powers granted to the judicial review committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

Section 6. Appellate Review Procedure

- a. The proceedings by the Management Committee or its designated appellate review committee shall be in the nature of an appellate review based upon the record of the hearing before the judicial review committee, that committee's decision, and all other documentation considered by the judicial review committee. The Management Committee or its designated appellate review committee shall also consider any written statements submitted pursuant to Section 6.b of this Article.
- b. Practitioner may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he or she disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Management Committee through the Executive Director or their designee at least fifteen (15) days prior to the scheduled date of the appellate review, unless such time limit is expressly waived by the Management Committee. A written statement in reply may be submitted by the Facility to the Management Committee through the Executive Director or their designee. The Executive Director or their designee shall provide a copy thereof to the practitioner.
- c. The chairman of the Management Committee or its designated appellate review committee shall be the presiding officer. The chairman shall determine the order of procedure during the review, make all required rulings, and maintain decorum.
- d. The Management Committee or its designated appellate review committee may, in its sole discretion, permit the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative who appears personally shall be required to answer questions put to him or her by any member of the Management Committee or its designated appellate review committee.
- e. New or additional matters or evidence not raised or presented during the judicial review committee hearing or in the hearing decision and not otherwise reflected in the record shall be introduced at the appellate review only in the discretion of the Management Committee or its designated appellate review committee, following an explanation by the party requesting the consideration of such matter or evidence as to why it was not

presented earlier. Any such additional oral or written evidence shall be subject to the same rights of cross-examination or confrontation provided at the judicial review committee hearing.

- f. A majority of the Management Committee or its designated appellate review committee shall be present throughout the review and deliberations. If a member of the Management Committee or its designated appellate review committee is absent from any part of the proceedings, said member shall not be permitted to participate in the deliberations or the decision.
- g. The Management Committee or its designated appellate review committee may recess the review proceedings for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation and may reconvene the proceedings without additional notice. Upon the conclusion of oral statements, if permitted, the appellate review shall be closed. The Management Committee or its appellate review committee shall thereupon, within the time set forth below, conduct its deliberations outside the presence of the parties, their representatives, or any other persons and shall render a written decision. The Management Committee or its designated appellate review committee may refer the matter back to the judicial review committee for further review and recommendation to be returned to the Management Committee within ten (10) days and in accordance with its instructions. The appellate review shall not be deemed to be concluded until all of the procedural steps provided hereinabove have been completed or waived.

Section 7. Final Decision of the Management Committee

Within fifteen (15) days after the conclusion of the proceedings of the appellate review, the Management Committee or its designated appellate review committee shall render its final decision in writing and shall deliver notice and a copy of the decision, in person or by certified or registered mail, to the practitioner, the Medical Director and the Executive Director or their designee. The final decision of the Management Committee following the appeal procedures shall be effective immediately and shall not be subject to further review.

Section 8. General Provisions

- a. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to each adverse action.
- b. By requesting a hearing or appellate review under this Article V, a practitioner agrees to be bound by the provisions of State and Federal Statutes relating to immunity from liability in all matters relating thereto.
- c. All minutes, reports, recommendations, communications, and actions made or taken pursuant to these Bylaws are intended to be covered by the provisions of Wis. Stat. § 146.37 or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations

pursuant to these Bylaws shall be considered to be acting on behalf of the Facility and its Board when engaged in such professional review activities and thus are “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.

ARTICLE VI. MEETINGS OF MEDICAL STAFF

Section 1. Meetings

Meetings of the Medical Staff to consider specific problems may be called at any time by the Medical Director at his or her discretion or at request of the chairman of the Management Committee. A meeting shall not be called without first consulting with the Executive Director or their designee. Written notice stating the purpose of the meeting shall be mailed to the Medical Staff members at least seven (7) calendar days prior to the date of the meeting.

Section 2. Quorum, Voting and Minutes

A quorum for a Medical Staff meeting shall consist of those present and voting. Action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. Written minutes of the annual meeting and all meetings shall be prepared and recorded.

Section 3. Attendance Requirements

Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance shall not be used in evaluating Medical Staff members at the time of reappointment; however, it is expected that members of the Medical Staff will make every effort to attend meetings.

ARTICLE VII. CLINICAL DEPARTMENTS

Section 1. Clinical Departments

The Facility shall be organized into the following Clinical Departments: surgery, anesthesiology/pain management and radiology.

Section 2. Surgery

The Surgery Department shall be concerned with the clinical surgery performed in the Facility and shall keep, or cause to be kept, careful supervision over all surgical work performed in the Facility. This department shall consist of the subspecialties of general surgery, otolaryngology, plastic surgery, ophthalmology, gastroenterology, orthopedic surgery, gynecology, urology, oral surgery, podiatric surgery, and such subspecialties recommended by the Medical Advisory Committee and approved by the Management Committee.

Section 3. Anesthesiology/Pain Management

The Anesthesiology/Pain Management Department shall be concerned with the administration of anesthesia, relief of pain, and all fields of analgesia. Anesthesiology shall be concerned with determining the acceptability of patients for ambulatory care, in accordance with these Bylaws, and the Medical Staff Rules and Regulations.

Section 4. Radiology

The Radiology Department shall be concerned with procedures in the field of radiology and will be concerned with supervision of all radiological procedures performed in or for the Facility.

ARTICLE VIII. MEDICAL ADVISORY COMMITTEE

Section 1. Organization, Appointment and Vacancy

The Medical Advisory Committee shall consist of the Medical Director and one (1) member of the Medical Staff from such specialties recommended by the Medical Advisory Committee and deemed appropriate and as approved by the Management Committee. The Medical Staff members of the Medical Advisory Committee shall be appointed by the Management Committee. Appointment to the Medical Advisory Committee shall be limited only to those practitioners who serve as active or consulting members of the Medical Staff. The Medical Director shall serve as an ex officio, voting member of the Medical Advisory Committee and shall serve as Chairperson of the Medical Advisory Committee. The Medical Director shall appoint a representative to function in the capacity of Chairperson during his or her absence. The Executive Director or their designee shall attend meetings of the Medical Advisory Committee as an ex officio, non-voting member of the Medical Advisory Committee.

Section 2. Meetings, Quorum and Voting Requirements

The Medical Advisory Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions. Members of the Medical Advisory Committee shall be expected to attend all meetings, but are required to attend a minimum of fifty percent (50%) of the official meetings unless excused by the Medical Director for such conditions as sickness, absence from the community, medical emergencies, etc. Unexcused absence from three (3) consecutive regular meetings shall be considered as resignation from the Medical Advisory Committee. A quorum of the Medical Advisory Committee shall consist of fifty percent (50%) of the members excluding excused absences, plus one; provided, however, the Executive Director or their designee shall not be treated as a member of the Medical Advisory Committee for purposes of determining quorum. In matters of dismissal, appeal, and any other adverse actions, no excused absences will be permitted for purposes of determining a quorum. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the vote's cast opposing the action.

Section 3. Special Committees

Special committees may be appointed by the Medical Advisory Committee or the Management Committee from time to time as may be required for a specific purpose, and until the duty

assigned is accomplished. All Committees shall be assigned with the knowledge and cooperation of the Management Committee.

Section 4. Functions

The Medical Advisory Committee shall act on behalf of the Medical Staff to coordinate the activities and general policies of the various services, pursuant to these Bylaws and the Medical Staff Rules and Regulations. Further functions and concerns of the Medical Advisory Committee shall include, but not be limited to, the following:

- 1) To receive and act upon the reports of Medical Staff committees;
- 2) To consider and recommend action on all matters of a medical-administrative nature;
- 3) To implement the approved policies of the Medical Staff;
- 4) To make recommendations to the Management Committee;
- 5) To take all reasonable steps to ensure professionally ethical conduct on the part of all members of the Medical Staff and to initiate such prescribed corrective measures as are indicated;
- 6) To fulfill the Medical Staff's accountability to the Management Committee for the medical care rendered to the patients in the Facility; and
- 7) To fulfill the following function in accordance with the Medical Staff Rules and Regulations:

Credentials Review
Medical Records Review
Tissue, Surgical Evaluation and Review
Infection Control Evaluation
Pharmacy and Therapeutics Review
Quality Assurance and Improvement/Risk Management

The function of the Medical Records Review, Tissue, Surgical Evaluation and Review, Infection Control Evaluation, Pharmacy and Therapeutics Review and Quality Assurance and Improvement/Risk Management may be delegated to sub-committees composed of Medical Staff members of the Facility staff who report their findings and activities at regular meetings of the Medical Advisory Committee.

ARTICLE IX. MEDICAL DIRECTOR

Section 1. Qualifications

The Medical Director shall be a board certified physician holding an unlimited license to practice in the State of Wisconsin and holding current DEA registration. The Medical Director must exhibit qualities of leadership, communication and responsiveness.

Section 2. Appointment

The Medical Director shall be appointed by the Management Committee.

Section 3. Functions

The Medical Director shall serve as the chairperson of the Medical Advisory Committee and shall serve such other functions as requested by the Management Committee. Duties of the Medical Director include, but are not limited to:

- 1) Responsibility for the overall professional activities of the Medical Staff in collaboration with the Medical Staff and the Medical Advisory Committee;
- 2) Serving as an ex-officio member of all committees of the Medical Staff;
- 3) Responsibility for developing, implementing, and reviewing medical policies, including Medical Staff Bylaws, in cooperation with the Medical Staff and the Medical Advisory Committee. These shall be approved by the Management Committee;
- 4) Responsibility for the enforcement of the Medical Staff Bylaws and policies;
- 5) Other duties and responsibilities as assigned from time to time by the Management Committee.

ARTICLE X. ADOPTION, AMENDMENT

Section 1. Bylaws

These Bylaws shall be adopted at any meeting of the Medical Staff by a two-thirds (2/3) vote of those present and shall become effective when approved by a majority vote of the Management Committee. Amendments of these Bylaws may be proposed by the Medical Advisory Committee at any of its meetings. Such amendments, if passed by the Medical Advisory Committee, shall be acted upon at the next regular meeting of the Management Committee. Amendments shall become effective when approved by a majority vote of the Management Committee. All members of the Medical Staff shall be notified by mail of Bylaw changes or changes in the Rules and Regulations within two weeks after approval by the Management Committee.

Section 2. Rules and Regulations

The Medical Staff Rules and Regulations shall be adopted and may be amended at any meeting of the Medical Advisory Committee by a two-thirds (2/3) vote of those present and shall become effective when approved by a majority vote of the Management Committee.

ARTICLE XI. POLICIES AND PROCEDURES

Policy and Procedures which are approved by the Medical Advisory Committee shall set standards of practice that are required of each Medical Staff member, and shall act as an aid to

evaluating performance under, and compliance with, these standards. All Medical Staff members shall cooperate with such rules, regulations and policies, and adhere to all laws, and such approved rules, regulations and policies applicable to their activities at the Facility, the practice of their profession, and their participation in any federal health care program as a condition of their continue appointment to the Medical Staff. In the event that any Medical Staff member suspects or knows that he or she, or any director, officer, employee or other Medical Staff member, has violated applicable laws or regulations, he or she shall immediately report the same to the Medical Director.

All Medical Staff members shall cooperate fully with the Corporate Compliance Policy of Froedtert Health, Inc. and adhere to all laws, regulations and standards of conduct applicable to his or her activities at the Facility, the practice of his or her profession and his or her participation in any federal health care program as a condition of his or her continued appointment to the Medical Staff. In the event that any Medical Staff member suspects or knows that he or she, or any director, officer, employee or other Medical Staff member, has violated applicable laws or regulations, he or she shall immediately report the same to the Medical Director or the Froedtert Health Corporate Compliance Officer.

Recommended for Approval: _____ Date: _____
Medical Director

Approved: _____ Date: _____
Chairman, Management Committee

MEDICAL STAFF

RULES AND REGULATIONS

FROEDTERT SURGERY CENTER, LLC

Milwaukee, Wisconsin

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SECTION A— DEFINITIONS

For purposes of these Rules and Regulations, unless otherwise defined herein, the definitions set forth in the Medical Staff Bylaws shall govern.

SECTION B — NON-DISCRIMINATION

The Facility shall be operated in a non-discriminatory manner without regard to age, race, color, religion, marital status, sex, national origin, disability, or sexual preference, except as may be permitted by law.

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2. No patient shall be admitted to the Facility unless it has been determined that the physical, mental, emotional or other characteristics of the patient make him/her an appropriate candidate for surgical treatment on an ambulatory basis, and that adequate resources for provision of post-surgical care are available to the patient. The admitting Medical Staff member shall be responsible for determining to his or her reasonable satisfaction that these factors are present.
3. In order to be accepted for admission to the Facility for outpatient surgery the patient must be in good health (A.S.A. Class I) or with mild systemic disease which is under control and does not require special management (A.S.A. Class II). An A.S.A. Class III patient must provide documents evidencing clearance from his or her operating physician, anesthesiologist, and primary care physician, if any, prior to being accepted for admission to the Facility.
4. The following patients shall not be accepted for admission to the Facility for outpatient surgery:
 - a. Patients that have infections or communicable diseases requiring isolation or additional professional help in surgical or recovery room services. Such patients shall be referred to a hospital for care. Surgery shall be cancelled automatically if a patient shows any evidence of communicable disease or infection.
 - b. Infants with significant oro-facial anomalies.
 - c. Children under sixty (60) weeks post conceptual age, unless the admitting Medical Staff member obtains the prior approval of an anesthesia practitioner.
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2. The Facility shall not provide accommodations for admissions longer than twenty-three and one half (23 & 1/2) hours. Any patients requiring care for a longer period of time must be transferred to a hospital by the admitting Medical Staff member.
3. In the case of a transfer of a patient to a hospital for admission, either a copy of the chart, descriptive narrative of the events leading to the need for hospitalization, or both, must accompany the patient to the hospital.

SECTION E — DISCHARGE

1. A descriptive discharge status summary is required by the admitting Medical Staff member, the anesthesiologist or the anesthesia practitioner. Patients shall be discharged only upon the written order of a physician.
2. Before discharge from the Facility, each surgical patient must be evaluated by a physician for proper anesthesia recovery.
3. Discharge from the Facility is based on the patient's ability to leave the Facility safely upon meeting the Facility's discharge criteria.
4. Should the patient leave the Facility against the advice of the admitting Medical Staff member, the surgeon, the anesthesiologist or the anesthesia practitioner, the Medical Director or his designee shall be promptly notified. Notation of the incident shall be made in the patient's medical record, and such occurrences reported to the Committee responsible for quality assurance and improvement/risk management.
5. Unless other arrangements have been approved by the admitting Medical Staff member or the attending anesthesiologist, all patients must be accompanied, upon admission and discharge, by a responsible adult.

6. At the time of discharge, the patient and any responsible adult accompanying the patient shall be provided with complete, written post-op instructions which have been personally reviewed and explained to the patient. The written post-operative instructions shall be signed by the patient and/or responsible adult accompanying the patient, to signify their acceptance of the instructions given.

SECTION F — CONSENTS

1. It is the responsibility of the admitting Medical Staff member to obtain the written informed consent of the patient, parent or legal guardian, for any procedure to be performed at the Facility.
2. Such consent form for treatment, signed by the patient, parent or guardian, shall be obtained preoperatively. Such completed form, evidencing informed consent, shall be required prior to pre-operative medication and admission to the operating suite, and shall include a statement that the nature of ambulatory surgery has been explained and understood by the patient, parent or guardian.

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1. A history and physical examination which contains a provisional diagnosis and current medications shall be completed by the admitting Medical Staff member within thirty (30) days before an operative or other procedure shall be performed at the Facility.
2. A medical clearance may be required from the patient's private physician at the discretion of the admitting Medical Staff member, the surgeon, anesthesiologist or anesthesia practitioner when such patients have a history of cardiac pathology or other underlying medical conditions which might affect the successful outcome of the planned procedure.
3. When such history and physical examination or medical clearance is not available at the time of admission for surgery, the procedure shall be cancelled or postponed.
4. A medical history and physical examination by a physician must be provided in writing for patients of all dentists, podiatrists or oral surgeons with an exception for oral surgeons where the Medical Advisory Committee has recommended, and the Management Committee has approved, specific privileges allowing an oral surgeon to perform his or her own history and physical examination.
5. Laboratory tests may be required for selected patients upon the discretion of the admitting Medical Staff member, the surgeon, anesthesiologist or anesthesia practitioner.

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1. Procedures are performed under the following categories of anesthesia.
 - a. General anesthesia (inhalation and/or IV anesthesia includes IV anesthesia)

- b. Regional anesthesia
 - c. Monitored anesthesia care with or without conscious sedation
 - d. Topical anesthesia with or without IV sedation
 - e. Intravenous sedation without topical anesthesia
 - f. Local anesthesia with and without pre-medication and/or intraoperative medications
2. Anesthesia may be administered only by qualified anesthesiologists or anesthesia practitioners. Anesthesia practitioners are certified registered nurse anesthetists performing services under the supervision of the operating Medical Staff member.
 3. Immediately before surgery, the patient receiving anesthesia care shall be personally interviewed by an anesthesiologist or anesthesia practitioner who, following the review of the patient's medical records and preadmission test results, shall determine whether to authorize preparation of the patient for surgery. If the review is performed by an anesthesia practitioner, the operating Medical Staff member must also do this evaluation immediately prior to surgery.
 4. Anesthesia shall not be started until the operating Medical Staff member is present in the Facility.
 5. No explosive or flammable agents shall be available at the Facility. The prevention of certain explosive anesthetic agents from being used in the operating room suite is the responsibility of the anesthesiologist or anesthesia practitioner.
 6. Strict adherence to the recommended safety precautions outlined in the current edition of NFPA Code are in effect at the Facility.

SECTION I — DRUGS

1. Drugs shall be available only for use by patients admitted to the Facility. The Facility shall not dispense drugs or fill outpatient prescriptions.
2. All drugs administered to patients shall meet the standards as listed in the latest edition of the U.S. Pharmacopeia, the National Formulary, New and Non-Official Remedies, the American Hospital Formulating Service, or the A.M.A. Drug Evaluations, with the exception of drugs for bona fide clinical investigations.
3. Adverse reactions to drugs shall be reported to the admitting Medical Staff member and shall be documented in the patient's medical record.
4. Blood and blood products may be administered only by physicians or registered nurses.

SECTION J — MEDICAL RECORDS

1. The admitting Medical Staff member shall be responsible for the preparation of a complete medical record for each patient. The admitting Medical Staff member shall have the responsibility for assuring that all relevant medical records are available at the Facility prior to surgery. Such records shall be reviewed, before the patient's arrival for pre-surgical examination, by the anesthesiologist or anesthesia practitioner and the pre-operative RN.
2. An accurate, complete and legible medical record shall be promptly completed for each patient. The medical record of each patient shall include the following:
 - a. patient identification;
 - b. chief complaint, present illness and care plan;
 - c. medical and family history;
 - d. physical examination and assessment of mental status;
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 - g. list of current medications and dosages;
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 - i. pre-operative diagnostic studies, if performed (including, but not limited to, presurgical test results as required);
 - j. consent forms;
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 - n. operative report (including, but not limited to, condition of patient at the conclusion of the procedure);
 - o. discharge instructions;
 - p. discharge summary and diagnosis;
 - q. physician orders;
 - r. pathology report on all tissues removed during surgery, when applicable.

The medical record of each patient receiving general anesthesia, monitored anesthesia care, or regional anesthesia shall include, in addition to the above: a surgical plan, an anesthesia record, post-operation nursing assessment and survey, and special reports, such as consultations.

3. If the patient has been discharged from the Facility by means of a transfer to another health care facility, a transfer report shall be completed, a copy of which will accompany the patient to the receiving facility, and the original will become a part of the medical record at the Facility.
4. The attending Medical Staff member shall ensure that the record is complete and signed within thirty (30) days from the date of the procedure. Medical records remaining incomplete more than thirty (30) days after the date of the procedure shall be considered delinquent. Medical Staff members with delinquent records shall be notified by registered letter, return receipt requested, within thirty (30) days of impending suspension of Medical Staff privileges. Unless records are completed within thirty (30) days after receipt of such letter, Medical Staff privileges shall be suspended until all delinquent records are completed.
5. All records shall remain the property of the Facility and shall not be taken from the Facility without the express written permission of the Medical Director. Medical records supplied prior to surgery by the patient's physician shall remain on permanent file at the Facility, appropriately supplemented by the results of laboratory and x-ray tests and examinations, and complete reports of the surgical procedure(s) performed.
6. Subject to the discretion of the Medical Director of the Facility, and as permitted by applicable state and federal law, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering procedures in which they attended such patients in the Facility.
7. Only those abbreviations listed on the "Abbreviations Approved for Use by the Medical and Nursing Staffs" shall be used in the medical record.
8. Identifying errors in the course of documentation within the medical record shall be done in the proper manner. The method shall include: a) single line through the part to be corrected; b) labeled "error"; c) insertion of correct documentation; and d) date, time and initials of person correcting.
9. Each consultative report shall include evidence of a review of the patient's record by the consultant, the pertinent findings resulting from the consultant's examination of the patient, and the consultant's opinion and recommendations. It shall be signed and made a part of the patient's medical record at the Facility. Consultative reports may be written or dictated; however in either event such consultative reports must be signed by the consultant. Except in cases of emergencies, consultative reports shall be submitted to the attending Medical Staff member prior to the performance of the operative procedure.

SECTION K — ORDERS

All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a registered nurse and signed by the prescribing Medical Staff member at his/her next visit to the Facility, but no later than twenty-four (24) hours after such order. Orders dictated over the telephone shall be signed by the registered nurse, and shall include the name of the prescribing Medical Staff member. At the next visit to the Facility, but no later than twenty-four (24) hours after such order, the prescribing Medical Staff member shall sign such telephone orders.

SECTION L — SCHEDULING

1. Except in the case of an emergency, all treatment provided at the Facility shall be on an elective and pre-scheduled basis.
2. Patients for surgical procedures shall be admitted no later than one (1) hour prior to the scheduled operation, or within the prearranged time frame in order to allow adequate time for preoperative preparation.
3. The Medical Director, an anesthesiologist or an anesthesia practitioner shall have discretionary authority to cancel scheduled surgery on review of any medical records which, in their judgment, suggest that the patient does not meet the criteria for admission to the Facility.
4. The operating Medical Staff member shall be in the operating room and ready to commence the operative procedure at the time scheduled, and in no case shall the operating room be held longer than fifteen (15) minutes after the time scheduled.

SECTION M — TISSUE REVIEW

1. All tissue removed during the operative procedure shall be sent to the Facility's pathologist who shall make such examinations as may be considered necessary to arrive at a pathological diagnosis, except in the following instances:
 - a. Non-tissue specimens (e.g., orthopaedic hardware, breast implants, ear tubes and foreign bodies) are not required to be sent to pathology. Appropriate notation in the operative report verifying the removal is required.
 - b. Tissue specimens such as teeth, bone plates, cataracts, bone and or nasal cartilage from nasal reconstructions, skin and subcutaneous tissue from plastic surgery procedures, veins from AV fistulas, and omental fat from hernia repairs are not required to be sent to pathology. Appropriate notation in the operative report verifying the removal of the tissue is required.
2. The pathologist shall sign the pathological diagnosis report, which shall become a part of the patient's permanent medical record at the Facility.

SECTION N — DEATHS

In the event of death of a patient at the Facility, including but not limited to deaths during a surgical procedure or during the post-surgical recovery period, proper notification shall be promptly made to the medical examiner's office and/or other appropriate authorities by the Medical Director. The attending Medical Staff member shall be responsible for notification to the patient's family of the circumstances resulting in death.

SECTION O — MEDICAL ADVISORY COMMITTEE

1. Credentials review shall be performed by the Medical Advisory Committee. The function of the credentials review shall be to: (a) investigate the credentials of all applicants for membership to the Medical Staff and Allied Health Staff, and to make recommendations in conformity with the Medical Staff Bylaws and Rules and Regulations; (b) review all information presented regarding the competence of Medical Staff members and Allied Health Staff, and as a result of such review, to make recommendations to the Management Committee for granting of privileges and reappointments; (c) investigate any breach of ethics that may be reported to the Medical Advisory Committee and transmit the Medical Advisory Committee's findings and recommendations to the Management Committee; and (d) review the qualifications of all applicants for temporary Medical Staff privileges and to make recommendations in conformity with the Medical Staff Bylaws and Rules and Regulations. The Medical Advisory Committee shall meet to review credentials at the request of the Medical Director.
2. Medical records review shall be performed by the Medical Advisory Committee or its appointed committee. The functions of the medical records review shall be to: (a) examine and appraise the medical records; (b) determine the adequacy of source documents; and (c) determine compliance with established standards of completeness and accuracy. The Facility's nurse clinical director shall perform periodic medical record reviews not less than quarterly and shall issue a written report to the Medical Advisory Committee or its appointed committee, as appropriate, prior to such committee's regularly scheduled meeting. The records reviewed shall include selected medical records of patients discharged during the preceding quarter, and any other records referred to the Medical Advisory Committee or its appointed committee, as appropriate, by the nurse clinical director or the Medical Director. At monthly intervals, the nurse clinical director shall inform the Medical Director of those Medical Staff members who are delinquent in their records. The Medical Director will take appropriate action according to the Medical Staff Bylaws and Rules and Regulations, including but not limited to, Section J(4) hereof. Records are considered delinquent when they have not complied with the provisions of the Medical Staff Bylaws or Rules and Regulations.
3. Tissue and surgical evaluation shall be performed by the Medical Advisory Committee or its appointed committee. The function of tissue and surgical evaluation shall be to study the agreement, or absence thereof, between the preoperative and post-operative (pathological) diagnosis, and to review whether surgical procedures undertaken in the Facility were justified. This study shall include those procedures in which no tissue was

removed for diagnosis. Any additional information required for this evaluation shall be supplied by the Medical Staff member in question at the next regular meeting of the Medical Advisory Committee or its appointed committee, as appropriate. Violation of this rule by the Medical Staff member may result in disciplinary action, including loss of Medical Staff membership, in accordance with the Medical Staff Bylaws. The Facility shall contract with a pathology consultant. The pathology consultant shall perform periodic record reviews and issue a written report to the Medical Advisory Committee or its appointed committee, as appropriate, prior to such committee's regularly scheduled meeting.

4. Infections control evaluation shall be performed by the Medical Advisory Committee or its appointed committee. The function of infections control evaluation shall be to control sterility and evaluate any infection or potential sources of infection within the Facility. The Facility shall contract with an infections control consultant. The consultant shall perform an evaluation semi-annually or more often when requested by the Medical Director, and shall issue a written report to the Medical Advisory Committee or its appointed committee, as appropriate, prior to such committee's regularly scheduled meetings.
5. Pharmacy and therapeutics review shall be performed by the Medical Advisory Committee or its appointed committee. The function of the pharmacy and therapeutics review shall be to: (a) approve all policies and procedures relating to pharmacy service within the Facility; (b) establish criteria relative to the safe and effective use of pharmaceuticals; (c) establish and maintain a pharmaceutical formulary of those drugs which may be used in the Facility; (d) review efforts aimed at cost containment; and (e) report drug shortages and recalls. The Facility shall contract with a pharmacist. The pharmacist shall review records and drug inventories on a quarterly basis and issue a written report to the Medical Advisory Committee or its appointed committee, as appropriate, prior to such committee's regularly scheduled meetings.
6. Quality assurance and improvement/risk management shall be performed by the Medical Advisory Committee or its appointed committee. The function of quality assurance and improvement/risk management shall be to conduct a formal program, in coordination with the Executive Director, to review quality standards at the Facility in order to: (a) help improve the quality of health care; (b) avoid improper utilization of health care services; (c) determine the reasonable charges for health care services provided by the Facility; and (d) provide risk prevention and incidents reporting as set forth in the Facility's risk management plan. The responsible committee will identify quality assurance standards, perform quality assurance audits, and evaluate care, and, if such activities are performed by an appointed committee, such committee shall report the same to the Medical Advisory Committee at its regularly scheduled meeting.

SECTION P — ALLIED HEALTH STAFF

1. The Allied Health Staff of the Facility shall consist of persons trained and qualified in allied health disciplines who exercise independent judgment and/or provide special professional advice or services to patients under the supervision or direction of an active

Medical Staff member. Allied Health Staff shall include, but not be limited to, physician assistants, CRNAs, registered nurses, licensed practical nurses, and scrub technicians. Allied Health Staff shall be qualified by training, education, licensure and/or certification appropriate for their special services and shall serve within the scope of their privileges granted by the Facility.

2. An applicant for Allied Health Staff shall present written application for appointment and privileges for specific duties and responsibilities utilizing the form prescribed by the Management Committee of the Facility. Upon making application, the applicant shall agree to abide by all policies of the Facility, including but not limited to, the Facility's Medical Staff Bylaws, Rules and Regulations, and Exposure Control Plan for compliance with OSHA Standard on Exposure to Blood Pathogens, as such documents may be modified from time to time. Allied Health Staff membership shall be available only: (a) to individuals sponsored by an active Medical Staff member, and (b) after the Allied Health Staff member's employer or sponsoring Medical Staff member signs an agreement utilizing the form prescribed by the Management Committee to assume full responsibility, and be fully accountable, for the conduct of the Allied Health Staff member within the Facility. The Allied Health Staff member's employer or sponsoring Medical Staff member shall provide proof of professional liability insurance coverage with minimum limits as the Facility's Management Committee may from time to time require and of proof of adequate worker's compensation insurance coverage. In addition, Allied Health Staff must provide documentation of Hepatitis B vaccination status consistent with OSHA requirements and documentation of Tuberculosis and Rubella vaccination status.
3. The application for Allied Health Staff privileges shall be submitted and processed in the same manner as applications to the Medical Staff. Allied Health Staff shall be required to apply for reappointment every two (2) years to coincide with the sponsoring Medical Staff member's reappointment.
4. Allied Health Staff shall practice under the supervision or direction of an active Medical Staff Member. Allied Health Staff may neither admit nor discharge patients. When requested by a supervising Medical Staff member, they may, within the scope of their privileges and the Medical Staff Bylaws and Rules and Regulations, attend that patient in the Facility.
5. Allied Health Staff membership shall automatically terminate: (a) upon the sponsoring Medical Staff member's resignation or termination for any reason from Medical Staff membership at the Facility; or (b) upon the sponsoring Medical Staff member's termination of the Allied Health Staff member's employment or sponsorship. It is the responsibility of the sponsoring Medical Staff member to notify Facility of such termination, in writing, within five (5) days of termination. Allied Health Staff shall not be considered members of the Medical Staff, and as such, shall not be expected to attend Medical Staff meetings, nor to have committee duties or any other rights or privileges of the Medical Staff. The privileges of an Allied Health Staff member may be terminated by the Management Committee for any reason and without due process at any time; provided, however, that if a CRNA is the subject of a recommendation or action

adversely affecting the CRNA’s privileges, the CRNA shall be entitled to the same hearing and appeal rights applicable to Medical Staff members under the Medical Staff Bylaws.

SECTION Q — AMENDMENTS

These Rules and Regulations may be amended at any meeting of the Medical Advisory Committee by a two-thirds (2/3) vote of those present and shall become effective when approved by a majority vote of the Management Committee.

Recommended for Approval: _____ Date: _____
Medical Director

Approved: _____ Date: _____
Chairman, Management Committee

MEDICAL STAFF

RULES AND REGULATIONS

FROEDTERT SURGERY CENTER, LLC

Milwaukee, Wisconsin

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The medical record of each patient receiving general anesthesia, monitored anesthesia care, or regional anesthesia shall include, in addition to the above: a surgical plan, an anesthesia record, post-operation nursing assessment and survey, and special reports, such as consultations.

3. If the patient has been discharged from the Facility by means of a transfer to another health care facility, a transfer report shall be completed, a copy of which will accompany the patient to the receiving facility, and the original will become a part of the medical record at the Facility.
4. The attending Medical Staff member shall ensure that the record is complete and signed within thirty (30) days from the date of the procedure. Medical records remaining incomplete more than thirty (30) days after the date of the procedure shall be considered delinquent. Medical Staff members with delinquent records shall be notified by registered letter, return receipt requested, within thirty (30) days of impending suspension of Medical Staff privileges. Unless records are completed within thirty (30) days after receipt of such letter, Medical Staff privileges shall be suspended until all delinquent records are completed.
5. All records shall remain the property of the Facility and shall not be taken from the Facility without the express written permission of the Medical Director. Medical records supplied prior to surgery by the patient's physician shall remain on permanent file at the Facility, appropriately supplemented by the results of laboratory and x-ray tests and examinations, and complete reports of the surgical procedure(s) performed.
6. Subject to the discretion of the Medical Director of the Facility, and as permitted by applicable state and federal law, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering procedures in which they attended such patients in the Facility.
7. Only those abbreviations listed on the "Abbreviations Approved for Use by the Medical and Nursing Staffs" shall be used in the medical record.
8. Identifying errors in the course of documentation within the medical record shall be done in the proper manner. The method shall include: a) single line through the part to be corrected; b) labeled "error"; c) insertion of correct documentation; and d) date, time and initials of person correcting.
9. Each consultative report shall include evidence of a review of the patient's record by the consultant, the pertinent findings resulting from the consultant's examination of the patient, and the consultant's opinion and recommendations. It shall be signed and made a part of the patient's medical record at the Facility. Consultative reports may be written or dictated; however in either event such consultative reports must be signed by the consultant. Except in cases of emergencies, consultative reports shall be submitted to the attending Medical Staff member prior to the performance of the operative procedure.

SECTION K — ORDERS

All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a registered nurse and signed by the prescribing Medical Staff member at his/her next visit to the Facility, but no later than twenty-four (24) hours after such order. Orders dictated over the telephone shall be signed by the registered nurse, and shall include the name of the prescribing Medical Staff member. At the next visit to the Facility, but no later than twenty-four (24) hours after such order, the prescribing Medical Staff member shall sign such telephone orders.

SECTION L — SCHEDULING

1. Except in the case of an emergency, all treatment provided at the Facility shall be on an elective and pre-scheduled basis.
2. Patients for surgical procedures shall be admitted no later than one (1) hour prior to the scheduled operation, or within the prearranged time frame in order to allow adequate time for preoperative preparation.
3. The Medical Director, an anesthesiologist or an anesthesia practitioner shall have discretionary authority to cancel scheduled surgery on review of any medical records which, in their judgment, suggest that the patient does not meet the criteria for admission to the Facility.
4. The operating Medical Staff member shall be in the operating room and ready to commence the operative procedure at the time scheduled, and in no case shall the operating room be held longer than fifteen (15) minutes after the time scheduled.

SECTION M — TISSUE REVIEW

1. All tissue removed during the operative procedure shall be sent to the Facility's pathologist who shall make such examinations as may be considered necessary to arrive at a pathological diagnosis, except in the following instances:
 - a. Non-tissue specimens (e.g., orthopaedic hardware, breast implants, ear tubes and foreign bodies) are not required to be sent to pathology. Appropriate notation in the operative report verifying the removal is required.
 - b. Tissue specimens such as teeth, bone plates, cataracts, bone and or nasal cartilage from nasal reconstructions, skin and subcutaneous tissue from plastic surgery procedures, veins from AV fistulas, and omental fat from hernia repairs are not required to be sent to pathology. Appropriate notation in the operative report verifying the removal of the tissue is required.
2. The pathologist shall sign the pathological diagnosis report, which shall become a part of the patient's permanent medical record at the Facility.

SECTION N — DEATHS

In the event of death of a patient at the Facility, including but not limited to deaths during a surgical procedure or during the post-surgical recovery period, proper notification shall be promptly made to the medical examiner's office and/or other appropriate authorities by the Medical Director. The attending Medical Staff member shall be responsible for notification to the patient's family of the circumstances resulting in death.

