

**MEDICAL STAFF BYLAWS,  
RULES AND REGULATIONS**

**SAINT CLARE'S HOSPITAL OF WESTON, INC.**

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## **MEDICAL STAFF BYLAWS**

### **SAINT CLARE'S HOSPITAL OF WESTON, INC.**

The medical staff of Saint Clare's Hospital is organized to promote safety and quality and to improve the quality of care delivered in this institution. Recognizing its responsibility for the overall quality of clinical services provided by its members, the medical staff organizes itself for the purpose of self-governance in conformity with these Bylaws. These bylaws are binding on the medical staff and St. Clare's Hospital. This governing document, and the policies and procedures it implements, will constitute the bylaws directing the Medical Staff and those active members and other providers of Saint Clare's Hospital of Weston, Inc. and other health care programs owned or operated by Saint Clare's Hospital of Weston, Inc. that require a Medical Staff.

The principal functions of the Medical Staff will be to:

1. Develop and implement policies, procedures, rules and regulations governing the Medical Staff and provision of patient care at the Hospital.
2. Perform all duties required by governmental or private agencies, including Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or other accreditation agencies, and Medicare Conditions of Participation, as are described as functions of the Medical Staff.
3. Determine clinical privileges for individual professionals and provide oversight as to the quality and scope of clinical practice of those professionals affiliated with the Hospital.
4. Monitors on an ongoing basis the scope and quality of patient care provided at Saint Clare's Hospital and account for same on a regular basis to the Hospital's Board of Directors.

## DEFINITIONS

For the purposes of these Bylaws, Rules and Regulations, the following words and phrases are defined as:

1. “Admit” or “admission” for purposes of patient care means registration of a patient as a patient of the Hospital for the purpose of treatment on either an outpatient or inpatient basis, but does not include registrations solely for the purpose of outpatient laboratory and diagnostic imaging not requiring the presence or supervision of the ordering professional.
2. “Allied Health provider” means an individual, other than a licensed physician, oral surgeon, dentist or podiatrist, who is admitted to practice in the Hospital either through the Medical Staff Bylaws process or an alternate approval process per Medical Staff policy and who is either licensed, certified or registered in the state or who is trained and qualified in a recognized health care discipline to exercise judgment within the areas of his or her professional competence and who is qualified to render direct or indirect medical care either independently or under the supervision of a practitioner who has been accorded privileges to provide such care in the Hospital. As used in these Bylaws, the term “Allied Health provider” includes midlevel providers as defined per Medical Staff policy.
3. “Chief Medical Officer” or “CMO” means the individual appointed by the governing body to serve as the lead administrative officer in overseeing the medical affairs of the Hospital, to act as a liaison between the Medical Staff and the Hospital and to serve as Chief of Staff.
4. “Chief executive officer” or “CEO” means the individual appointed by the governing body to act on its behalf in the overall management of the Hospital. The official title of the chief executive officer shall be “Regional Chief Executive Officer.”
5. “Chief Operating Officer” or “COO” means the individual appointed by the governing body to act as the lead administrative officer in managing the day-to-day operations of the Hospital. The official title of the Chief Operating Officer shall be “President.”
6. “Clinical privileges” means the authorization granted by the governing body to a practitioner or Allied Health provider to provide specific patient care services in the Hospital within defined limits, based on the individual’s license, education, training, experience, competence, health status, and judgment.
7. “Completed application” means a fully-filled out application accompanied by primary source verification of licensure, education, training, practice history (including all hospital affiliations and department chair verification from each hospital where the applicant held active staff or locum tenens status), professional liability coverage and claims history, applicable board certifications, caregiver background check results, Office of the Inspector General (OIG) exclusions and professional references.

8. “Ex officio” means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.
9. “Governing body” means the Board of Directors of the Hospital, except that, to the extent authorized in the Hospital’s corporate bylaws, the governing body may delegate its authority to act on Medical Staff matters (including but not limited to Medical Staff appointments and the granting of clinical privileges) to its Professional Activities Committee (as that committee is defined in the Hospital’s corporate bylaws), subject to subsequent ratification by the governing body.
10. “Health status” means the physical, emotional, and mental health status of an individual.
11. “Hospital” means Saint Clare’s Hospital of Weston, Inc.
12. “In good standing” for the purpose of these Bylaws will mean an individual who at the time the issue with respect to his or her standing is raised, is current on the payment of dues, has not been suspended in the previous 12 months for any purpose, and is further current and has met for the previous calendar year the meeting attendance requirements set forth in these Bylaws. Only members in good standing shall be eligible to vote for the election of officers, or for any other matters which are presented for vote at a committee or general meeting of the Medical Staff.
13. “Interactive telemedicine” for purposes of these Bylaws consists of responsibility (either total or shared) for patient care, treatment and services (as evidenced by having the authority to write orders and direct care, treatment and services) through a telemedicine link.
14. “Interpretive telemedicine” for purposes of these Bylaws consists of providing official readings of images, tracings, or specimens through a telemedicine link, but not engaging in interactive telemedicine.
15. “Medical Executive Committee” or “MEC” means the executive committee of the Medical Staff unless specific reference is made to the executive committee of the governing body.
16. “Medical Management Team” or “MMT” means a team of physicians that is appointed by the governing body to assist the MEC in the overall management of the Medical Staff.
17. “Medical Staff” means the Hospital’s organized component of physicians, podiatrists, oral surgeons and dentists appointed by the governing body of the Hospital and granted specific clinical privileges for the purpose of providing adequate medical, podiatric and dental care for the patients of the Hospital.
18. “Medical Staff member” or “Medical Staff membership” means the prerogative of Medical Staff participation and does not necessarily include any clinical privilege whatsoever.

19. “Oral surgeon” means an appropriately licensed dentist or physician who has successfully completed a postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education.
20. “Patient” means an individual who receives preventative, diagnostic or therapeutic services relating to the patient’s health from individuals authorized to provide such services by the hospital and utilizing hospital resources in the provision of the services. The term “patient” applies to all individuals described above from the point in time that they begin receiving the services or are admitted for services, whether on an inpatient or outpatient basis, whichever occurs first, and continues until they are discharged or stop receiving services (whichever occurs last).
21. “Plan” shall mean the Corrective Action Procedures and Fair Hearing Plan Addendum to the Bylaws of the Medical Staff of the Hospital.
22. “Practitioner” means an appropriately licensed medical or osteopathic physician, oral surgeon, dentist or podiatrist.
23. Service means an operating unit with a specific clinical scope incorporating all the stakeholders of the clinical disciplines.
24. “Special notice” means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee.