SECTION O — MEDICAL ADVISORY COMMITTEE

1. Credentials review shall be performed by the Medical Advisory Committee. The function of the credentials review shall be to: (a) investigate the credentials of all applicants for membership to the Medical Staff and Allied Health Staff, and to make recommendations in conformity with the Medical Staff Bylaws and Rules and Regulations; (b) review all information presented regarding the competence of Medical Staff members and Allied Health Staff, and as a result of such review, to make recommendations to the Management Committee for granting of privileges and reappointments; (c) investigate any breach of ethics that may be reported to the Medical Advisory Committee and transmit the Medical Advisory Committee's findings and recommendations to the Management Committee; and (d) review the qualifications of all applicants for temporary Medical Staff privileges and to make recommendations in conformity with the Medical Staff Bylaws and Rules and Regulations. The Medical Advisory Committee shall meet to review credentials at the request of the Medical Director.
2. Medical records review shall be performed by the Medical Advisory Committee or its appointed committee. The functions of the medical records review shall be to: (a) examine and appraise the medical records; (b) determine the adequacy of source documents; and (c) determine compliance with established standards of completeness and accuracy. The Facility's nurse clinical director shall perform periodic medical record reviews not less than quarterly and shall issue a written report to the Medical Advisory Committee or its appointed committee, as appropriate, prior to such committee's regularly scheduled meeting. The records reviewed shall include selected medical records of patients discharged during the preceding quarter, and any other records referred to the Medical Advisory Committee or its appointed committee, as appropriate, by the nurse clinical director or the Medical Director. At monthly intervals, the nurse clinical director shall inform the Medical Director of those Medical Staff members who are delinquent in their records. The Medical Director will take appropriate action according to the Medical Staff Bylaws and Rules and Regulations, including but not limited to, Section J(4) hereof. Records are considered delinquent when they have not complied with the provisions of the Medical Staff Bylaws or Rules and Regulations.
3. Tissue and surgical evaluation shall be performed by the Medical Advisory Committee or its appointed committee. The function of tissue and surgical evaluation shall be to study the agreement, or absence thereof, between the preoperative and post-operative (pathological) diagnosis, and to review whether surgical procedures undertaken in the Facility were justified. This study shall include those procedures in which no tissue was

removed for diagnosis. Any additional information required for this evaluation shall be supplied by the Medical Staff member in question at the next regular meeting of the Medical Advisory Committee or its appointed committee, as appropriate. Violation of this rule by the Medical Staff member may result in disciplinary action, including loss of Medical Staff membership, in accordance with the Medical Staff Bylaws. The Facility shall contract with a pathology consultant. The pathology consultant shall perform periodic record reviews and issue a written report to the Medical Advisory Committee or its appointed committee, as appropriate, prior to such committee's regularly scheduled meeting.

4. Infections control evaluation shall be performed by the Medical Advisory Committee or its appointed committee. The function of infections control evaluation shall be to control sterility and evaluate any infection or potential sources of infection within the Facility. The Facility shall contract with an infections control consultant. The consultant shall perform an evaluation semi-annually or more often when requested by the Medical Director, and shall issue a written report to the Medical Advisory Committee or its appointed committee, as appropriate, prior to such committee's regularly scheduled meetings.
5. Pharmacy and therapeutics review shall be performed by the Medical Advisory Committee or its appointed committee. The function of the pharmacy and therapeutics review shall be to: (a) approve all policies and procedures relating to pharmacy service within the Facility; (b) establish criteria relative to the safe and effective use of pharmaceuticals; (c) establish and maintain a pharmaceutical formulary of those drugs which may be used in the Facility; (d) review efforts aimed at cost containment; and (e) report drug shortages and recalls. The Facility shall contract with a pharmacist. The pharmacist shall review records and drug inventories on a quarterly basis and issue a written report to the Medical Advisory Committee or its appointed committee, as appropriate, prior to such committee's regularly scheduled meetings.
6. Quality assurance and improvement/risk management shall be performed by the Medical Advisory Committee or its appointed committee. The function of quality assurance and improvement/risk management shall be to conduct a formal program, in coordination with the Executive Director, to review quality standards at the Facility in order to: (a) help improve the quality of health care; (b) avoid improper utilization of health care services; (c) determine the reasonable charges for health care services provided by the Facility; and (d) provide risk prevention and incidents reporting as set forth in the Facility's risk management plan. The responsible committee will identify quality assurance standards, perform quality assurance audits, and evaluate care, and, if such activities are performed by an appointed committee, such committee shall report the same to the Medical Advisory Committee at its regularly scheduled meeting.

SECTION P — ALLIED HEALTH STAFF

1. The Allied Health Staff of the Facility shall consist of persons trained and qualified in allied health disciplines who exercise independent judgment and/or provide special professional advice or services to patients under the supervision or direction of an active

Medical Staff member. Allied Health Staff shall include, but not be limited to, physician assistants, CRNAs, registered nurses, licensed practical nurses, and scrub technicians. Allied Health Staff shall be qualified by training, education, licensure and/or certification appropriate for their special services and shall serve within the scope of their privileges granted by the Facility.

2. An applicant for Allied Health Staff shall present written application for appointment and privileges for specific duties and responsibilities utilizing the form prescribed by the Management Committee of the Facility. Upon making application, the applicant shall agree to abide by all policies of the Facility, including but not limited to, the Facility's Medical Staff Bylaws, Rules and Regulations, and Exposure Control Plan for compliance with OSHA Standard on Exposure to Blood Pathogens, as such documents may be modified from time to time. Allied Health Staff membership shall be available only: (a) to individuals sponsored by an active Medical Staff member, and (b) after the Allied Health Staff member's employer or sponsoring Medical Staff member signs an agreement utilizing the form prescribed by the Management Committee to assume full responsibility, and be fully accountable, for the conduct of the Allied Health Staff member within the Facility. The Allied Health Staff member's employer or sponsoring Medical Staff member shall provide proof of professional liability insurance coverage with minimum limits as the Facility's Management Committee may from time to time require and of proof of adequate worker's compensation insurance coverage. In addition, Allied Health Staff must provide documentation of Hepatitis B vaccination status consistent with OSHA requirements and documentation of Tuberculosis and Rubella vaccination status.
3. The application for Allied Health Staff privileges shall be submitted and processed in the same manner as applications to the Medical Staff. Allied Health Staff shall be required to apply for reappointment every two (2) years to coincide with the sponsoring Medical Staff member's reappointment.
4. Allied Health Staff shall practice under the supervision or direction of an active Medical Staff Member. Allied Health Staff may neither admit nor discharge patients. When requested by a supervising Medical Staff member, they may, within the scope of their privileges and the Medical Staff Bylaws and Rules and Regulations, attend that patient in the Facility.
5. Allied Health Staff membership shall automatically terminate: (a) upon the sponsoring Medical Staff member's resignation or termination for any reason from Medical Staff membership at the Facility; or (b) upon the sponsoring Medical Staff member's termination of the Allied Health Staff member's employment or sponsorship. It is the responsibility of the sponsoring Medical Staff member to notify Facility of such termination, in writing, within five (5) days of termination. Allied Health Staff shall not be considered members of the Medical Staff, and as such, shall not be expected to attend Medical Staff meetings, nor to have committee duties or any other rights or privileges of the Medical Staff. The privileges of an Allied Health Staff member may be terminated by the Management Committee for any reason and without due process at any time; provided, however, that if a CRNA is the subject of a recommendation or action

adversely affecting the CRNA’s privileges, the CRNA shall be entitled to the same hearing and appeal rights applicable to Medical Staff members under the Medical Staff Bylaws.

SECTION Q — AMENDMENTS

These Rules and Regulations may be amended at any meeting of the Medical Advisory Committee by a two-thirds (2/3) vote of those present and shall become effective when approved by a majority vote of the Management Committee.

Recommended for Approval: _____ Date: _____
Medical Director

Approved: _____ Date: _____
Chairman, Management Committee

MEDICAL STAFF BYLAWS

MENOMONEE FALLS AMBULATORY SURGERY CENTER

(Incorporating Amendments Adopted *prior* to 04/03/11)

Preamble

Recognizing that physicians and dentists and podiatrists are responsible for the quality of medical care at the Menomonee Falls Ambulatory Surgery Center (MFASC) and must assume and accept this responsibility subject to the ultimate authority of the Governing Body, and that the best interests of the patients are protected by a concerted effort, the practitioners at MFASC do hereby organize themselves in conformity with these Bylaws, rules, and regulations hereinafter stated.

Definitions

Medical Staff (Staff) means the licensed physicians, dentists, and podiatrists who have been appointed to the Medical Staff of the MFASC.

Governing Body means the nine member Management Committee of the Menomonee Falls Ambulatory Surgery Center.

Medical Advisory Board (MAB) means a committee of the Medical Staff as defined in these Bylaws.

Credentials Committee. The Medical Advisory Board shall act as the Credentials Committee.

Medical Director means the individual appointed as Medical Director by the Governing body to act in its behalf in the overall management of the MFASC.

Practitioner means an appropriately licensed physician, dentist, or podiatrist.

Physician means an individual with the degree of Doctor of Medicine (MD), or doctor of Osteopathy (DO) who is fully licensed by the state of Wisconsin Department of Regulation and Licensing to practice medicine.

Allied Health Professional (AHP) means an individual who is not a physician or a dentist, but whose training, experience, licensure, or certification qualifies such person to perform the duties for which that person is qualified when assisting a practitioner during procedures performed in the MFASC.

Podiatrist means an individual with the degree of Doctor of Podiatric Medicine (DPM) who is fully licensed to practice podiatry by the State of Wisconsin Department of Regulation and Licensing.

Dentist means an individual with a degree of Doctor of Dentistry (DDS) who is fully licensed to practice dentistry by the State of Wisconsin Department of Regulation and Licensing.

Article I - NAME

The name of this organization shall be the Medical Staff of the Menomonee Falls Ambulatory Surgery Center.

Article II - PURPOSE

The purposes of this organization are:

1. To ensure that all patients treated in the MFASC receive the best possible care. However, the care of each individual patient is the legal and medical responsibility of the physician, dentist, or podiatrist member of the Medical Staff who is treating said patient.
2. To ensure a high level of professional performance of all practitioners authorized to practice at the MFASC through an ongoing review and evaluation of each practitioner's qualifications, performance, professional competence, and conduct in the treatment of patients.
3. To initiate rules for the self-governance of the Medical Staff.
4. To provide a means whereby issues concerning the Medical Staff at the MFASC may be discussed with the Governing Body and the Medical Director.
5. To provide an environment which minimizes patient anxiety prior to, during, and after surgery while assuring high quality patient care.
6. To provide an environment which encourages physicians, dentists and podiatrists to utilize the MFASC, thus contributing to cost containment in the health care delivery system.

Article III - MEMBERSHIP IN MEDICAL STAFF

SECTION 1 - GENERAL

- A. Appointment to the MFASC Medical Staff is a privilege which shall be extended only to professionally competent persons who meet, and continue to meet, the qualifications, standards, and requirements set forth in these Bylaws and in such policies as may be adopted from time to time by the Governing Body.
- B. Sex, race, creed, age and/or national origin of applicant are not considered in making decisions regarding the granting or denying of Medical Staff membership.
- (11) C. No applicant shall be appointed to the Medical Staff unless the Governing body shall have determined that there is patient care need for additional medical, dental or podiatry Staff with applicant's skill and training. Applicant must be able to demonstrate a reasonable expectation that s/he will be able to perform a minimum of two procedures per year during a

single appointment period OR provide evidence of an active practice and verifiable medical staff privileges at another facility.

- D. No applicant shall be entitled to membership on the Medical Staff, or to the exercise of any particular clinical privileges in the MFASC, merely by virtue of the fact that said applicant is duly licensed to practice medicine, dentistry, podiatry, or any other profession in the State of Wisconsin or any other state, or that said applicant is a member of any professional organization or has in the past, or presently has, such privileges at another hospital or ambulatory surgery center in this or any other state.

SECTION 2 - QUALIFICATIONS FOR MEMBERSHIP

Only physician, dentist, and podiatrist applicants who satisfy the following conditions, shall be qualified for appointment to the Medical Staff. An applicant shall:

- A. Be a graduate of an approved medical, osteopathic, podiatric, or dental school with a degree of Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Dental Surgery, or Doctor of Dental Medicine; and
- (4) B. Hold an unlimited license to practice medicine, osteopathy, dentistry, or podiatry in the State of Wisconsin.
- C. Be practicing in the MFASC community or within a reasonable distance of the MFASC; and
- D. Be able to document: their background, experience, training, and demonstrated competence; their adherence to the ethics of their profession; their good reputation and unquestioned professional integrity, and their ability to work with others, with sufficient adequacy to assure the Governing body that any patient treated by the applicant in the MFASC will be given high quality medical care; and
- E. Possess current, valid professional liability insurance coverage in such form and such amounts as is satisfactory to the Governing body; and
- (1) F. Have completed a residency program approved by the American College of Graduate Medical Education if applicant is a Doctor of Medicine or Osteopathy; and must have completed a residency program approved by the Education Council of the American Podiatric Association if applicant is a podiatrist; except that this requirement is waived:
 - i. if the applicant is a doctor of Medicine who: completed his medical internship prior to January 1, 1981, and at the time of application is a member of the Medical Staff at Community Memorial Hospital, Menomonee Falls, Wisconsin, having surgical privileges at that hospital; or

(11) Revised 01/11/10

(1) Revised 7/11/94

(4) Revised 2/19/96

(5) Revised 6/17/96 Removed 04/03/11

- ii. if the applicant is a Doctor of Medicine, of Osteopathy, or of Podiatric Medicine whose MFASC staff privileges are limited to the use of MFASC's laser equipment for treatment of superficial skin lesions; and
- (2) G. Be board certified by the applicable specialty board if the applicant has completed his or her residency eight or more years prior to application; except that this requirement is waived:
 - i. if the applicant's residency was completed more than 20 years prior to the application;
 - ii. if the applicant is a Doctor of Medicine, of Osteopathy, or of Podiatric Medicine whose MFASC staff privileges are limited to the use of MFASC's laser equipment for treatment of superficial skin lesions; and
- H. Be free of any physical or mental illness or hardship which would in any way restrict or impair applicant's ability to provide high quality medical care and supervision to MFASC patients; and
- (12) I. Except for anesthesiologists and radiologists, have admitting privileges at Community Memorial Hospital, or present a signed letter of agreement from a Staff member of that Hospital indicating said Staff member's willingness to admit patients from the MFASC for a MFASC Medical Staff member who does not have admitting privileges as said Hospital; and
- J. For the duration of applicant's Medical Staff membership, be actively engaged in the practice of medicine, dentistry or podiatry according to the criteria established by the Medical Advisory Board and approved by the Governing Body; and
- K. Pledge that if they are accepted as a member of the Medical Staff, they will not receive from or pay to another practitioner, either directly or indirectly, any fee for sending, referring, or recommending a practitioner to a patient, or for any professional services not actually rendered by the member or at said member's direction.

SECTION 3 - OBLIGATIONS OF STAFF MEMBERSHIP

Acceptance of appointment to membership in the Medical Staff by an applicant shall constitute an agreement by that practitioner that said practitioner:

- A. Will abide by the Principles of Medical Ethics of the American Medical Association or the American Osteopathic Association, or the Code of Ethics of the American Dental Association or the American Podiatric Association, whichever is applicable; and
- B. Will cooperate with MFASC Medical Director, Medical Staff and Allied Health Professionals; and

(2) Revised 12/19/94 (12) Revised 04/03/11

- C. Will at all times follow and abide by the then existing MFASC Medical Staff Bylaws, rules and regulations; and
- D. Will certify bi-annually to freedom from physical or mental illness or handicaps which would in any way restrict or impair his or her ability to provide quality care and supervision to MFASC patients. The Governing Body may precondition appointment or reappointment upon practitioner undergoing such tests and/or examinations it may deem necessary to verify practitioner's freedom from said illness and handicap. Practitioner agrees to undergo and allow the Governing body to have free access to the results of such examinations and/or tests as may be requested by the Governing Body at any time if required to evaluate the practitioner's ability to continue to provide quality patient care; and
- E. Agree to subject his performance to and participate in any MFASC's Quality Assurance Program which may from time to time be in effect in accordance with the requirements of the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), the responsible peer review organization, and other external regulatory agencies; and
- F. Prepare and complete in a timely fashion the medical, surgical, and other required records for all patients seen in consultation, or cared for on an ambulatory basis, at the MFASC.

SECTION 4 - ETHICS AND EXTERNAL RELATIONSHIPS

The professional conduct of appointees to the Medical Staff shall be governed by the principle of ethics of the American Medical Association, American Osteopathic Association, American Dental Association or the American Podiatric Association, as appropriate.

SECTION 5 - TERMS AND CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

All appointments and reappointments to the Medical Staff shall be made by the Governing body acting on a recommendation from the Medical Advisory Board and shall confer on the appointee only such limited privileges as are specified in the notice of appointment or reappointment.

- A. **Types of Appointments:** Appointments shall be either regular, temporary, or conditional.
 - i. Regular appointments shall be made by the Governing Body and shall be for the period specified by the Governing board not to exceed two years.
 - (6) ii. Temporary appointments may be granted by the Medical Director until the next meeting of the Medical Advisory Board, at which time the applicant's credentials will be substantially complete and available for review and action. If action needs to be deferred for reasons other than rejection of application to the medical staff, then the temporary period will be extended until such time as the Medical Advisory Board meets again.

(6) Revised 10/4/99

- iii. Temporary appointments for a period not exceeding 90 days may be made by the Medical Advisory board until the next meeting of the Governing Body.
- iv. Conditional appointments for a term not to exceed two years may be made by the Governing body containing such restrictions and limitations of practitioner privileges as said body may prescribe.
- (3) v. Initial appointments to the Staff shall be made by the Governing Body for a period of one year, and may contain such restrictions, limitations and evaluation requirements as said Body may prescribe.
- (6) vi. Courtesy appointments for a term not to exceed 6 months may be made by the Governing Body containing such restrictions and limitations of practitioner privileges as said body may prescribe. A Courtesy appointment may be approved for (but is not limited to) the following:
 - performing a procedure secondary to a procedure being performed by another physician, provided that the physician is on staff at the ASC
 - performing examination under anesthesia
 - performing physician is being proctored or mentored by another physician.
- B. **Initial Appointments:** During the period of their initial appointments to the Medical Staff, all Staff appointees, regardless of the Staff practice specialty to which they are appointed, shall be subject to the following:
 - i. During the term of their initial appointment, the individual receiving the initial appointment shall be evaluated by the Medical Advisory Board and the Governing Body as to the individual's clinical competence, general behavior, and conduct in the MFASC.
 - ii. Initial clinical privileges shall be adjusted to reflect clinical competence at the end of the initial appointment period, or sooner, if warranted.
 - iii. Continued appointment after the initial appointment period shall be conditioned on an evaluation of the factors to be considered for reappointment.
- C. **Reappointments:** Reappointments shall be for a two-year period as determined by the Governing Body.

SECTION 6 - PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

- (4) A. **General Procedure:** The Medical Advisory Board, through its designated committees, officers and representatives shall investigate and consider each application for appointment or reappointment to the Medical Staff, and each request for modification of Staff

(3) Revised 10/16/95

(4) Revised 2/19/96

(6) Revised 10/4/99

appointment status or privileges, and shall adopt and transmit recommendations thereon to the Governing Body. The Medical Advisory Board shall perform these same investigation, evaluation, and recommendation functions in connection with any Allied Health Professional or other individual who seeks to exercise clinical privileges or provide specified services in the MFASC.

B. Application for Initial Appointment

- i. **Application Form:** Each application for appointment to the Staff shall be submitted in writing to the Medical Director on the prescribed form signed by the applicant and accompanied by such non-refundable application fee as may be established by the Governing Body. When a practitioner requests an application form, he/she shall be given a copy of, or access to, a copy of these By-laws and the MFASC Rules and Regulations relating to medical practice.
- ii. **Content:** The application form shall include:
 - a. **Acknowledgment and Agreement:** A statement that the applicant has received (or has had access to) and read the Bylaws and Rules and Regulations of the Medical Staff relating to medical practice and that he/she agrees to be bound by the terms thereof if he/she is granted appointment and/or clinical privileges.
 - b. **Qualifications:** Detailed information concerning the applicant's qualifications, including information on satisfaction of the basic qualifications specified in Article III, Section 2 and of any additional qualifications specified in these Bylaws for the particular Staff category to which the applicant requests appointment.
 - c. **Requested Privileges:** Requests stating the Staff practice specialty and clinical privileges for which the applicant wishes to be considered.
 - d. **References:** The names of at least two (2) persons who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time, and who can and will provide reliable information regarding the applicant's relevant training and/or experience, current competence, fulfillment of obligations as a member of the Medical Staff, ability to work with others and any effect of applicant's health status on the privileges to be recommended. At least one such person shall be a practitioner in the applicant's specialty.
 - e. **Other Hospitals:** The names of all hospitals or other healthcare institutions at which the applicant presently has, or within the last five (5) years has had previously held privileges, the surgical privileges granted to applicant at said hospital or institution as identified in applicant's Current Delineation of Privileges from said hospital or institution, and copies of said Consent Delineation of Privileges.

- f. **Professional Sanctions:** Information as to whether any of the following has ever been or are in the process of being denied revoked, suspended, reduced, not renewed, or voluntarily relinquished. If any such actions ever occurred or are pending, the particulars thereof shall be included.
- AA. Staff membership status or clinical privileges at any other hospital or healthcare institution;
 - BB. Membership/fellowship in local, state or national professional organizations;
 - CC. Specialty Board certification/eligibility;
 - DD. License to practice any profession in any jurisdiction;
 - EE. Drug Enforcement Agency (D.E.A.) number.
- g. **Professional Liability Insurance and History:** A statement that the applicant carries professional liability insurance coverage at least equal to that required by law, the name of the company and the amount and classification of such coverage, whether said insurance coverage includes the clinical privileges the applicant seeks to exercise at MFASC, and information on his/her malpractice claims history and experience including: a list of all malpractice judgments entered against the applicant and all malpractice actions and patient compensation panel actions brought against the applicant; a statement as to whether the applicant's malpractice insurance has ever been limited, canceled, or not renewed, and the reasons therefore; and a consent to the release of information by his/her present and past malpractice insurance carrier(s).
- h. **Notification of Release and Immunity Provisions:** Statements notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions contained in Article III, Section 6.
- i. **Administrative Remedies:** A statement whereby the practitioner agrees that when an adverse ruling is made with respect to his/her Staff appointment, Staff status, and/or clinical privileges, he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.
- j. **Health Information:** A statement of applicant's current mental and physical health status as it might affect his/her ability to provide quality care and supervision to MFASC patients.
- k. **Other Information**

- AA. Information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such incident;
- BB. The citizenship or Visa status of the applicant;
- CC. Such other information as the Medical Advisory Board or Governing Body may require.

C. **Effect of Application**

By submitting an application for appointment to the Medical Staff, each applicant:

- i. **Interview Authorization:** Signifies his/her willingness to appear for interviews in regard to his/her application.
- ii. **Consultation Authorization:** Authorizes MFASC representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications.
- iii. **Consent to Examination:** Specifically agrees to undergo any physical or mental examination and tests as may be requested by the MAB or the Governing Body, and to allow MFASC representatives to have free access to the results thereof and any and all data and opinions issued in connection therewith.
- iv. **Consent to Records Inspection:** Consents to MFASC representatives inspecting all records and documents that may be material to an evaluation of: his/her professional qualifications and competence to carry out the clinical privileges he/she requests, his/her character, physical and mental health status, emotional stability, and of his/her professional ethical qualifications.
- v. **Liability Release for MFASC:** Releases from any liability all MFASC representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials.
- vi. **Liability Release for Information Providers:** Releases from any liability all individuals and organization who provide information, including otherwise privileged or confidential information, to MFASC representatives in good faith and without malice concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for Medical Staff appointment and clinical privileges.
- vii. **Consent to Release of Information:** Authorizes and consents to MFASC representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the MFASC may have concerning the applicant, and releases MFASC representatives

from liability for so doing, provided that such furnishing of information is done in good faith and without malice.

- viii. **Agreement to Report change in Staff Privileges:** Agrees that, if applicant is appointed to the Medical Staff, and if for any reason applicant's Medical Staff privileges at any other hospital or healthcare facility are revoked, suspended or materially altered, complete information concerning said revocation, suspension or material change shall be immediately reported to the Medical Director and the Medical Advisory Board.

For purposes of this Section, the term "MFASC representative" includes the Governing body, its officers, members, and committees, its Medical Director, the Medical Staff and all Medical Staff appointees, departments and committees which have responsibility for collecting or evaluating the applicant's credentials or acting upon his/her applications; and any authorized representative of any of the foregoing.

D. **Processing the Application**

- i. **Applicant's Burden:** The applicant shall have the burden of producing information which MFASC deems to be adequate for a proper evaluation of his/her competence, character, experience, background, training, ability, and physical and mental health status, and of resolving any doubts about these or any of the other basic criteria specified in Article III, Section 2.
- (4) ii. **Verification of Information:** The applicant shall deliver a completed application and any required application fee to the Medical Director. The Medical Director, or his authorized representative, shall, in a timely fashion, seek to collect and verify the references, licensure, and other qualification evidence submitted and any other qualification evidence submitted and any other relevant data available. The Medical Director shall promptly notify the applicant of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information within 60 days of notification. If at the end of 60 days the applicant has not satisfactorily completed the application or supplied the required information, the application will be deemed to have been withdrawn and a new application will have to be completed and submitted if the applicant again wishes to apply for appointment to the MFASC Medical Staff. When collection and verification is accomplished, the Medical Director shall transmit the application and all supporting materials to the Medical Advisory Board acting as the Credentials Committee, for evaluation.
- iii. **Credentials Committee Action:** Upon receipt of properly completed and qualifying application, the Medical Advisory Board (acting as the Credentials Committee) shall review the application, the supporting documentation, and such other information available to it that may be relevant to consideration of the

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applicant's qualifications for the Medical Staff category and clinical privileges requested. Candidates who meet qualification per Article III, Section 2 may then be required to be interviewed by the Credentials Committee.

The Credentials Committee shall transmit to the Governing Body a written report and recommendations as to the Medical Staff appointment and, if appointment is recommended, as to Staff category, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may also

recommend that the Governing Body defer action on the application. In all cases these recommendations shall be presented to the Governing Body within 90 days of the Credentials Committee's receipt of the completed application.

The reasons for any recommendation to deny appointment or requested privileges shall be stated and supported by reference to the completed application and all other documentation considered by the committee, all of which shall be transmitted with the report. Whether or not appointment is recommended, any minority views shall also be reduced to writing, supported by reasons and references, and transmitted with the Credentials Committee's report.

- (8) When new technology or an innovative technique is introduced into a physician's practice, that technique or technology will be reviewed by the Medical Advisory Board and a determination regarding the need for special privileges will be made.
- iv. **Governing Body Action:** The Governing body shall review the application, the supporting documentation, the Credentials Committee's report and recommendations, and such other information available to it that may be relevant to consideration of the applicant's qualifications for the Medical Staff and clinical privileges requested. The Governing Body shall adopt or reject the recommendation of the Credentials Committee, or refer it back to said Committee for further consideration stating the reasons for such referral. In the event of unwarranted delay by the Credentials Committee in making its report to the Governing Body on any application, the Governing Body may act without such report and recommendation on the basis of documented evidence of the applicant's professional and ethical qualifications determined from reliable sources.

Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Governing Body shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of the Credential Committee's subsequent recommendation and of new evidence in the matter, if any, the Governing Body shall render its decision. The Governing body's decision shall be rendered within thirty (30) days of its receipt of the new recommendation of the Credentials Committee.

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iv. **Notice of Final Decision.**

- a. Notice of the Governing Body's final decision shall be given through the Medical Director to the applicant by means of a special notice.
- b. A decision and notice to appoint shall include:
 - AA. The privileges the applicant may exercise; and
 - BB. The terms of the appointment.
 - CC. Any special conditions, restrictions or limitations applicable to the appointment.

vii. **Reapplication After Adverse Appointment Decision**

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as the Governing Body or the Medical Advisory Board may require to demonstrate that the basis for the earlier adverse action no longer exists.

E. **Reappointment Process**

- i. **General Information for Reappointment:** The Medical Director on behalf of the Medical Advisory Board shall, at least seventy-five (75) days prior to the expiration date of the present Medical Staff appointment of each Medical Staff appointee, provide such Staff appointee with an Interval Information Form for use in considering his/her reappointment. Each Staff appointee who desires appointment shall, at least sixty (60) days prior to such expiration date, return his/her Interval Information Form. Failure, without good cause, to so return the Form **(9)** and/or any non-refundable fees as may be due may be deemed a voluntary resignation from the Staff and may result in automatic termination of appointment at the expiration of the appointee's current term. A practitioner whose appointment is so terminated shall be entitled to the procedural rights provided in Article VIII, Hearing and Appeal Procedure, for the sole purpose of determining the issue of good cause. **(10)** A physician who is on a leave of absence and whose re-appointment comes due during such leave shall immediately upon their return, complete and submit his/her Interval Information Form and pay any non-refundable fees as may be due.
- ii. **Content of Interval Information Form:** The Interval Information Form shall request data necessary to update the Medical Staff file. This form shall include information about the following:
 - a. Participation in relevant continuing education programs,
 - b. Current mental and physical health status,
 - c. Membership, awards or other recognition conferred by any professional health care societies, institutions or organizations,

- (9) Revised 01/09/09
(10)
- d. Voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or medical facility,
 - e. Involvement in any professional liability action or patient compensation panel action, or changes in malpractice insurance coverage effected since last appointment,
 - f. Changes in specialty board certification or membership in professional organization, and
 - g. Previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration, and
 - h. Such other information as the Medical Advisory Board or Governing body may require.
- iii. **Credentials Committee Action:** The Credentials Committee and the Medical Director shall review all pertinent information on each appointee prior to reappointment. After they have completed their review, the Credentials Committee shall transmit their request and recommendation as to reappointment to the Governing Body. The review shall consist of a review of:
- a. Professional and clinical performance, including patterns of care, based at least in part on the findings of medical quality assurance studies, utilization review, infection control activities, tissue review and medical record review,
 - b. Current privileges and the basis for any requested modifications,
 - c. Current licensure,
 - d. Health status,
 - e. Documented participation in a minimum of thirty (30) hours of relevant continuing education program biannually,
 - f. Service on Medical Staff and MFASC committees,
 - g. Timely completion of medical records, and
 - h. Compliance with applicable MFASC policies and with Medical Staff Bylaws, Rules and Regulations.
- iv. **Basis for Recommendations:** Each recommendation concerning the reappointment of a Medical Staff appointee and the clinical privileges to be granted upon

reappointment shall be based upon documented evidence of such appointee's professional ability and clinical judgment in the treatment of patients, his/her professional ethics, his/her discharge of Staff obligations, his/her compliance with the medical Staff Bylaws, Rules and Regulations, and Hospital policies relating to medical practice, his/her cooperation with MFASC personnel and other practitioners and with patients, and other matters bearing on his/her ability and willingness to contribute to good patient care in the MFASC. Non-compliance may result in reduction of Staff privileges, a reduced period of reappointment, or non-reappointment.

- v. **Final Processing and Governing Body Action:** The recommendation of the Medical Advisory Board shall be transmitted to the Governing body. Thereafter, the procedure provided in Article III, Section 6D iv through vii shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" shall be read as "Staff member" and "reappointment."

- F. **Right to Notice and Hearing:** The notice and hearing rights of applicants for appointment and reappointment to the Medical Staff who have received an adverse recommendation or action shall be as set forth in Article VIII of these Bylaws.

Article IV - ALLIED HEALTH PROFESSIONALS (AHP)

SECTION 1 - APPLICATION FOR PRIVILEGES

An Allied Health Professional employed by a member of the Medical Staff may be granted privileges at the MFASC to assist members of the Medical Staff in providing care for their patients. The AHP shall complete an application for such privileges in the form prescribed by the Governing body which shall be submitted to and acted upon by the MAB and the Governing Body in the same manner as provided for in Article III, Section 6, A and D, for Medical Staff applications.

SECTION 2 - MINIMUM REQUIREMENTS

In order to be eligible for such privileges, the AHP must document to the satisfaction of the MAB and the Governing Body:

- A. Adequate background, training and/or experience to satisfy the granting of the requested privileges to assist the member of the Medical Staff by whom the AHP is employed; and
- B. Adequate coverage under the malpractice insurance policy of the member of the Medical Staff by whom said AHP is employed for services to be rendered at the MFASC.

SECTION 3 - RESTRICTIONS

AHP's granted privileges to assist members of the Medical Staff at the MFASC shall work exclusively at the direction of, and under the authority of, the member of the Medical Staff whom they are assisting.

Article V - COMMITTEES

There shall be such standing and special committees of members of the Medical Staff as may from time to time be deemed by the Governing Body to be or desirable to perform the functions of the Medical Staff required by these Bylaws or necessarily incidental thereto, including the following:

- A. **Medical Advisory Board (MAB):** The MAB shall be a standing committee appointed by the Governing Body acting on the recommendation of the Medical Director.
 - i. **Composition:** The MAB shall consist of at least one practitioner from each of the major specialties currently practicing at the MFASC.
 - ii. **Chairman:** The MFASC Medical Director shall act as chairman of the committee and shall represent the specialty of anesthesiology.
 - iii. **Chairman of Governing Body Ex Officio Member:** The Chairman of the Governing Body shall be an ex-officio voting member of the MAB.
 - (7) iv. **Terms of Members:** Appointments of MAB members shall be for terms of two years as determined by the Governing Body. Appointments shall be made based on the calendar year.
 - (7) v. **Meetings:** The MAB shall meet quarterly at the call of the Chairman. One staff appointee committee member present shall constitute a quorum.
 - vi. **Minutes:** Written minutes of all MAB meetings shall be kept and copies thereof shall be promptly transmitted to the Governing body.
 - vii. **Duties:** The duties of the MAB shall be to:
 - a. Advise the Governing Body and the Medical Director on clinical and other matters as requested by the Governing Body or the Medical Director;
 - b. Serve as a communications link between the Medical Staff and the Governing Body;
 - (4) c. To investigate, and consider applications for appointment or reappointment to the Medical Staff and each request for modification of Staff appointment status or privileges, and to adopt and transmit recommendations thereon to the Governing Body.
 - d. Act as the Credentials Committees for purpose of receiving all applications for appointment and reappointment to the Medical Staff and for changes in Staff privileges for Medical Staff members;

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(7) Revised 7/10/00

- e. Review pathology reports on tissue removed at the MFASC.
 - f. Investigate all complaints involving any practitioner and recommend to the Medical Director and Governing Body any corrective action deemed appropriate;
 - g. Review facility utilization information to assure:
 - AA. Documentation of a legitimate indication for surgery performed.
 - BB. Appropriate care was rendered to the patient.
 - CC. Appropriate performance of the procedure on an outpatient basis.
 - DD. Collection, collation, verification, and timely submission of data as required by Wisconsin Administrative Code Section HSS 120.30 and any other governmental regulation.
 - h. Review the reports from the MFASC Quality Control Committee and make recommendations to the Medical Director and Governing body for further studies or corrective action when necessary.
- B. **Other Committees:** The Governing Body, and the Medical Director with the consent of the Governing Body, may appoint and designate chairmen for such other committees of the Medical Staff as may be deemed appropriate to carry out the duties of the Medical Staff. Such committees shall: meet at the call of their respective chairmen and confine their work to the purposes for which they were appointed.

Article VI - RULES AND REGULATIONS

The Medical Staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations may be formulated or amended by a majority vote of the Medical Advisory Board and subsequent approval by the Governing Body.

Article VII - CORRECTIVE ACTION

SECTION 1 - PROCEDURE

- A. Whenever the activities or professional conduct of any Medical Staff appointee, or any person for whom such Staff appointee is responsible, are considered not to meet the medical standards of the Medical Staff, to be disruptive to the operations of the MFASC, or to be in violation of these Medical Staff Bylaws, Rules and Regulations, or MFASC policies, corrective action against such Medical Staff appointees may be requested by the Medical Director, the Medical Advisory Board, or the Governing Body. All requests for corrective action shall be in writing, shall be made to the Medical Director and the Governing Body, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

- B. The Medical Advisory Board shall investigate all complaints or requests for corrective action made to it. Prior to the making of any report or recommendation, the involved appointee or appointees shall be permitted to meet with the Medical Advisory Board to present any information related to the matter. This appearance shall not constitute a hearing as per Article VII, and shall be informal in nature.
- C. The action of the Medical Advisory Board on a request for corrective action may be: (i) to reject or modify the request; (ii) to issue a warning or letter of reprimand; (iii) to impose terms of probation or a requirement for consultation; (iv) to require observation of surgical procedures performed; (v) to require retrospective chart monitoring for a specified time period; (vi) to require review of all admissions to the MFASC for a specified time period; (vii) to seek an opinion or recommendation on the matter from the State Medical Society's Impaired Physician Program, or other outside consultant, provided that confidential peer review information may not be disclosed in obtaining such opinion or recommendation other than in the manner prescribed by law; (viii) to recommend reduction, suspension or revocation of clinical privileges; (ix) to recommend that an already imposed summary suspension of clinical privileges be terminated, modified, or sustained; or (x) to recommend that Staff appointment be suspended or revoked.
- D. Any physician/dentist/podiatrist who is engaged by the MFASC in an administrative capacity with related clinical responsibilities is entitled to the same procedural fairness accorded any other Medical Staff appointee when his/her Medical Staff privileges are terminated or otherwise affected unless otherwise provided by agreement with the MFASC.

SECTION 2 - SUMMARY SUSPENSION

The Chairman of the Governing Body, or in his absence the Medical Director, upon determination that action must be taken immediately in the best interest of patient care in the MFASC, shall have the authority to temporarily suspend, limit, or restrict a physician's/dentist's/podiatrist's privileges effective immediately. In such a case the suspended Staff appointee shall be entitled to meet with the Medical Advisory Board as soon as said meeting can reasonably be convened to review and consider the action taken. That Board may recommend a modification, continuation, or termination of terms of the summary suspension or limitation or restriction of privileges. Unless that Committee recommends immediate termination of the suspension or privilege limitation or restriction, the Staff appointee shall be entitled to the procedural rights described in Article VIII of these Bylaws. The terms of the summary suspension or privilege limitation or restriction as sustained or as modified by the Medical Advisory Board shall remain in effect pending a final decision by the Governing Body.

SECTION 3 - AUTOMATIC SUSPENSION

- A. If a Staff appointee's license to practice his or her profession in the State of Wisconsin is revoked or suspended, such Staff appointee shall be immediately and automatically suspended from practicing in the MFASC.
- B. A Staff appointee whose Drug Enforcement Administration (DEA) number is revoked, suspended or voluntarily relinquished shall immediately and automatically be divested of the

right to prescribe medications covered by such number. As soon as reasonably possible after such automatic suspension, the Medical Advisory Board shall convene to review and consider the facts under which the DEA number was revoked, suspended or relinquished. That Committee may then take such further action as is appropriate to the facts disclosed in its investigation.

- C. A Staff appointee who fails to complete medical records as required by the Rules and Regulation of the Staff shall immediately and automatically be suspended from all admitting, consultative and surgical privileges until the incomplete medical records are completed in accordance with the applicable Staff rules regarding completion of medical records.
- D. Upon exhaustion of appeals after conviction of a felony of a Staff appointee in any federal or state court, the appointee's Staff appointment is automatically revoked. Revocation pursuant to this section of the Bylaws does not preclude the Staff appointee from subsequently reapplying for Staff appointment. The filing of criminal charges or a finding of guilt by a court of record may constitute sufficient basis for invoking some type of corrective action.

SECTION 4 - CONTINUITY OF PATIENT CARE

Upon the imposition of summary suspension or the occurrence of an automatic suspension or limitation or restriction of privilege, of a Staff appointee, the Medical Director shall be responsible to provide for alternative coverage for the MFASC patients of the subject Staff appointee. The wishes of the patient shall be considered, where feasible, in choosing a substitute physician/dentist/podiatrist. The Staff appointee involved shall confer with the substitute physician/dentist/podiatrist to the extent necessary to safeguard the patient.

Article VIII - HEARING AND APPEAL PROCEDURE

SECTION 1 - RIGHT TO HEARING

- A. **Recommendations or Actions:** The following recommendations or actions shall, if deemed adverse pursuant to Section 1B below, entitle the physician/dentist/podiatrist affected thereby to a hearing:
 - i. Denial of Staff appointment;
 - ii. Denial of reappointment;
 - iii. Suspension of Staff appointment;
 - iv. Revocation of Staff appointment;
 - v. Reduction in Staff category;
 - vi. Limitation of admitting prerogatives;
 - vii. Denial of requested clinical privileges;

- viii. Reduction in clinical privileges;
 - ix. Suspension of clinical privileges; and
 - x. Revocation of clinical privileges.
- B. **When Deemed Adverse:** A recommendation or action listed in Section 1A above shall be deemed adverse only when it has been:
- i. Recommended by the Medical Advisory Board or
 - ii. Adopted or directed by the Governing body contrary to a favorable recommendation by the Medical Advisory Board under circumstances where no prior right to a hearing existed; or
 - iii. Adopted or directed by the Governing Body on its own initiative without benefit of a prior recommendation by the Medical Advisory Board.

SECTION 2 - REQUEST FOR HEARING

- A. In all cases in which the Governing body or the Medical Advisory Board shall have made a recommendation or taken an action entitling a physician/dentist/podiatrist to a hearing, the Medical Director shall give prompt written notice thereof by certified mail to the physician/dentist/podiatrist affected. The notice shall contain the following:
- i. That a professional review action has been proposed to be taken against him/her;
 - ii. The reasons for the proposed action, including a list of charts being questioned, if any;
 - iii. That the physician/dentist/podiatrist has a right to request a hearing on the proposed action;
 - iv. The thirty (30) day time limit with which he/she must request such a hearing; and
 - v. That the request for hearing must be in writing, and delivered in person or by certified mail to the Medical Director.
- iv. A summary of his/her rights in the hearing, which are: (a) representation by an attorney or other person of his/her choice, provided that, at least three (3) days prior to the date of the hearing the physician/dentist/podiatrist shall submit to the Medical Director the written agreement of his/her representative to abide by the procedural rules applicable to such hearing, (b) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of a reasonable charge associated with the preparation thereof, (c) to call, examine and cross-examine witnesses, (d) to present evidence determined to be relevant by the hearing officer,

regardless of its admissibility in a court of law, and (e) to submit a written statement at the close of the hearing.

- B. The failure of a physician/dentist/podiatrist to request a hearing to which he or she is entitled by these Bylaws within the time and in the manner provided herein shall be deemed a waiver of his or her right to such hearing, and to any appellate review to which he or she might otherwise have been entitled.
- C. Upon receipt of a timely request for hearing, the Medical Director shall deliver such request to the Governing Body. The governing Body shall, within fifteen (15) days after the receipt of such request for hearing, schedule and arrange for such a hearing, and shall send to the affected physician/dentist/podiatrist, by certified mail, a written notice containing the following:
 - i. The time, place and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice, except as set forth in subsection 2D. below; and
 - ii. A list of the witnesses expected to testify at the hearing in support of the adverse recommendation or action.
- D. The date of the hearing shall be not more than ninety (90) days from the date of receipt of the request for hearing, except that when a request for hearing is received from a Staff appointee who is then under suspension, the hearing shall be held as soon as the arrangements may reasonably be made, but not more than ten (10) days from the date of receipt for the request for hearing.
- E. When a hearing is requested, the Governing Body shall appoint a Hearing Committee which shall be composed of no fewer than three (3) appointees of the Medical Staff, at least one of whom shall be board certified in the affected physician's specialty, none of whom shall be members of the Medical Advisory Board or previously have actively participate in the initial evaluation of the physician, and none of whom shall be in direct economic competition with the physician, dentist, or podiatrist. A hearing officer who is not in direct competition with the physician/dentist/podiatrist involved shall be appointed by the Governing Body preside over the hearing.

SECTION 3 - HEARING PROCEDURE

- A. The attendance of the physician/dentist/podiatrist for whom the hearing has been scheduled shall be required. A physician/dentist/podiatrist who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his or her right to such hearing, and to any appellate review to which he or she might otherwise have been entitled.
- B. The hearing officer shall preside over the hearing to determine the order of procedure, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. If requested by the Hearing Committee, the hearing officer may participate in the deliberation of such body and be advisor to it, but he/she shall not be entitled to vote.

- C. The hearing Committee shall keep an accurate record of the hearing by means of a tape recorder or court reporter, and may, but shall not be required to, require that oral evidence be taken on oath or affirmation administered by a person entitled to notarize documents in the State of Wisconsin.
- D. If the physician/dentist/podiatrist does not testify on his/her own behalf, he or she may be called and examined as if under cross-examination.
- E. The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matter upon which reasonable 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 evidence inadmissible over objection in a civil or criminal action. The physician/dentist/podiatrist for whom the hearing is being held shall be entitled to submit memoranda concerning any issue of procedure or of fact prior to, during or at the close of the hearing, and such memoranda shall become part of the hearing record.
- F. In reaching a decision, official notice may be taken by the Hearing Committee, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing, and of any facts which may be judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be noticed, and those matters shall be noted in the hearing record. The physician/dentist/podiatrist for whom the hearing is being held shall be given the opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner such refutation to be determined by the Hearing Committee. The Committee shall also be entitled to consider any pertinent material contained on file on the MFASC, and all other information which can be considered in connection with applications for appointment to the Staff or for clinical privileges pursuant to these Bylaws. The Governing Body, when its action has prompted the hearing, shall appoint one (1) of its members or some other Staff appointee to represent it at the hearing, to present the facts in support of its recommendation, and to examine witnesses. The Medical Advisory Board, when its action has prompted the hearing, shall appoint one (1) of its members to represent it at the hearing, to present the facts in support of its decision, and to examine witnesses. It shall be the obligation of such representatives to present appropriate evidence in support of the adverse recommendation or decision, but the affected physician, dentist, or podiatrist shall thereafter be responsible for supporting his or her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis, or that such basis or any action based there on is either arbitrary, unreasonable or capricious.
- G. The Hearing Committee may, without special notice, recess the hearing and reconvene the same 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. The hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the physician/dentist/podiatrist for whom the hearing was convened.

- H. Within fifteen (15) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation, and shall forward same together with the hearing record to the Governing Body and the Medical Advisory Board. The report may recommend confirmation, modification or rejection of the original recommendation or action of the Governing Body or the Medical Advisory Board. A copy of the report and recommendations, which shall include a statement of the basis for the recommendations, shall at the same time be delivered to the physician/dentist/podiatrist involved in person or by certified mail.

SECTION 4 - APPEAL TO THE GOVERNING BODY

- A. Within ten (10) days after receipt of the report and recommendation of the Hearing Committee, the affected physician/dentist/podiatrist may, by written notice to the Governing body, delivered through the Medical Director by certified mail, request an appellate review by the Governing Body. If such appellate review is not requested within such ten-(10) days period, the affected physician/dentist/podiatrist shall be deemed to have waived his or her right to the same.
- B. Within fifteen (15) days after receipt of a request for appellate review, the Governing Body shall schedule and arrange for an appellate hearing. The Governing body shall cause the physician/ dentist/podiatrist to be notified, by certified mail, of the time, place and date of the appellate hearing. The date thereof shall be as soon as is mutually agreeable, but not more than forty-five (45) days from the date of receipt of the request for appellate review, except that when a request for appellate review is received from a physician/dentist/podiatrist who is then under suspension, the appellate hearing shall be held as soon as the arrangements may reasonably be made, but not more than ten (10) days from the date of receipt of the request.
- C. The proceedings by the Governing Body shall be in the nature of an appellate review, based upon the record of the proceedings before the Hearing Committee, without the taking of additional evidence. However, the Governing Body may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination and confrontation applicable to the proceedings before the Hearing Committee. At the appellate hearing the physician/dentist/podiatrist shall have the right to be represented by legal counsel and to present written and oral statements and authorities in support of his position on appeal. Following the appellate hearing, the Governing body may refer the matter for further review and recommendation, but this shall not extend the time within which the Governing Body shall render it final decision.
- D. Within thirty (30) days after the conclusion of the proceedings before the Governing Body, the Governing Body shall render a final decision in writing and shall deliver copies thereof to the physician/dentist/podiatrist and to the Medical Advisory Board and the Medical Director personally or by certified mail.
- E. The final decision of the Governing Body following the appeals procedure set forth in this article shall be effective immediately and shall not be subject to further appeal.

- F. No physician/dentist/podiatrist shall be entitled as a matter of right to more than one hearing before the Governing Body on any single matter which may be the subject of an appeal without regard to whether such subject is the result of action by the Medical Advisory Board or the Governing body, or both.
- G. All records and tapes of the proceedings provided for in this Article VIII shall be kept on file in the MFASC until all applicable Statutes of Limitation expire, or, if a judicial appeal is then pending, until the final determination of such appeal.
- H. Whether or not a hearing or appellate review has been requested or granted, the final decision of the Governing body on the matter shall be sent to the affected physician, dentist, or podiatrist by the Medical Director by certified mail, including a statement of the basis for the decision.

Article IX - IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at the MFASC.

SECTION 1 - IMMUNITY PRIVILEGE

Any act, communication, report, recommendation, or disclosure, with respect, to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

SECTION 2 - IMMUNE PARTIES

Such privilege shall extend to appointees of the MFASC's Medical Staff and members of its Governing body, its other practitioners, its officers and representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article IX, the term "third parties" means both individuals and organization from whom information has been requested by an authorized representative of the Governing body or of the MFASC Medical Staff.

SECTION 3 - CIVIL LIABILITY

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

SECTION 4 - APPLICABLE ACTIVITIES

Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this, or any other health care institution's activities related, but not limited to:

- A. Applications for appointment or clinical privileges.
- B. Periodic reappraisals for reappointment or clinical privileges.
- C. Corrective action, including summary suspension.
- D. Hearings and appellate reviews.
- E. Medical Care evaluations.
- F. Utilization review.
- G. Other MFASC, departmental, service or committee activities related to quality patient care and professional conduct.

SECTION 5 - EXTENT OF PRIVILEGE

The acts, communications, reports, recommendations and disclosures referred to in this Article VII may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

SECTION 6 - LIABILITY RELEASE

In furtherance of the foregoing, each practitioner shall, upon request of the MFASC execute releases in accordance with the tenor and import of this Article IX in favor of the individuals and organization specified in Section 2, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.

SECTION 7 - EFFECT ON APPOINTMENT AND REAPPOINTMENT PROCEDURE

The consents, authorizations, releases, rights, privileges, and immunities provided by Article III of these Bylaws for the protection of the MFASC's practitioners, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article IX.

Article X - STAFF DUES AND ASSESSMENTS

Medical Staff dues and special assessments shall be those that may be established by the Governing Body from time to time.

Article XI - AMENDMENTS

These Bylaws may be amended by the Governing Body or by the Medical Advisory Board at any regular or agreed meeting of that Board provided fourteen (14) days notice of the proposed amendment is given in writing to all members of that Board prior to said meeting. Amendments shall require a majority of the Governing Body or a two-third (2/3) vote of the Medical Advisory Board present at the meeting at which the amendment is adopted. Amendments proposed and approved by the Medical Advisory Board shall be effective only when approved by the Governing Body.

Article XII - Adoption

These Bylaws, together with the appended rules and regulations, were adopted at any regular meeting of the Governing Body on December 19, 1994, and shall become effective and be equally binding on the Governing Body and the Medical Staff as of that date.

GOVERNING BODY, MFASC:

Date

By: _____

Secretary

May 9, 1994 (Original)

MEDICAL STAFF RULES AND REGULATIONS

MENOMONEE FALLS AMBULATORY SURGERY CENTER

1. Admission

Patients may be admitted to the MFASC on request by a physician, dentist, or podiatrist. This request will be made on a form supplied by the MFASC, or on a form that contains all of the information requested on the MFASC form. In general, this will include the following:

- a. Patient identification, including name, date of birth, address, phone (home, work).
- b. Insurance identification: company, policy number, and patient's relation to subscriber.
- c. Diagnosis at the time request is made for admission. (Either ICD-9 code or sufficient information to determine that code).
- d. Proposed procedure, including any special instruments, equipment, or supplies that will be utilized.
- e. Any information regarding the patient's physical or mental condition which might be problematic in relation to other patients or staff members.

2. The medical Staff member who admits the patient is responsible for the care and treatment of the patient in the MFASC and after the patient has been discharged until full recovery. That responsibility may be delegated to another Medical Staff member who must then acknowledge (in writing) acceptance of that responsibility.

3. A medical history and appropriate physical exam which meets the requirements of the Wisconsin State Board of Health and other regulatory agencies shall be included in the chart before any procedure is performed. The results of any lab tests, x-rays, EKG, or consultations ordered for the admission shall be available at the time of admission. It is the responsibility of the admitting physician, podiatrist, or dentist to provide the required information.

4. Verbal orders shall be reduced to writing and signed on the day of the patient's admission and before the patient has left the facility.

- (1) 5. All procedures performed shall be described in the medical record with notes written immediately following the procedure. In other than minor procedures, a procedure note shall be dictated which shall contain the operative findings, a detailed account of the procedure, and note of all tissues or foreign materials removed. Procedure notes should be dictated on the same day as the procedure, and, in any case, shall be dictated within 5 working days after the procedure and signed by the physician within 30 days following dictation.

- (2) 6. Patients having anesthetic care shall be discharged by an anesthesiologist. An anesthesiologist must be in the facility whenever any patient who has received anesthesia services is in the building and receiving or recovering from any medication, including intravenous fluids.
7. All patient records, pathological examinations, laboratory reports, etc. are the property of the MFASC and shall not be removed from the MFASC except on court order.
8. All patients, or in the case of a minor, his/her parent or guardian, must sign the MFASC Informed Consent Form prior to any procedure. It is the responsibility of the attending physician, podiatrist, or dentist to explain to the patient, or in the case of a minor, his/her parent or guardian, in detail the clinical condition, the planned procedure, the alternatives to the procedure, the usual risks of the procedure, and the expected consequences of not having the procedure performed. The patient, or in the case of a minor, his/her guardian, must acknowledge receiving this information from the attending physician, podiatrist, or dentist by signing an Informed Consent prior to any procedure.
9. From time to time, the Anesthesia Department at the MFASC shall publish Guidelines for Ambulatory Surgery with Anesthesia. Those guidelines shall reflect current medical literature on the subjects of selection and evaluation of patients, NPO requirements, and any conditions which preclude anesthesia on an outpatient basis.
10. Guidelines for monitoring and sedation of patients undergoing procedures without anesthesia care will be issued by the Medical Director and the Department of Anesthesiology and distributed to all members of the Medical Staff.
- (2) 11. Medical staff (and allied health professionals) are responsible for complying with the Surgery Center's HIPAA security policies and procedures. Failure to do so will result in corrective action.
12. These Rules and Regulations may be modified or amended as provided for in VI of the Bylaws of the MFASC.

(1) Revised 10/02/00

(2) Revised 09/13/05

MEDICAL STAFF BYLAWS

***ST. JOSEPH'S COMMUNITY HOSPITAL
OF WEST BEND, INC.***

Effective: 03/2012

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ARTICLE I

Definitions

The name of this organization shall be “Medical Staff of Froedtert Health St. Joseph’s Hospital.” When used herein, the following terms shall have the following meanings:

“**Allied Health Staff**” or “**Allied Health Professional**” or “**AHP**” means any health professional, who is not a Member of the Medical Staff, but who is qualified by academic and clinical training and by prior and continuing experience and current competence in a discipline who the Governing Body has permitted to assist the Medical Staff in the care of patients in the Hospital.

“**Applicant**” means either a Practitioner who has completed an application for appointment or reappointment to the Medical Staff, or a Practitioner or an AHP who has completed an application for clinical privileges to provide patient care at the Hospital.

“**Governing Body**” means the Board of Directors of Froedtert Health St. Joseph’s Hospital.

“**Hospital**” means, unless the context requires otherwise, Froedtert Health St. Joseph’s Hospital.

“**In Good Standing**” means a Member is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the Medical Staff.

“**Investigation**” means a process specifically initiated by the medical executive committee to determine the validity, if any, of a concern or complaint raised against a Medical Staff Member or individual holding clinical privileges.

““**Medical Executive Committee**” or “**MEC**” means the Executive Committee of the Medical Staff.

“**Medical Staff**” or “**Staff**” means, unless otherwise expressly stated, the Hospital’s organized component of all physicians, dentists, and podiatrists who are privileged to attend to patients in the Hospital.

“**Member**” means Practitioners who have satisfied all credential requirements and have been approved to attend patients as part of the Medical Staff at the Hospital.

“**Physician**” means all medical physicians and osteopathic physicians holding license to practice in the State of Wisconsin.

“**Practitioner**” or “**Licensed Independent Practitioner**” means, unless otherwise expressly limited, any physician, dentist or podiatrist applying for or exercising clinical privileges in the Hospital or Allied Health Staff granted privileges.

“**President of the Medical Staff**” or “**President**” shall refer to the President of the Medical Staff as elected by the Medical Staff and appointed by the Governing Body for the purpose of

administering the affairs of the Medical Staff. Unless otherwise stated, when used herein, the term President of the Medical Staff or President is construed to include his/her designee.

“Special Notice” means written notification sent by certified mail or registered mail, return receipt requested, or hand delivered to the addressee.

“VPMA” means Vice President of Medical Affairs.

ARTICLE II

Purpose

The purpose of the Medical Staff shall be:

1. To promote quality care for all Hospital patients and to provide leadership for the Hospital’s performance review activities.
2. To provide a means whereby problems of medico-administrative nature may be discussed by the Medical Staff with the Governing Body and the Administration.
3. To adopt hospital policies governing medical practice.
4. To provide education and to maintain educational standards.
5. To promote a professional performance of and to oversee the quality of patient care, treatment and services provided by all practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the Hospital and through an ongoing review and evaluation of each practitioner’s performance in the Hospital.
6. To carry out such other responsibilities as may be reasonably delegated by the Governing Body.
7. To provide a utilization review program to allocate inpatient medical and health services based upon determination of individual medical needs and to improve the appropriate allocation of medical and health service resources.
8. To conduct reviews and evaluate and improve the quality of patient care through patient care audit procedures and other processes.
9. To initiate and pursue corrective action with respect to Members when warranted.

ARTICLE III

Membership

Section 1 Membership Privileges.

Membership on the Medical Staff of the Hospital is a privilege that shall be extended only to those Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws.

Section 2 Criteria For Appointment.

- A. Education. The Applicant for appointment to the Medical Staff shall be a graduate of an approved medical school, approved osteopathic school, approved dental school, or approved podiatric school, legally licensed to practice medicine, dentistry, or podiatry in the state of Wisconsin, and practicing in the community or within a reasonable distance of the Hospital.
- B. Training. Only physicians, dentists, or podiatrists who can document their background, experience, training and demonstrated current competence, their adherence to the ethics of their profession, their good reputation, their adherence to the appropriate utilization of Hospital resources as determined through quality assurance and utilization review activities, and their ability to work with others with sufficient adequacy to assure the Medical Staff and the Governing Body that any patient treated by them in the Hospital will be given a high quality of safe medical care, and who can continue to demonstrate and maintain these standards shall be qualified for appointment to the Medical Staff.
- C. Board Certification. Unless waived by the Governing Body after consultation with the MEC, Physicians whose initial appointment occurs on or after August 22, 2002 shall be board certified within five (5) years of appointment by a specialty board approved by either the American Board of Medical Specialties or the American Osteopathic Association in the area of practice in which privileges are requested, and meet at least one of the following:
 - 1. Have completed a residency program approved by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the area of practice in which privileges are requested.
 - 2. Have completed a fellowship program in the area of practice in which privileges are requested, provided the fellowship program is approved by either the Accreditation Council for Graduate Medical Education or the American Osteopathic Association and has admission standards requiring completion of a residency program either (i) approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or (ii) with training and education standards that

meet or exceed those of the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

When no qualifying certification exists in a Physician's primary specialty (i.e., Hospitalist, Immediate Care, etc.), current qualifying certification in the Physician's specialty of training most similar to the chosen specialty of practice shall be deemed acceptable.

- D. Board Recertification. Unless waived by the Governing Body after consultation with the MEC, recertification by a specialty board is encouraged but not required for reappointment to the Medical Staff.
- E. Requirements. Applicants assigned to active or associate Staff agree to actively participate in providing emergency services and other duties as may be designated by the Medical Staff.
 - 1. Applications for appointment to the Medical Staff shall not be granted unless it is determined, under the procedure set forth in Article II, Section 4 below that: (1) there is a sufficient appointment load to justify the appointment of a physician, dentist, or podiatrist with the Applicant's skill and training; and (2) the Hospital is able to provide adequate facilities and supportive services for the Applicant and his/her patients.
 - 2. Applications for appointment to the Medical Staff shall not be granted unless the Applicant completes a background check required by Section 50.065 of the Wisconsin Statutes, or successor statute thereto, the results of which do not prevent the Hospital from extending Medical Staff membership to the Applicant.
 - 3. Appropriate call coverage arrangements (where one or more practitioners holding appropriate clinical privileges at the Hospital have agreed to attend to the reasonably anticipated needs of the Applicant's patients) must be established in the event of the Applicant's unavailability (planned or unplanned).
 - 4. No Applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid, is eligible or qualified for appointment to the Medical Staff or to exercise clinical privileges at the Hospital. An individual may be excluded from such health care program upon action by a federal or state agency.

Section 3 Ethics and Ethical Relationships.

The professional conduct of appointees to the Medical Staff shall be governed by the principles of ethics of the American Medical Association, American Osteopathic Association, American Dental Association, or American Podiatric Medical Association, as appropriate. Specifically, all appointees to the Medical Staff shall pledge themselves

that they will not receive from or pay to another physician, dentist, or podiatrist, either directly or indirectly, any part of a fee received for professional services. They shall provide for continuous patient care, seek consultation whenever necessary and delegate in their absence the responsibility for care of patients to a qualified practitioner. This commitment is inherent in accepting appointment to the Medical Staff.

Section 4 Terms of Appointment.

- A. Initial Appointment/Modifications. All initial appointments and all modifications of appointment status or privileges pursuant to Article VI, Section 1, shall be for two (2) years.
- B. Reappointments. Reappointments to any category of the Medical Staff shall be for a period of not more than two (2) years.
- C. Appointment/Reappointment Authority.
 - 1. Appointments and reappointments shall be made by the Governing Body after recommendation of the Executive Committee of the Medical Staff.
 - 2. Appointment to the Medical Staff shall confer on the appointee only such privileges as may hereinafter be provided.

Section 5 Procedure of Appointment and Reappointment.

- A. General Procedure. The Medical Staff, through its designated committees, departments and officers shall investigate and consider each application for appointment or reappointment to the Staff and each request for modifications of Staff appointment status or privileges and shall adopt and transmit recommendations thereon to the Governing Body. In all matters concerning Medical Staff appointments and the granting of clinical privileges, the Governing Body retains final authority. The Medical Staff shall perform these same investigation, evaluation, and recommendation functions in connection with any Allied Health Professional or other individual who seeks to exercise clinical privileges or provide specified services in the Hospital.
- B. Application for Initial Appointment. The Applicant must sign and submit the application and in so doing:
 - 1. Attests to the accuracy and completeness of all information on the application and accompanying documents and agrees that any inaccuracy, omission, or misrepresentation, whether intentional or not, will be grounds for termination of the application process. If the inaccuracy, omission or misstatement is discovered after an individual has been granted appointment, the discovery will be grounds for automatic relinquishment of appointment and Clinical Privileges. Neither the rejection of the application, nor the relinquishment of appointment and Clinical Privileges

pursuant to this Section 5 shall entitle an individual to any hearing or appeals.

2. Signifies his/her willingness to appear for any requested interviews in regard to his/her application.
3. Authorizes Hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the Privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for Medical Staff membership and Clinical Privileges requested.
4. Consents to Hospital and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the Clinical Privileges requested, including but not limited to his/her physical and mental health status.
5. Releases from liability, promises not to sue and grants immunity to the Hospital, its Medical Staff, and its representatives for acts performed and statements made in connection with evaluation of the application and his/her credentials and qualifications, to the fullest extent permitted by law.
6. Releases from liability and promises not to sue all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives concerning his/her background, experience, competence, professional ethics, character, physical and mental health, emotional stability, utilization practice patterns, and other qualifications for appointment to and membership on the Medical Staff and Clinical Privileges.
7. Consents to authorized Hospital Medical Staff and administrative representatives providing other hospitals, medical associations, licensing boards, and other groups or organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that Hospital may have concerning him/her and releases Hospital Medical Staff and administrative representatives from liability for so doing. For the purposes of this provision, the term "Hospital representatives" includes the Governing Body, its directors and committees, the CEO or his/her designee, registered nurses and other employees of Hospital, the Medical Staff organization, and all Medical Staff appointees, clinical units, and committees that have responsibility for collecting and evaluating the Applicant's credentials or acting upon his/her application, and any authorized representative of any of the foregoing.

8. Signifies that he/she has been oriented to the current Medical Staff Bylaws and associated manuals and agrees to abide by their provisions in regard to his/her application for appointment to the Medical Staff, with such orientation to include at least one of the following: receiving a copy of the Bylaws and associated manuals, or receiving a summary of expectations of Medical Staff Members and having the Bylaws and manuals made available to him/her.
9. Agrees to notify the Medical Staff office within twenty-four (24) hours of occurrence of any of the following:
 - (a) Disciplinary actions are initiated or pending by any state licensure board.
 - (b) The individual's license to practice in any state is relinquished, denied, limited, suspended, or revoked, whether voluntarily or involuntarily.
 - (c) The individual is asked to surrender his/her license.
 - (d) The individual is suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, CHAMPUS, or Medicaid) and/or barred from providing direct patient care under Wisconsin's caregiver misconduct law.
 - (e) The individual is the subject of an investigation by any private, federal, or state agency concerning his/her participation in any private, federal, or state health insurance program.
 - (f) The individual's narcotics registration certificate is challenged, relinquished, limited, denied, suspended or revoked.
 - (g) The individual is named as a defendant in any criminal proceeding.
 - (h) The individual's employment, medical staff appointment, or clinical privileges are suspended, diminished, revoked, refused, or limited at any hospital or other health care facility, whether voluntarily or involuntarily.
 - (i) The individual withdraws his/her application for appointment, reappointment, or clinical privileges or resigns from the medical staff of a hospital or health facility before the Governing Body made a decision.
 - (j) The individual is the subject of focused individual monitoring at any hospital or health care facility.

- (k) The individual is examined by any specialty board, but fails to pass the examination.
 - (l) A professional liability claim or suit is filed against the individual.
 - (m) A judgment or settlement is made against the individual in a professional liability case.
- C. A completed application includes, at a minimum, a signed, dated application form and request for Privileges, copies of all documents and information necessary to confirm that the Applicant meets criteria for Medical Staff membership and Privileges, and references. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time and if it is not provided by the Applicant within thirty (30) days of the request for additional information. An incomplete application will not be processed and will be considered voluntarily withdrawn.
- D. The burden is on the Applicant and it is the Applicant's responsibility for ensuring that the Medical Staff office receives supporting documents verifying information on the application. If all supporting documents required are not received within thirty (30) days of request, this will constitute a voluntary withdrawal of the application. Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.
- E. Upon receipt of a completed application as defined above, the Applicant will be sent a letter of acknowledgment by the Medical Staff services office.

Section 6 Procedure for Processing Applications for Initial Appointment.

All qualified candidates for appointment to the Medical Staff shall be considered by the Credentials Committee.

- A. Verification of Information. Upon receipt of a completed application, the Medical Staff office will verify its contents through relevant sources and collect additional information as follows:
 1. Information from all prior and current liability insurance carriers concerning claims, suits, settlements and judgments, (if any) during the past five years;
 2. Documentation of the Applicant's past clinical work experience;
 3. Licensure status in all current and past states of licensure;
 4. Information from the AMA or AOA Physician Profile and criminal background check;

5. Completion of professional training programs including residency and fellowship programs;
 6. Information from the National Practitioner Data Bank;
 7. Current picture hospital ID card or valid picture ID issued by a state or federal agency (e.g. driver's license or passport);
 8. Data from professional practice review by an organization(s) that currently privileges the Applicant (if available);
 9. Relevant practitioner-specific data as compared to aggregate data, when available;
 10. Morbidity and mortality data, when available;
 11. Reference information from at least two (2) persons who have recently worked with the individual and directly observed his/her professional performance over a reasonable period of time and who can and will provide reliable information regarding the individual's medical/clinical knowledge, technical and clinical skills, clinical judgment, relevant training and/or experience, current competence, fulfillment of obligations as a Member of the Medical Staff, interpersonal skills, communication skills, professionalism and any effect of health status of the individual's ability to practice medicine or the privileges to be recommended. These references must be peers who are practitioners in the same or a related professional discipline as the individual.
 12. Additional information as may be requested to ensure Applicant meets the criteria for Medical Staff membership.
- B. Categorization of Application. When the items identified in Article III, Section 6.A above have been obtained, the file will then be reviewed by the appropriate section chair, and the Medical Staff Service Professional who will categorize the application as follows:
1. Category 1: A completed new application that does not raise concerns as identified in the criteria for Category 2 below will be considered a "Category 1" application. Applicants with Category 1 applications will be granted Medical Staff membership and Privileges following approval by the following: section chair (and medical director, as applicable), Credentials Committee Chair acting on behalf of the Credentials Committee, a quorum of the MEC, and a Governing Body committee consisting of at least two individuals (as delineated in the Hospital Bylaws). At all stages in this process, the burden is upon the Applicant to provide evidence that he/she meets the criteria for membership on the Medical Staff and for the granting of requested Privileges.

2. Category 2: If one or more of the following characteristics are identified in the course of review of a completed application, or if the section chair (and medical director, as applicable), in consultation with the CEO and Medical Staff office, or the Credentials Committee Chair, or the MEC, or the Governing Body subcommittee or CEO, reasonably determine that for other reasons the application should be treated as a “Category 2” application, the application will be treated as a “Category 2” application. The section chair (and medical director, as applicable), the Credentials Committee, the MEC and Governing Body must review and approve applications in Category 2 in order for Medical Staff membership and privileges to be granted. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the Applicant to provide evidence that he/she meets the criteria for membership on the Medical Staff and for the granting of requested Privileges. Characteristics of Category 2 applications include but are not necessarily limited to the following:
- (a) The application is deemed to be incomplete.
 - (b) The recommendation of the MEC is to deny or limit Medical Staff membership or Clinical Privileges.
 - (c) 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.
 - (d) The Applicant is, or has been, under investigation by a state medical board or has had prior disciplinary actions or legal sanctions.
 - (e) The Applicant has had two (2) or more malpractice cases filed within the past five (5) years or one final adverse judgment or settlement in a professional liability action that has not been previously considered by the Credentials Committee.
 - (f) The Applicant changed medical schools or residency programs or has gaps in training or practice.
 - (g) The Applicant has changed practice locations more than three times in the past ten (10) years.
 - (h) The Applicant has practiced or been licensed in three (3) or more states.
 - (i) The Applicant has one or more reference responses that raise concerns or questions.

- (j) A discrepancy has been found between information received from the Applicant and references or verified information.
- (k) The Applicant has an adverse National Practitioner Data Bank Report that has not been previously considered by the Credentials Committee.
- (l) The request for Clinical Privileges is not reasonable based upon Applicant's experience, training, and competence, and/or is not in compliance with applicable criteria.
- (m) The Applicant has been removed from a managed care panel for reasons of professional conduct or quality.
- (n) The Applicant has a physical or mental health condition relevant to his/her ability to provide patient care.
- (o) The Applicant has been in practice for more than two years and has never held an active staff appointment at another hospital.