## SECTION 1 – PURPOSES AND RESPONSIBILITIES

### 1.1 **The purposes of the Medical Staff are:**

- (a) To provide that all patients admitted to or treated in any of the facilities of the Hospital receive appropriate, quality medical care;
- (b) To be the formal organizational structure through which the benefits of membership on the Medical Staff may be obtained by individual practitioners and the obligations of Medical Staff membership may be fulfilled;
- (c) To serve as the primary means for providing assurances as to the appropriateness of the professional performance and ethical conduct of its members and Allied Health providers and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available; and
- (d) To provide a means through which the Medical Staff may participate in the Hospital's policy-making and planning processes.

### 1.2 **The responsibilities of the Medical Staff are:**

- (a) To ensure an appropriate level of professional performance for all members of the Medical Staff and Allied Health providers authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each individual may exercise in the Hospital and through an ongoing review and evaluation of each individual's performance in the Hospital;
- (b) To provide a continuing education program fashioned, at least in part, on the needs demonstrated through a patient care audit and other quality assessment and improvement programs;
- (c) To provide a utilization review program to allocate inpatient medical and health services based upon determinations of patients' medical, social and emotional needs consistent with sound health care resources utilization management;
- (d) To provide an organizational structure that allows continuous monitoring and improvement of patient care practices;
- (e) To conduct reviews and evaluation of the quality of patient care through quality assessment, risk management and improvement activities;
- (f) To recommend to the governing body action to be taken with respect to medical staff appointments, reappointments, staff category, clinical privileges and corrective action;
- (g) To assure the governing body that appropriate clinical procedures have been delineated;

- (h) To account to the governing body for the appropriateness, quality and efficiency of patient care rendered to patients at the Hospital through regular reports and recommendations;
- (i) To initiate and pursue corrective action with respect to members when warranted;
- (j) To develop, administer, and seek compliance with these Bylaws, the Rules and Regulations of the Medical Staff, Medical Staff policies and procedures and other patient care related Hospital policies and procedures;
- (k) To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs;
- (l) To conduct all of its affairs involving the Medical Staff, patients and employees in a willing manner and in an atmosphere of civility, dignity and respect, free of unlawful discrimination because of age, sex, creed, national origin, race, handicap, disability, color, ancestry, religion, sexual orientation, mental status, newborn status, source of payment or any other unlawful basis; and
- (m) To carry out such other responsibilities as may be delegated to the Medical Staff by the governing body.

1.3 **The basic obligations of A Medical Staff member is:**

- (a) To provide patients with care at the generally recognized and accepted professional level of safety, quality and efficiency;
- (b) To abide by these Bylaws and by all other applicable standards, policies, rules and regulations of the Hospital or the Medical Staff; and
- (c) To willingly and in a collegial manner discharge the staff, committee, department and/or Hospital functions for which he or she is responsible, whether by membership category, appointment, election or otherwise.

## **SECTION 2 – MEMBERSHIP**

2.1 **Privilege of Membership.**

Membership on the Medical Staff of Saint Clare’s Hospital of Weston, Inc. 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 on the practitioner only such prerogatives as the governing body grants in accordance with these Bylaws.

## 2.2 **Qualifications.**

Medical Staff members shall include practitioners who:

- (a) Possess a valid and current license to practice their profession in the State of Wisconsin;
- (b) Submit and maintain on file at all times current evidence of continued licensure, DEA registration (if applicable to their profession) and financial responsibility in at least the minimum amounts determined by Wisconsin Statutes, which responsibility may be satisfied by acceptable malpractice insurance coverage. This requirement may be satisfied by submitting copies of the practitioner's current license, DEA registration and insurance certificates each time these documents change or are updated. Failure to do so may result in automatic suspension under the Fair Hearing Plan;
- (c) Have completed education and graduate training from a medical or osteopathic school meeting the standards of the Accreditation Council of Graduate Medical Education or the American Osteopathic Association, a dental school meeting the standards of the Council on Dental Education of the American Dental Association, or a school of podiatry meeting the standards of the Council on Education of the American Podiatric Medical Association;
- (d) Have provided evidence of their background, experience, training and demonstrated current competency in his or her specialty for all privileges requested, sufficient to assure, in the judgment of the governing body, that any patient treated by those in the Hospital will be given appropriate, quality medical care;
- (e) Have provided evidence of their good reputation, adherence to the ethical code of their respective professions and ability to work competently and cooperatively with others and to efficiently use resources, to the satisfaction of the governing body;
- (f) Are not excluded from participation in any federally-funded health care program;
- (g) Are not barred from providing direct patient care in the Hospital under Wisconsin's caregiver misconduct laws;
- (h) Have certified that their current health status does not in any way impair their ability to safely exercise the clinical privileges requested or to care for patients. The governing body may precondition appointment, reappointment or the continuing exercise of any or all clinical privileges upon the practitioner undergoing a health examination by a physician acceptable to the governing body or upon submission of any other reasonable evidence of current health status that may be requested by the MEC or the governing body. The MEC may require that a member of the Medical Staff, including an affiliated Medical Staff member, submit to a physical or mental health examination by an appropriate

physician at such other times as the committee deems appropriate. A physical or mental condition that can reasonably be accommodated shall not bar the grant of Medical Staff membership or clinical privileges; and

- (i) Are either: (1) certified by a certifying board that is either a member of the American Board of Medical Specialties (ABMS) or recognized by the American Osteopathic Association (AOA), the American Board of Podiatric Medicine (ABPM) or a Dental Specialty Certifying Board in the practitioner's primary specialty; or (2) have completed all of the residency or other specialized training required for admission to the examination of such a certifying board and have an active application for certification to include meeting any minimum years in practice requirements followed by certification within five years of the date of completion of residency or specialized training. The governing body may waive this requirement in unusual circumstances, based on the favorable recommendation of the MEC, when the practitioner has extensive experience, qualifications and training. Physicians not meeting the above criteria but who are certified in emergency medicine by the American Board of Physician Specialists and have five years of full-time practice in an emergency department may apply for membership and privileges for the limited purposes of staffing the emergency department.

### 2.3 **Governing Body Considerations.**

- (a) The governing body shall be the sole determining entity regarding whether to approve or reject any applicant, based on the limitations of facilities, services, equipment, staff, support capabilities or any combination of these.
- (b) The governing body may also decide not to appoint or reappoint or grant privileges to a practitioner or Allied Health provider in accordance with the criteria of a Medical Staff development plan or existence of contracts for provision of clinical services, whether exclusive or not, with other practitioners or affiliated providers, or for other reasons, when consistent with the Hospital's purposes, needs and capabilities, or community need.

### 2.4 **Conditions of Appointment.**

- (a) All practitioners and Allied Health providers shall participate in and be subject to the quality and safety assessment and improvement activities of the Hospital and Medical Staff.
- (b) As a condition of appointment or reappointment to the Medical Staff or as an Allied Health provider, appointees have a continuing obligation to promptly, but in no case more than 15 days after the triggering action, notify the CMO of, and to provide such additional information as may be requested regarding each of the following:
  - (1) The revocation, limitation, voluntary relinquishment, or suspension of his or her professional license or DEA registration, any reprimand or other

- disciplinary action taken by any state or federal government agency relating to his or her professional license, or the imposition of terms of probation or limitation by any state;
- (2) Voluntary relinquishment or loss of staff membership or privileges at any hospital or other health care facility, 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 regarding health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, the Office of the Inspector General, or any law enforcement agency or health regulatory agency of the United States or State of Wisconsin;
  - (5) any criminal conviction or pending criminal charge, and any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient, or has misappropriated a patient's property;
  - (6) 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;
  - (7) 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 in or at the Hospital; and
  - (8) 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 appointee relating to the treatment of any patient in or at the Hospital.
- (c) As part of their appointment and reappointment to the Medical Staff or as Allied Health providers, Appointees agree to honor their continuing obligation to comply with federal and state laws and regulations applicable to the practice of their profession.
- (d) As part of their appointment and reappointment to the Medical Staff or as Allied Health providers, Appointees agree to honor their obligation to comply with the rules and policies established by the MEC, the standing committees of the Medical Staff or the governing body, including but not limited to the Hospital's

and Medical Staff's Code of Conduct, Corporate Compliance Plans and Conflict of Interest Policy.

- (e) By accepting membership on the Medical Staff, a practitioner or Allied Health provider specifically agrees to abide by the Hospital's mission statement, the Bylaws, Rules and Regulations of the Medical Staff, the Medical Staff's Code of Conduct, the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the National Conference of Catholic Bishops and the Code of Ethics of the American Medical, Dental, Osteopathic or Podiatry Association or other Code of Ethics applicable to their profession, whichever is applicable. Should there be a conflict between any provisions of the applicable Code of Ethics and the Ethical and Religious Directives, the latter shall prevail.
- (f) All members of the Medical Staff must pledge not to receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services. All members of the Medical Staff pledge that their recommendations relating to patient care, treatment plans, and levels of service will not be based solely on the patient's ability to pay for the services provided. All members also must pledge that they will provide continuous care for their patients, and refrain from delegating the responsibility for diagnosis or care of hospitalized patients to an individual who is not qualified to undertake the responsibility and is not adequately supervised. The member must agree to furnish the Hospital with a current list of covering physicians with appropriate privileges, in accordance with departmental policy or practice, or a telephone answering service which can then supply the name of the available alternate, to contract when the practitioner is unavailable.
- (g) As a condition of appointment to the Medical Staff or as Allied Health Staff and the granting of any clinical privileges, all Medical Staff members and other individuals granted any clinical privileges to provide patient care in the Hospital acknowledge they participate in the organized health care arrangement (OHCA) comprised of all clinically integrated settings in which patients receive services at the Hospital (Saint Clare's Hospital OHCA). As a condition of appointment and of the grant of any clinical privileges, all individuals with clinical privileges must follow the privacy practices of Saint Clare's Hospital OHCA, as set forth in its notice of privacy practices, with respect to protected health information received through Saint Clare's Hospital OHCA.
- (h) As part of their appointment and reappointment to the Medical Staff, practitioners have a continuing obligation to comply with health requirements established by the MEC.
- (i) As a condition of appointment to the Medical Staff and the granting of any clinical privileges, all Medical Staff members and individuals granted any clinical privileges are expected to willingly undertake a fair share of responsibility for the discharging of Medical Staff responsibilities, at all times treating other practitioners as colleagues, treating all individuals with respect and

dignity and maintaining the confidentiality of information obtained through the discharge of these responsibilities, in accordance with Medical Staff policy.

- (j) The professional conduct of members of the Medical Staff and Allied Health providers shall at all times be governed by applicable Wisconsin and federal laws and Saint Clare's Hospital Medical Staff Code of Conduct. In the event the provisions of these Bylaws, Rules and Regulations shall not be in conformity with any Wisconsin or federal law or regulation, these Bylaws and Rules and Regulations shall be deemed automatically superseded to comply with such law or regulation. As soon thereafter as may be practicable, the Bylaws or Rules and Regulations will be amended to comply with the law.

## 2.5 **Term of Appointment.**

- (a) All initial appointments to the Medical Staff shall be made by the governing body of the Hospital upon the recommendation of the MEC and shall be for a period extending to the applicant's birth date following the first twelve months of the initial appointment. Reappointments of all members of the Medical Staff shall be for a period up to but not more than two years.
- (b) The governing body shall not act on an application for appointment, reappointment or cancel an appointment previously made without prior conference and consultation with the MEC. However, in the event of unwarranted delay on the part of the MEC in acting upon an application, the governing body may act on the basis of the applicant's professional and ethical qualifications obtained from reliable sources.
- (c) Appointments to the Medical Staff shall confer on appointees only such privileges and prerogatives as are specified in the notice of appointment in conformity with these Bylaws, Rules and Regulations.

## 2.6 **Dues.**

- (a) The Medical Staff will assess dues annually according to its needs. Staff dues shall be determined by a majority vote of the MEC. Dues will be designated for use by the MEC, consistent with the purposes and responsibilities of the Medical Staff, and subject to the approval of the governing body.

## **SECTION 3 – CATEGORIES OF THE MEDICAL STAFF**

The Medical Staff shall be divided into provisional, active, limited, courtesy, consulting, and honorary staffs. All Medical Staff members, regardless of their category, must fulfill the qualifications listed under Section 2.