C. Section Chair Action.

1. All completed applications are presented to the appropriate section chair and medical director (as applicable) for review and recommendation. The section chair and medical director (as applicable) review the application to ensure that it fulfills the established criteria for membership and Clinical Privileges. The section chair and medical director (as applicable), in consultation with the CEO and Medical Staff office, determine whether the application is forwarded as a Category 1 or Category 2. The section chair and medical director (as applicable) must take action by forwarding a report to the Credentials Committee within fifteen (15) days of receiving a completed application which indicates one of the following:
 - (a) Favorable recommendation. The section chair and medical director (as applicable) must document his/her 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 section chair's and medical director's (as applicable) recommendations are favorable to the Applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, to the Credentials Committee; or
 - (b) Adverse recommendation. The section chair and medical director (as applicable) 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 section chair and medical director's (as

applicable) adverse recommendation and supporting documentation, will be forwarded to the Credentials Committee.

D. Credentials Committee Action.

1. Review of Application. If the application has been designated Category 1, it is presented to the Credentials Committee Chair for review and recommendation. The Credentials Committee Chair reviews the application to ensure that it fulfills the established criteria for Medical Staff membership and Clinical Privileges. The Credentials Committee Chair has the opportunity to determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2. If the application will be forwarded to the MEC as a Category 1, the Credentials Committee Chair acts on behalf of the Credentials Committee and the application is presented to the MEC for review and recommendation. If the application has been designated Category 2, the Credentials Committee reviews the application and votes for one of the following actions:
 - (a) Deferral. Action by the Credentials Committee to defer the application for further consideration or 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, section affiliations, and/or scope of Clinical Privileges.
 - (b) Favorable recommendation. When the 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.
 - (c) Adverse recommendation. When the Credentials Committee's recommendation is adverse to the Applicant, the application shall be forwarded to the MEC along with the reasons for the adverse recommendation. The Credentials Committee may recommend the imposition of specific conditions. The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.
2. Applicant Interview.
 - (a) Procedure. 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 Credentials Committee. The interview

is to be conducted by the Credentials Committee. A permanent record of the interview will be documented.

- (b) Scheduling. The Applicant will be notified when the verification process is complete and that he/she should contact the responsible individual 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 leader within thirty (30) days of notification will be deemed a voluntary withdrawal of the application.

E. Medical Executive Committee Action.

- 1. If the application has been forwarded as Category 1, it is presented to the MEC where the application is reviewed to ensure that it fulfills the established criteria for Medical Staff membership and Clinical Privileges. The MEC has the opportunity to determine whether the application is forwarded to the Governing Body as a Category 1 with a favorable recommendation or may change the designation to a Category 2. If the application is to be forwarded as a Category 1, the MEC acts, and the application is presented to the Governing Body.

If the application has been forwarded to the MEC as a Category 2, the MEC reviews the application and votes for one of the following actions:

- (a) Deferral. Action by the MEC to defer the application for further consideration 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, section affiliations, and/or Clinical Privileges. The CEO shall promptly notify the Applicant by special, written notice of the action to defer.
- (b) 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 Governing Body.
- (c) Adverse recommendation. When the MEC's recommendation is adverse to the Applicant, a special notice shall be sent to the Applicant. No such adverse recommendation will be acted upon by the Governing Body until after the Practitioner has exercised or has waived his/her right to a hearing as provided in the Hearing and Appeal Policy and Process. A recommendation shall not be considered adverse to the Applicant if Clinical Privileges not central and directly related to the Applicant's prior training and

practice are deferred until such time as the Hospital has had sufficient opportunity (after initial appointment) to observe the Applicant's practice and qualifications to exercise the deferred Privileges.

F. Governing Body Action.

1. If the application has been forwarded as Category 1, it is presented to an appropriate Governing Body subcommittee of at least two (2) Members and to the CEO, and both the Governing Body subcommittee and CEO review the application to ensure that it fulfills the established criteria for Medical Staff membership and Clinical Privileges. When Governing Body subcommittee and CEO have designated the application as a Category 1, a report is prepared for the Governing Body identifying those Practitioners who were appointed and granted Clinical Privileges as Category 1 Applicants. This report is for information only, since the Governing Body subcommittee is authorized to act on behalf of the Governing Body with respect to Category 1 Applicants.

If the application comes to the Governing Body designated as Category 2, or is so designated by the Governing Body subcommittee or the CEO, the Governing Body reviews the application and votes for one of the actions:

- (a) Favorable recommendation. The Governing Body 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 Governing Body is effective as its final decision.
 - (b) Adverse recommendation. In cases where the MEC has made a favorable recommendation, if the Governing Body's action is adverse to the Applicant, the matter will be submitted to a committee of equal members of the MEC and Governing Body for review and recommendation before the Governing Body makes its decision, and the committee will submit its recommendation to the Governing Body within thirty (30) days of submission of the matter to the committee. If still adverse, special notice will be sent to the Applicant, and he/she shall then be entitled to the procedural rights provided in the Hearing and Appeal Policy and Process. The Governing Body shall take final action in the matter as provided in the Hearing and Appeal Policy and Process.
2. Whenever the Governing Body's proposed decision will be contrary to the MEC's recommendation, the Governing shall submit the matter to a joint meeting of equal members of Medical Staff Members and Governing

Body members for review and recommendation before making its final decision and giving notice of final decision. The ultimate decision regarding whether to appoint an Applicant rests, however, with the Governing Body.

3. All appointments to Medical Staff membership and the granting of Privileges are for a period not to exceed twenty-four (24) months. An Applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the Applicant shall submit such additional information as the Staff or the Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.
- G. Basis for Recommendation and Action. The report of each individual or group required to act on an application, including the Governing Body, must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered.
- H. Notice of Final Decision. Notice of the Governing Body's final decision shall be given through the CEO to the MEC and to the chair of each section 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 section to which he/she is assigned, the Clinical Privileges he/she may exercise, and any special conditions attached to the appointment.
- I. Time Periods for Processing. All individuals and groups required to act on an application for staff appointment must do so in good faith and in a timely manner, guided by the following timeline:
- Medical Staff Office collects, verifies and summarizes application information: sixty (60) days
- Section Chair (and medical director, as appropriate) reviews and reports: fifteen (15) days
- Credentials Committee analyzes and recommends: thirty (30) days
- Medical Executive Committee reaches recommendation: thirty (30) days
- Governing Body renders decision: thirty (30) days

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 and Appeal Policy and Process are activated, the time requirements provided therein govern the continued processing of the application.

J. Leave of Absence.

1. Leave Request. A staff appointee may obtain a voluntary leave of absence by providing written notice to the President of the Medical Staff. The notice must state the reasons for the leave and approximate 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.
2. Termination of Leave. A staff appointee seeking reinstatement must send written notice to the President of the Medical Staff at least thirty (30) days prior to the termination of the leave, or at any earlier time. The staff appointee also must submit a written summary of relevant activities during the leave if the MEC or Governing Body so requests. Following the applicable procedures for the granting of privileges, the MEC will make a recommendation to the Governing Body concerning reinstatement.

K. Practitioner Providing Contractual Services.

1. Exclusivity Policy. Whenever Hospital policy specifies that certain Hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between Hospital and qualified practitioners, then other staff appointees must, except in an emergency or life threatening situation, adhere to this exclusivity policy in arranging care for their patients. Application for initial appointment or for Clinical Privileges related to Hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the Hospital.
2. Qualifications. A Practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the Hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other Applicant or staff appointee.
3. Effect of Staff Appointment Termination. Because practice at the Hospital is always contingent upon continued staff appointment and also constrained by the extent of Clinical Privileges enjoyed, a Practitioner's right to use Hospital facilities is automatically terminated when the staff appointment expires or is terminated. The extent of his/her Clinical Privileges is automatically limited to the extent that the pertinent Clinical Privileges are diminished, restricted or revoked. The effect of an adverse change in Clinical Privileges on continuation of a contract or employment is governed solely by the terms of the contract or employment arrangement. If the contract or employment agreement is silent on the matter, the Governing Body will make a determination after soliciting and considering the recommendations of relevant components and officials of the staff.

4. Effect of Contract on Right to Fair Hearing. A Medical Staff Member providing professional services under a contract shall not have his/her Clinical Privileges terminated for reasons pertaining to quality of care or professional conduct issues without the same rights to the Hearing and Appeal Policy and Process identified in the Medical Staff Bylaws and policies as available to all Members of the Medical Staff.
 5. Effect of Contract or Employment Expiration or Termination. The effect of expiration or other termination of a contract upon a Practitioner's staff appointment and Clinical Privileges will be governed solely by the terms of the Practitioner's contract with 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.
- L. Nondiscrimination. No person who is otherwise qualified shall be denied appointment or reappointment to the Medical Staff, or the exercise of clinical privileges, on the basis of age, sex, race, creed, color, handicap, national origin, religion, disability, sexual orientation, or on the basis of any other criterion unrelated to the delivery of good patient care, to professional qualifications, to the purposes, needs and capabilities of the Medical Staff, to community need, or to any requirements set forth in these Bylaws.
- M. Reappointment Process-General. All reappointments and renewals of Clinical Privileges are for a period not to exceed twenty-four (24) months. Medical Staff Members will be subject to ongoing professional practice evaluation as set forth in the Quality Policy and Procedure Manual throughout periods of appointment Information Collection and Verification:
1. Information Provided by Appointee. On or before four (4) months prior to the date of expiration of a Medical Staff appointment, a representative from the Medical Staff office will notify the appointee of the date of expiration and supply him/her with an application for reappointment, a copy of which is attached and is incorporated by reference. At least ninety (90) days prior to the date of expiration, the appointee must furnish, in writing:
 - (a) A completed reapplication form that includes complete information to update his/her file on items listed in his/her original application.
 - (b) Information concerning continuing training and education internal and external to the Hospital during the preceding period.
 - (c) Specific request for the Clinical Privileges sought on reappointment, with any basis for changes.

- (d) Acknowledgement that by signing the reapplication form, the appointee agrees to the same terms as identified in Article III, Section 5 above.
- (e) The appointee must also pay an application for reappointment fee. Failure to make such payment within sixty (60) days of submission of an application for reappointment shall constitute a voluntary resignation of the appointee's Medical Staff membership.

Failure, without good cause, to provide any additional requested information, at least thirty (30) days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment on the expiration date. Once the information is received, the Medical Staff office verifies this additional information and notifies the staff appointee of any information inadequacies or verification problems. Throughout the reappointment application process, the staff appointee has the burden of producing adequate information and resolving any doubts about the information presented.

- 2. Information From Internal and/or External Sources. The Medical Staff office shall collect information regarding each staff appointee's professional and collegial activities including those items listed in Article III, Section 6.A above.
- 3. Additional Information Collected. The Medical Staff office shall also collect the following information:
 - (a) A summary of clinical activity at Hospital for each appointee due for reappointment.
 - (b) Performance and conduct in Hospital and/or other healthcare organizations, including, without limitation, patterns of care as demonstrated in findings of quality assessment/performance improvement activities, his/her clinical judgment and skills in the treatment of patients, and his/her behavior and cooperation with hospital personnel, patients and visitors.
 - (c) Timely and accurate completion of medical records.
 - (d) Compliance with all applicable Bylaws, policies, rules, regulations and procedures of the Hospital and Medical Staff.
 - (e) Any gaps in employment or practice since the previous appointment or reappointment.
 - (f) When insufficient practitioner-specific data are available, peer recommendations from a practitioner in the same professional discipline as the Applicant with personal knowledge of the

Applicant's ability to practice. Peer recommendations shall include written information regarding the Applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

N. Procedure for Processing Applications for Staff Reappointment:

1. When the items identified in Section 6.M above have been obtained, the file will then be reviewed by the Credentials Committee Chair who, in consultation with the Medical Staff Service Professional (or designee), will categorize the reapplication as follows:
 - (a) Category 1: A completed reapplication that does not raise concerns as identified in the criteria for Category 2 below will be considered a "Category 1" reapplication. Re-Applicants with Category 1 reapplications will be reviewed through the same process as for Category 1 initial applications as described in Article III, Section 6 above.
 - (b) Category 2: If one or more of the following characteristics are identified in the course of review of a completed reapplication, the reapplication will be treated as Category 2. Reapplications in Category 2 are approved through the same procedure as Category 2 initial applications as described in Article III, Section 6 above. Criteria for Category 2 reapplications include but are not necessarily limited to the following:
 - (1) The application is deemed to be incomplete.
 - (2) The final recommendation of the MEC is adverse or with limitation.
 - (3) 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.
 - (4) Applicant is, or has been, under investigation by a state medical board or has had prior disciplinary actions or legal sanctions.
 - (5) Applicant has had two (2) or more malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action.
 - (6) Applicant has gaps in practice since the most recent re-credentialing.

- (7) Applicant has one or more reference responses that raise concerns or questions.
 - (8) A discrepancy has been found between information received from the Applicant and references or verified information.
 - (9) Applicant has an adverse National Practitioner Data Bank report.
 - (10) The request for Clinical Privileges is not reasonable based upon Applicant's experience, training, and competence and/or is not in compliance with applicable criteria.
 - (11) Applicant has been removed from a managed care panel for reasons of professional conduct or quality.
 - (12) Applicant has potentially relevant physical or mental health problems.
 - (13) Information from the quality monitoring and improvement program at Hospital raises possible concerns with the Applicant's quality of care or capacity to fulfill the responsibilities of Medical Staff membership and the requested Privileges.
2. All applications for reappointment will be processed through the same procedure described in Article III, Section 6 above for initial appointment. In addition, as part of the assessment of the appointee's performance, the section chair or one or more Subject Matter Experts may be asked to provide relevant information concerning Practitioner's clinical and professional qualifications for reappointment for staff category and clinical privileges and to evaluate the application. Such evaluation will include providing information as to whether or not he/she knows of, or has observed or been informed 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, as well as relevant information concerning Practitioner's clinical and professional qualifications for reappointment for staff category and Clinical Privileges.
3. For the purpose of the reappointment procedures set forth herein, the terms "Applicant" and "appointment" as used in Article III shall be read respectively, as "staff appointee" and "reappointment."
- O. Criteria for Reappointment. It is the policy of Hospital to approve for reappointment only those individuals who continue to meet the criteria for initial appointment as identified in Article III, Section 2 and who have been determined

by the MEC to provide ongoing, high quality, effective care. Board certification status will be considered during reappointment evaluation. Medical Staff Members who have received a waiver from board certification requirements from the Governing Body, after consultation with the MEC, shall maintain a process to otherwise adequately demonstrate their ongoing satisfactory participation in learning and assessment activities (e.g., by providing evidence of sixty (60) or more CME credit hours in Category 1, approved by the Accreditation Council for Continuing Medical Education, over the previous two-year appointment term). It is the responsibility of the reappointment Applicant to maintain and provide documentation of such educational activities, for consideration by the MEC and the Governing Body.

ARTICLE IV

Categories of the Medical Staff

Section 1 The Medical Staff.

- A. The Medical Staff shall be divided into honorary, active and associate groups.
- B. Appointees of the Medical Staff shall be assigned to a department.

Section 2 The Honorary Medical Staff.

- A. The Honorary Medical Staff shall consist of Medical Staff appointees who are not active in the Hospital, and who have retired from active hospital service; or appointees of outstanding reputation who are not necessarily residents in the community.
- B. The Honorary Medical Staff are not eligible to vote or hold office, do not admit patients, and shall have no assigned duties, but are eligible to serve on councils and committees, except the Medical Executive Committee.
- C. Appointees to the Honorary Medical Staff are appointed by the Governing Body upon the recommendation of the Medical Executive Committee, do not serve for any specified term, and are not required to apply for such status.

Section 3 The Active Medical Staff.

- A. The Active Medical Staff shall consist of Medical Staff appointees who (a) maintain an active clinical practice in the community and provide patient care or inpatient consultative services for twenty-four (24) or more inpatients, day surgery patients or emergency patients per year and are not hospital-contracted physicians; (b) maintain an active clinical practice in the community and, in recognition that hospitalists frequently provide patient care services for inpatients, either provide patient care or inpatient consultative services or are identified as the primary care physician for inpatients cared for by hospitalists for a combined total of more than twenty-four (24) inpatients, day surgery patients or emergency

patients per year and are not hospital-contracted physicians; or (c) are hospital-contracted physicians who are identified by the contracted physician group as the core physicians for the clinical service.

- B. Active Medical Staff appointees shall be eligible to vote on all matters presented to the Medical Staff, participate on and chair committees, and hold office at any level within the Medical Staff organization.
- C. Appointees of the Active Medical Staff shall be required to participate in the emergency services back-up coverage and provide, within their scope of privileges, emergency care without regard to source of payment or ability to pay. Medical Staff appointees who are age sixty (60) or beyond shall be excused from this requirement at their option.

Section 4 The Associate Medical Staff.

- A. The Associate Medical Staff shall consist of those Medical Staff appointees who are qualified for Medical Staff membership, accept the responsibilities of membership, maintain an active medical practice in the community served by the Hospital, and refer their patients to the Hospital for inpatient or outpatient services, but who do not have a level of activity at the Hospital commensurate with Active Medical Staff status.
- B. Appointees shall not be eligible to vote or hold office.
- C. Appointees are eligible for appointment to certain Medical Staff committees, as further set forth in these Bylaws. Additionally, those Appointees moving from Active to Associate status at the time of reappointment remain eligible to serve out their current committee term on any Medical Staff committees, despite their change in membership status. If an Appointee serves on one or more Medical Staff committee annually, he or she may be advanced to Active Medical Staff at the time of reappointment or sooner, if requested by the Appointee. To change membership status under these conditions, the Appointee must attend a minimum of fifty percent (50%) of the committee meetings.
- D. Appointees of the Associate Medical Staff (other than the hospital-contracted physicians) shall be limited to providing care (admitting, consulting, performing procedures or attending) for twenty-four (24) inpatients, day surgery patients or emergency patients per year. A hospital-contracted physician is determined to be a Member of the Associate Medical Staff if not designated as a core physician for the clinical service by the contracted physician group. If twenty-four (24) patient contacts per year are exceeded, the physician is advanced to Active Medical Staff at the time of reappointment or sooner if requested by the physician.

ARTICLE V

Organization of the Medical Staff

Section 1 Section Designation.

The Medical Staff shall be organized as a sectionalized staff. The sections organized by the Medical Staff and formally recognized by the MEC are as follows: Family Practice (family practice, emergency medicine), Surgery (surgery specialties, anesthesia, dentistry), Maternal and Child Health (OB/GYN, family practice holding Privileges in maternal and child health, pediatrics), and Combined Services (internal medicine, gastroenterology, radiology and pathology, psychiatry, neurology and other medical specialties) and such other sections as may later be designated by the Governing Body.

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

Each section shall be organized as a division of the Medical Staff and shall have a chair who shall serve a term of two (2) years commencing on July 1 of even calendar years and is eligible to serve successive terms. Section chairs and vice-chairs will be elected biennially in Spring of even calendar years by majority vote of the active members of the section, subject to ratification by the MEC.

Section chairs shall carry out the following responsibilities:

- A. Oversee all clinically related activities of the section.
- B. Oversee all administratively related activities of the section otherwise provided for by Hospital.
- C. Provide ongoing surveillance of the performance of all individuals in the section who have been granted Clinical Privileges and enforce the Medical Staff Bylaws and rules within the section, including but not limited to FPPE and OPPE.
- D. Recommend to the Credentials Committee the criteria for Clinical Privileges that are relevant to the care provided in the Medical Staff section.
- E. Recommend Clinical Privileges for each member of the section and for allied health professionals who provide care within the section.
- F. Assess and recommend to the MEC and Administration off-site sources for needed patient care services not provided by the Medical Staff section or Hospital.
- G. Monitor and evaluate the quality and appropriateness of patient care provided by the section, and implement action following review and recommendations by the Performance Improvement Committee and/or the MEC.
- H. Integrate the section into the primary functions of Hospital.

- I. Coordinate and integrate intersectional and intrasectional services and communication.
- J. Participate in the administration of the section through cooperation with nursing services and Administration in matters affecting patient care.
- K. Assist with development and implementation of Medical Staff and Hospital policies and procedures that guide and support the provision of patient care services, and formulate special rules and policies for the section.
- L. Recommend to the CEO the sufficient numbers of qualified and competent persons to provide patient care services.
- M. Provide input to the Credentials Committee regarding the qualifications and competence of allied health professionals, such as nurse practitioners and physician assistants, who are granted permission to provide clinical services and are not Members of the Medical Staff.
- N. Make recommendations to the MEC and the CEO for space and other resources needed by the Medical Staff section to provide patient care services, and cooperate with Hospital's administrative staff on purchase of supplies and equipment.
- O. Make recommendations to Hospital's administrative staff regarding the planning of Hospital facilities, equipment, routine procedures and any other matters concerning patient care.
- P. Arrange and implement inpatient and outpatient programs, including organizing and engaging in educational activities and supervising and evaluating clinical work of section members.
- Q. Work with information management personnel to maintain the quality of medical records.
- R. Represent the section in a medical advisory capacity to Hospital's administrative staff and governing body.
- S. Be responsible for arranging appropriate emergency service on call coverage.
- T. Be responsible for assuring the orientation and continuing education of all persons in the section.
- U. Be responsible for maintenance of quality control programs, as appropriate.

Section 3 Family Practice Section.

The Section of Family Practice shall include family practice, emergency medicine, and such sections and divisions as deemed necessary by the section, each of which may elect

its own chair, but which will be collectively represented on the Medical Executive Committee by the elected chair of the Section of Medicine.

Section 4 Surgery Section.

The Section of Surgery shall include surgical specialties, anesthesia, dentistry, and such sections as deemed necessary by the section, each of which may elect its own chair, but which will be collectively represented on the Medical Executive Committee by the elected chair of the Section of Surgery.

Section 5 Maternal and Child Health.

The Section of Maternal and Child Health shall include OB/GYN, family practice holding Privileges in maternal and child health, pediatrics, and such sections as deemed necessary by the section, each of which may elect its own chair, but which will be collectively represented on the Medical Executive Committee by the elected chair of the Section of Maternal and Child Health.

Section 6 Combined Services.

The Section of Combined Services shall include internal medicine, radiology and pathology, psychiatry, neurology, gastroenterology, and such sections as deemed necessary by the section, each of which may elect its own chair, but which will be collectively represented on the Medical Executive Committee by the elected chair of the Section of Combined Services.

Section 7 Section Chair Elections.

- A. Subject to MEC ratification, section chairs and vice-chairs shall be elected biennially in Spring by majority vote of the active members of their respective sections prior to the annual Medical Staff meeting for a two (2) year term. Section chairs may be removed from office by the MEC for good cause. In the event of a vacancy, an election to fill the chair's unexpired term shall be held at the next Section meeting. In the interim, such vacancies shall be filled by the Medical Staff President or his or her appointee.
- B. Section chairs must be board certified in a specialty included within his/her Section, or establish comparable competence through the Privilege delineation process.

ARTICLE VI

Clinical Privileges

Section 1 Exercise of Privileges.

A Practitioner providing clinical services at Hospital may exercise only those Privileges granted to him/her by the Governing Body, or emergency or disaster Privileges as described herein.

Section 2 Requests.

Each application for appointment or reappointment to the Medical Staff must contain a request for specific Clinical Privileges desired by the Applicant. Specific requests must also be submitted for temporary Privileges and for modification of Privileges in the interim between reappraisals.

Section 3 Basis for Privileges Determination.

- A. Requests for Clinical Privileges will be considered only when accompanied by evidence of education, licensure, training, experience, judgment, health status, physical ability to perform the requested privileges, and demonstrated current competence as specified by the Hospital in its Governing Body-approved criteria for Clinical Privileges.
- B. Privileges for which no criteria have been established:
 - 1. In the event a request for Privileges is submitted for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) days, during which the MEC will, upon recommendation from the Credentials Committee and appropriate Subject Matter Experts, formulate the necessary criteria and recommend these to the Governing Body. Once objective criteria have been established, the original request will be processed as described herein.
 - 2. For the development of criteria, the Medical Staff Service Professional (or designee) will compile information relevant to the Privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region, as appropriate.
 - 3. Criteria to be established for the Privilege(s) in question include education, training, board status or certification (if applicable), and experience. 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 and management will be referred to the appropriate Hospital section director.

4. If the Privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the Credentials Committee Chair to recommend criteria for the Privilege(s) in question. This committee will consist of at least one, but not more than two, Members from each involved discipline. The chair of the ad hoc committee will be a member of the Credentials Committee who has no vested interest in the issue. The ad hoc committee shall report recommended criteria to the Credentials Committee within two (2) weeks.
- C. 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. Additional factors that may be used in determining Privileges are patient care needs for and the Hospital's capability to support the type of Privileges being requested and the availability of qualified coverage in the Applicant's absence. If an issue arises concerning the availability of resources necessary to support a requested Privilege, the MEC will investigate the issue and determine the resource needs and availability in a consistent manner.
- The basis for Privileges determination to be made in connection with periodic reappointment or a requested change in Privileges must include observed clinical performance and documented results of the staff's performance improvement program activities. Privileges determinations may also be based on pertinent information from other sources, especially other institutions and health care settings where a professional exercises Clinical Privileges.
- D. The procedure by which requests for Clinical Privileges are processed are as outlined in Article III, Section 5 of these Bylaws.

Section 4 Special Conditions for Dental Privileges.

Requests for Clinical Privileges for Dentists are processed in the same manner as all other Privilege requests. Privileges for surgical procedures performed by Dentists and/or oral surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician Member of the Medical Staff with Privileges to perform such an evaluation, which will be recorded in the medical record. Oral surgeons may be granted the Privilege to admit but must prearrange and confirm with an M.D. or D.O. responsibility for management of the patient's medical condition when admitting the patient and indicate in the admitting order the responsible physician. Oral surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral/maxillofacial surgery and demonstrated current competence.

Section 5 Special Conditions for Licensed Independent Practitioners not Qualified for Medical Staff Appointment but Practicing without Supervision.

Requests for Privileges from such individuals are processed in the same manner as requests for Clinical Privileges by physicians, with the exception that such individuals are not granted membership on the Hospital Medical Staff and do not have the rights and Privileges of such membership. Only those categories of Practitioners approved by the board for patient care at Hospital are eligible to apply for Privileges. Such professionals may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of his/her professional competence and participate directly in the medical management of patients under the sponsorship of a physician who has been accorded Privileges to provide such care. See Medical Staff Allied Health Practitioner Policy. (See Exhibit C.)

Section 6 Special Conditions for Podiatric Privileges.

Requests for Clinical Privileges for Podiatrists are processed in the same manner as all other Privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician Member of the Medical Staff that will be recorded in the medical record.

Section 7 Special Conditions for Residents or Fellows in Training.

Residents and fellows, who are not Members of the Medical Staff, shall include physicians, podiatrists, psychologists, and dentists, in accredited raining programs where the Hospital participates in graduate medical education. Each resident or fellow, both licensed or unlicensed, participates in patient care under the supervision of a Member of the Medical Staff, who retains responsibility for the actions of the residents and fellows.

The extent to which authority and autonomy are delegated are determined by regulatory and accreditation requirements and on an individual basis by the Medical Staff Member responsible for the patient.

Prior to participation, residents and fellows must meet all requirements for patient care under state law and Hospital policies. A resident in the first year of training is not eligible for Wisconsin licensure, but may, under supervision, perform acts such as writing and signing chart notes, patient care orders, and prescriptions in accord with applicable law. Supervision of residents and fellows is provided consistent with criteria of the accrediting organizations such as Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or the American Dental Association's Commission on Dental Accreditation.

Section 8 Time-Limited Privileges.

Temporary privileges may be granted by the CEO or designee, acting on behalf of the Governing Body, upon written concurrence of the chairperson of the section in which the Privileges will be exercised and President of the Medical Staff, provided there is verification of current licensure and current competence. Temporary Privileges may be

granted only in two circumstances: (1) to fulfill an important patient care need, and (2) when an initial Applicant or re-Applicant with a complete, clean application (i.e., a Category 1 application) is awaiting review and approval of the MEC and the Governing Body.

- A. Important Patient Care Need. Temporary Privileges may be granted on a case-by-case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Examples include:
 - 1. Care of specific patient(s). Upon receipt of a written request for specific temporary Privileges for the care of one or more specific patients from a Practitioner who is not an Applicant for staff appointment, such Privileges may be granted no more than four (4) times in any twelve month period.
 - 2. Locum tenens. Upon receipt of a written request for specific temporary Privileges, an appropriately licensed Practitioner of documented competence who is serving as a locum tenens for an appointee of the Medical Staff may, without applying for appointment to the staff, be granted temporary Privileges for a period of thirty (30) days. Privileges for locum tenens may be renewed for an additional thirty (30) day period. Generally, such Practitioner is limited to treatment of the patients of the staff appointee for whom he/she is serving as a locum tenens, and Privileges granted do not entitle him/her to admit his/her own patients to the Hospital. Locum tenens providers may be required to provide emergency room specialty coverage as determined by the MEC.
 - 3. Visiting proctor. Upon receipt of a written request for specific temporary Privileges, an appropriately licensed Practitioner of documented competence who is serving as a proctor for an appointee of the Medical Staff may, without applying for appointment to the staff, be granted temporary Privileges for a period of sixty (60) days. Proctoring Privileges may be renewed for an additional sixty (60) day period. Such Practitioner is limited to proctoring and otherwise supervising the treatment of the patients of the staff appointee for whom he/she is serving as a proctor, and Privileges granted do not entitle him/her to admit his/her own patients to the Hospital.
- B. Pending Application. Temporary Privileges may be granted for up to one hundred twenty (120) calendar days when a new Applicant for Medical Staff membership or Privileges is waiting for a review and recommendation of his/her application by the MEC and approval by the Governing Body. Criteria for granting temporary Privileges in these circumstances include the Applicant providing evidence of the following which has been verified by Hospital: current licensure, education, training and experience; current competence; current DEA registration (if applicable); current professional liability insurance in the amount required; malpractice history; one positive reference from a responsible medical

peer specific to the Applicant's competence and ability to perform the Privileges requested; and results from a query to the National Practitioner Data Bank. Additionally, the application must meet the criteria for Category 1 expedited credentialing consideration as noted in Article II, Section 6 of these Bylaws.

- C. Conditions of Temporary Privileges. Special requirements of consultation and reporting 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 Hospital in all matters relating to his/her 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.
- D. Termination of Emergency/Time-Limited Privileges. The CEO, acting on behalf of the Governing Body and after consultation with the President of the Medical Staff, may terminate any or all of a Practitioner's emergency or time-limited Privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about the Practitioner's professional qualifications or ability to exercise any or all of the temporary Privileges granted. Where the life or well-being of a patient is determined to be endangered, any person entitled to impose summary suspension under the Medical Staff Bylaws may effect the termination. In the event of any such termination or suspension, the Practitioner's patients then at Hospital will be assigned to another Practitioner by the CEO or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute Practitioner.
- E. Rights of the Practitioner with Time-Limited Privileges. The fact that a Practitioner's request for temporary Privileges is refused or that all or any part of his/her temporary Privileges are terminated or suspended does not entitle a Practitioner to the procedural rights afforded by the Hearing and Appeal Policy and Process.

Section 9 Emergency Privileges.

In case of an emergency, where, without immediate medical attention, a patient's life or health would be in immediate and serious jeopardy, any physician is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the physician's license, and regardless of section affiliation, staff category, or level of Privileges. A Practitioner exercising emergency Privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up care for the patient.

Section 10 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, section assignment, and/or Clinical Privileges by

submitting a written request to the Medical Staff services office. A modification request must contain all pertinent information supportive of the request. All requests for additional Clinical Privileges must be accompanied by information demonstrating additional education, training, and current clinical competence for the specific Privileges requested. A modified application is processed in the same manner as a reappointment, which is outlined in Article III, Section 5 of these Bylaws. A Practitioner who determines that he/she no longer exercises, or wishes to restrict or limit the exercise of, particular Privileges that he/she has been granted shall send written notice, through the Medical Staff services office, to the Credentials Committee and MEC. A copy of this notice shall be included in the Practitioner's credentials file.

Section 11 Resignation of Staff Appointment or Privileges.

A Practitioner may resign his/her staff appointment and/or Clinical Privileges by providing written notice to the appropriate section chair or President of the Medical Staff. The resignation shall specify the reason for the resignation and the effective date. A Practitioner who resigns his/her staff appointment and/or Clinical Privileges is obligated to fully and accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of resignation. Such action, unless as a result of disciplinary action or investigation or in lieu thereof, shall not create a right of hearing under the Fair Hearing Plan nor generate any reporting requirements under Wisconsin Statutes Section 50.36.

Section 12 Telemedicine Privileges.

- A. Interpretive Telemedicine Privileges. Practitioners based at distant sites whose practice at the Hospital will be limited to interpretive telemedicine only may apply for telemedicine privileges by submission of the same application required of all other Practitioners for Medical Staff membership or clinical privileges.
- B. Interactive Telemedicine Privileges. Practitioner based at distant sites requesting any form of interactive telemedicine privileges may apply for privileges by submission of the same application required of all other Practitioners for Medical Staff membership or clinical privileges.
- C. Practitioners with only telemedicine privileges will be assigned to the Associate Medical Staff category.

Section 13 Allied Health Staff Professionals.

- A. General Provisions. Allied Health Professionals shall consist of professionally competent licensed and/or certified practitioners and other health professionals who participate in hospital care and are not part of the Medical Staff. Allied Health Professionals include, but are not limited to the following categories of professionals: physician's assistants, advanced practice nurses, optometrists, clinical social workers, marriage and family therapists, and certain professional counselors, as defined by policy. Allied Health Professionals may be either: (1) employed by the hospital, or (2) employed by Members of the Medical Staff

or legal organizations of Members of the Medical Staff. Allied Health Professionals may practice in relative independence or under the direct supervision of a Medical Staff Member, depending on their training and the supervision required by state law or regulation for licensure or certification. Allied Health Professionals shall continuously meet the qualifications, standards and requirements as set forth in these Bylaws and associated policies of the Medical Staff Office. Allied Health Professionals do not vote at any Medical Staff meeting, or otherwise participate in the benefits of Medical Staff membership.

Each individual will present qualifications for review by the Medical Staff Office in accord with the policies and procedures outlined in Article III of these Bylaws for the appointment of Medical Staff Members.

- B. Qualifications and Responsibilities. Allied Health Professionals may provide patient care services within the limits of their professional skills and abilities and delineated scope of practice, meeting all state licensure and certification requirements, as applicable. The degree of participation by Allied Health Professionals in patient care shall be determined according to policies recommended by the Medical Staff and approved by the Governing Body.

An individual applying for appointment as an Allied Health Professional must be continuously sponsored by or collaborating with, a Member of the Medical Staff who will review the adequacy of the individual's performance on a regular basis. The Medical Staff Member sponsor/collaborator will attest to this in writing.

If an Allied Health Professional is employed by a Medical Staff Member or the same employer as the Medical Staff Member, the Medical Staff sponsor shall assume full responsibility, and be fully accountable for the conduct of the individual within the hospital. The sponsoring Medical Staff Member shall provide supervision of the Allied Health Professional as required by state licensure and certification requirements. It is further the responsibility of the employer of the Allied Health Professional to acquaint the individual with the applicable policies of the Medical Staff and the hospital, as well as appropriate Members of the Medical Staff and hospital personnel with whom said individual shall have contact with at the hospital.

- C. Application/Appointment Process.

- 1. Applications for appointment to provide specified services as Allied Health Professionals shall be obtained and processed as follows:
 - (a) The Allied Health Professionals shall complete an application;
 - (b) The appropriate Hospital Section Director shall interview the provider and recommend approval or disapproval. Requests for approval of Allied Health Professionals and the recommendation of the Hospital Department Director shall then be reviewed by the

appropriate Section Chair, sponsoring collaborating Medical Staff Member and the CEO or designee; all must approve the request in order for it to be granted. The actions on these requests will be reviewed by the Credentials Committee;

- (c) The Allied Health Professional shall comply with Occupational Health policy regarding immunizations and TB surveillance;
- (d) The Allied Health Professional shall participate in orientation and in-hospital training requirements as outlined by the Hospital. Completion of this requirement shall be documented.