### 3.1 **Provisional Medical Staff.**

- (a) The provisional Medical Staff shall consist of members of the Medical Staff in their first year of association with the Medical Staff (except the inaugural

members of the active Medical Staff) and those members appointed to provisional membership for an additional period after completion of the initial term.

- (b) The staff category to which a provisional member of the Medical Staff is seeking to advance must be specified by the practitioner at the time of application.
- (c) Provisional Medical Staff members will be expected to fulfill the responsibilities and abide by the restrictions applicable to the staff category designated for advancement, as a condition of advancement upon completion of the provisional term. However, provisional Medical Staff members shall not be eligible to (1) vote on any medical staff issues; (2) serve on the MEC, the MMT or the Professional Activities Committee; or (3) hold office.
- (d) A Provisional Medical Staff member shall be assigned to a service. The provisional Medical Staff member's clinical performance will be monitored and reviewed by the Service Chief(s) or his or her representative, as appropriate to their staff membership category (refer to New Provider Evaluation Policy).
- (e) A member of the provisional staff who does not qualify at the end of his or her initial term of appointment for advancement to the staff category designated may be scheduled for a personal interview with the MMT at the time of reappointment to discuss the status of his or her continued interest in membership on the Medical Staff of the Hospital. The MMT, after consultation with the Service Chief involved, will recommend continuation on the provisional staff for a specified period of time, not to exceed a single appointment term; appointment to the active, courtesy, limited or consulting Medical Staff; or non-reappointment to the Medical Staff. In the case of non-reappointment, the practitioner shall be entitled to the procedural rights set forth in these Bylaws.
- (f) The facts to be considered by the MEC when determining whether to recommend advancement shall be those identified in Section 2 of these Bylaws, and a demonstrated ability to meet the requirements and responsibilities of the staff category to which the practitioner seeks to advance. Continuation of provisional status may be recommended in lieu of non-reappointment where the practitioner either fails to meet the criteria for advancement or had not experienced a sufficient volume of cases for such a determination to be made, but is reasonably expected to be eligible for advancement by the end of a second provisional appointment.
- (g) If the practitioner fails to meet the requirements or responsibilities of the staff category to which he or she was initially designated to advance (e.g., active staff), the practitioner may be advanced to any other staff category for which he or she qualifies (e.g., courtesy or limited staff), if approved by the governing body.

### 3.2 **Active Medical Staff.**

- (a) The active Medical Staff shall consist of those practitioners who regularly admit patients to, or are otherwise regularly involved in the care of patients in the Hospital; who are located close enough to the Hospital to provide proper care to their patients; and who assume all of the functions and responsibilities of membership on the active Medical Staff.
- (b) Emergency specialty call coverage requirements will be determined for each specialty by each department, subject to the approval of the MEC. Each active Medical Staff member must comply with the call coverage requirements so established.
- (c) For purposes of this Section, a practitioner will be considered to be located close enough to the Hospital to provide proper care if the practitioner meets the following on call requirements:
  - (1) Maintains a telephone response time of 15 minutes or less when on call; and
  - (2) Unless specific arrangements have been made to transfer care responsibilities to an alternative practitioner qualified to cover for the individual, or to appropriately transfer patients to another facility that is equipped to handle the patients' emergency medical conditions, arrives at the Hospital within 60 minutes of being called in; and
  - (3) Can arrive at the Hospital within 60 minutes of being called in (day and night).
- (d) New members of the active Medical Staff (except the inaugural members of the active Medical Staff) must have been members of the provisional active Medical Staff or the courtesy Medical Staff and regularly involved in the care of 12 or more patients at the Hospital for a period of at least one year, which requirement may be waived in unusual circumstances by the MEC and the governing body. They must have attained acceptable qualifications in their field of practice according to current American Board of Medical Specialties, American Osteopathic Association, American Board of Preventive Medicine or Dental Specialty Certifying Board standards and have an active interest in the operation of the Hospital.
- (e) Members of the active Medical Staff shall promote the quality and safety of medical care in the Hospital, offer sound counsel to the CMO and the governing body and participate in the internal governance of the Medical Staff according to these Bylaws. The members of the active staff shall, within their scope of privileges, provide care to patients without regard to source of payment or ability to pay.

- (f) Members of the active Medical Staff shall:
  - (1) Be eligible to vote, hold office and serve on the MEC, the MMT and the Professional Activities Committee;
  - (2) Be required to serve on Medical Staff committees and attend and committee meetings as provided in Section 8 of these Bylaws.

### 3.3 **Limited Medical Staff.**

- (a) The limited Medical Staff shall consist of those practitioners whose primary hospital affiliation is the Hospital, but whose professional practice is largely outpatient with infrequent use of Hospital facilities and who have an active interest in the operation of the Hospital, and those practitioners who are only applying for history and physical privileges.
- (b) Members of the limited Medical Staff shall:
  - (1) Not be eligible to vote at general staff meetings or committee meetings;
  - (2) Be eligible to serve, without voting rights, on all Medical Staff committees, except the MEC, the MMT and the Professional Activities Committee;
  - (3) Not be eligible to hold office;
  - (4) Be allowed, but not required to, attend general Medical Staff meetings or committee meetings, except shall not be eligible to attend and participate in those portions of meetings devoted to peer review of Medical Staff members in other categories of the Medical Staff;
  - (5) Not have admitting or treating privileges;
  - (6) Be allowed to order, but not perform, outpatient diagnostic or therapeutic procedures that can be performed without their being present and that are within their scope of practice to order; and
  - (7) Be allowed to provide pre-procedural history and physical examinations.
- (c) Review of the office practice of members of the limited Medical Staff may be performed by the appropriate Medical Staff committees to provide a basis for evaluation of the member's current professional competence and judgment.

### 3.4 **Courtesy Medical Staff.**

- (a) The courtesy Medical Staff shall consist of practitioners who desire to treat patients in the Hospital, but who are unable to participate actively in the functions of the Medical Staff. New members of the courtesy Medical Staff

must have been members of the provisional courtesy Medical Staff, the active Medical Staff or the consulting Medical Staff for a period of at least one year before being eligible for the courtesy Medical Staff.

- (b) Members of the courtesy staff may, but are not required to, attend general Medical Staff meetings or committee meetings.
- (c) Members of the courtesy staff are not eligible to vote, hold office or serve on the MEC, the MMT or the Professional Activities Committee; however, they may be required to serve on other Medical Staff committees.
- (d) Members of the courtesy Medical Staff shall be restricted to admitting 12 patients (inpatient or outpatient) per year. If this number is exceeded at any time during the Medical Staff year, the member will automatically be considered to have applied for advancement to active staff membership.

### 3.5 **Honorary Medical Staff.**

- (a) The honorary Medical Staff shall consist of practitioners who are not active in the Hospital and who are honored by emeritus positions. These may be practitioners who have retired from active hospital service, or who are of outstanding reputation, not necessarily residents of the community.
- (b) Honorary Medical Staff members shall have no assigned duties and they shall not have privileges to admit or treat patients in the Hospital. Honorary Medical Staff members are not eligible to vote or hold office, but may serve on Medical Staff committees, except the MEC, the MMT and the Professional Activities Committee.
- (c) Honorary Medical Staff members may, but are not required to, attend general Medical Staff meetings or committee meetings, except they shall not be eligible to attend and participate in those portions of the meetings devoted to peer review of Medical Staff members in other categories of the Medical Staff.

### 3.6 **Consulting Medical Staff.**

- (a) The consulting Medical Staff shall consist of recognized specialists who are active in their specialties and have indicated a willingness to accept such appointments to the Medical Staff. Members of the consulting staff must be members of specialty boards, diplomates of one of the national boards of medical specialties, or other practitioners who, in the opinion of the MEC and the MMT, are qualified for consultation work in their specialty. Membership on the consulting staff shall not, per se, qualify the member for active staff membership.
- (b) Members of the consulting staff shall provide their services in the care of patients in the Hospital at the request of any member of the Medical Staff and in circumstances where consultation is required by the Rules and Regulations of the

Medical Staff. Consulting staff members may not admit patients on their own initiative.

- (c) Members of the consulting staff shall have no assigned duties and shall not be eligible to vote or hold office, but may serve on Medical Staff committees, except the MEC, the MMT and the Professional Activities Committee.
- (d) Members of the consulting staff may, but are not required to, attend general Medical Staff meetings and committee meetings.
- (e) Members of the consulting staff shall have such clinical privileges as may be granted by the governing body in accordance with these Bylaws. All surgical privileges require active or courtesy staff membership or provisional staff membership with advancement to either of these two Medical Staff categories.
- (f) A member of the consulting staff must be a member of the active Medical Staff of another hospital where he or she actively participates in a patient care audit program or other quality assessment and improvement activities similar to those required of the members of the active staff of this Hospital.

### 3.7 **Dental and Podiatric and Oral Surgeon Staff Functions.**

- (a) Oral surgeons, dentists and podiatrists granted membership on the Medical Staff in accordance with the procedures set forth in Section 4 may be members of any category of the Medical Staff for which they qualify and shall be under the direction of the Surgical Service Chief.
- (b) Except as provided in Section 3.7(d) below, patients admitted to the Hospital for dental or podiatric care shall be given the same medical appraisal as those admitted for other services. Admission of a dental or podiatric patient shall be the dual responsibility of the dentist or podiatrist and a physician member of the Medical Staff. The physician shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of a dental or podiatric patient.
- (c) Oral surgeons who have been granted clinical privileges to do so may admit and discharge patients without medical problems without first obtaining the concurrence of a physician member of the Medical Staff, but such oral surgeons must designate a physician member of the Medical Staff with appropriate clinical privileges to be responsible for the care of any medical problem that may arise. If granted clinical privileges to do so, oral surgeons may, in lieu of a physician member of the Medical Staff, perform the admission history and physical examination and assess the medical risks of the proposed surgical procedures on those patients admitted without medical problems.
- (d) Oral surgeons, dentists and podiatrists shall conform to these Bylaws, Rules and Regulations of the Medical Staff with the following additions:

- (1) Patients may be admitted for dental or podiatric services by a dentist or podiatrist after obtaining the concurrence of the consulting physician;
- (2) Surgical procedures performed by oral surgeons, dentists or podiatrists shall be done under the overall supervision of the chief of surgery or his or her designee;
- (3) Podiatrists, dentists, and oral surgeons may not supervise CRNAs in providing anesthesia services; only physician members of the medical staff may provide this supervision;
- (4) At the time of surgery (whether inpatient or outpatient) and at the time of admission, the name of the medical consultant must appear on the appropriate forms. This consultant or his/her designee shall be responsible for pre- and post-operative medical evaluation and care of the patient;
- (5) The dentist or podiatrist may discharge the patient after obtaining the concurrence of the consulting physician; and
- (6) Complete records, both dental or podiatric and medical, shall be required on each patient and shall be part of the Hospital record.

### 3.8 **Locum Tenens**

Practitioners who provide locum tenens coverage may not be members of the Medical Staff and will not have any of the rights and responsibilities conferred upon medical staff members, but may be granted privileges in accordance with these Bylaws and applicable policies and procedures which are approved by the MEC and governing body. (Refer to Locum Tenens Policy.)

### 3.9 **Telemedicine Service Providers**

Practitioners who provide telemedicine services may not be members of the Medical Staff and will not have any of the rights and responsibilities conferred upon medical staff members, but may be granted privileges in accordance with these Bylaws and applicable policies and procedures which are approved by the MEC and governing body. (Refer to Telemedicine Policy.)

### 3.10 **Allied Health Providers**

Allied Health providers include, but are not limited to, clinical nurse practitioners (NPs), psychologists, advanced practice nurse prescribers (APNPs) certified physician assistants (PA)s, certified registered nurse anesthetists (CRNAs), certified nurse-midwives, surgical assistants, who are not employees of the hospital. Allied health providers shall be expected to document their qualifications as set forth in Section 2 and modified, as appropriate, to reflect the differences in education, training and licensure of their particular professions. Allied Health providers who are not employees of the hospital must apply for privileges and be credentialed through the medical staff processes and

approved by the MMT and MEC. Hospital-employed Physician Assistants (PA's), Certified Registered Nurse Anesthetists (CRNA's), Advanced Practice Nurse Practitioneres (APNP's), Nurse Practitioners (NP's) and Nurse Midwives must apply for privileges and be credentialed through the medical staff processes and approved by the MMT and MEC. Allied Health providers are not members of the Medical Staff and have none of the prerogatives of Medical Staff membership, such as any rights under the Plan or rights to attend meetings of the Medical Staff or to vote. (Refer to the Allied Health Policy approved by the MEC and Board of Directors.)