- D. Reappointment Process/Termination. Applications for reappointment to provide specified services in the Hospital as an Allied Health Professional shall be obtained and processed in the same manner as applications for Medical Staff reappointment. The Hospital retains the right; either through the Administration or upon recommendation of the Medical Executive Committee, to suspend or terminate any or all of the privileges or functions of any category of Allied Health Professional, without recourse on the part of the person in that category, to the procedures provided in the Fair Hearing Plan. Should any such action occur, and result in a reduction or removal of the clinical privileges of the Allied Health Professional, the individual shall be entitled to a hearing conducted by the CEO or designee. Such hearing shall be promptly conducted and shall provide the Allied Health Professional with the reasons for the hospital's actions.

An Allied Health Professional's ability to practice at the hospital shall automatically terminate when: (1) the Allied Health Professional is no longer employed by a Member of the Medical Staff or the same employer as the Medical Staff Member or the Hospital, (2) if the Medical Staff Member sponsor is terminated, or (3) if the Medical Staff Member's clinical privileges are curtailed to the extent that the professional services of said individual within the hospital are no longer necessary or permissible to assist the employer. When privileges are terminated under this Section, the Allied Health Professional shall have no right to an appeal, unless provided under the Hospital's Human Resource policy.

Section 14 Disaster Privileges.

- A. For purposes of this Section, a "disaster" exists when the Hospital implements its disaster plan and the Hospital is unable to meet patient needs.
- B. During a disaster and in the best interest of immediate patient care, the CEO/designee may, at his or her discretion, grant disaster privileges on a case-by-case basis to volunteer physicians upon presentation of the following:
 - 1. A valid government-issued photo identification (i.e., driver's license or passport); and

2. At least one of the following:
 - (a) A current picture hospital ID card/badge (a photocopy will be made when possible); or
 - (b) A current license to practice (a photocopy will be made when possible); or
 - (c) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (“DMAT”), the Medical Reserve Corps (“MRC”), the Emergency System for the Advance Registration of Volunteer Health Professionals (“ESAR-VHP”), or other recognized state or federal response organization or group. Identification indicating that the individual has been granted authority by a federal, state or municipal entity to render patient care in emergency circumstances (a photocopy will be made when possible); or
 - (d) Presentation by current Medical Staff Member(s) with personal knowledge regarding the Practitioner’s ability to act as a volunteer during a disaster.
3. The CEO will have the overall responsibility for assignment of duties to any volunteer Practitioners that are granted disaster privileges.
4. As soon as possible, additional information will be gathered from the volunteer Practitioners on a “Disaster Privileges” form. Primary source verification of a volunteer’s license will begin as soon as the immediate situation is under control and must be completed within seventy-two (72) hours from the time the volunteer begins to provide service at the Hospital. In extraordinary circumstances where primary source verification can not be completed within seventy-two (72) hours, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer’s demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
5. When possible, all Practitioners granted privileges during a disaster will be identified by a “Voluntary Practitioner: Disaster Privileges Granted” ID badge. The badges shall be maintained in the Emergency Department.
6. When the Hospital deems a “disaster or emergency situation to no longer exist or to be under control”:
 - (a) The disaster privileges shall expire.

- (b) The Practitioners that were granted disaster privileges must request Medical Staff membership and the clinical privileges necessary to continue to treat patients.
- (c) In the event such privileges are denied or the voluntary Practitioner does not desire such privileges, any patients still receiving care at the Hospital shall be assigned to an appropriate Medical Staff Member.
- (d) After-the-fact/retroactive credentialing for temporary privileges will occur as soon as possible if feasible to cover the time period of the disaster.

Such action, unless as a result of disciplinary action or investigation or in lieu thereof, shall not create a right of hearing under the Fair Hearing Plan nor generate any reporting requirements under Wisconsin Statutes Section 50.36.

Section 15 Orders from Individuals Without Clinical Privileges or Medical Staff membership.

The Hospital may accept and execute orders per policy for outpatients from Practitioners, Allied Health Professionals and individuals licensed to practice medicine, podiatry or dentistry in Wisconsin who are not Members of the Medical Staff and who have not been granted any clinical privileges only if all the following conditions are met:

- A. The order is within the scope of practice, as established by state law, of the ordering professional.
- B. The ordering professional is currently licensed, certified or registered in Wisconsin in a field of practice recognized by Wisconsin law and, upon the Hospital's request, provides satisfactory evidence of such current licensure, certification or registration.
- C. The ordering professional is not excluded from any federally-funded health program (such as Medicare or Medicaid).
- D. The order can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering professional.
- E. The ordering professional does not hold himself/herself out to be associated or affiliated with the Hospital or its Medical Staff.

Section 16 Focused Professional Practice Evaluation.

- A. A period of focused professional practice evaluation shall be implemented:
 - 1. for all initially requested privileges; and

2. in response to concerns regarding the provision of safe, high quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend.
- B. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the Practitioner's current clinical competence, practice behavior and ability to perform the requested privilege.
 - C. Information for focused professional practice evaluation includes, as appropriate, chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient.

Section 17 Ongoing Professional Practice Evaluation.

- A. A process of ongoing professional practice evaluation exists to continuously review Medical Staff Members' care and to identify professional practice trends that impact on quality of care and patient safety.
- B. The criteria used in the ongoing professional practice evaluation may include such factors as:
 1. The review of operative and other clinical procedures performed and their outcomes;
 2. Patterns of blood and pharmaceutical usage;
 3. Requests for tests and procedures;
 4. Length of stay patterns;
 5. Morbidity and mortality data;
 6. Practitioner's use of consultants; and
 7. Other relevant factors as determined by the Medical Staff.
- C. The information used to review the ongoing professional practice evaluation factors shall include, as appropriate, periodic chart reviews, direct observations, monitoring of diagnostic and treatment techniques and discussions with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing, and administrative personnel.
- D. Relevant information obtained from the ongoing professional practice evaluation shall be integrated into Medical Staff performance improvement activities. Such information shall help determine whether existing privileges should be maintained, revised or revoked. Such information will be used and disclosed to third parties only in accordance with Medical Staff policies.

ARTICLE VII

Officers and Committees

Section 1 Officers.

- A. **Qualifications.** The officers of the Medical Staff shall be the Medical Staff President, the Vice President, and the Secretary-Treasurer. Officers must be Members in good standing of the active category, have previously served the Medical Staff in a significant capacity, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges, attend continuing education relating to Medical Staff leadership and/or credentialing functions prior to or during the term of office, have demonstrated an ability to work well with others, and have excellent administrative and communication skills.
- B. **Term of Office.** All officers serve a term of two years. Officers shall take office on the first day of July during even calendar years. An officer may be reelected to a position for two (2) consecutive terms.
- C. **Election of Officers.** During even calendar years, the MEC shall appoint a nominating committee chaired by the President of the Medical Staff and including two other members of the MEC and two members at large. This committee shall offer a nominee for each office. Nominations must be announced, and the names of the nominees distributed to all Members of the active Medical Staff, at least 30 days prior to the election.

Nominations may also be submitted by a petition signed by at least ten percent (10%) of the appointees of the active staff. Such petition must be submitted to the President of the Medical Staff at least fourteen (14) days prior to the election for placement of the nominee(s) named in the petition on the ballot.

Officers shall be elected every other year at the annual meeting according to written or secure electronic ballot. Only Members of the active category shall be eligible to vote. The Governing Body shall be given an opportunity to confirm all officers. Actions taken by the Governing Body not to confirm the officer(s) shall be forwarded back to the MEC with the reason for the action.

- D. **Removal and Vacancies.** Officers who fail to maintain Active status and remain an appointee in good standing shall immediately create a vacancy in the office involved. The Medical Staff may remove from office any officer by petition of twenty percent (20%) of the active staff members, a subsequent two-thirds (2/3) affirmative vote by vote by written or secure electronic ballot of the Active Staff, and approval by the MEC and Governing Body. Such vote may be taken at any regular or special meeting of the Staff. . Vacancies in the office of Medical Staff President shall be filled by the Vice President until the end of the term. Vacancies

in other Staff offices shall be temporarily filled by appointment by the Medical Staff President, with the approval of the Medical Executive Committee.

E. Duties of Officers.

1. President. The President of the Medical Staff is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Governing Body and the Administration. The President of the Medical Staff, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff. Specific responsibilities and authority are to:
 - (a) Call and preside at all general and special meetings of the Medical Staff.
 - (b) Serve as chair of the MEC and as Ex Officio member of all other Medical Staff committees without vote; and participate as a member of the Governing Body, as invited by the Governing Body and the CEO on Hospital or Governing Body committees.
 - (c) Enforce Medical Staff bylaws, the Credentials Policy and Procedure Manual, Medical Staff Rules and Regulations, and Hospital policy.
 - (d) Appoint committee chairpersons and all Members of the Medical Staff standing and ad hoc committees; in consultation with Hospital, appoint Medical Staff Members to appropriate Hospital committees; in consultation with the chair of the Governing Body, appoint Medical Staff Members to appropriate Governing Body committees when those are not designated by position or by specific direction of the Governing Body.
 - (e) Support and encourage Medical Staff leadership and participation on the interdisciplinary clinical performance improvement activities.
 - (f) Report to the Governing Body the MEC's recommendations concerning appointment, reappointment, delineation of Clinical Privileges or specified services, and corrective action with respect to Practitioners or allied health professionals who are applying for appointment or Privileges, or who are granted Privileges or providing services at Hospital.
 - (g) Continuously evaluate and periodically report to the Hospital, MEC, and the Governing Body regarding the effectiveness of the credentialing and health care services review processes.

- (h) Review and enforce compliance with standards of ethical conduct and professional demeanor among the Members of the Medical Staff in their relations with each other, the Governing Body, Hospital management, other professional and support staff, and the community that Hospital serves.
 - (i) As appropriate, communicate and represent the opinions and concerns of the Medical Staff and its individual Members on organizational and individual matters affecting hospital operations to Administration, the MEC, and the Governing Body.
 - (j) Attend Governing Body meetings and Governing Body committee meetings.
 - (k) Ensure that the decisions of the Governing Body are communicated and carried out within the Medical Staff.
 - (l) Perform such other duties, and exercise such authority commensurate with the office, as are set forth in the Medical Staff Bylaws.
2. Vice President. In the absence of the President of the Medical Staff, the Vice President shall assume all the duties and have the authority of the President of the Medical Staff. He or she shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may from time to time request.
 3. Secretary/Treasurer. The secretary/treasurer shall collaborate with the Medical Staff office to keep accurate minutes of the MEC meetings and annual Medical Staff meeting, attend to correspondence, coordinate all communication with the Medical Staff and act as treasurer.

Section 2 Committees.

- A. Committees. There shall be a Medical Executive Committee and such other standing and special committees of the Staff as may from time to time be necessary and desirable to perform the functions of the Staff required by these Bylaws or necessarily incidental thereto. The composition, duties and meeting requirements of all committees not specifically set forth in this Article shall be determined by Medical Staff policy.
- B. Appointments. All committees and committee chairs shall be appointed by the Medical Staff President, with notice to the Medical Executive Committee, except as otherwise provided in these Bylaws. Committee appointments shall be for a period of two (2) years. All appointments to special and standing committees shall be formal appointments. All committee members shall be voting members unless otherwise provided in these Bylaws and/or the Committee Formats.

The standing committees of the Medical Staff shall be those set forth in these Bylaws and those which may be created by action of the Medical Executive Committee from time to time, and details of committee format.

The Medical Staff Office shall retain a list of all special and standing committees in existence. Any additions to or deletions from the list of standing and special committees, or any material changes in the composition or duties of such committees, shall not be effective until written notice of such changes has been given to the Active Staff and the Active Staff has been given ten (10) days to object thereto in writing, delivered to the Medical Staff President. If ten percent (10%) or more of the Members of the Active Staff so object, a special meeting of the Active Staff shall be called at which such changes shall be considered and voted upon, and in such event, such changes shall not become effective until such vote has been taken.

- C. Medical Executive Committee. The MEC is organized to improve patient care provided at Hospital and thus functions as a health care services review committee consistent with Wisconsin law. All members of the MEC, consistent with the Medical Staff and Hospital confidentiality policies and applicable law, shall keep in strict confidence all papers reports, and information obtained by virtue of membership on the MEC.
 - 1. Composition. The Medical Executive Committee shall consist of the officers of the Medical Staff, the chair of each clinical section, the Credentials Committee Chair and two (2) at large Members, all of whom shall serve for two years. The at-large Members will be nominated by the nominating committee, which will announce its two nominees to all Members of the Active Medical Staff at the same time that it announces nominees for officer positions. The at-large Members shall be elected by Active Staff Members every other year at the annual meeting according to written or secure electronic ballot. . The Chair of the Committee shall be the Medical Staff President. The CEO and chief nurse executive shall be ex-officio members.
 - 2. Duties. The duties of the Medical Executive Committee shall be to:
 - (a) Receive and when appropriate act upon reports and recommendations concerning patient care quality and appropriateness reviews, and evaluation and monitoring functions; and recommend to the Governing Body specific programs and systems to implement these functions.
 - (b) Supervise the CME program and library.
 - (c) Biannually review the Medical Staff Bylaws for any recommendations concerning amendments, revisions and rewriting.

- (d) Coordinate the implementation of policies adopted by the Governing Body and the activities and general policies of the various departments, as appropriate.
- (e) Submit recommendations to the Governing Body concerning the structure of the Medical Staff and all matters relating to appointment, reappointment, staff category, section assignments, Clinical Privileges, and corrective action.
- (f) Account to the Governing Body and to the Medical Staff for the overall quality and efficiency of professional patient care services provided at Hospital by individuals with Clinical Privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities.
- (g) Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff appointees including collegial and educational efforts and Investigations, when warranted.
- (h) Make recommendations to the Governing Body on medico-administrative and Hospital management matters.
- (i) Keep the Medical Staff up-to-date concerning the licensure and accreditation status of Hospital.
- (j) Consistent with Hospital's mission and philosophy, participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.
- (k) Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.
- (l) Formulate, and recommend to the Governing Body, Medical Staff rules, policies, and procedures.
- (m) Consult with Administration on the quality, timeliness and appropriateness of contracted patient care services provided by entities outside Hospital.
- (n) Oversee that portion of the corporate compliance plan that pertains to the Medical Staff Members through receipt of an annual report.
- (o) Supervise overall Medical Staff compliance with accreditation and other state and federal regulatory requirements applicable to the Medical Staff.

- (p) Receive and act upon the reports of all other Medical Staff committees.
- 3. Meetings. The Medical Executive Committee shall meet at least ten times per year or more often as needed to perform its assigned functions and shall maintain a permanent record of its proceedings and actions. . Failure to meet these requirements, unless excused for just cause, shall be considered grounds for corrective action under Article VIII of these Bylaws.
- 4. Removal of Medical Executive Committee Members.
 - (a) Reason for Removal.
 - (1) Removal from current office or chair position.
 - (2) Loss or suspension of Medical Staff appointment.
 - (3) A Medical Executive Committee member shall be considered for removal from service by the Medical Executive Committee. Upon written request of twenty percent (20%) of the Active Medical Staff directed to the chair of the Medical Executive Committee, or the Medical Staff President or CEO, or by certification by two (2) physicians with special qualification in the appropriate medical field(s) that the Member cannot be expected to perform his or her duties because of illness for minimum of three (3) months. Such request shall include a list of the allegations or concerns precipitating the request for removal.
 - (b) Procedures.
 - (1) A Member removed from service pursuant to Section (a)(3) above shall be so notified in writing by the chair of the Medical Executive Committee and advised of his or her rights to a review by the Medical Executive Committee, if any. When the Chair of the Medical Executive Committee is the Member in question, the Vice President of the Medical Staff shall carry out the duties of the Chair during the removal process until the issue is resolved, at which time the Chair (if not removed) will resume his or her duties or the Vice President will take over the remaining term of the removed Chair.
 - (2) The Member in question will be relieved of his or her Medical Executive Committee duties until the question is resolved.

(c) Review Procedures.

- (1) A meeting of the Medical Executive Committee shall be called within seven (7) business days to consider the matter. A quorum of the Medical Executive Committee must be present to act on the matter. The Member in question shall have no vote in the matter and may be excluded from the meeting except as in Section (c)(2) below .
- (2) The Member in question shall be permitted to make an appearance before the Medical Executive Committee prior to its taking final action on the request.
- (3) A Member may be removed by an affirmative vote of two-thirds of the Medical Executive Committee members present at a meeting at which there is a quorum.
- (4) The final decision of the Medical Executive Committee shall be given promptly to the Member in question in writing by the Chair of the Medical Executive Committee.

- (d) Override of the Medical Executive Committee. The Active Medical Staff may submit a matter to the Governing Body based upon a petition signed by twenty percent (20%) of the Active Medical Staff, opposing an action or inaction of the Medical Executive Committee.

D. Credentials Committee.

1. Composition. The Credentials Committee shall consist of at least five (5) Members of the Active Staff, with at least one from each section. The President of the Medical Staff will appoint the Credentials Committee Chair and other Members. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third (1/3) of the members will be appointed each year. The Credentials Committee Chair will be appointed for a three (3) year term. The Credentials Committee Chair and members may be reappointed for additional terms without limit. Any member of the Credentials Committee, including the Credentials Committee Chair, may be relieved of his/her committee membership by a two-thirds (2/3) vote of the MEC. Service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee, and other Medical Staff duties shall not interfere. The Credentials Committee may also include ex-officio members such as representatives from the Administration and the Governing Body.

2. Responsibilities. The Credentials Committee shall: receive and consider each new application, review and if applicable, interview the Applicant and make its recommendation to the Medical Executive Committee for acceptance or rejection; investigate any breach of ethics that may be reported; review any records that may be referred by Medical Staff Committees; arrive at a decision regarding the performance of the Staff appointees, or refer the case to the appropriate department; review all information available regarding the competence of Staff appointees, and as the result of such reviews, to make recommendations for the granting of privileges, reappointments, and the assignment of appointees of the various departments and sections, as provided in Article V and Article VI of these Bylaws.
 3. Confidentiality. The Credentials Committee is organized to improve the quality of patient care provided in the Hospital and shall function as a healthcare services review (peer review) committee consistent with federal and state law. All members of the Credentials committee shall, consistent with the Medical Staff and Hospital confidentiality policies and applicable law, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.
- E. Cancer Committee. The Cancer Committee shall consist of representatives of the Medical Staff appointed by the Medical Director of Oncology, Chief of Staff or designee and shall be multidisciplinary. The representatives shall include, but not limited to: Administration, Surgery, Hematology/Oncology, Nursing, Palliative Care, Pathology, Quality Assurance, Radiation Oncology, Radiology, Social Work or Case Management and Cancer registry.

An Oncology specialist, appointed by the Medical Director of Oncology, Chief of Staff or designee will chair the Cancer Committee.

The Cancer Committee structure includes designated leadership roles for Cancer Conference, quality control of Cancer Registry data, quality improvement and community outreach. A Cancer Liaison Physician (appointed by the chair of the Cancer Committee) will provide a relationship with the American College of Surgeons: Commission on Cancer.

The Cancer Committee will meet at least quarterly. (Minutes of the meetings will be maintained.)

The Cancer Committee shall be responsible for:

1. Developing and overseeing all aspects of the comprehensive cancer program.
2. Meeting or exceeding current Commission on Cancer program standards.
3. Promoting a coordinated multidisciplinary approach for patient care at all levels.

4. Verification of an active support system for patients, families, and staff.
 5. Patient care audits.
 6. Assurance that education and cancer conferences cover all major types of cancer and that issues of cancer care are addressed.
 7. Cancer registry (accurate, timely abstracting, staging, and reporting of data).
 8. Evaluation of the effectiveness of program quality improvement activities.
 9. Assurance of regular attendance by the majority of participating physicians at cancer conferences.
 10. Promoting clinical research.
 11. Overseeing preparation and publication of the annual committee report.
 12. Upholding medical ethical standards.
- F. Quality Review Committee. The Quality Review Committee shall consist of Members of the Active Medical Staff and appropriate administrative personnel. The Quality Review Committee shall supervise the maintenance of medical records and the required standard of completeness and perform the duties of the Medical Record Committee. On the basis of documented evidence, the Committee shall evaluate the quality of medical care given patients. The Quality Review Committee shall meet as frequently as necessary, at least annually.
- G. Resource Management Committee. The Resource Management Committee consists of Members of the Medical Staff and appropriate administrative personnel. The resource management review shall be the responsibility of the Committee and shall be bound by the Resource Management Plan as adopted by the Medical Staff. The Committee shall meet at least every other month, and submit a report in writing to the Medical Executive Committee.
- H. Bylaws Committee. There shall be a Medical Staff Bylaws Committee composed of Members of the Active Medical Staff, and appropriate administrative personnel. The Committee shall keep current the Bylaws of the Medical Staff, reflecting Staff organization and policies in accordance with legal requirements, utilizing the guidelines established by The Joint Commission ("JC"). The Committee shall meet as often as deemed necessary by itself or the Medical Executive Committee, but at least biennially, and submit a report in writing to the Medical Executive Committee.
- I. Ethics Advisory Committee. The Ethics Advisory Committee shall provide guidance, counsel, and support to the medical and nursing staff to facilitate the decision making process in matters relating to the moral and ethical issues of medical care. The Committee shall consist of Members of the Medical Staff, appropriate administrative personnel, representatives of nursing, social services and the clergy. The Committee will meet as appropriate and submit a report in writing to the Medical Executive Committee.

- J. Nominating Committee. There shall be a Nominating Committee which shall recommend Medical Staff officer candidates to be elected by the Medical Staff. The Committee shall consist of Members of the Active Medical Staff and appropriate administrative personnel. The President or President-Elect shall serve as Chair. At least fourteen (14) days prior to the Medical Staff annual meeting, the Nominating Committee shall submit to the President a list of at least one (1) nominee for each open office, each of whom has previously agreed if elected to fulfill the duties of the office for which he/she has been nominated.
- K. Practitioner's Health Committee. The Practitioners' Health Committee shall be responsible for addressing problems dealing with impairment of LIPs. Issues related to impaired Practitioners may be referred to the President who will determine the need for, or appropriateness of referral to the Practitioners' Health Committee, or such issues may be referred to the Practitioners' Health Committee directly. Guidelines for this committee, including its stated purpose, function, membership and the process for consultation shall be maintained in the Medical Staff office and shall be provided to all new members of the Medical Staff and redistributed to members of the Medical Staff at two year intervals.
1. Composition. The Practitioners' Health Committee shall consist of three core members of the active Medical Staff and shall include (if feasible) a physician with a previous history of impairment whose impairment has been successfully treated, and other members of the Medical Staff selected by the President of the Medical Staff in order to bring the total complement to three physician members. Additional ad hoc members may be appointed as indicated, to address specific issues or cases.
 2. Responsibilities.
 - (a) To establish a program for identifying and contacting LIPs who have become professionally impaired in varying degrees because of drug/alcohol dependence or because of mental, physical or aging problems. The Committee is to offer recommendations and assistance concerning rehabilitative help to such individuals to the extent of its ability; however the Committee is not a substitute for a LIP's personal physician, and it is not a disciplinary body.
 - (b) To monitor LIPs for compliance with terms of agreements between the Committee and the LIPs.
 - (c) To develop educational programs or related activities for LIPs and other organization staff about illness and impairment recognition issues specific to LIPs (at-risk criteria).
 - (d) To report to the MEC periodically regarding its activities. The Committee will also report to the MEC any instances in which it determines that a LIP has provided unsafe treatment and any

instances involving LIPs who have not cooperated with the Committee's requests for recommendations.

3. Health Care Services Review. The Practitioners' Health Committee is organized to improve patient care provided at Hospital and thus functions as a health care services review committee consistent with Wisconsin law. All members of the Practitioner's Health Committee, consistent with Medical Staff and Hospital confidentiality policies and applicable law, shall keep in strict confidence all papers, reports, and information obtained by virtue of membership on the Practitioner's Health Committee.
- L. Medical Records Committee. The duties of the Medical Records Committee shall be performed by the Quality Review Committee.
 1. Duties of the Medical Records Committee include:
 - (a) Development and maintenance of policies and procedures outlining:
 - (1) specification of the minimal content of medical histories and physical examinations;
 - (2) requirements for a patient's medical history and physical examination and required updates, timeframes for validation and countersignature including the requirement that a patient's medical history and physical examination (i) be completed and documented for each patient no more than thirty (30) days before and twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, and (ii) when the medical history and physical examination is completed within thirty (30) days before admission or registration, be updated, including any changes in the patient's condition, and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services; and
 - (3) definition of the scope of the medical history and physical examination when required for non-inpatient services.
 - (b) Monitoring the quality of medical histories and physical examinations.
 - (c) Monitoring delinquencies in medical recordkeeping.

ARTICLE VIII

Corrective Action

Section 1 Procedure.

- A. Whenever the activities or professional conduct of any Medical Staff appointee, or any person for whom such Staff appointee is responsible, are considered not to meet the medical standards of the Medical Staff, to be disruptive to the operations of the Hospital or any department, or to be in violation of these Bylaws, corrective action against such Medical Staff appointee may be requested by a chair of any department, any officer of the Medical Staff, the chair of any standing committee of the Medical Staff, the President of the Medical Staff, the CEO, or the chair of the Governing Body. Grounds for corrective action shall also include, but are not limited to, failure to keep adequate records, criminal charges or convictions, significant misstatement in or omission from any application for membership or privileges or any misrepresentation in presenting the practitioner's credentials, or any other violation of Hospital regulations, rules or policies.

All requests for corrective action shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

- B. The Medical Executive Committee shall Investigate complaints or requests for corrective action made to it, either on its own or through an ad hoc committee appointed by the chair of the appointee's department

Prior to the making of any report or recommendations, the involved appointee or appointees shall be permitted to meet with such ad hoc committee and/or Medical Executive Committee to present any information related to the matter. This appearance shall not constitute a hearing as per Article IX, and shall be informal in nature.

- C. The action of the Medical Executive Committee on a request for corrective action may be: (1) to reject or modify the request; (2) to issue a warning or letter of reprimand; (3) to impose terms of probation; (4) to require daily observation of inpatient care; (5) to require retrospective chart monitoring for a specified time period; (6) to require review of all admissions for a specified time period; (7) to seek an opinion or recommendation on the matter from the State Medical Society's Impaired Physician Program, or other outside consultant, provided that confidential peer review information may not be disclosed in obtaining such opinion or recommendation other than in the manner prescribed by law; (8) to recommend reduction, suspension or revocation of clinical privileges; (9) to recommend that an already imposed summary suspension of clinical privileges be terminated, modified or sustained; or (10) to recommend that Staff appointment be suspended or revoked.

- D. Any Medical Staff appointee who is engaged by the Hospital in an administrative capacity with related clinical responsibilities is entitled to the same procedural fairness accorded any other Medical Staff appointee when his/her Medical Staff privileges are terminated or otherwise affected unless otherwise provided by agreement with the Hospital.

Section 2 Summary Suspension.

Whenever there are reasonable grounds to believe the conduct or activities of a Medical Staff appointee poses a threat to the life, health or safety of any patient, employee or other person at the Hospital and that failure to take prompt action may result in imminent danger to the life, health or safety of any such person, the Medical Staff President, the CEO, the chair of the applicable department of the Staff, or in their absence, any member of the Medical Executive Committee shall have the authority to temporarily suspend a Medical Staff appointee's privileges effective immediately.

In such a case, the suspended appointee shall be entitled to meet with the Medical Executive Committee as soon as said meeting can reasonably be convened to review and consider the action taken, the Medical Executive Committee may recommend a modification, continuation or termination of terms of the summary suspension. Also, if the Medical Executive Committee does not recommend termination of the summary suspension of the affected Practitioner, and the summary suspension lasts longer than thirty (30) days, the adverse action shall be reportable to the National Practitioner Data Bank/PDS.

Unless the Medical Executive Committee recommends immediate termination of the suspension, the Staff appointee shall be entitled to the procedural rights described in Article IX of these Bylaws. The terms of the summary suspension as sustained or as modified by the Medical Executive Committee shall remain in effect pending a final decision by the Governing Body.

Section 3 Automatic Suspension.

- A. If a Staff appointee's license to practice his/her profession in the State of Wisconsin is revoked or suspended, such Staff appointee shall be immediately and automatically suspended from practicing in the Hospital.
- B. If a Staff appointee's license to practice his/her profession in the State of Wisconsin is partially limited or restricted in any way, those clinical privileges granted to the Staff appointee that are within the scope of the limitation or restriction shall be similarly and automatically limited or restricted.
- C. If a Staff appointee fails to renew his/her license to practice his/her profession in the State of Wisconsin, his/her Staff appointment and clinical privileges shall be immediately and automatically be suspended until the appointee's license is renewed.

- D. A Staff appointee whose Drug Enforcement Administration (DEA) Certificate or any of the prescribing schedules are revoked, suspended or voluntarily relinquished shall immediately and automatically be divested of the right to prescribe medications covered by such certificate. As soon as reasonably possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA certificate or the prescribing schedules were revoked, suspended or relinquished. The Medical Executive Committee may then take such further corrective action as is appropriate to the facts disclosed in its Investigation.
- E. A Staff appointee who fails to complete medical records as required by the Rules and Regulations of the Staff shall immediately and automatically be suspended from all admitting, consultative and surgical privileges until the incomplete medical records are completed, in accordance with the applicable Staff rules regarding completion of medical records.
- F. Upon exhaustion of appeals after conviction of a felony of a Staff appointee in any federal or state court, the appointee's Staff appointment is automatically revoked. Revocation pursuant to this Section of the Bylaws does not preclude the Staff appointee from subsequently reapplying for Staff appointment. The filing of criminal charges or a finding of guilt by a court of record may constitute sufficient basis for invoking some type of corrective action.
- G. The action of any government agency or court terminating, suspending or excluding, in whole or in part, a Staff appointee from participating in a federally-funded health care program shall effectuate a suspension of the Staff appointment and the clinical privileges.
- H. In the event that the policy of professional liability insurance of a Practitioner or AHP is canceled, terminated without renewal, or reduced in coverage limits or extension of financial guarantees to below limits required of Medical Staff Members or otherwise required by law, all privileges of that Practitioner or AHP shall be automatically suspended.
- I. An automatic suspension of all privileges shall occur upon notification received by the Credentials Committee of the existence of (a) pending criminal felony charges of an offense affecting caregiver eligibility as identified in the Wisconsin Caregiver Background Check Law ; (b) a criminal felony conviction; (c) pending investigations into or a final administrative finding of patient abuse, neglect or misappropriation of patient property or similar offenses as addressed in the Wisconsin Caregiver Criminal Background Check Law; or (d) a determination under the Children's Code to have abused or neglected a child against a practitioner. The Practitioner shall promptly provide written notice to the Credentials Committee of such pending criminal felony charges or investigation, criminal felony conviction, or final administrative finding of patient abuse, neglect, misappropriation of patient property or similar offenses addressed in the

Wisconsin Caregiver Criminal Background Check law or a determination under the Children's Code of child neglect against the Practitioner.

- J. An automatic suspension of all privileges may be imposed upon a Practitioner's failure to provide written notification to the Credentials Committee within five (5) calendar days of receipt by the Practitioner of an initial sanction notice of a gross and flagrant violation, or of the commencement of a formal Investigation, or the filing of charges, or a final determination by a Medicare quality improvement organization, the Department of Health and Human Services, the Wisconsin Department of Health Services, the Office of the Inspector General or any law enforcement or health regulatory agency of the United States or the State of Wisconsin.
- K. An automatic suspension may be imposed upon a Practitioner's failure, without good cause, to supply information or documentation requested by any of the following: the President of the Medical Staff, the CEO, the Credentials Committee, or the Medical Executive Committee. A suspension shall be imposed only if: (a) the request for information or documentation was in writing; (b) the request was related to evaluation of the Practitioner's qualifications for membership or privileges; (c) the Practitioner failed to either comply with the request or to satisfactorily explain his or her inability to comply; and (d) the Practitioner was notified in writing that failure to supply the requested information or documentation within fifteen (15) days from receipt of the notice would result in automatic suspension. Any automatic suspension imposed pursuant to this Section may be a suspension of any portion or all of the Practitioner's privileges and shall remain in effect until the Practitioner supplies the information or documentation sought or satisfactorily explains his or her failure to supply it.

Section 4 Continuity of Patient Care.

Upon the imposition of summary suspension or the occurrence of an automatic suspension, the Medical Staff President or the chair of the department to which the suspended Staff appointee is assigned shall be responsible to provide for alternative coverage for the Hospital patients of the suspended Staff appointee. The wishes of the patient shall be considered, where feasible, in choosing a substitute Medical Staff appointee. The suspended Staff appointee shall confer with the substitute Medical Staff appointee to the extent necessary to safeguard the patient.

Section 5 Medical Executive Committee Deliberation.

Unless otherwise specified in Section 3 above, after a staff appointee's license is suspended, restricted, or placed on probation under Section 3 above, the Medical Executive Committee convenes to review and consider the facts under which such action was taken. The Medical Executive Committee may then recommend such further corrective action as is appropriate to the facts disclosed in the Investigation, including

limitation of privileges. Thereafter, the hearing and appeal procedure in Article IX is followed.

Section 6 No Right of Hearing.

Automatic suspension activated pursuant to Section 3 of this Article shall not be a professional review action and thus not give rise to any right of hearing or appellate review, except as otherwise expressly set forth in this Article.

Section 7 Enforcement of Automatic Suspensions.

It shall be the duty of the President to cooperate with the CEO in enforcing all automatic suspensions.

ARTICLE IX

Fair Hearing Plan

Section 1 Right to Hearing.

A. Recommendations or Actions. The following recommendations or actions shall, if deemed adverse pursuant to Section 1, B below, entitle the Medical Staff appointee affected thereby to a hearing:

1. Denial of initial Staff appointment;
2. Denial of reappointment;
3. Suspension of Staff appointment;
4. Revocation of Staff appointment;
5. Reduction in Staff category;
6. Limitation of admitting privileges;
7. Denial of requested clinical privileges;
8. Reduction in clinical privileges;
9. Suspension of clinical privileges (other than automatic suspensions pursuant to Article VIII, Section 3); and
10. Revocation of clinical privileges.

B. When Deemed Adverse. A recommendation or action listed in Section 1.A above shall be deemed adverse only when it has been:

1. Recommended by the Medical Executive Committee; or

2. Taken by the Governing Body contrary to a favorable recommendation by the Medical Executive Committee under circumstances where no prior right to a hearing existed; or
3. Taken by the Governing Body on its own initiative without benefit of a prior recommendation by the Medical Executive Committee.

Section 2 Request for Hearing.

- A. Notice. In all cases in which the Governing Body or the Medical Executive Committee shall have made a recommendation or taken an action entitling a Medical Staff appointee to a hearing, the CEO shall give prompt special notice to the Medical Staff appointee affected.