### 3.11 **Provisional Appointments and New Clinical Privileges - Monitoring Protocol**

- (a) During the term of any appointment to the provisional Medical Staff, it will be the responsibility of the Service Chief(s) to orient the practitioner to the department(s), and establish and oversee a monitoring protocol (refer to New Provider Evaluation Policy).
- (b) The Credentials Committee and/or Service Chief will determine when a provisional member of the Medical Staff will be reviewed by the means of a monitoring protocol (refer to new provider evaluation policy approved by MEC and Board of Directors). The Credentials Committee and/or Service Chief will also determine when Medical Staff members who exercise new or increased clinical privileges will have their cases reviewed by means of the monitoring protocol. The Credentials Committee and/or Service Chief will determine either a fixed number of cases or a fixed time period in which all cases will be reviewed for the individual member subject to review according to the volume of cases in which the practitioner is expected to participate so that a sufficient number of cases will have been performed for the Service Chief to make a determination about the need for continued review. The Service Chief will determine those provisional members of the Medical Staff who will not be reviewed by the means of a monitoring protocol. The Service Chief may also review cases of a provisional member of the Medical Staff from another hospital where the member has privileges. In that instance, it will be the practitioner's responsibility to assure access to the records requested for this purpose.
- (c) At the conclusion of the cases or period of time established by the Credentials Committee, the Service Chief(s) shall recommend to the MMT that the monitoring be terminated or that an additional period of monitoring be established. Should the MEC extend the monitoring of a practitioner for an additional period, such may be done with no further action being required by the governing body. Further, the practitioner shall not be entitled to a hearing or review on the decision under the Plan. Any decision to extend the monitoring protocol beyond the term of the next renewal appointment following the initial provisional appointment or provisional grant of new or increased clinical privileges must be ratified by the governing body. The decision to extend monitoring is not subject to review under the Plan.

- (d) At the time of the granting of the clinical privileges that will be subject to monitoring, the Service Chief(s) responsible for monitoring the privileges at issue will be designated, according to the areas of practice to which the clinical privileges relate. If more than one Service Chief is designated, one shall be designated to be responsible for implementing the monitoring for the clinical privileges. The MEC shall base its determination in Section 3.8(c) above upon the recommendation of each Service Chief responsible for monitoring.
- (e) During the provisional appointment, the monitoring protocol shall afford the Hospital and the practitioner the following:
  - (1) The ability to establish pretreatment consultation requirements.
  - (2) A current review of the clinical abilities of the practitioner.
  - (3) A resource person or committee from whom the practitioner can or must seek voluntary or required consultation.
  - (4) A resource in the form of the monitor or monitoring committee with whom other staff members or hospital personnel may confer concerning the practitioner.
  - (5) A basis for recommending privileges at the completion of the provisional appointment.

## **SECTION 4 – APPOINTMENT AND REAPPOINTMENT**

### **4.1 Application for Appointment**

- (a) Practitioners desiring appointment to the Medical Staff shall obtain an application and privilege request form from the Medical Staff office, which office will, in addition to the forms, supply the applicant with a copy of the Hospital Bylaws, Medical Staff Bylaws, Rules and Regulations, Medical Staff Code of Conduct and Conflict of Interest Policy and of the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops, and the Hospital mission statement. A copy of the principles of medical ethics of the American Medical, Dental, Podiatric, or Osteopathic Association, as appropriate, shall be made available for practitioner review upon request.
- (b) All applications for appointment to the Medical Staff shall be submitted on a form prescribed by the MEC. The applicant shall sign a statement that he or she agrees to provide continuous care to his or her patients and that the applicant has received and read these Bylaws, Rules and Regulations of the Medical Staff and the Medical Staff Code of Conduct and Conflict of Interest Policy, and agrees to be bound by their terms if granted membership or clinical privileges, and to be bound by their terms relating to consideration of his or her application without

regard to whether or not the applicant is ultimately granted membership or clinical privileges.

- (c) The application shall include information as to whether the applicant's membership and/or clinical privileges have ever been revoked, suspended, reduced, not renewed, denied, investigated, voluntarily relinquished or subjected to probationary conditions, whether proceedings towards any of those ends have been instituted or recommended; or whether he or she has been subject to any other disciplinary action or sanction at any other hospital or institution, by any specialty board, by any local, state or national medical organization or other professional society, or by any employer of the applicant in a clinical position or practice arrangement. The applicant shall also include information as to whether or not the applicant has ever been refused liability insurance or renewal or had it canceled, or limitations placed on scope of coverage, had coverage rated up because of unusual risk or been notified of any intent by any insurer to do so. The applicant shall also include information as to any involvement in any professional liability action, information as to any past or pending involvement in any quality inquiry, sanction action or formal investigation by Medicaid or a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state, and information as to whether any license or registration of the applicant has ever been suspended or revoked, and whether the applicant has ever been reprimanded or otherwise disciplined by any state or federal governmental agency relating to the practice of his or her profession. The applicant shall also include information as to any currently pending challenges to any licensure or registration of the applicant and as to the applicant's ability to safely exercise the privileges requested. The application shall include information as to whether the applicant has any criminal conviction or pending criminal charge, 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 any patient. The applicant must provide a fully completed Background Information Disclosure form with the completed application and must cooperate with the Hospital in obtaining any additional information required for the Hospital to comply with the requirements of Chapter HFS 12 of the Wisconsin Administrative Code.
- (d) The applicant must submit current evidence of financial responsibility in at least the minimum amounts determined by Wisconsin Statutes, which responsibility may be satisfied by acceptable malpractice insurance coverage.
- (e) The application shall identify as references at least two individuals who have recently worked with the applicant and directly observed his or her professional performance over a reasonable period of time, and who can and will provide reliable information regarding the applicant's current clinical ability, ethical character and ability to work with others.

- (f) Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence, references and other relevant information, including an appraisal by the Service Chief in which such privileges are sought. The applicant shall have the burden of establishing both qualifications and competency in the clinical privileges requested.
- (g) 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. Failing to adequately complete the application form, withholding requested information, providing false or misleading information (whether intentional or not), or omitting material information necessary for a full picture of the applicant's professional history shall cause the processing of the application to be suspended until such deficiencies are corrected and may be a basis for denial of membership on or removal from the Medical Staff.
- (h) Additional details regarding the applicant's health status (including physical, mental and emotional stability) shall be obtained following a favorable recommendation for appointment by the MEC.
- (i) By applying for appointment or reappointment, the applicant signifies a willingness to appear and be interviewed in regard to the application. The applicant by signing the application authorizes the Hospital to consult with any and all members of Medical Staffs of other hospitals or other health care entities with which the applicant has been associated, as well as with others who may have information bearing on the competence, character, health status, and ethical qualifications of the applicant and to inspect such records and documents as shall be material to an evaluation of stated professional qualifications, and competence to carry out the clinical privileges requested as well as the applicant's moral and ethical qualifications and health status. By so applying, the applicant also releases all individuals who submit information, including otherwise privileged and confidential information, at the request of the Hospital to facilitate the assessment of his or her qualifications for staff appointment and clinical privileges from any liability for their statements and releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in connection with evaluating the applicant.

#### 4.2 **Administrative Denial.**

The Medical Staff office may, upon the approval of the CMO, 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 Medical Assistance programs

or is currently excluded from any federally-funded health care program; (4) he or she is barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code; or (5) he or she has only requested clinical privileges: (a) in a department that has been closed pursuant to any medical staff development plan adopted by the Hospital or (b) that have been exclusively granted to another practitioner pursuant to a written contract then in effect without notice from either party to the contract of intent to terminate, which contract covers all the clinical privileges being requested by the applicant. Applicants who are administratively denied under this Section 4.2 do not have a right to a fair hearing under the Plan, but may submit evidence to the Medical Staff office to refute the basis for the administrative denial.

### **SECTION 3. Automatic Suspension**

Please refer to the Fair Hearing Plan approved by MEC and Board of Directors.

### **SECTION 4. Special Meeting Attendance Requirements**

Whenever suspected deviation from standard clinical or professional practice is identified, the Medical Executive Committee (MEC), Service Chief, or applicable committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the conference at least five (5) days prior to the conference, including the date, time, place, a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such conference after two notices, unless excused by the MEC upon showing good cause, will result in an automatic termination of membership. Such termination will not give rise to a fair hearing, but will automatically be rescinded upon the practitioner's participation in the previously referenced conference. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in the Fair Hearing Plan.

#### **4.3 Appointment Process.**

- (a) The completed application form shall be presented to the CMO. The CMO or his or her designee will obtain verifying information from the National Practitioner Data Bank, the appropriate state licensing boards and other related sources. If required, the applicant will sign any special releases that may be required. The CMO or his or her designee will also obtain primary source verification of the medical license, residency training, or other postgraduate education of the applicant, particularly as it applies to the privileges requested. After collecting the references and other materials deemed pertinent, the CMO shall transmit the application and all supporting materials to the MMT. The MMT shall simultaneously transmit the completed application to the appropriate Service Chief(s), as determined by the MMT. The Hospital is responsible for verifying the information provided, but the applicant has a continuing obligation to facilitate the release of information necessary for verification and evaluation of the applicant's credentials.

- (b) The MMT:
  - (1) Shall verify, through references and other sources, that the applicant meets and has established all basic qualifications set forth in these Bylaws. This includes verification of the applicant's current competence.
  - (2) May request that the applicant arrange for a personal interview with the Service Chief(s) and the CMO or his or her designees, who must be Medical Staff members.
- (c) Within 60 days after receipt of the completed application for membership, references, reports and other supporting data requested of the applicant, the MMT shall make a written report of its recommendations. In preparing this report, the MMT shall examine the character, professional competence including quality of patient care and services,, qualifications and ethical standing of the applicant and shall verify, through information contained in references given by the applicant and from other sources available to the committee, including the appraisals from the Service Chief(s), that the applicant meets and has established all the necessary qualifications for the category of staff membership and the clinical privileges requested as set forth in Section 3 of these Bylaws. The recommendations of the Service Chief(s) are advisory to the MMT and do not themselves constitute professional review action. While the recommendation and the appointment to the Medical Staff shall be based primarily on professional competence of applicants, the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his or her patients and patient care needs for additional staff members with the applicant's skill and training shall also be considerations in determining Medical Staff membership. To the extent the geographic location of the applicant and his or her practice affects the ability of the applicant to provide effective continuity of care for hospital patients, it shall also be a consideration.
- (d) The governing body or any Medical Staff committee or Service Chief may, at any time, request additional information in connection with a completed application, and the processing of the application shall be suspended for 60 days or until the applicant has provided the information requested or satisfactorily explains his or her failure to do so, whichever occurs first.
- (e) The MMT shall submit a written report concerning the applicant to the MEC. The report may be in the form of the committee's minutes with attachments, but it must address the following requirements:
  - (1) The written report shall state the applicant's qualifications, other current hospital affiliations, interest in the Hospital, and the MMT's opinion in regard to the applicant's current professional competence, character, and ability to safely perform the clinical privileges requested, with or without accommodation, and recommend that the application be approved, deferred or rejected.

- (2) The MMT report shall include a recommendation as to a delineation of privileges to be extended and any limitations or restrictions, based upon the recommendations from the Service Chief(s). Any recommendations as to limitations or restrictions, if temporary, shall specify the time period and conditions required to remove such limitations or restrictions. If there are differences in privilege recommendations between Service Chiefs, both recommendations shall be submitted with each Service Chief's reasons set forth.
  - (3) Each recommendation for initial appointment shall be for assignment to the provisional staff.
  - (4) When a recommendation to defer is made, the recommendation shall state the basis for deferral and shall specify the date of meeting at which the application will be recommended for acceptance or rejection.
  - (5) The recommendations of the MMT are advisory to the MEC and do not of themselves constitute professional review action.
- (f) The MEC shall at its next regular meeting after the receipt of the report of the MMT:
- (1) Give careful consideration to the new applicant in reference to current professional competence, ethical conduct and willingness to contribute toward meeting the educational and professional needs of the Hospital;
  - (2) Decide by a majority vote to recommend to approve, defer or reject the application and submit its recommendation to the governing body through the CMO. Any recommendation for appointment may include probationary conditions. A recommendation by the MEC to defer for further consideration or investigation must be followed up within three months by a recommendation for appointment to the Medical Staff with specified privileges or for rejection of staff membership;
  - (3) Should the recommendation of the MEC be negative or not in accord with the staff status or privileges requested by the applicant, then prior to any referral of the recommendation to the governing body for action, the practitioner involved should be notified of the recommendation pursuant to these Bylaws and given an opportunity either to waive any procedural rights by accepting the recommendations or to exercise such review rights as are set forth in the Plan; and
  - (4) When the recommendation of the MEC is favorable, additional information regarding the applicant's current health status shall be obtained prior to forwarding the recommendation to the governing body. The MEC at its discretion may require the practitioner to submit to a physical examination by an appropriate physician or psychologist for the purpose of determining the practitioner's current ability to competently

and safely exercise the privileges requested, with or without reasonable accommodation. Upon receipt of the completed health assessment questionnaire, the CMO shall determine whether further investigation and review is warranted.