The notice shall contain the following:

1. That a professional review action has been taken or proposed to be taken against him/her;
2. The reasons for the action or proposed action, including a list of charts being questioned, if any;
3. That the Medical Staff appointee has a right to request a hearing on the proposed action;
4. The time limit (which shall be thirty (30) days) within which he/she must request such a hearing;
5. A statement that failure to request a hearing within the specified time, to submit a statement of the case, if required by the hearing committee, or to personally appear at the scheduled hearing, shall constitute a waiver of the appointee's right to the hearing and subsequent appellate review;
6. A summary of his/her rights in the hearing, which are: (a) representation by an attorney or other person of his/her choice, provided that, at least three (3) days prior to the date of the hearing, the Medical Staff appointee shall submit to the Hearing Committee the written agreement of his/her representative to abide by the procedural rules applicable to such hearing; (b) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of a reasonable charge associated with the preparation thereof; (c) to call, examine and cross-examine witnesses; (d) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; (e) to submit a written statement at the close of the hearing; (f) upon completion of the hearing, to receive a copy of the written recommendation of the hearing committee, including a statement of the basis of the recommendation;

7. That a record of the hearing and, if appointee so requests, of the appellate review, will be made and that appointee has a right to receive a copy upon payment of reasonable charges for the preparation of a copy; and
 8. If the adverse action necessitated a report to the National Practitioner Data Bank.
- B. Written Request. The request for hearing must be in writing, and delivered in person or by certified mail to the CEO.
- C. Waiver. The failure of a Medical Staff appointee to request a hearing to which he or she is entitled by these Bylaws within the time and in the manner provided herein or the failure of the practitioner to personally appear at the scheduled hearing shall be deemed a waiver of his/her right to such hearing, and to any appellate review to which he or she might otherwise have been entitled.
- D. Scheduling a Hearing. Upon receipt of a timely request for hearing, the CEO shall deliver such request to the Medical Executive Committee. The Medical Executive Committee shall, within fifteen (15) days after the receipt of such request for hearing, schedule and arrange for such a hearing, and shall send to the affected Medical Staff appointee by certified mail, a written notice containing the following:
1. The time, place and date of the hearing, which date shall not be less than thirty (30) days after the date of the notice of the hearing is provided to the Medical Staff appointee, unless the appointee, in writing, agrees to an earlier date.
 2. A list of the witnesses expected to testify at the hearing in support of the adverse recommendation or action. The date of the hearing shall be not more than ninety (90) days from the date of receipt of the request for hearing, except that when a request for hearing is received from a Staff appointee who is then under suspension, the hearing shall be held as soon as the arrangements may reasonably be made, but not more than ten (10) days from the date of receipt of the request for hearing.
 3. A list by number of the specific or representative patient records in question (if any).
 4. A short and plain statement of the basis for the adverse recommendation or action, which shall identify acts, omissions or transactions with which appointee is charged and, when appropriate, other reasons or subject matter that justify the adverse recommendation or action.
- E. The Medical Staff appointee shall be notified in writing of any subsequent modifications to the grounds for the adverse recommendation or action, or the list of expected witnesses, within a reasonable period prior to the hearing date.

- F. The Hearing Committee. When a hearing is requested, the Medical Executive Committee shall appoint a Hearing Committee which shall be composed of no fewer than five (5) appointees of the Active Staff, none of whom shall have actively participated in the consideration of the matter at the departmental or Medical Executive Committee level, and none of whom shall be in direct economic competition with the Medical Staff appointee involved. A hearing officer who is not in direct competition with the physician, dentist or podiatrist involved shall be appointed by the Governing Body to preside over the hearing upon the written request of the Medical Executive Committee or the physician, dentist or podiatrist who has requested the hearing.

Section 3 Hearing Procedure.

- A. Attendance. The attendance of the Medical Staff appointee for whom the hearing has been scheduled shall be required. A physician, dentist, or podiatrist who fails to appear and proceed at such hearing shall be deemed to have waived his/her right to such hearing, and to any appellate review to which he or she might otherwise have been entitled.
- B. Hearing Officer. Either the hearing officer, if one is appointed, or the Chair of the Hearing Committee (elected by the Hearing Committee), shall preside over the hearing to determine the order of procedure, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum. If requested by the Hearing Committee, the hearing officer may be advisor to it, but he/she shall not be entitled to vote.
- C. Hearing Committee. The Hearing Committee shall keep an accurate record of the hearing by means of a tape recorder or court reporter, which shall be chosen at the discretion of the Hearing Committee, and may, but shall not be required to, mandate that oral evidence be taken on oath or affirmation administered by a person entitled to notarize documents in the State of Wisconsin. A practitioner desiring an alternate method of recording the hearing shall bear the primary cost thereof.
- D. Testimony. If the Medical Staff appointee does not testify on his/her own behalf, he or she may be called and examined as if under cross-examination, but may not be compelled to testify.
- E. Evidence. The hearing need not be conducted strictly according to the rules of law related to the examination of witnesses or presentation of evidence. Any relevant matter upon which reasonable 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 evidence inadmissible over objection in a civil or criminal action. The Medical Staff appointee for whom the hearing is being held shall be entitled to submit memoranda concerning any issue of procedure or of fact prior to, during or at the close of the hearing, and such memoranda shall become part of the hearing record.

- F. **Decision.** In reaching a decision, official notice may be taken by the Hearing Committee either before or after submission of the matter for decision of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing, and of any facts which may be judicially noticed by the courts of this state. Participants in the hearing shall be informed of the matters to be noticed, and those matters shall be noted in the hearing record. The Medical Staff appointee for whom the hearing is being held shall be given the opportunity on request to refute the officially noticed matters by evidence or by written oral presentation of authority, the manner of such refutation to be determined by the Hearing Committee.

The Committee shall also be entitled to consider in connection with applications for appointment to the Staff or for clinical privileges pursuant to these Bylaws. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one (1) of its members or some other Staff appointee to represent it at the hearing, to present the facts in support of its recommendation, and to examine witnesses. The Governing Body, when its action has prompted the hearing, shall appoint one (1) of its members to represent it at the hearing, to present the facts in support of its decision, and to examine witnesses. It shall be the obligation of such representatives to present appropriate evidence in support of the adverse recommendation or decision, but the affected physician, dentist or podiatrist shall thereafter be responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis, or that such basis or any action based thereon is either arbitrary, unreasonable or capricious.

- G. **Deliberations.** The Hearing Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants, or for the purpose of obtaining new or additional evidence of consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Medical Staff appointee for whom the hearing was convened.
- H. **Adjournment.** Within fifteen (15) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation, and shall forward same together with the hearing record to the Medical Executive Committee. The report may recommend confirmation, modification or rejection of the original recommendation or action of the Medical Executive Committee or the Governing Body. A copy of the report and recommendations, which shall include a statement of the basis for the recommendations, shall at the same time be delivered to the Medical Staff appointee involved by special notice.
- I. If, after the Medical Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, its reconsidered recommendation is favorable to the Medical Staff appointee, it shall be forwarded to the Governing Body for action at its next regularly scheduled

meeting. If such recommendation continues to be adverse, the CEO shall promptly notify the Medical Staff appointee by special notice. The CEO shall also forward such recommendation and documentation to the Governing Body, but the Governing Body shall not take any action on the matter until after the Medical Staff appointee has exercised or has been deemed to have waived his or her rights to an appellate review as provided in Section 4 of this Article IX.

- J. A favorable reconsidered decision of the Governing Body shall be final and effective immediately upon transmittal of such reconsidered decision to the Medical Staff appointee. If the Governing Body's decision following a hearing is adverse to the Medical Staff appointee in respect to either appointment or clinical privileges, the CEO shall promptly send him or her a copy of such adverse decision by special notice. This notice shall also state that he or she has a right to an appellate review, that he or she has fifteen (15) days following receipt of the special notice to file a written request for appellate review, and that failure to properly request review shall constitute a waiver of the right to review and a summary of the appellate review procedures. The adverse decision shall then be held in abeyance until the Medical Staff appointee has exercised or been deemed to have waived his or her rights to appellate review under Section 4 of this Article IX. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

Section 4 Appeal to the Governing Body.

- A. Written Notice/Appellate Review. Within fifteen (15) days after receipt of the report and recommendation of the Hearing Committee, the affected Medical Staff appointee may, by written notice to the Governing Body delivered through the CEO by special notice, request an appellate review by the Governing Body. If such appellate review is not requested within such ten (10) day period, the affected physician, dentist, or podiatrist shall be deemed to have waived his/her right to the same.
- B. Appellate Hearing. Within fifteen (15) days after receipt of a request for appellate review, the Governing Body shall schedule and arrange for an appellate hearing. The Governing Body shall cause the physician, dentist or podiatrist to be notified, by special notice, of the time, place and date of the appellate hearing. The date thereof shall be as soon as is mutually agreeable, but not less than twenty (20) days, nor more than forty-five (45) days from the date of receipt of the request for appellate review, except that when a request for appellate review is received from a Medical Staff appointee who is then under suspension, the appellate hearing shall be held as soon as the arrangements may reasonably be made, but not more than ten (10) days from the date of receipt of the request.
- C. Appellate Review. The proceedings by the Governing Body shall be in the nature of an appellate review, based upon the record of the proceedings before the Hearing Committee, without the taking of additional evidence. However, the Governing Body may, in its discretion, accept additional oral or written evidence

subject to the same rights of cross-examination and confrontation applicable to the proceedings before the Hearing Committee. At the appellate hearing, the Medical Staff appointee shall have the right to be represented by legal counsel and to present written and oral statements and authorities in support of his position on appeal. However, new or additional matters not raised during the original hearing or in the hearing committee report and not otherwise reflected in the record shall only be introduced at the appellate review under unusual circumstances, and the Governing Body shall, in its sole discretion, determine whether such new matters shall be accepted. Following the appellate hearing, the Governing Body may refer the matter for further review and recommendation, but this shall not extend the time within which the Governing Body shall render its final decision.

- D. Written Decision. Within thirty (30) days after the conclusion of the proceedings before the Governing Body, the Governing Body shall render a final decision in writing and shall deliver copies thereof to the Medical Staff appointee and to the Medical Executive Committee by special notice.
- E. Final Decision. The final decision of the Governing Body following the appeals procedure set forth in this Article shall be effective immediately and shall not be subject to further appeal.
- F. Additional Hearing. No Medical Staff appointee shall be entitled as a matter of right to more than one hearing before the Governing Body on any single matter which may be the subject of an appeal without regard to whether such subject is the result of action by the Medical Executive Committee or the Governing Body, or both.
- G. Record and Tapes. All records and tapes of the proceedings provided for in this Article IX shall be kept on file in the Hospital until all applicable Statutes of Limitation expire, or if a judicial appeal is then pending, until the final determination of such appeal.
- H. Final Decision of the Governing Body. Whether or not a hearing or appellate review has been requested or granted, the final decision of the Governing Body on the matter shall be sent to the affected Medical Staff appointee by the Medical Staff President by special notice, and shall include a statement of the basis for the decision.
- I. Failure by the Governing Body, Medical Executive Committee or any hearing committee under this Article IX to comply with a time limit specified herein shall not be deemed to invalidate their actions.

Section 5 General Provisions.

A. Attorneys.

1. At Hearing. The Medical Staff appointee may be represented by an attorney at the hearing, but his/her request for the hearing should indicate intent as to whether or not he/she will be so represented. Failure to do so shall result in the appointee's not being permitted to be accompanied by an attorney at the hearing.
2. At Appellate Review. The Medical Staff appointee may be represented by an attorney at an appellate review appearance, but the request for the review must so declare.
3. Equal Representation and Preparation Assistance. If, and only if, the Medical Staff appointee is represented by an attorney at the hearing or appellate review may the Hearing Committee or the Governing Body be allowed such representation. The preceding sentence shall not be deemed to deprive any of the parties or committees of the right to legal counsel in connection with preparation for a hearing or an appellate review.
4. Payment of Attorney Fees. If any Practitioner who is the subject of an adverse recommendation or action in connection with the Practitioner's Medical Staff membership or clinical privileges initiates a suit against any entity or person who is in any way involved in any peer review, credentialing, recredentialing, corrective action or other action, recommendation or decision, the Practitioner filing the suit shall be required to pay all costs and expenses incurred by each individual defendant in defending the suit, including reasonable attorneys fees, unless the Practitioner substantially prevails against the individual defendant.

B. Number of Hearings and Reviews. Notwithstanding any other provision of the Bylaws, no Medical Staff appointee is entitled, as a right, to more than one evidentiary hearing and appellate review with respect to an adverse action.

C. Release. By requesting a hearing or appellate review under this Article, a Medical Staff appointee agrees to be bound by the provisions of Article XI relating to immunity from liability.

D. Substantial Compliance. Technical or insignificant deviations from the procedures set forth in this Article IX shall not be grounds for invalidating the action taken.

E. Reporting Requirements. If adverse action is required to be reported to the Wisconsin Medical Examining Board or the National Practitioner Data Bank, the CEO/designee shall submit such reports within fifteen (15) days of the final action taken by the Governing Body, unless otherwise required by law to be submitted earlier.

ARTICLE X

Meetings

Section 1 The Annual Meeting.

- A. The annual meeting of the Medical Staff shall be held in Spring. At this meeting, the retiring officers and committees shall make such reports as may be desirable, officers for the ensuing year shall be elected from the list of nominees prepared by the Nominating Committee in accordance with Article VII, Section 2 of these Bylaws.
- B. Election shall be carried out by secret written or secure electronic ballot. Voting by proxy shall be permitted. Nominations from the floor shall not be permitted. A nominee shall be elected upon receiving a majority of the votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

Section 2 Regular Meetings.

- A. The Medical Staff shall meet semiannually.
- B. In addition to matters of organization, the program of Medical Staff meetings shall include a report of the Medical Executive Committee and/or other committees or departments. Executive sessions may be conducted by the Active Staff with other categories of the Staff excluded.

Section 3 Sectional Meetings.

- A. Individual sections shall determine the frequency of meetings based on their business, clinical, quality monitoring and evaluation activities and/or educational needs.
- B. The primary objective of the section meetings is to improve the care and treatment of patients in the Hospital, and to provide the mechanism for monitoring and evaluating activities, including: identifying important aspects of care, identifying the indicators used to monitor the important aspects of care and evaluating the care provided; as well as to periodically review care to draw conclusions, formulate recommendations and initiate actions based on findings of review activities; and to communicate to appropriate section members the findings, conclusions, recommendations and actions taken.

Section 4 Special Meetings.

Special meetings of the Medical Staff may be called at any time by the Medical Staff President. Meetings shall be called at the request of the Governing Body, the Medical Executive Committee, or any five appointees of the Active Medical Staff. At any special

meeting, no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any meeting shall be posted on the bulletin board in the Staff room at least one (1) week (if possible) before the time set for the meeting.

Section 5 Attendance at Meetings.

- A. Appointees' attendance at meetings shall be considered in Staff reappointments.
- B. Members of the MEC, Credentials, and Performance Improvement Committees are expected to attend at least fifty percent (50%) of the meetings held.
- C. Members of committees and department/sections are required to complete their work, especially in review of charts.

Failure to meet these requirements, unless excused for just cause, shall be considered in Staff reappointments and advancements.

- D. An appointee of any category of the Staff who has attended a case that is to be presented for discussion at any meeting shall be notified and shall be required to be present. Failure to attend on receipt of such notice unless for just cause shall be grounds for corrective action under Article VIII of these Bylaws.

Should any appointee of the Staff be absent from any meeting at which a case that he has attended is to be discussed, it shall be presented nevertheless unless the appointee is unavoidably absent and has requested that discussion be postponed. In no case shall postponement be granted for a period longer than until the next regular meeting.

Section 6 Quorum.

There shall be no quorum requirement for the Semiannual Medical Staff meetings. Those Active Staff members present and voting shall constitute a quorum. The MEC's vote on proposed medical staff bylaws amendments requires a quorum of two-thirds (2/3) of the voting members. The MEC may act on requests for routine appointment, Clinical Privileges and reappointment only when a quorum of at least three voting members is present. All other regular business items requiring MEC action will require a fifty percent (50%) quorum. At other committee, department, and section meetings, a quorum shall consist of those present.

ARTICLE XI

Immunity from Liability

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at the Hospital.

Section 1 Immunity Privilege.

Any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

Section 2 Immune Parties.

Such privilege shall extend to appointees of the Hospital's Medical Staff and members of its Governing Body, its other practitioner's, its officers and representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this Article XI, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

Section 3 Civil Liability.

There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Section 4 Applicable Activities.

Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this, or any other health care institution's activities related, but not limited to:

- A. Applications for appointment or clinical privileges;
- B. Periodic reappraisals for reappointment or clinical privileges;
- C. Corrective action, including summary suspension;
- D. Hearings and appellate reviews;
- E. Medical care evaluations;
- F. Utilization review;
- G. Other Hospital, departmental, service or committee activities related to quality patient care and professional conduct.

Section 5 Extent of Privilege.

The acts, communications, reports, recommendations and disclosures referred to in this Article XI may relate to a practitioner's professional qualifications, clinical competency,

character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Section 6 Liability Release.

In furtherance of the foregoing, each practitioner shall upon request of the Hospital execute releases in accordance with the tenor and import of this Article XI in favor of the individuals and organizations specified in Section 2, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state.

Section 7 Effect on Appointment and Reappointment Procedure.

The consents, authorizations, releases, rights, privileges, and immunities provided by Article III of these Bylaws for the protection of the Hospital's practitioners, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XI.

ARTICLE XII

Staff Dues

Section 1 Assessment.

- A. Staff dues shall be payable on October 31st, the end of the first month of the membership (fiscal) year. Appointees appointed during a membership year shall have dues prorated for the partial year.
- B. Formal notice of dues shall be sent to each appointee by the Secretary/Treasurer promptly at the beginning of each fiscal year. Failure to remit dues within a period of sixty (60) days after receipt of a notice of dues delinquency sent by certified mail, shall be called to the attention of the Medical Executive Committee, and may be grounds for suspension or termination of Staff privileges.
- C. Honorary Staff Appointees and Medical Staff Appointees seventy (70) years of age and over regardless of Staff status are not be required to pay dues.
- D. Staff dues and special assessments shall be those that are determined by a majority vote of the Active Medical Staff.

ARTICLE XIII

Amendments

Section 1 Medical Staff Bylaws.

All proposed amendments to the Medical Staff Bylaws approved by the Medical Executive Committee shall be subject to the approval by the Governing Body, and

following approval by the Governing Body shall be subject to approval by majority vote of the Medical Staff members present and voting at the next meeting of the Medical Staff, or may be mailed to members of the Active Staff entitled to vote for approval by written or secure electronic ballot. The Medical Executive Committee shall determine whether to submit the proposed amendments for approval by mail or at a meeting of the Medical Staff. Bylaw amendments submitted for approval by mail shall be subject to approval by a majority of the members of the Active Staff by submitting written or secure electronic ballots. Written or secure electronic ballots shall be prepared and validated in such manner as the Medical Executive Committee shall approve and only ballots received in the Medical Staff Office within twenty-one (21) calendar days after the ballots are mailed or electronically delivered shall be counted.

The Medical Executive Committee shall have the authority to provisionally revise these Bylaws without approval of the full Medical Staff if such amendments do not materially amend any Bylaw provision and are solely for technical modifications or clarifications, reorganization or renumbering, or to correct grammatical, spelling or punctuation errors. Such revisions are not formal amendments, but still require formal approval by the Governing Body to become effective. In addition, the MEC may provisionally adopt any urgent amendments as required to comply with any legal, regulatory or accreditation requirements. The need for such urgent amendments shall be documented, and the Governing Body shall then approve such amendment without prior notice to the Medical Staff. The MEC shall immediately notify the Medical Staff. The Medical Staff shall then have an opportunity for retrospective review and comment on the provisional amendment. If no conflict exists between the Medical Staff and the MEC, the provisional amendment stands. If conflict does arise between the Medical Staff and MEC, the matters shall be submitted to a joint meeting of equal members of the Medical Staff and the MEC for review and recommendation to the Governing Body. If resolution cannot be made through this process, both groups shall submit their position to the Governing Body for final decision.. Such amendments shall be effective when approved as decided by the Governing Body. In the event the Medical Staff proposes an amendment that is not approved by the MEC, the same process for resolving conflict between the Medical Staff and the MEC shall be followed.

Except as otherwise provided herein, all amendments to these Bylaws shall be effective at such time as is specified by the Medical Executive Committee and approved by the Governing Body at the time any amendment is adopted. If the Medical Executive Committee and the Governing Body do not otherwise specify when any Bylaw amendments shall be effective, such amendments shall be effective immediately at such time as they are finally approved by the Medical Staff and shall apply to all matters currently pending to the extent practical, regardless of whether any individual Medical Staff member received actual notice of the amendment.

ARTICLE XIV

Adoption

These Bylaws may be adopted at any regular or special meeting of the Medical Staff, shall replace any previous Bylaws and rules and regulations, and shall become effective when approved by the Governing Body. Errors, alterations, or additions to these Bylaws shall be effected through the due process outlined in Article XIII of these Bylaws.

Adopted at a regular meeting of the Active Medical Staff.

_____	_____
Date	President of the Medical Staff
_____	_____
Date	Secretary/Treasurer of the Medical Staff
_____	_____
Date	Secretary of the Board of Trustees

ST. JOSEPH'S HOSPITAL

MEDICAL STAFF BYLAWS AND PROCEDURAL MANUAL

PART VII

RULES AND REGULATIONS

Approved by the Board of Directors

March 25, 2008

Amendments

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PART VII

RULES AND REGULATIONS

SECTION 1. PATIENT CARE

1. Patient Admissions

- a. Only Practitioners who are members of the Medical Staff and who have admitting Privileges granted in accordance with applicable law and criteria and policies established by the Medical Staff may admit patients.
- b. Practitioners admitting patients who may pose a danger shall be held responsible for relating to appropriate Hospital personnel such information as may be necessary to assure the protection and safety of other patients and Hospital staff.
- c. Except in emergencies, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

2. Attendance of Patients

One or more members of the Medical Staff shall attend all patients. The attending physician, Dentist, oral or maxillofacial surgeon or Podiatrist must be able to provide proper care to his/her patients. On the initial application for appointment and subsequent applications for reappointment, each member shall name an alternate with similar Privileges at the Hospital who may be called on to attend patients in his/her absence. Continued failure by the admitting staff member to name an alternate shall subject the member to review of such action by the MEC. In the event that neither the responsible Practitioner nor the designated alternate is available, a qualified Medical Staff member may be called by the section chair, President of the Medical Staff or Hospital President.

3. Management (diagnosis and treatment)

Management (diagnosis and treatment) of each patient is the responsibility of a qualified member of the Medical Staff or Allied Health Professional staff who has appropriate Clinical Privileges. The patient's general medical condition shall always be the responsibility of a qualified physician member of the Medical Staff. Individuals providing treatment and performing operative or other procedures may only do so within the scope of their delineated Clinical Privileges. Consultations will be obtained in those circumstances where the patient's treatment is outside of scope of the admitting Practitioner's delineated Privileges.

4. Consents

- a. Except in an emergency, an Admission Consent Form shall be signed by or on behalf of every patient admitted to the Hospital at the time of admission.
- b. For special treatment or surgical procedure, including invasive procedures, high risk therapies/drugs, the administration of blood or blood components, and experimental treatments, except in an emergency, a specific consent form shall be signed by or on behalf of the patient prior to the special treatment or surgical procedure being performed that verifies that the patient has been informed by his/her physician, Dentist or Podiatrist of:

- 1) the nature and purpose of the proposed procedure or treatment (including anesthesia to be used), and the likelihood of achieving goals;
 - 2) possible alternative procedures and methods of treatment along with the potential relevant risks, benefits and side effects of such alternatives;
 - 3) potential benefits, risks, or side effects of the proposed procedure or treatment (including anesthesia to be used), including potential problems that might occur during recuperation;
 - 4) the use or non-use of blood and blood products;
 - 5) the prospects for success and the probability of complications;
 - 6) the possibility of complications and prognosis if no treatment is rendered;
 - 7) the names of Practitioner(s) performing the procedure/treatment or important aspects of the procedure/treatment, as well as the name(s) and specific surgical tasks that will be conducted by Practitioners other than the primary Practitioner; and
 - 8) when indicated, any limitations on the confidentiality of information learned from or about the Patient.
- c. In emergencies involving a minor or decisionally incapacitated adult in which consent for special treatment or surgical procedure cannot be immediately obtained from parents, next of kin, healthcare agent or guardian, or other appropriate surrogates, these circumstances should be fully explained in the patient's medical record.

5. Physician Orders/Verbal Orders

- a. All orders affecting patient care shall be in writing unless such orders are given in accordance with the guidelines below for telephone and verbal orders. Orders must be written clearly to avoid misinterpretation. When an individual is unable to determine the intent of an order, he/she shall call the ordering Practitioner or Allied Health Professional for clarification.
- b. Verbal and telephone orders may be used only in emergent situations when it is not feasible to use a written order. To be acted upon, verbal and telephone orders must comply with the following:
 - 1) A telephone or verbal order must be dictated by: (i) a physician; (ii) a nurse clinician, physician's assistant or pharmacist acting on the orders of a physician; or (iii) a Dentist, Podiatrist, oral and maxillofacial surgeon or other independent or dependent Allied Health Professional, as allowed pursuant to the Medical Staff Bylaws, these Rules and Regulations, or other Medical Staff policies.
 - 2) A verbal or telephone order must be received by an appropriately licensed person (e.g., Registered Pharmacist, Registered Dietitian, Registered Nurse, Licensed Practical Nurse, Certified or Registered Therapist [physical therapist, speech therapist, occupational therapist, respiratory therapist, radiation therapist] or Nuclear Medicine Technologist). The person receiving the order must write it down or enter it into a computer and read back the written order to the individual giving the order to confirm that it has been received and recorded correctly. The person receiving the order must record it in the appropriate location in the patient's medical record and include the name and title of the person giving the order.

- 3) The order must be signed, timed and dated by the person receiving the order at the time of acceptance.
- 4) All verbal orders relating to “Do Not Resuscitate” or to restraint and/or seclusion are required to be signed according to applicable Nursing and Hospital Policy.
- 5) All verbal and telephone orders shall be signed, timed and dated by the individual giving the order within 48 hours. Peers may sign orders for each other within their general scope of practice; a peer’s signature indicates that the peer assumes responsibility for his/her colleague’s order as being complete, accurate and final.

c. *Chemotherapy Orders*

- 1) All chemotherapy orders, including changes in medication, dosage and administration must be signed by an attending physician prior to preparation and administration. Direct facsimile transmission with the attending physician’s signature is acceptable. A telephone or verbal order may be used for the time of administration or a change in solution. No other verbal or telephone orders for chemotherapy will be accepted.
- 2) No abbreviations for chemotherapy medications will be accepted.

6. Laboratory and Radiology Requests

- a. *Laboratory and Radiology Examinations:* All requests for laboratory and radiology examinations for patients are to be transmitted to the Hospital laboratory or radiology department. If an examination is requested that the Hospital laboratory or radiology department cannot perform, the director of the laboratory or radiology department will arrange for the examination to be performed by an outside, approved laboratory or radiology department and the charge for such examination will be made to the patient.
- b. All specimens removed at operation, must be submitted for pathological examination with the exception of:
 - hernia sacs
 - bunions
 - IUDs
 - pace makers
 - orthopedic hardware
 - teeth
 - placentas (at discretion of physician)
 - neonatal foreskins
 - lens (cataract)
 - medical devices such as catheters, stents, tubes – unless such device may be causative of illness or injury
 - bones from routine traumatic fractures

7. Pharmacy Services

- a. Except as specified herein, all drugs used in the care of patients shall be secured in accordance with Hospital policy.
- b. When a physician writes an order for the patient to “continue medications from home,” it is the responsibility of that physician to approve the orders for each such medication and

the dosage regimen before the order is sent to the Pharmacy for the medication to be dispensed.

- c. Orders to be reinstated after surgery or delivery must be written out or a check off continue order format must be used. Blanket reinstatement of orders is not allowed. Providers must rewrite orders in their entirety or use the Hospital's computer generated transfer forms.
- d. Medication orders will contain the name of the medication, dose, route, frequency, and special instructions. Indications and parameters will be listed on "as needed" orders. The use of range orders will be avoided unless parameters are associated with each segment of the order. The use of standardized order sheets will be fostered to reduce the chance of misunderstanding with look alike sound alike medications. The Medical Staff Performance Improvement Committee and the Pharmacy will have responsibility for interventions used to reduce the chance of error in medication ordering.
- e. Medication orders for pediatric patients under the age of one year old will be based on the patient weight (which does not exclude dosing per square meter).
- f. Medications may not be brought into the Hospital by prescribers unless authorized by the Medical Staff Performance Improvement Committee.

8. Research and Clinical Investigation

- a. Research of any nature involving patients shall be governed by existing research policies, procedures, and rules of St. Joseph's Hospital.
- b. All protocols for research and clinical investigation and their informed consents shall be reviewed and approved by the Institutional Review Board prior to initiation of studies. In addition, all protocols involving radioisotopes must also be reviewed and approved by the Radiation Safety Committee of the Hospital.
- c. All subjects must give informed consent in accordance with applicable law and Hospital policies prior to being involved in research.

9. Consultations

- a. Situations in which consultations are required include: 1. Complicated situations involving high risk where specific skills may be indicated; 2. Where patient is seriously ill and diagnosis continues to be obscure; 3. Where there is significant doubt about choice of therapy, or 4. When consultation is requested by patient or the patient's surrogate if the patient is not decisional.
- b. Consultants must be qualified to give an opinion in their specialty based upon training, experience and competence, as determined by the Medical Staff.
- c. The patient's attending physician, Podiatrist, Dentist or independent Allied Health Professional is responsible for requesting consultations. All requests for consultations shall be documented in the patient's medical record. In addition to the written order, any consult that is needed in less than 24 hours notice must have physician to physician contact to report on the patient condition and urgency of consult. If consult is written to be seen the next day or earliest convenience, note in the chart as to the reason for the consult is acceptable.

- d. A consultation includes examination of the patient and the record. The written opinion signed by the consultant must be included in the patient's medical record.
- e. When an operative procedure is involved, the consultation note, except in emergency, shall be recorded prior to the operation.
- f. Routine procedures, such as an x-ray examination, electrocardiogram determination, tissue examination, and proctoscopic and cystoscopic procedures, are not necessarily considered to be consultations.
- g. If there is doubt about care of a patient, the attending physician may be contacted by the department chair.

10. Coordination of Care, Treatment and Services

- a. As part of each patient's plan for care, treatment and services, there will be coordination of care, treatment and services provided through the Hospital's internal resources.
- b. When external resources are needed for patient care, the Hospital and the patient's care providers will participate in coordinating care, treatment and services with these resources (including sharing and receiving relevant information to facilitate coordination).
- c. The patient's plan of care, treatment and services will be designed to occur in a time frame that meets the patient's health needs.

11. Patient Discharge

- a. Patients shall be discharged only on order of the attending Practitioner or independent or dependent Allied Health Professional if such action is within his/her scope of practice and permitted under the Medical Staff Bylaws, policies and Rules and Regulations.
- b. At the time of discharge, the individual discharging the patient shall assure that the order discharging the patient provides instruction on activity, diet, follow-up, medications, medical equipment, rehabilitation needs and referral services.
- c. The attending Practitioner shall see that the record is complete, state final diagnosis, and sign the record, including the history, physical examination and discharge summary.
- d. A patient who leaves the Hospital without the approval of his/her attending Practitioner or other independent or dependent Allied Health Professional shall sign a statement that he/she is leaving contrary to medical advice and that he/she releases both the Hospital and his/her caregivers from responsibility in connection with his/her decision to leave, in accordance with Hospital and Medical Staff policy. If the patient refuses to sign such a statement, the statement will be read to him/her (if possible), and his/her refusal will be documented in the medical record.

12. Autopsies

- a. No autopsy shall be performed without the written consent of the next of kin or other legally responsible person, unless otherwise required or permitted by law.
- b. All autopsies shall be performed by the Hospital pathologist or by a physician to whom he/she may delegate the duty.

- c. The clinical situations where an autopsy should be sought include, but are not limited to, the following:
- 1) Unanticipated or unknown medical complications. (Sudden or questionable deaths.)
 - 2) All deaths in which the cause of death or major diagnosis is not known with reasonable certainty on clinical grounds.
 - 3) Unexpected or unexplained deaths occurring during or following dental, medical, surgical or diagnostic procedures or therapies. (Including deaths occurring 24-48 hours post-op.)
 - 4) Deaths of subjects who have participated in clinical research within 3 months of death.
 - 5) Deaths resulting from high risk infections and contagious diseases. (e.g., T.B.)
 - 6) All perinatal and pediatric deaths. (Perinatal time period of 24 weeks gestation and within 7 days of delivery, pediatric deaths age less than 17 years.)
 - 7) All obstetric deaths.
 - 8) Natural deaths that are subject to, but waived by a forensic medical jurisdiction, such as persons dead on arrival at hospitals, deaths occurring in hospitals within 24 hours of admission and deaths in which patients sustained or apparently sustained an injury while hospitalized.
 - 9) Deaths known or suspected to have resulted from environmental or occupational hazards.
 - 10) Deaths in which it is believed that autopsy would disclose unknown or suspected illness that may have a bearing on recipients of transplant organs.
 - 11) Sudden deaths of persons not disabled by recognizable disease processes in which a fracture of a major bone (femur, humerus, fibia) has occurred within the past six months.
- d. If no autopsy was performed on a death involving the above clinical situations, then the physician must document in the medical record that the attempt was made to obtain permission to perform one.
- e. The primary care physician and/or attending physician will be notified that an autopsy will be performed.
- f. Autopsy findings will be incorporated into the Medical Staff peer review quality assurance activities. The gross provisional diagnosis sheet will be available on the medical record within 72 hours from the time of completion of the gross autopsy. The final autopsy report will be on the medical record within 60 days.
- g. It is the responsibility of physicians to immediately report to the medical examiner's office deaths which occur under any of the following circumstances:
- 1) All deaths in which there are unexplained, unusual or suspicious circumstances;
 - 2) All homicides;

- 3) All suicides;
- 4) All deaths following an abortion;
- 5) All deaths due to poisoning, whether homicidal, suicidal or accidental;
- 6) All deaths following accidents, whether the injury was or was not the primary cause of death;
- 7) When there was no physician or accredited practitioner of a bona fide religious denomination relying on prayer or spiritual means for healing, who attended or treated the decedent within thirty (30) days preceding death; and
- 8) When, after reasonable efforts, a physician cannot be obtained to sign the medical certification section of the death certificate within six days after the pronouncement of death, or sooner under circumstances that the coroner or medical examiner determine to be an emergency.

Any death in which there is doubt as to whether it is a medical examiner's case should be reported and discussed with a medical examiner's investigator.

13. Outside Contracts for Patient Care

All contracts with outside agencies for the provision of patient care shall require that while on Hospital premises, personnel from such agencies shall observe the general operating protocols, regulations and policies of the Hospital, and the appropriate provisions of the Medical Staff Bylaws, policies, Rules and Regulations. Quality assessment monitoring of the performance of such services will occur in the appropriate committees of the Medical Staff and be reported to the Medical Executive Committee through normal channels.

14. Patients Not Seen By Attending (Ordering) Physicians

The Emergency Department (ED), at the discretion of the attending Emergency Department physician, may provide services to patients sent by physicians to the ED for procedures, including labs and medication, without the ordering physician present.

- a. The ordering physician shall notify the ED physician of such patient, including requested orders and pertinent history. Such requests and details shall be documented in the patient's chart by nursing personnel.
- b. The ED physician shall determine if the patient should be evaluated by the ordering physician prior to provision of requested services. Should such evaluation be necessary and if time and circumstances permit, attempts will be made to inform the ordering physician prior to full evaluation by the ED physician.

15. Policy for Discharge of Certain Medicated Outpatients

In the interest of patient safety and responsible medical care, the Hospital requires that:

- a. Unless previously notified otherwise, all patients presenting for ambulatory surgery or diagnostic procedures requiring the administration of any general or regional anesthetics, narcotics or sedative drugs must, upon discharge, be transported home by at least one responsible adult.

- b. Failure on the part of any patient described in paragraph a, above, upon admission to the Hospital facilities, to provide verification that they will be transported home by a responsible third party may result in the cancellation of such patient's surgery or test.
- c. The Medical Staff member responsible for scheduling the patient's surgery or test (or his or her staff) shall, at the time of scheduling, properly inform the patient, using materials provided by the Hospital, of the necessity of having a responsible individual to transport the patient after completion of surgery or test and the reasons for this requirement.
- d. Prior to discharge from any Hospital facility, Hospital personnel will advise any patient who has received any anesthetics, narcotics or sedative drugs against making major decisions of any kind, operating motor vehicles or working with power equipment for at least twenty-four (24) hours.
- e. Receipt by the patient of the instructions described in 15(d) above shall be acknowledged by the patient in writing prior to discharge and documented in the patient's medical record.

16. Psychiatric or Substance Abuse

Members of the Medical Staff will treat medical problems of patients who are emotionally ill or abuse substances (drugs or alcohol). When the patient's medical problems are resolved and the patient's psychiatric or substance-abuse condition cannot be treated by the member of the Medical Staff, the patient, family (as appropriate) and Medical Staff member will make reasonable attempts to collaborate regarding treatment options, including transfer to an appropriate facility.

SECTION 2. MEDICAL RECORDS

The medical record must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

1. Medical Record Contents

The complete medical record shall include:

- a. Patient's name, address, date of birth, and the name of any legally authorized representative;
- b. Legal status of patients receiving mental health services;
- c. Emergency care provided to patient prior to arrival, if any;
- d. The record and findings of the patient's assessment (including allergies);
- e. A statement of the conclusions or impressions drawn from the medical history and physical examination;
- f. The diagnosis or diagnostic impression;
- g. The reasons for admission or treatment;
- h. The goals of treatment and the treatment plan;
- i. Evidence of known advance directives;

- j. Evidence of informed consent for procedures and treatments for which informed consent is required;
- k. Diagnostic and therapeutic orders, if any;
- l. All diagnostic and therapeutic procedures and tests performed and the results;
- m. Reports of all operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate, and tissue reports for any removed tissue;
- n. Progress notes made by the Medical Staff and other authorized individuals;
- o. All reassessments and any revisions of the treatment plan;
- p. Clinical observations (including vital signs);
- q. The patient's response to the care provided (including complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia);
- r. Consultation reports;
- s. Every medication ordered or prescribed for an inpatient;
- t. Every dose of medication administered and any adverse drug reaction;
- u. Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;
- v. All relevant diagnoses established during the course of care, including the final diagnosis;
- w. Any referrals/communications made to external or internal care providers and to community agencies;
- x. Clinical resumes and discharge summaries, or a final progress note or transfer summary;
- y. Documentation of discharge instructions to the patient and family as listed in Section 1 (11) of the Medical Staff Rules and Regulations;
- z. Autopsy findings when an autopsy is performed;
- aa. Anatomical gift information, if any; and
- bb. Records of communication with the patient and any patient-generated information.

2. Medical Record Entries

Entries into the Medical Record will be made by members of the Medical Staff and other providers of patient care to document care provided.

3. Symbols and Abbreviations

Symbols and abbreviations may be used only when they have been approved by the Medical Staff Performance Improvement Committee. An official record of approved abbreviations shall be

kept on file at the Nurses' Station.

4. Progress Notes

The medical record shall include progress notes by the attending physician or designee at least daily identifying all significant changes in patient's (including newborns) condition except: a. psychiatrists may record progress notes every 48 hours for patients on the psych unit; b. physicians can write progress notes every 48 hours for stable patients who are waiting for placement at another facility; and c. physicians can write progress notes every 7 days for subacute unit patients.

5. Responsibility for Aspects of Care and Record Preparation

The admitting physician shall be responsible for all aspects of care and preparation of the medical record, including the history and physical unless the patient's care is transferred by order to an accepting physician and the accepting physician signifies agreement to accept that responsibility on the order sheet. This transfer must be done with the consent of the patient and/or his/her surrogate decisionmaker(s).

6. Authentication

Every medical record entry must be authenticated and dated promptly by the person (identified by name and discipline) responsible for ordering, providing, or evaluating the service provided. Use of an electronic signature or rubber stamp by a Medical Staff member is acceptable if the Practitioner whose signature it represents is the only one who is authorized to use the electronic signature or rubber stamp and signs a statement to this effect which is kept in the Health Information Services Department.

7. History and Physical Examination

An admission note, diagnosis, and current history and physical examination shall be recorded in the patient's medical record within 24 hours after a patient's admission to the Hospital, but prior to surgery. The medical history and physical examination must be performed within 30 days prior to admission by a physician or oral and maxillofacial surgeon who has been granted Privileges to perform H & Ps. If the H & P was performed more than 7 but less than 30 days prior to admission, an appropriate assessment (including a physical assessment) must be performed by the physician or oral and maxillofacial surgeon who has been granted Privileges to perform H & Ps and an update note must be attached to the H & P within 24 hours of admission but prior to surgery and must include any significant changes.

- a. In the case of elective surgical patients, the history and physical examination shall be recorded prior to the induction of anesthesia.
- b. In the case of emergencies, an H & P is not required prior to surgery but must be recorded in writing or dictation within 24 hours of admission. There is to be documentation by the surgeon, prior to the procedure, that the procedure is an emergency. If this is not documented, an H & P and update, if appropriate, must be present on the chart within 24 hours of admission but prior to the start of the procedure.
- c. H & P's older than 30 days are not acceptable. There are no exceptions.
- d. Inpatients require a full H & P regardless of the type of anesthesia or ASA class.
- e. Outpatients require a full H & P if General, Spinal or Epidural or with ASA class of 4 and 5. The short form can be utilized on IV sedation, MAC, Local, and IV regional block patients with ASA class 1, 2 and 3.

- f. An update note and physical examination will be sufficient if readmission occurs within thirty (30) days from discharge and is for the same condition or a direct complication.
- g. The Newborn Physical Examination at Birth form must be completed for all newborns.
- h. *Obstetrical Records:*
 - 1) A copy of the prenatal record is to be forwarded to the Hospital for inclusion in the patient's medical record.
 - 2) The history and physical examination requirements for obstetrical patients are as stated above.
 - 3) A dictated H & P must be documented on the patient's chart prior to a planned surgical procedure where a general or regional anesthetic is used. (Example: Planned C-section; External version)
- i. Qualified oral and maxillofacial surgeons may perform the medical history and physical examination, if they have such Privileges, in order to assess the medical, surgical, and anesthetic risks of the proposed operative and other procedures. The findings, conclusions, and assessment of anesthesia risk must be confirmed or endorsed by a member of the Medical Staff, with appropriate Privileges, prior to procedures requiring regional or general anesthesia.
- j. Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry.
- k. Podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry.
- l. Allied Health Professionals may perform all or part of the medical history and physical examination, if granted such Privileges. However, the physician involved must sign the H & P and assume full responsibility for the H & P.

8. Discharge Summary

Discharge summaries are required for all inpatients and observation patients and must be completed within ten (10) days after discharge.

- a. *Inpatients and Observation Patients.* A discharge summary shall contain (as applicable):
 - 1) Reason for hospitalization;
 - 2) Diagnostic studies performed during hospitalization;
 - 3) Treatment rendered;
 - 4) Consultations;
 - 5) Significant findings;
 - 6) Conclusions at termination of hospitalization to include final principal diagnosis, secondary diagnoses and all procedures performed;

- 7) Documentation of complications, hospital-acquired infections, and adverse reactions to drugs and anesthesia.
 - 8) Condition of patient on discharge;
 - 9) Plan of care following discharge including: medications, referrals and consultations and pertinent instructions to patient/family for discharge/follow-up.
- b. *Newborns.* Completion of the newborn physical exam at discharge will meet the Discharge Summary requirements in a. above.
 - c. *OB Patients.* Completion of the standard Obstetrical Discharge Summary form or a written progress note which includes the principal and other diagnoses will meet the Discharge Summary requirements.

9. Medical Students

Medical students may make entries into the medical record; all entries must be signed by a supervising physician within 24 hours. Medical student history and physicals, once countersigned, may be accepted as the H & P of the medical record.

10. Delinquent Medical Records/Privileges Temporarily Suspended

Quality patient care requires that all medical records be completed in a timely fashion, in accordance with applicable law, policies and procedures. Privileges are temporarily suspended under the following conditions:

- a. *Documentation Responsibilities.* It is the responsibility of the admitting physician to provide a History and Physical and update note, as required herein, within 24 hours of admission. It is the responsibility of the surgeon to provide a complete operative report immediately after the procedure. It is the responsibility of the discharging physician to provide a Discharge Summary within 10 days after discharge.
- b. *Warning:* A written warning will be initiated by the Hospital President for failure to complete medical records within the timeframe defined in 10.a. The recipient will have 72 hours after the date of notice to provide the medical records requested.
- c. *Suspension:* If a Practitioner receives a written warning by specific notice from the Hospital President and fails to comply with the parameters outlined therein, a written notice of suspension will be initiated by the Hospital President. The Practitioner's admitting Privileges, consulting Privileges, surgical Privileges, voting rights, office-holding prerogatives and any other Privileges except those Privileges of attending his/her patients currently in the Hospital and previously scheduled procedures automatically shall be suspended effective as of fourteen (14) days after the date of the notice until the deficiency is remedied. The affected Practitioner shall not be entitled to any of the hearing and appeal rights otherwise afforded under the Medical Staff Bylaws and the Hearing and Appeal Policy and Process.
- d. *Reporting:* Temporary suspension of Privileges under this rule shall not be considered as disciplinary action relating to professional practice and therefore does not require reporting to the Department of Regulation and Licensing or the National Practitioner Data Bank.
- e. *Notifications:* Upon imposition of a suspension, the Hospital President shall immediately notify the President of the Medical Staff, the applicable section chair, the Credentials Committee Chair, the admitting office, the operating room, the emergency room, and the vice president of patient care services of the suspension. The Hospital President shall

also provide notice to those stated above, and to the Practitioner, either in person or by special notice, when the suspension is lifted.

- f. *Repeated Suspensions:* At the time of the third suspension for delinquent medical records, and all additional suspensions within a 12 month period, a \$100 fine will be imposed on the Practitioner. Reactivation of Medical Staff Privileges will require payment of the fine in addition to completion of medical record(s).
- g. *Review of Medical Staff Appointment:* After the third suspension in any 12 month period for failure to complete or prepare records, or one suspension of longer than 90 days for failure to complete or prepare records, the matter shall be brought before the MEC to review the Practitioner's continued appointment to the Medical Staff.
- h. *Reinstatement:* Privileges shall be automatically reinstated upon completion of all incomplete records unless the Medical Executive Committee has taken corrective action in accordance with the Credentials Policy and Procedure Manual, or unless the Practitioner has voluntarily relinquished all Clinical Privileges and Medical Staff appointment in accordance with the Credentials Policies and Procedure Manual.

11. General Rules Regarding Operative and Invasive Procedures and Use of Anesthesia

a. *Definitions*

For purposes of these Rules and Regulations:

- 1) "Invasive" is defined as procedures involving puncture or incision of the skin or insertion of an instrument or foreign material into the body including blood transfusions, percutaneous aspirations and biopsies, cardiac and vascular catheterizations, endoscopies, and/or angioplasties, but excluding venipuncture, injectable drug therapy, or injection of radiographic contract media.
- 2) "Anesthesia" is defined as administration of general, spinal or other major regional anesthesia or sedation, with or without analgesia, for which there is expectation that, in the manner used, the sedation or analgesic will result in loss of protective reflexes.

b. *Documentation*

- 1) **Required Documentation Prior to Surgery:** Except in emergencies, all patients undergoing "invasive" procedures requiring use of anesthesia shall have the following recorded in the medical record prior to the procedure, or the case will not proceed: history and physical, the pre-operative diagnosis, indications/symptoms for the procedure, current medications and dosages, allergies including medication reactions, existing co-morbid conditions, mental status, assessment, patient/surrogate consent, and required laboratory tests and examination of the patient specific to the procedure performed. In an emergency, the Practitioner shall record at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.
- 2) Patients undergoing conscious sedation and/or other anesthesia modalities may also require additional documentation of other elements of history, physical, or other studies as outlined in applicable policies.
- 3) Operative reports must record the date and time of surgery; name of the primary surgeon and assistants; pre-operative and post-operative diagnosis; findings; technical procedures used; specimens removed or altered (if any); blood loss (if any); complications (if any); type of anesthesia used; surgeons or Practitioners'

names and a description of significant surgical tasks that were conducted by Practitioners other than the primary surgeon/Practitioner; and prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

- 4) The Practitioner performing the surgery is responsible for dictating the operative report. Operative reports shall be dictated immediately following the procedure. The complete operative report must be authenticated by the surgeon and filed in the medical record as soon as possible after surgery.
 - 5) A progress note containing pertinent information needed by an individual who might attend the patient must be entered immediately after surgery.
 - 6) Postoperative documentation must record the patient's vital signs and level of consciousness; administration of medications (including intravenous fluids), blood and blood components administered; any unusual events or post-operative complications, including blood transfusion reactions and management of those events; patient's discharge from post-anesthesia care area by the responsible member of the Medical Staff or the Allied Health Professional according to discharge criteria; and name of the licensed independent practitioner responsible for discharge.
 - 7) Compliance with discharge criteria must be fully documented in the patient's medical record.
- c. All specimens removed at operation shall be sent to the Hospital pathologist for examination except as otherwise stated in Section 1, paragraph 6.b.
- d. *Rewriting of Medical Orders Following Surgery*
- 1) All orders will be discontinued when a patient goes to surgery. Following surgery requiring general or major regional anesthesia, all orders must be rewritten individually. Following other surgery, an RN will verify with the physician which pre-operative orders should be resumed if the physician enters an order to "resume pre-op."
 - 2) Physician's written standing orders will be transcribed and used only after verified upon receipt of physician's order to "Use standing orders."
 - 3) Exceptions: Tracheotomy and central line placement do not require orders to be rewritten individually.
- e. *Responsibilities for Dental Patients:* A patient admitted for dental care is a dual responsibility involving the Dentist and physician member of the Medical Staff.
- 1) Dentist's Responsibilities:
 - a) A detailed dental history justifying Hospital admission.
 - b) A detailed description of the examination of the oral cavity and pre-operative diagnosis.
 - c) A complete operative report describing the findings and technique. In cases of extraction of teeth, the Dentist shall clearly state the number of teeth and fragments removed.
 - d) Progress notes as are pertinent to the oral condition.

- e) Clinical resume (or summary statement).
 - f) The discharge of the patient shall be on written order of the Dentist member of the Medical Staff.
- 2) Physician's Responsibilities:
 - a) Medical history pertinent to the patient's general health.
 - b) A physical examination to determine the patient's condition prior to anesthesia and surgery.
 - c) Supervision of the patient's general health status while hospitalized.
- f. *Responsibilities for Podiatric Patients:* For Podiatrists having surgical Privileges, the method of management must be detailed in much the same manner as the above for Dentists. However, the discharge of the patient shall be on written concurrence of both the Podiatrist and the physician involved.
- g. *Anesthesia Record:* The anesthesiologist/anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow up of the patient's condition.
- h. *Required Assistant in Surgery:* In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed.

12. Emergency Services

- a. *Medical Coverage:* The Medical Staff shall adopt a method of providing medical coverage in the Emergency Department. This shall be in accord with applicable law (including but not limited to EMTALA) and the Hospital's basic plan for the delivery of such services, including the delineation of Clinical Privileges for all physicians who render emergency care. On call physicians shall come to the Hospital within 30 minutes of being requested to do so by the ER physician for an unstable patient. The MEC shall have overall responsibility for emergency medical care.
- b. *Emergency Services Medical Record:* An appropriate medical record shall be kept for every patient receiving emergency services and be incorporated in the patient's Hospital record. The record shall include:
 - 1) Adequate patient identification;
 - 2) Information concerning the time of the patient's arrival, means of arrival, and by whom transported;
 - 3) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the Hospital;*
 - 4) Description of significant clinical, laboratory, and roentgenological findings;*
 - 5) Diagnosis and procedures performed;*
 - 6) Treatment given;*
 - 7) Time of treatments and time of physician notification;

- 8) Chief complaint;*
- 9) Physical examination;*
- 10) Medications;*
- 11) Allergies;*
- 12) History of present illness;*
- 13) Condition of the patient on discharge or transfer;*
- 14) Final disposition, condition at discharge, and instructions given to the patient and/or his/her family for necessary follow up care.*
- 15) Time that patient left against medical advice or was discharged.

* To be included in the dictated Emergency Room Report

13. Ownership and Removal of Medical Records

The Hospital owns a storage media associated with medical records (including, but not limited to, paper records and master electronic files). Electronic medical records must be maintained in an environment which is both physically and technologically secured. Paper medical records must be physically secured and must remain on Hospital premises unless removal is in accordance with applicable law and with approval of Administration. Information contained in all medical records may only be released upon proper authorization from the patient or his/her legal representative or as required or allowed by applicable law.

14. HIPAA Privacy Rule

All members of the Medical Staff of the Hospital, including Allied Health Professionals, are participants in an Organized Health Care Arrangement with , as defined by the Privacy Rule adopted under the Health Insurance Portability and Accountability Act of 1996(the "HIPAA Privacy Rule"). As participants in 's Organized Health Care arrangement all members of the Medical Staff are required to review 's Notice of Privacy Practices. All members of the Medical Staff will abide by 's Notice of Privacy Practices, unless they give written notice to 's Privacy Officer that they do not agree to abide by 's Notice of Privacy Practices.

Any member of the Hospital's Medical Staff who has given written notice to the Hospital's Privacy Officer that he or she does not agree to abide by 's Notice of Privacy Practices will comply with the requirements of the Privacy Rule regarding delivery of his or her notice of privacy practices and good faith effort to obtain a written acknowledgment of receipt of his or her notice of privacy practices.

SECTION 3. APPLICATION FEE AND PAYMENT OF OFFICERS

1. Application Fees.

- a. An application fee of \$250 shall accompany each application for appointment to any category of the Medical Staff. This fee shall not apply to Allied Health Professionals.

- b. The application fee for Allied Health Professionals shall be \$125.

2. Reappointment Application Fees.

- a. Reappointment application fees for appointees to the Medical Staff shall be \$400, with a \$200 waiver for those who serve on Medical Staff committees or the Ethics Committee, provided the committee member satisfies the 50% committee meeting attendance requirement. A \$200 waiver shall also apply for chart reviewers who review 5 or more charts per year, section chairs, the ICCU director, the CME medical director and general Dentists on the ER call list who use the Hospital only infrequently. Medical Staff appointees who serve on task forces and committees not included in the Medical Staff Bylaws but established on an ad hoc basis or who review fewer than 5 charts per year may appeal to the Medical Executive Committee for a reappointment application fee waiver of \$200.
- b. Reapplication fees for allied health professionals shall be \$125.

3. Payments to Medical Staff Officers, Section Chairs, Committee Chairs.

Officers of the Medical Staff shall be paid annually with Medical Staff (one third)/Hospital (two thirds) revenue as follows:

President	\$15,000
Vice President	\$8,000 (\$4,000 as PI Committee Chair)
Secretary/Treasurer	\$2,000

Section Chairs shall be paid annually with Medical Staff (one third)/Hospital (two thirds) revenue as follows:

Family Practice Section Chair	\$2,000
Combined Services Section Chair	\$2,000
Surgery Section Chair	\$2,000
Maternal/Child Health Section Chair	\$2,000

Committee Chairs shall be paid annually with Medical Staff (one third)/Hospital (two thirds) revenue as follows:

Credentials	\$2,000
Physician Health Committee	\$1,000
Performance Improvement	\$4,000

(if PI Chair is not Vice President – then pay of \$8,000 for Vice President is divided equally between the VP & PI Chair with each receiving \$4,000.)

Medical Directors shall be paid annually with Medical Staff funds as follows:

CME Director	\$6,000
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Members of the Medical Staff Performance Improvement Committee shall be paid annually with Hospital funds as follows:

Each member, providing he/she attends 50% of meetings	\$2,000
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SECTION 4. MEDICAL STAFF HEALTH SCREENING

1. Medical Staff members and those holding Privileges must comply with health screening requirements as a condition of their Medical Staff membership and/or Privileges.
2. The purpose of this rule is to comply with Wisconsin Administrative Code HFS 124.07 and with CDC guidelines for preventing the transmission of tuberculosis.
3. A Practitioner or Allied Health Professional cannot declare him/herself free of disease, do his/her own physical exam or interpret his/her own tests.
4. The following items are required prior to initial appointment (except for proof of measles immunization or titre, which will be required, prior to initial appointment, for all Applicants as of May 2002) and will be included on the Application for Appointment form.
 - a. Proof of rubella immunization.
 - b. Proof of measles immunization or titre.
 - c. Proof of TB screening within one year.
 - d. Offered Hepatitis B vaccination.
5. The following items are required during appointment for all Active, Affiliate, Locum Tenens, and Emergency Room Practitioners and Allied Health Professionals:
 - a. When there is a history of a positive reaction to a PPD skin test, the individual shall provide evidence of a chest x-ray, or a Screening Exam. A screening exam may consist of one of the following: 1. Letter from the physician's physician on clinic letterhead stating the individual is free of communicable disease; 2. A TB Symptom Survey completed and signed by the individual's physician; 3. TB Symptom Survey completed and signed by the clinic employee health nurse; 4. TB Screening Tool Form completed and signed by the St. Joseph's Hospital employee health nurse.
 - b. When symptoms of TB are identified, a chest x-ray is required.
 - c. When there is a high risk identified by the Employee Health Department, a PPD skin test will be required more frequently.
6. An annual health record shall be maintained by the Medical Staff office which shall notify the Practitioner or Allied Health Professional by letter when a PPD skin test is necessary. The information will be filed in the medical staff file. If the Practitioner or Allied Health Professional does not respond to the initial request, a reminder letter will be sent indicating that admitting, surgical and other Clinical Privileges will be suspended if the information is not received.
7. Noncompliance will be reported by the Medical Staff office to the section chair with notification to Credentials Committee Chair and Medical Executive Committee.

Adopted by:

President, Medical Staff

Date

President Hospital

Date

Chair, Governing Board

March 25, 2008
Date

MEDICAL STAFF

BYLAWS

APPROVED BY GOVERNING BODY FEBRUARY 6, 2012

WEST BEND SURGERY CENTER, LLC
West Bend, Wisconsin

**WEST BEND SURGERY CENTER
MEDICAL STAFF BYLAWS
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ARTICLE I. DEFINITIONS

For purpose of these Bylaws, the following definitions shall apply:

1. The term “Board of Directors” or “Board” means the governing body responsible for conducting the ordinary business affairs of the Facility.
2. The term “Executive Director or their designee” means the individual appointed by the Board of Directors to serve as the chief administrative officer of the Facility. The Executive Director is responsible to the Board of Directors for supervising the management of the Facility and its employees.
3. The term “Facility” means West Bend Surgery Center, LLC.
4. The term “Medical Advisory Committee” means the advisory committee of the Medical Staff consisting of active Medical Staff and consulting Medical Staff members appointed by the Board of Directors.
5. The term “Allied Health Staff” means those individuals who are qualified to render health care services at the Facility under the supervision of a member of the Medical Staff, in accordance with the terms and conditions of the Medical Staff rules and regulations, and who are not members of the Medical Staff.
6. The term “Medical Director” means the Medical Staff member appointed by the Board of Directors to serve as the chairperson of the Medical Advisory Committee.
7. The term “Medical Staff” means all physicians, dentists and podiatrists who are privileged to attend patients in the Facility.
8. The term “physician” means an appropriately licensed medical physician or osteopathic physician.
9. The term “practitioner” means an appropriately licensed medical physician, osteopathic physician, dentist or Doctor of Podiatric Medicine.

ARTICLE II. CATEGORIES OF MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into active, consulting and provisional categories.

Section 2. Active Medical Staff

Active Medical Staff shall consist of practitioners qualified for Medical Staff membership who are regularly involved in the care of patients at the Facility, at minimum, one (1) case per annum of their appointment cycle, and who assume the functions and responsibilities of the active Medical Staff. Members of the active Medical Staff must have completed at least six (6) months as a member of the provisional Medical Staff. Members of the active Medical Staff shall be entitled to vote and shall be eligible to hold office and serve on Medical Staff committees.

Section 3. Consulting Medical Staff

Consulting Medical Staff shall consist of practitioners qualified for Medical Staff membership who provide consultation in the diagnosis and treatment of patients in the Facility at the request of an active Medical Staff member. Members of the consulting Medical Staff shall be entitled to vote, and shall be eligible to hold office and serve on Medical Staff committees.

Section 4. Provisional Medical Staff

Provisional Staff shall consist of practitioners new to the Medical Staff who are seeking appointment as a member of the active Medical Staff. Members of the provisional Medical Staff shall not vote, hold office or serve on Medical Staff committees. All initial appointments to the provisional Medical Staff shall be for a period of up to two (2) years. During the provisional appointment, a provisional staff member shall perform a minimum of ten (10) cases to advance to active staff status. If a practitioner does not meet this requirement during the initial two (2) year period, the Medical Advisory Committee may, by written notice to the provisional Medical Staff member, extend the provisional period for an additional two (2) years, after which time failure to advance a practitioner to active Medical Staff status shall terminate such practitioner's staff appointment. The provisional Medical Staff member will be observed by the Medical Advisory Committee representative from the appropriate clinical department to assess clinical and professional performance and eligibility for advancement to the active staff.

Section 5. Allied Health Staff

- a. Allied Health Staff include, but are not limited to the following categories of professionals: physician's assistants, advanced practice nurses, optometrists, clinical social workers, marriage and family therapists, and certain professional counselors as defined by policy. Allied Health Staff may be either: (1) employed by the Facility, or (2) employed by Members of the Medical Staff or legal organizations of Members of the Medical Staff. Allied Health Staff may practice in relative independence or under the direct supervision of a Medical Staff member, depending on their training and the supervision required by state law or regulation for licensure or certification. Allied Health Staff shall continuously meet the qualifications, standards and requirements as set forth in these Bylaws and associated Medical Staff Rules and Regulations. Allied Health Staff do not vote at any Medical Staff meeting, or otherwise participate in the benefits of Medical Staff membership.

Each individual will present qualifications for review by the Medical Advisory Committee in accord with the policies and procedures outlined in Article III of these Bylaws for the appointment of Medical Staff members.

All initial applicants for Allied Health Staff status will be appointed as Allied Health Staff for a provisional period of not less than two (2) years. Upon successful completion of the applicant's provisional term, he or she may be considered for regular Allied Health Staff appointment.

- b. **Qualifications and Responsibilities.** Allied Health Staff may provide patient care services within the limits of their professional skills and abilities and delineated scope of practice,

meeting all state licensure and certification requirements, as applicable. The degree of participation by Allied Health Staff in patient care shall be determined according to policies recommended by the Medical Staff and approved by the Board of Directors.

An individual applying for appointment as an Allied Health Staff member must be continuously sponsored by or collaborating with, a member of the Medical Staff who will review the adequacy of the individual's performance on a regular basis. The Medical Staff member sponsor/collaborator will attest to this in writing.

If an Allied Health Staff member is employed by a Medical Staff member or the same employer as the Medical Staff member, the Medical Staff sponsor shall assume full responsibility, and be fully accountable for the conduct of the individual within the Facility. The sponsoring Medical Staff member shall provide supervision of the Allied Health Staff member as required by state licensure and certification requirements. It is further the responsibility of the employer of the Allied Health Staff member to acquaint the individual with the applicable policies of the Medical Staff and the Facility, as well as appropriate members of the Medical Staff and Facility personnel with whom said individual shall have contact with at the Facility.

- c. **Application/Appointment Process.** Applications for appointment to provide specified services as Allied Health Staff shall be obtained and processed as follows:
 - 1) The Allied Health Staff shall complete an application;
 - 2) Requests for approval of Allied Health Staff members shall be reviewed by the sponsoring collaborating Medical Staff member and the Executive Director or their designee; both must approve the request in order for it to be granted. The actions on these requests will be then reviewed by the Medical Advisory Committee and sent to the Board for final approval;
 - 3) The Allied Health Staff member shall comply with Occupational Health policy regarding immunizations and TB surveillance;
 - 4) The Allied Health Staff member shall participate in orientation and in-Facility training requirements as outlined by the Facility. Completion of this requirement shall be documented.
- d. **Reappointment Process/Termination.** Applications for reappointment to provide specified services in the Facility as an Allied Health Staff member shall be obtained and processed in the same manner as applications for Medical Staff reappointment. The Facility retains the right; either through the administration or upon recommendation of the Medical Advisory Committee, to suspend or terminate any or all of the privileges or functions of any category of Allied Health Staff member, without recourse on the part of the person in that category to the procedures provided in the Fair Hearing Plan outlined in the Medical Staff Bylaws. Should any such action occur, and result in a reduction or removal of the clinical privileges of the Allied Health Staff member, the individual shall be entitled to a hearing conducted by the Medical Director. Such hearing shall be promptly conducted and shall provide the Allied Health Staff member with the reasons for the Facility's actions.

An Allied Health Staff member's ability to practice at the Facility shall automatically terminate when: (1) the Allied Health Staff member is no longer employed by a member of the Medical Staff or the same employer as the Medical Staff member or the Facility, (2) if the Medical Staff member sponsor is terminated and replaced with another Medical Staff member sponsor for the Allied Health Staff member, or (3) if the Medical Staff member's clinical privileges are curtailed to the extent that the professional services of said individual are no longer necessary or permissible to assist the employer and there is not a Medical Staff member sponsor for the Allied Health Staff member. When privileges are terminated under this Section, the Allied Health Staff member shall have no right to an appeal, unless provided under the Facility's Human Resource policy.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section 1. Qualifications for Membership

- a. Membership on the Medical Staff of the Facility shall be a privilege available only to those professionally competent practitioners within the Facility's primary service area who consistently meet the qualifications, standards and requirements set forth in these Bylaws and the Medical Staff Rules and Regulations. Only practitioners who satisfy the following conditions shall be qualified for appointment to the Medical Staff:
 - 1) Are able to document their background, experience, training, competence, their adherence to the ethics of their profession, and their good reputation and ability to work with other practitioners and staff with sufficient adequacy to assure the Medical Staff and the Board of Directors that any patient treated by them in the Facility will receive high quality medical care;
 - 2) Have an unlimited license to practice medicine, osteopathy, dentistry or podiatry in the State of Wisconsin;
 - 3) Are board certified, or board eligible or board qualified and receive board certification within five (5) years, and maintain such board certification by the applicable specialty for the duration of practitioner's Medical Staff membership; except that this requirement is waived:
 - a) if the practitioner is a podiatrist who has completed a residency program approved by an appropriate specialty board recognized by the Council of Podiatric Medical Education of the American Podiatric Medical Association;
 - b) if the practitioner is a dentist;
 - c) or if the practitioner was approved for clinical privileges at Froedtert Memorial Lutheran Hospital prior to 3/1/2005 and has maintained clinical privileges continuously since that date.
 - 4) Graduated from a medical school, osteopathic school, dental school or podiatric school program accredited in accordance with Wisconsin law;

- 5) Possess a current federal Drug Enforcement Agency (DEA) certificate, unless the practitioner practices in a specialty in which DEA certification is not necessary and is not customarily mandated;
 - 6) Annually submit evidence of current professional malpractice insurance coverage with limits not less than those specified in Wis. Stat. §655.23 or successor statutes thereto; and each practitioner must maintain compliance with the provisions of Wis. Stat. §655.27, or successor statutes thereto, regarding participation in the Injured Patients and Families Compensation Fund;
 - 7) Are not excluded from any healthcare program funded in whole or in part by the federal government;
 - 8) Have completed a background check required by Wis. Stat. §50.065 or successor statute thereto, the results of which do not prevent the Facility from extending Medical Staff membership to the practitioner;
 - 9) Obtain or have the Facility obtain, a report from the National Practitioner Data Bank, the results of which do not prevent the Facility from extending Medical Staff membership to the practitioner;
 - 10) Provide documentation of Hepatitis B vaccination status consistent with OSHA requirements and agree to comply with Facility's Exposure Control Plan for compliance with OSHA Standard on Occupational Exposure to Bloodborne Pathogens as modified from time to time, and provide documentation of Tuberculosis and Rubella vaccination status; and
 - 11) Have signed an acknowledgement that the practitioner has received and read copies of these Bylaws, the Medical Staff Rules and Regulations, and associated policies, and agrees to be bound by and comply with the same.
- b. In addition, the practitioner shall be required to provide the Facility the following information:
- 1) The practitioner's professional liability claims history;
 - 2) Any revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations on the practitioner's license to practice any profession in any jurisdiction;
 - 3) Any denial, revocation, suspension, limitation, reduction, termination, nonrenewal, investigation or voluntary relinquishment of any specialty board certification or eligibility;
 - 4) Any complaints or adverse action reports filed against the practitioner with a local, state, or national professional society or licensure board;
 - 5) Any refusal or cancellation of professional liability coverage;

- 6) Any denial, revocation, suspension, limitation, reduction, termination, nonrenewal, investigation or voluntary relinquishment of the practitioner's professional privileges at any clinic, hospital, health plan or other institution;
 - 7) Any DEA and state license action;
 - 8) Any Medicare/Medicaid sanctions;
 - 9) Any conviction of a criminal offense (other than minor traffic violations);
 - 10) A current and valid picture identification issued by a state or federal agency;
 - 11) Certification that the practitioner is free from a physical, a mental health or an alcohol dependency condition or incapacity which would in any way restrict the practitioner's ability to care for patients. The Board of Directors may precondition appointment or reappointment, and granting or continued exercise of clinical privileges, upon the practitioner undergoing mental or physical examinations and/or such test or tests as it may deem necessary at that time or at any intervening time, to evaluate the practitioner's ability to provide or continue to provide quality care and supervision to the practitioner's patients; and
 - 12) Signed statement releasing the Facility from liability and attesting to the correctness and completeness of the submitted information.
- c. The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications, in the appointment, reappointment and privileging process.
 - d. No practitioner shall be entitled to membership on the Medical Staff or to exercise of clinical privileges merely by virtue of the fact that he or she is licensed to practice medicine, podiatry or dentistry in this or any other state, or that he or she is a member of any professional organization, or that he or she had or presently has such privileges at another hospital or similar facility.
 - e. No practitioner who is otherwise qualified shall be denied appointment or reappointment to the Medical Staff, or the exercise of clinical privileges, by reason of race, color, creed, age, sexual orientation, disability, sex or national origin, except as may be permitted by law.

Section 2. Conditions and Duration of Appointment

- a. Appointments to the Medical Staff shall be made by the Board of Directors upon recommendation by the Medical Advisory Committee. Initial appointment for practitioners new to the Medical Staff who are seeking appointment as a member of the active Medical Staff shall be for a provisional period of up to two (2) years. Initial active or consulting staff appointments are for a period of up to two (2) years, and thereafter renewal is for two (2) years. For the purpose of the bylaws, the Medical Staff year

commences on the first day of January and ends on the thirty-first day of December of each year.

- b. The codes of ethics as adopted or amended by the American Medical Association and the American College of Surgeons, the American Podiatric Medical Association, Inc., the American Dental Association, or the American Osteopathic Society, respectively, shall govern the professional conduct of the members of the Medical Staff.
- c. Upon application for appointment or reappointment to the Medical Staff, each applicant or Medical Staff member shall agree not to engage in the practice of the division of fees under any guise whatsoever, and shall agree to abide by these Bylaws, the Medical Staff rules and regulations and by such bylaws, rules and regulations as may be, from time to time, enacted. Along with the application for appointment or reappointment, practitioner must execute and submit authorization for the release of information and release from liability as required by the Facility in order to verify and evaluate the application.
- d. All Medical Staff members shall promptly notify the Executive Director or their designee of any condition affecting his or her continued right to Medical Staff membership.
- e. Activity Threshold. An activity threshold has been established at ten (10) cases per appointment period as discussed in Article II, Section 5 below, which must be performed at the Facility. Any practitioner not meeting this threshold may be considered to be voluntarily relinquishing his or her privileges, but may re-apply at any time.
- f. Leave of Absence. A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written notice to the Medical Director stating the exact period of time of the leave, which may not exceed one (1) calendar year for reasons related to illness, continuing and/or further formal education. During such period of absence, the Medical Staff member's privileges shall be suspended. At least thirty (30) days prior to the termination of leave, or at any earlier time, the staff member may request the reinstatement of privileges by submitting a written notice to the Medical Director. The Medical Staff member shall submit a summary of his or her relevant activities during the leave.

Section 3. Application Procedure

- a. An applicant for the Medical Staff of the Facility shall present written application for appointment and privileges for specific procedures to the Medical Director utilizing the form prescribed by the Facility. The application shall include all of the Medical Staff qualifications outlined in Section 1 of this Article.
- b. Upon receipt of the application, the Medical Director or their designee shall verify the application and transmit it to the Medical Advisory Committee for evaluation. If requested, the applicant shall appear for interviews in regard to his or her application. The Medical Advisory Committee shall review the character, qualifications, professional standing and suitability of the applicant and shall submit recommendation to the Board of Directors within ninety (90) days of receipt of application, including recommendations regarding specific procedures to be granted.

- c. The Board of Directors shall either accept or reject the recommendations of the Medical Advisory Committee, or refer them back for further consideration, stating the reasons for such action. This shall be done at the next regularly scheduled meeting of the Board of Directors not to occur later than one hundred twenty (120) days after receipt of the Medical Advisory Committee recommendation by the Board of Directors. In the event the application is referred back to the Medical Advisory Committee, the applicant shall be notified and the Medical Advisory Committee shall submit a report to the Board of Directors within ninety (90) days of the referral by the Board. The Board of Directors shall take action within ninety (90) days of the Medical Advisory Committee's second report. Failure of the Medical Advisory Committee or the Board of Directors to meet the time deadlines contained in this Section, unless extended by mutual agreement of the applicant and either the Medical Director or the Executive Director or their designee, shall result in the denial of the application. When final action has been taken by the Board of Directors, the Executive Director or their designee will transmit this information to the applicant.
- d. If the Board's action with respect to an application for appointment or reappointment to the Medical Staff is adverse to the applicant or Medical Staff member, as the case may be, as further described in Article V hereof, the Executive Director or their designee shall promptly so inform the applicant or Medical Staff member by certified mail, return receipt requested, and the applicant or Medical Staff member shall be entitled to the procedural rights as provided in Article V.

Section 4. Clinical Privileges

- a. Every practitioner practicing at the Facility shall be entitled to exercise only those clinical privileges specifically granted by the Board of Directors.
- b. Except as set forth in Section 1.a.3) (a & b) of this Article, all applicants requesting surgical admitting privileges must have admitting or co-admitting privileges in a local licensed and accredited hospital and must, in accordance with the requirements of the appropriate board, be (1) either board certified, or (ii) board eligible or board qualified and receive board certification within five (5) years.
- c. Upon receipt of a complete application for Medical Staff appointment and clinical privileges, temporary privileges may be granted on the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, with the written approval of the Medical Director and the Executive Director or their designee. This request shall be made in writing by the applicant and directed to the Medical Director. In exercising such temporary privileges, the applicant shall act under the supervision of the Medical Director. These privileges may be granted for a period of thirty (30) to one hundred twenty (120) days total. Temporary privileges may be immediately suspended or terminated by the Medical Director or their designee upon the occurrence of any event of a professional or personal nature which casts doubt on the applicant's qualifications or ability to exercise the temporary privileges granted. An applicant will have no right to a hearing, appeal or appellate review of any kind because of inability to obtain temporary privileges, failure or renewal of such privileges, or termination of such privileges.

- d. Case-specific privileges may be granted for the care of a specific patient for a period of one (1) to five (5) days to practitioners who are potential staff applicants but who have not submitted a complete application for appointment to the Medical Staff, upon written approval by the Medical Director and the Executive Director or their designee. Prior approval for each surgical case performed in the Facility by the potential applicant with case-specific privileges shall be required, and the practitioner shall act under the supervision of the Medical Director.
- e. Privileges granted to Allied Health Staff shall be based upon their training, licensure, experience, ability to work with others, demonstrated competence and judgment, applicable state and federal laws, and such other requirements as may be set forth in these bylaws and the rules and regulations.
- f. Disaster Privileges and Emergency Preparedness.
 - 1) For purposes of this Section, a “disaster” exists when the Facility implements its disaster plan and the Facility is unable to meet patient needs.
 - 2) During a disaster and in the best interest of immediate patient care, the Executive Director or their designee may, at their discretion, grant disaster privileges on a case-by-case basis to volunteer physicians upon presentation of the following:
 - a) A valid government-issued photo identification (i.e., driver’s license or passport); and
 - b) At least one of the following:
 - (i) A current picture hospital ID card/badge (a photocopy will be made when possible); or
 - (ii) A current license to practice (a photocopy will be made when possible); or
 - (iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (“DMAT”), the Medical Reserve Corps (“MRC”), the Emergency System for Advance Registration of Volunteer Health Professionals (“ESAR-VHP”), or other recognized state or federal response organization or group. Identification indicating that the individual has been granted authority by a federal, state or municipal entity to render patient care in emergency circumstances (a photocopy will be made when possible); or
 - (iv) Presentation by current Medical Staff member(s) with personal knowledge regarding the practitioner’s ability to act as a volunteer during a disaster.

- c) The Executive Director or their designee will have the overall responsibility for assignment of duties to any volunteer practitioners that are granted disaster privileges.
- d) As soon as possible, additional information will be gathered from the volunteer practitioners on a "Disaster Privileges" form. Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within seventy-two (72) hours from the time the volunteer begins to provide services at the Facility. In extraordinary circumstances where primary source verification can not be completed within seventy-two (72) hours, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- e) When possible, all practitioners granted disaster privileges during a disaster will be identified by a "Voluntary Practitioner: Disaster Privileges Granted" ID badge.
- f) When the Facility deems a "disaster or emergency situation to no longer exist or to be under control":
 - (i) The disaster privileges shall expire.
 - (ii) The practitioners that were granted disaster privileges must request Medical Staff membership and the clinical privileges necessary to continue to treat patients.
 - (iii) In the event such privileges are denied or the voluntary practitioner does not desire such privileges, any patients still receiving care at the Facility shall be assigned to an appropriate Medical Staff member.
 - (iv) After-the-fact/retroactive recredentialing for temporary privileges will occur as soon as possible if feasible to cover the time period of the disaster.

Section 5. Reappointment

- a. All appointments and privileges shall be reviewed for reappointment during the year of their two (2) year anniversary after appointment to the active or consulting Medical Staff and every two (2) years thereafter.
- b. Each applicant for reappointment to the Medical Staff shall submit to the Medical Advisory Committee and the Executive Director or their designee all information

necessary to update the Medical Staff file on the Medical Staff member's health care related activities which shall include, but not be limited to, a specific request for privileges and, upon the request of the Medical Advisory Committee or the Executive Director or their designee, any or all of the Medical Staff qualifications required for initial appointment discussed in Article III, Section 1. No Medical Staff member shall be reappointed without specific review of the individual's performance and qualifications by the Medical Advisory Committee which will make specific recommendations to the Board of Directors, setting forth its recommendations for renewal of staff privileges for each Medical Staff member.

- c. Each recommendation concerning the reappointment for a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon such member's professional competence and clinical judgment in the treatment of patients, his or her professional ethics and conduct, physician and mental capabilities, his or her ability to perform the essential functions of his or her professional, with or without accommodation, according to accepted standards of professional performance and without posing a threat to the safety of patients, his or her attendance at Medical Staff meetings and participation in Medical Staff affairs, his or her compliance with the Facility's corporate bylaws and these Medical Staff Bylaws, cooperation with personnel, efficient and economical use of the organization's facility for patients, relations with other staff members, and general attitude toward patients, the organization and the public.
- d. If the practitioner has submitted a reappointment application, but the reappointment process has not been fully completed by the end of the current appointment, the applicant's privileges will be suspended until such time as the application has been processed as outlined herein. A practitioner who fails to submit a reappointment application by the end of his or her current appointment will be considered resigned from the staff and the resignation will be accepted by the Medical Advisory Committee and the Executive Committee. Should the resigned practitioner wish to again join the staff, it will be necessary for him to submit an initial application for staff membership.

Section 6. Exercise of Privileges

- a. Members of the Medical Staff are strongly discouraged from acting as physician to their family members who are treated at the Facility and should do so only when no viable alternative treatment is available in the area, in accordance with AMA policy #E-8.19, entitled "Self Treatment or Treatment of Immediate Family Members."

ARTICLE IV. DISCIPLINARY MEASURES

Section 1. Corrective Action

- a. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the Medical Staff or to be disruptive to the operations of the Facility, corrective action against such practitioner may be initiated by the Medical Director, the Medical Advisory Committee representative from the affected practitioner's clinical department, the Executive Director or their designee or the Board of Directors.

- b. All requests for corrective action shall be in writing, submitted to the Medical Advisory Committee, and supported by reference to the specific activities or conduct which constitute the grounds for request. The Medical Director shall promptly notify the Executive Director or their designee in writing of all requests for corrective action received by the Medical Advisory Committee and shall continue to keep the Executive Director or their designee fully informed of all action taken in conjunction therewith. The Medical Director shall inform the affected practitioner in writing of the request for corrective action and the reported grounds for the request.
- c. The Medical Advisory Committee shall forward the request for corrective action to an ad hoc committee, which shall immediately investigate the matter. The Medical Director shall designate the members of the ad hoc committee. The affected practitioner shall be afforded an opportunity for an interview with the ad hoc committee. At such interview, the practitioner shall again be notified of the general nature of the charges against him or her, and the practitioner shall be invited to explain the activities or conduct involved or to refute the charges. The interview shall not constitute a hearing, and it need not be conducted according to the procedural rules provided in these Bylaws with respect to hearings. A record by mechanical device or minutes of such interview shall be made by the ad hoc committee and included with its written report to the Medical Advisory Committee. Within thirty (30) days after the receipt of the request for investigation, the ad hoc committee shall forward a written report of the investigation to the Medical Advisory Committee.
- d. Within thirty (30) days after the receipt of the ad hoc committee's report, the Medical Advisory Committee shall take action upon the request for corrective action. Such action may include without limitation: rejecting the request for corrective action; issuing a warning, a letter of admonition, or a letter of reprimand; recommending terms of probation or individual requirements of consultation; recommending reduction, suspension or revocation of clinical privileges; recommending reduction of staff category or limitation of any staff prerogatives directly related to patient care; or recommending suspension or revocation of Medical Staff membership;
- e. Any action by the Medical Advisory Committee that is adverse to the practitioner, as defined in Article V, shall entitle the practitioner to the procedural rights as provided in Article V, and shall not become effective until the procedural rights in Article V are either waived or exhausted.

Section 2. Summary Suspension

- a. Whenever a practitioner's conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Facility, either the Medical Director, the Executive Director or their designee, the Medical Advisory Committee or the Board shall have the authority to summarily suspend the Medical Staff membership, status, and all or any portion of the clinical privileges of such practitioner. Such summary suspension shall become effective immediately upon imposition, and the Executive Director or their designee shall promptly give notice of the suspension to the practitioner in person, or via certified mail, return receipt requested.

- b. As soon as possible after such summary suspension, but in no event more than ten (10) days after the imposition of the summary suspension, a meeting of the Medical Advisory Committee shall be convened to review and consider the appropriateness of the action taken. The Medical Advisory Committee may modify, continue or terminate the terms of the summary suspension.
- c. Unless the Medical Advisory Committee immediately terminates the suspension and ceases all further corrective action, any summary suspension that is adverse to the practitioner as defined in Article V shall entitle the practitioner to the procedural rights as provided in Article V.
- d. If the Medical Advisory Committee's action pursuant to Section 2.b of this Article is to terminate the suspension and to cease all further corrective action, notice of such action shall be transmitted immediately, together with all supporting documentation, to the Board. At its next meeting after receipt of such a recommendation, the Board shall adopt or reject, in whole or in part, the recommendation of the Medical Advisory Committee. If the Board's action is adverse to the practitioner as defined in Article V hereof, the Executive Director or their designee shall promptly so inform the practitioner by certified mail, return receipt requested, and the practitioner shall be entitled to the procedural rights as set forth in Article V hereof. The Board shall take final action in the matter only after the practitioner has exhausted or has waived his or her procedural rights as provided in Article V. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Board.

Section 3. Automatic Suspension, Termination and Resignation

- a. A Medical Staff member whose license authorizing him to practice in the State of Wisconsin is revoked or suspended shall immediately and automatically be suspended from practicing in the Facility. In the event of action by the pertinent licensing agency placing a practitioner on probation, limitations and restrictions shall automatically be placed on the practitioner's Medical Staff membership and clinical privileges under the same terms and conditions as contained in the agency's order.
- b. A Medical Staff member whose DEA number is revoked, suspended, voluntarily relinquished, or subject to probation, shall immediately and automatically be suspended from prescribing medications covered by the number. As soon as possible after such automatic suspension, the Medical Advisory Committee shall convene to review and consider the facts under which the DEA number was revoked, suspended, relinquished, or subject to probation. The Medical Advisory Committee may then take such further corrective action as is appropriate to the facts disclosed in its investigation.
- c. An automatic suspension shall be imposed, effective thirty (30) days after written warning, for failure to complete and sign or authenticate medical records within thirty (30) days following the patient's discharge. Such suspension may take the form of withdrawal of a practitioner's surgical, admitting, or consulting privileges and shall be effective until all delinquent medical records are completed.

- d. An automatic suspension shall be imposed for failure to complete an application for reappointment as required. Failure to complete an application for reappointment within thirty (30) days after written notice of suspension shall be deemed to be a resignation of the practitioner's Medical Staff membership.
- e. An automatic suspension of all privileges at the Facility shall be imposed if the Medical Staff member, at any time, fails to maintain adequate professional liability insurance as required by the Facility. If within thirty (30) days after written notice of the suspension, the Medical Staff member does not provide evidence of required professional liability insurance coverage, the practitioner's Medical Staff membership shall be automatically terminated.
- f. The Medical Staff member shall be entitled to reinstatement of Medical Staff privileges only upon written request to the Medical Advisory Committee with documentation of having cured or satisfied the delinquency resulting in automatic suspension. Upon receipt of the request and documentation, unless the Medical Advisory Committee immediately terminates the automatic suspension and ceases all further corrective action, any automatic suspension that is adverse to the practitioner as defined in Article V shall entitle the practitioner to the procedural rights as provided in Article V. The terms of the automatic suspension shall remain in effect pending a final decision of the Board.

Section 4. Continuity of Patient Care

Upon the imposition of summary suspension or the occurrence of an automatic suspension or limitation or restriction of privilege of a Medical Staff member, the Medical Director shall be responsible to provide for alternative coverage for the patients of the subject Medical Staff member. The wishes of the patient shall be considered, where feasible, in choosing a substitute physician/dentist/podiatrist. The Medical Staff member involved shall confer with the substitute physician/dentist/podiatrist to the extent necessary to safeguard the patient.

Section 5. Voluntary Relinquishment of Clinical Privileges or Medical Staff Appointment

A Medical Staff member may voluntarily relinquish any or all of his or her clinical privileges at any time, so long as the relinquishment is not found by the Medical Advisory Committee to be for the purpose of avoiding a suspension of clinical staff privileges. Any voluntary relinquishment of clinical privileges that extends beyond ninety (90) days will require the practitioner, should he or she wish to reinstate clinical privileges, to reapply for Medical Staff membership and clinical privileges through the initial appointment process.

Section 6. Reporting Requirements

The Executive Director or their designee shall notify the National Practitioner Data Bank when the clinical privileges of any Medical Staff member are adversely affected for a period in excess of thirty (30) days or the Facility accepts the surrender of clinical privileges of a practitioner (i) while the practitioner is under investigation by the Facility relating to possible incompetence or improper professional conduct or (ii) in return for not conducting such investigation or proceeding. Such report shall be filed within fifteen (15) days of the time such action becomes final.

Section 7. Enforcement

It shall be the duty of the Medical Director to cooperate with the Executive Director or their designee in the enforcement of all suspensions of members of the Medical Staff.

ARTICLE V. HEARING AND APPELLATE REVIEW PROCEDURE

Section 1. Initiation of Hearing

- a. One or more of the following actions without limitation, shall, if deemed adverse pursuant to Section 1.b of this Article V, entitle the practitioner affected thereby to a hearing:
 - 1) Denial of initial staff appointment;
 - 2) Denial of staff reappointment;
 - 3) Suspension of staff membership if such suspension or restriction is for more than fourteen (14) days;
 - 4) Revocation of staff membership;
 - 5) Denial of requested advancement in staff category;
 - 6) Reduction in staff category;
 - 7) Limitation or suspension of admitting privileges if such limitation or suspension is for more than fourteen (14) days;
 - 8) Denial of requested clinical privileges;
 - 9) Reduction in clinical privileges;
 - 10) Suspension of clinical privileges if such suspension or restriction is for more than fourteen (14) days;
 - 11) Revocation of clinical privileges; and/or,
 - 12) Individual requirement of consultation.
- b. An action enumerated in Section 1.a of this Article V shall be deemed adverse only when it has been:
 - 1) taken by the Medical Advisory Committee;
 - 2) taken by the Board contrary to a favorable recommendation by the Medical Advisory Committee; or

- 3) taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Advisory Committee. Notwithstanding anything herein to the contrary, the Board shall have this power.
- c. A practitioner against whom an adverse action has been taken which constitutes grounds for a hearing pursuant to Section 1.a and Section 1.b of this Article V shall promptly be given notice of such action by certified or registered mail, return receipt requested. Such notice shall include a statement of the reasons for such action and shall advise the practitioner of his or her right to request a hearing and a summary of his or her rights in the hearing. Such notice shall specify that the practitioner has thirty (30) days following the date of receipt of notice within which a written request for a hearing by the judicial review committee as described in Section 2.c must be submitted to the Executive Director or their designee.
- d. A practitioner shall have thirty (30) days following the receipt of notice of adverse action to file a written request for a hearing. Such request shall be delivered to the Executive Director or their designee either in person or by certified or registered mail. A practitioner who fails to request a hearing within the time and in the manner specified hereof waives any right to such hearing and to any appellate review to which he or she might otherwise have been entitled. In the event the applicant or Medical Staff member does not request a hearing within the time and in the manner set forth above, he or she shall be deemed to have accepted the action involved. Such action shall thereupon immediately become the final decision in the matter.

Section 2. Hearing Requirements

- a. Upon receipt of a proper and timely request for hearing, the Executive Director or their designee shall deliver such request to the Medical Director and shall notify the Board of such request. Within ten (10) days after receipt of such request, the Medical Director shall schedule and arrange for a hearing by a judicial review committee. At least thirty (30) days prior to the hearing, the Executive Director or their designee shall send the practitioner notice of the time, place, date of hearing and a list of the witnesses expected to testify at the hearing on behalf of the Facility. The hearing date shall be not less than thirty (30) nor more than forty-five (45) days from the date of receipt of the notice of hearing.
- b. The practitioner shall, within ten (10) days of receiving the Facility's witness list, furnish to the Executive Director or their designee a written list of the names and addresses of the witnesses, if any, expected to testify at the hearing on behalf of the practitioner. The witness lists of either party shall be amended when additional witnesses are identified.
- c. When a hearing is properly requested, the Medical Director shall appoint a judicial review committee composed of five (5) members of the Medical Staff who have not actively participated in the consideration of the matter involved at any previous level and who are not in direct economic competition with the practitioner. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the judicial review committee.

Section 3. Hearing Procedure

- a. The personal presence of the practitioner who requested the hearing shall be required at the hearing. A practitioner who fails, without good cause, to appear and proceed at such hearing shall be deemed to have forfeited his or her right to a hearing and appellate review.
- b. The affected practitioner shall be entitled to be accompanied and represented at the hearing by an attorney or other person of the practitioner's choice. If the practitioner is to be represented by an attorney at the hearing, the affected practitioner shall notify the Executive Director or their designee at least fifteen (15) days prior to the hearing. The Facility shall at all times be entitled to be represented at the hearing by legal counsel.
- c. During the hearing, each of the parties shall have the right to call, examine and cross-examine witnesses, and to introduce evidence on any matter relevant to the issues. If the affected practitioner does not testify on his or her own behalf, he or she may be called as if under cross-examination.
- d. The hearing shall not be conducted according to rules of courts of law relating to the examination of witnesses or presentation of evidence. Information upon which reasonable persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled to submit written memoranda and such documents shall become part of the hearing record. The chairperson of the judicial review committee shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present oral and documentary evidence. The chairperson of the judicial review committee shall determine the order of procedure during the hearing, the admissibility of evidence and may limit evidence that is cumulative or irrelevant. The chairperson may order that oral evidence be taken only on oath or affirmation administered by any person who is entitled to notarize documents in Wisconsin and who has been designated by the chairperson to administer such oath or affirmation. The judicial review committee may examine the witnesses or call additional witnesses if the committee deems such action appropriate.
- e. During the hearing, the chairperson of the judicial review committee may take official notice of any generally accepted technical or scientific matter relating to the issues under consideration. Parties to the hearing shall be informed of the matters to be officially noticed and those matters shall be noted in the hearing record.
- f. Unless otherwise determined for good cause, the Facility shall have the initial duty to present evidence in support of its action or recommendation for each ground or issue. The practitioner shall be obligated to present evidence in response. Throughout the hearing, the Facility shall have the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.
- g. A record of the proceedings shall be made by a court reporter. The Facility shall bear the cost of the reporter's appearance. Either party may request a copy of the record made of

the proceedings upon payment of any reasonable charges associated with the preparation thereof.

- h. A majority of the members of the judicial review committee may act as and for the judicial review committee. No committee member may vote by proxy. A majority of the judicial review committee members must be present throughout the hearing and deliberations. If a committee member is absent from any part of the proceedings, the member shall not be permitted to participate in the deliberations or the decision.
- i. The judicial review committee may recess the hearing and reconvene the same without additional notice 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. The judicial review committee shall thereupon, within the time specified in Section 4.a hereof, outside the presence of the parties or their representatives or any other persons, conduct its deliberations and render a recommendation and the hearing shall be declared finally adjourned.

Section 4. Judicial Review Committee Recommendation and Further Action

- a. Within thirty (30) days after closing of the hearing (except that the time shall be ten (10) days in the case of a Medical Staff member currently under suspension), the judicial review committee shall render a written recommendation in the matter, based on the evidence produced at the hearing, and shall forward the same, together with the hearing records and all other documentation considered by the committee, to the Executive Director or their designee. The judicial review committee's recommendation shall be supported by reference to the hearing records and the other documentation considered by the committee. The Executive Director or their designee shall promptly send a copy of the judicial review committee's recommendation to the practitioner by registered or certified mail, to the Medical Director, to the Medical Advisory Committee, and to the Board.
- b. If the hearing was the result of Article V, Section 1.b.1), then the Medical Advisory Committee shall consider the judicial review committee's recommendation and issue a decision. If the decision is favorable to the practitioner it shall be forwarded to the Board for action. If the hearing was a result of Article V, Section 1.b.2) or Section 1.b.3), then the Board shall consider the judicial review committee's recommendation and issue a decision. If the decision is favorable to the practitioner it shall be final and effective immediately. The Executive Director or their designee shall notify the practitioner by certified mail of the favorable decision of either the Medical Advisory Committee or the Board.
- c. If the decision of the Medical Advisory Committee or Board, pursuant to Article V, Section 4.b, continues to be adverse, the Executive Director or their designee shall notify the practitioner by certified mail of the decision. The notice shall inform the practitioner of the basis of the decision and the practitioner's right to request appellate review. If the practitioner fails to request appellate review within the time and in the manner specified in Section 5.a and Section 5.b of this Article, the practitioner waives any right to such review.

Section 5. Initiation and Requirements of Appellate Review

- a. Within ten (10) days following receipt of the notice of the adverse decision of the Medical Advisory Committee or Board, the practitioner may file a written request for an appellate review by the Board. Such request shall be delivered to the Executive Director or their designee either in person or by certified or registered mail.
- b. The request for appellate review shall include an identification of the grounds for appeal and a statement of facts in support of the appeal. Grounds for appeal shall be:
 - 1) substantial non-compliance with the procedures required by these Bylaws; or
 - 2) the decision was not supported by a preponderance of the evidence based upon the hearing record or such other additional information as may be permitted pursuant to Section 6.e of this Article.
- c. Upon receipt of a proper and timely request for appellate review, the Executive Director or their designee shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review which shall be conducted not less than twenty (20) days nor more than forty-five (45) days from the date of receipt of the appellate review request; provided, however, that an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as arrangements for it may reasonably be made. At least ten (10) days prior to the appellate review, the Executive Director or their designee shall deliver to the practitioner notice of the time, place and date of the review. The chairman of the Board or chairman of the Board's designated appellate review committee shall permit postponements or extensions of the appellate review only on good cause and if the request therefore is made as soon as is reasonably practicable. In all cases, the appellate review shall be postponed until the transcript of the judicial review committee hearing is available.
- d. The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by an appellate review committee of three (3) members of the Board appointed by the chairman of the Board. If an appellate review committee is appointed, one of its members shall be designated as chairman. Knowledge of the matter involved shall not preclude any person from serving as a member of the appellate review committee or the Board, so long as that person did not take part in a prior hearing on the same matter. The appellate review committee or the Board shall have all the powers granted to the judicial review committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

Section 6. Appellate Review Procedure

- a. The proceedings by the Board or its designated appellate review committee shall be in the nature of an appellate review based upon the record of the hearing before the judicial review committee, that committee's decision, and all other documentation considered by the judicial review committee. The Board or its designated appellate review committee shall also consider any written statements submitted pursuant to Section 6.b of this Article.

- b. Practitioner may submit a written statement detailing the findings of fact, conclusions and procedural matters with which he or she disagrees, and the reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Board through the Executive Director or their designee at least fifteen (15) days prior to the scheduled date of the appellate review, unless such time limit is expressly waived by the Board. A written statement in reply may be submitted by the Facility to the Board through the Executive Director or their designee. The Executive Director or their designee shall provide a copy thereof to the practitioner.
- c. The chairman of the Board or its designated appellate review committee shall be the presiding officer. The chairman shall determine the order of procedure during the review, make all required rulings, and maintain decorum.
- d. The Board or its designated appellate review committee may, in its sole discretion, permit the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative who appears personally shall be required to answer questions put to him or her by any member of the Board or its designated appellate review committee.
- e. New or additional matters or evidence not raised or presented during the judicial review committee hearing or in the hearing decision and not otherwise reflected in the record shall be introduced at the appellate review only in the discretion of the Board or its designated appellate review committee, following an explanation by the party requesting the consideration of such matter or evidence as to why it was not presented earlier. Any such additional oral or written evidence shall be subject to the same rights of cross-examination or confrontation provided at the judicial review committee hearing.
- f. A majority of the Board or its designated appellate review committee shall be present throughout the review and deliberations. If a member of the Board or its designated appellate review committee is absent from any part of the proceedings, said member shall not be permitted to participate in the deliberations or the decision.
- g. The Board or its designated appellate review committee may recess the review proceedings for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation and may reconvene the proceedings without additional notice. Upon the conclusion of oral statements, if permitted, the appellate review shall be closed. The Board or its designated appellate review committee shall thereupon, within the time set forth below, conduct its deliberations outside the presence of the parties, their representatives, or any other persons and shall render a written decision. The Review Committee may refer the matter back to the judicial review committee for further review and recommendation to be returned to the Board within ten (10) days and in accordance with its instructions. The appellate review shall not be deemed to be concluded until all of the procedural steps provided hereinabove have been completed or waived.

Section 7. Final Decision of the Board

Within fifteen (15) days after the conclusion of the proceedings of the appellate review, the Board or its designated appellate review committee shall render its final decision in writing and shall deliver notice and a copy of the decision, in person or by certified or registered mail, to the practitioner, the Medical Director and the Executive Director or their designee. The final decision of the Board following the appeal procedures shall be effective immediately and shall not be subject to further review.

Section 8. General Provisions

- a. Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to each adverse action.
- b. By requesting a hearing or appellate review under this Article V, a practitioner agrees to be bound by the provisions of State and Federal Statutes relating to immunity from liability in all matters relating thereto.
- c. All minutes, reports, recommendations, communications, and actions made or taken pursuant to these Bylaws are intended to be covered by the provisions of Wis. Stat. § 146.37 or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to these Bylaws shall be considered to be acting on behalf of the Facility and its Board when engaged in such professional review activities and thus are “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.

ARTICLE VI. MEETINGS OF MEDICAL STAFF

Section 1. Meetings

Meetings of the Medical Staff to consider specific problems may be called at any time by the Medical Director at his or her discretion or at request of the chairman of the Board of Directors. A meeting shall not be called without first consulting with the Executive Director or their designee. Written notice stating the purpose of the meeting shall be mailed to the Medical Staff members at least seven (7) calendar days prior to the date of the meeting.

Section 2. Quorum, Voting and Minutes

A quorum for a Medical Staff meeting shall consist of those present and voting. Action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. Written minutes of all meetings shall be prepared and recorded.

Section 3. Attendance Requirements

Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance shall not be used in evaluating Medical Staff members at the time of reappointment, however it is expected that members of the Medical Staff will make every effort to attend meetings.

ARTICLE VII. CLINICAL DEPARTMENTS

Section 1. Clinical Departments

The Facility shall be organized into the following Clinical Departments: surgery, anesthesiology/pain management and radiology.

Section 2. Surgery

The Surgery Department shall be concerned with the clinical surgery performed in the Facility and shall keep, or cause to be kept, careful supervision over all surgical work performed in the Facility. This department shall consist of the subspecialties of general surgery, otolaryngology, plastic surgery, ophthalmology, gastroenterology, orthopedic surgery, gynecology, urology, oral surgery, podiatric surgery, and such subspecialties recommended by the Medical Advisory Committee and approved by the Board of Directors.

Section 3. Anesthesiology/Pain Management

The Anesthesiology/Pain Management Department shall be concerned with the administration of anesthesia, relief of pain, and all fields of analgesia. Anesthesiology shall be concerned with determining the acceptability of patients for ambulatory care, in accordance with the bylaws, rules and regulations.

Section 4. Radiology

The Radiology Department shall be concerned with procedures in the field of radiology and will be concerned with supervision of all radiological procedures performed in or for the Facility.

ARTICLE VIII. MEDICAL ADVISORY COMMITTEE

Section 1. Organization, Appointment and Vacancy

The Medical Advisory Committee shall be comprised of one member of the Medical Staff from such specialties recommended by the Medical Advisory Committee and deemed appropriate and as approved by the Board of Directors. The Medical Staff members of the Medical Advisory Committee shall be limited only to those practitioners who serve as active members of the Medical Staff. The Medical Director shall serve as an ex officio, voting member of the Medical Advisory Committee and shall serve as Chairperson of the Medical Advisory Committee. The Medical Director shall appoint a representative to function in the capacity of Chairperson during his or her absence. The Executive Director or their designee shall attend meetings of the Medical Advisory Committee as an ex officio, non-voting member of the Medical Advisory Committee.

Section 2. Meetings, Quorum and Voting Requirements

The Medical Advisory Committee shall meet at least quarterly and must maintain a permanent record of its proceedings and actions. Members of the Medical Advisory Committee shall be expected to attend all meetings, but must attend a minimum of fifty percent (50%) of the official meetings unless excused by the Medical Director for such conditions as sickness, absence from the community, medical emergencies, etc. Unexcused absence from three (3) consecutive meetings shall be considered as resignation from the Medical Advisory Committee. A quorum of the Medical Advisory Committee shall consist of fifty percent (50%) of the members excluding excused absences, plus one; provided, however, the Executive Director or their designee shall not be treated as a member of the Medical Advisory Committee for purposes of determining quorum. In matters of dismissal, appeal, and any other adverse actions, no excused absences will be permitted for purposes of determining a quorum. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the vote's cast opposing the action.

Section 3. Special Committees

Special committees may be appointed by the Medical Advisory Committee or the Board of Directors from time to time as may be required for a specific purpose, and until the duty assigned is accomplished. All Committees shall be assigned with the knowledge and cooperation of the Board.

Section 4. Functions

The Medical Advisory Committee shall act on behalf of the Medical Staff to coordinate the activities and general policies of the various services, pursuant to these Bylaws and the Medical Staff Rules and Regulations. Further functions and concerns of the Medical Advisory Committee shall include, but not be limited to, the following:

- 1) To receive and act upon the reports of Medical Staff committees;
- 2) To consider and recommend action on all matters of a medical-administrative nature;
- 3) To implement the approved policies of the Medical Staff;
- 4) To make recommendations to the Board of Directors;
- 5) To take all reasonable steps to ensure professionally ethical conduct on the part of all members of the Medical Staff and to initiate such prescribed corrective measures as are indicated;
- 6) To fulfill the Medical Staff's accountability to the Board of Directors for the medical care rendered to the patients in the Facility; and
- 7) To fulfill the following function in accordance with the Medical Staff Rules and Regulations:

Credentials Review
Medical Records Review
Tissue, Surgical Evaluation and Review
Infection Control Evaluation
Pharmacy and Therapeutics Review
Quality Assurance and Improvement/Risk Management

The function of the Medical Records Review, Tissue, Surgical Evaluation and Review, Infection Control Evaluation, Pharmacy and Therapeutics Review and Quality Assurance and Improvement/Risk Management may be delegated to sub-committees composed of Medical Staff members of the Facility staff who report their findings and activities at meetings of the Medical Advisory Committee.

ARTICLE IX. MEDICAL DIRECTOR

Section 1. Qualifications

The Medical Director shall be a board certified physician holding an unlimited license to practice in the State of Wisconsin and holding current DEA registration. The Medical Director must exhibit qualities of leadership, communication and responsiveness.

Section 2. Appointment

The Medical Director shall be appointed by the Board of Directors.

Section 3. Functions

The Medical Director shall serve as the chairperson of the Medical Advisory Committee and shall serve such other functions as requested by the Board. Duties of the Medical Director include, but are not limited to:

- 1) Responsibility for the overall professional activities of the Medical Staff in collaboration with the Medical Staff and the Medical Advisory Committee;
- 2) Serving as an ex-officio member of all committees of the Medical Staff;
- 3) Responsibility for developing, implementing, and reviewing medical policies, including Medical Staff Bylaws, in cooperation with the Medical Staff and the Medical Advisory Committee. These shall be approved by the Board of Directors;
- 4) Responsibility for the enforcement of the Medical Staff Bylaws and policies;
- 5) Other duties and responsibilities as assigned from time to time by the Board.

ARTICLE X. ADOPTION, AMENDMENT

Section 1. Bylaws

These Bylaws shall be adopted at any meeting of the Medical Staff by a two-thirds (2/3) vote of those present and shall become effective when approved by a majority vote of the Board of Directors. Amendments of these Bylaws may be proposed by the Medical Advisory Committee at any of its meetings. Such amendments, if passed by the Medical Advisory Committee, shall be acted upon at the next regular meeting of the Board. Amendments shall become effective when approved by a majority vote of the Board of Directors. All members of the Medical Staff shall be notified by mail of Bylaw changes or changes in the Rules and Regulations within two weeks after approval by the Board of Directors.

Section 2. Rules and Regulations

The Medical Staff Rules and Regulations shall be adopted and may be amended at any meeting of the Medical Advisory Committee by a two-thirds (2/3) vote of those present and shall become effective when approved by a majority vote of the Board of Directors.

ARTICLE XI. POLICY AND PROCEDURES

Policy and Procedures which are approved by the Medical Advisory Committee shall set standards of practice that are required of each Medical Staff member, and shall act as an aid to evaluating performance under, and compliance with, these standards. All Medical Staff members shall cooperate with such rules, regulations and policies, and adhere to all laws, and such approved rules, regulations and policies applicable to their activities at the Facility, the practice of their profession, and their participation in any federal health care program as a condition of their continue appointment to the Medical Staff. In the even that any Medical Staff member suspects or knows that he or she, or any director, officer, employee or other Medical Staff member, has violated applicable laws or regulations, he or she shall immediately report the same to the Medical Director.

All Medical Staff members shall cooperate fully with the Corporate Compliance Policy of Froedtert Health, Inc. and adhere to all laws, regulations and standards of conduct applicable to his or her activities at the Facility, the practice of his or her profession and his or her participation in any federal health care program as a condition of his or her continued appointment to the Medical Staff. In the event that any Medical Staff member suspects or knows that he or she, or any director, officer, employee or other Medical Staff member, has violated applicable laws or regulations, he or she shall immediately report the same to the Medical Director or the Froedtert Health Corporate Compliance Officer.

Recommended for Approval: _____
Medical Director

Date: _____

Approved: _____
Chairperson, Board of Directors

Date: _____

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