- (i) If the CMO determines that the applicant's health information may affect the MEC's recommendation, the matter will be referred to the MMT for further investigation and review. Following review, the MMT may recommend affirmation or modification of the MEC's recommendation and submit a report to that effect to the MEC for processing in accord with the process above.
  - (ii) If the CMO determines that the information does not affect the recommendation, the MEC's recommendation shall be forwarded to the governing body and be deemed final unless disapproved by the governing body or authorized committee of the governing body within 60 days of receipt of the MEC's recommendation. This Section shall not preclude referral to the practitioner's advisory committee for recommendation for monitoring.
- (g) The governing body, at its next regular meeting after the receipt of the recommendation of the MEC (provided all procedural rights to hearing and appellate review have either been waived or exhausted), shall:
- (1) For favorable recommendations, either ratify the final action or refer it back to the MEC, indicating reasons for non-acceptance.
  - (2) For adverse recommendations, either accept the recommendation or refer it back to the MEC, indicating reasons for non-acceptance.
- (h) When the governing body's action is final, it shall send notice of such decision through the CMO to the Service Chief(s) concerned and, by special notice, to the practitioner.

#### 4.4 **Procedure for Reappointment.**

- (a) In order to be eligible for reappointment to the medical staff of Saint Clare's Hospital, practitioners must have provided patient care services or had clinical activity at the Hospital in the preceding two years, or be a member of a group in which clinical privileges are obtained for the purpose of providing specialty service cross coverage.
- (b) The CMO will provide each staff member scheduled for reappointment who has had any patient admissions or consultations at the Hospital during the current term of appointment with a reappointment application form no more than 120 days prior to expiration of the member's current appointment. Practitioners who have had no patient admissions or consultations at the Hospital during their current term of appointment will be considered to have resigned and will not be

sent a reappointment application unless they request one at least 120 days before the expiration of their current term. Practitioners who have no patient admissions or consultations for two consecutive terms may choose to be members of the Limited Medical Staff; otherwise, they will not be eligible to apply for reappointment unless they provide written evidence of a change in circumstance that will result in their use of the Hospital's facilities for patient care in the future.

- (c) Each staff member who desires reappointment shall submit his or her completed reappointment form to the CMO within 60 days of receipt. Failure without good cause to return the form shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the member's current term. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in the Plan for the sole purpose of determining the issue of good cause.
- (d) The reappointment application form shall include all information necessary to update the information contained in the applicant's initial application for appointment since the last time such information was supplied including, without limitation:
  - (1) Changes in Medical Staff membership or clinical privileges at any other hospital or institution, including, without limitation, any revocation, suspension, reduction, limitation, denial or non-renewal thereof, whether voluntary or involuntary;
  - (2) Suspension or revocation of licensure or registration (state, district or DEA) or any reprimand or imposition of sanctions related thereto or suspension or revocation of membership or imposition of other sanctions by any local, state or national professional society;
  - (3) Any malpractice claims, suits, settlements or judgments, whether pending or finally determined and any refusal or cancellation of professional liability insurance;
  - (4) Any additional training, education or experience relevant to the privileges sought on reappointment;
  - (5) Any criminal conviction or pending criminal charges;
  - (6) Current evidence of licensure and DEA registration and of professional liability insurance coverage;
  - (7) Documentation of the health assessment required under state regulations on persons providing direct patient services in the Hospital and reporting of any adverse findings relevant to the applicant's exercise of clinical privileges;

- (8) Any exclusion or pending exclusion from any federally-funded health care program;
  - (9) Receipt of any sanction notice or notice of proposed sanction or of the initiation of a formal investigation or the filing of charges relating to health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, the Office of the Inspector General, or any law enforcement agency or health regulatory agency of the United States or any state;
  - (10) Updated information regarding 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 any patient, including a fully completed Background Information Disclosure form; and
  - (11) Such other information about the applicant's ethics, qualifications, and ability as may be relevant to his or her ability to provide quality patient care at the Hospital.
- (e) All promotions in or changes in Medical Staff category or scope of clinical privileges shall be subject to the procedures in the Bylaws applicable to initial appointments.
  - (f) Prior to the last scheduled governing body meeting before expiration of the practitioner's current appointment, the MMT shall complete its review of all pertinent information available on each applicant for reappointment for the purpose of determining its recommendations for reappointment to the Medical Staff and for the granting of clinical privileges for the ensuing term and shall transmit its recommendations, in writing, to the MEC. In arriving at recommendations for reappointment of each Medical Staff member and the assignment of privileges, specific consideration shall be given to the practitioner's current professional competency and clinical judgment in the treatment of patients, ethics and conduct, compliance with the Medical Staff Code of Conduct and Conflict of Interest Policy, physical and mental capabilities, attendance at Medical Staff meetings and participation in staff affairs, compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations (including timeliness of medical record completion), cooperation with Hospital personnel, appropriate use of the Hospital's facilities for patients, relations with other staff members, and general attitude toward patients, the Hospital and the public. Reappointment policies include the periodic appraisal of the professional activities of each member of the Medical Staff and of all other individuals granted clinical privileges in the Hospital through the Medical Staff approval process.
  - (g) The assessment of the competence of the practitioner by the Service Chief(s) shall be considered.

- (h) The results of quality assessment and improvement activities including peer review activities, and the monitoring performed during a term of provisional appointment, if applicable, shall be considered in the appraisal of the applicant's professional performance, judgment and technical and/or clinical skills.
- (i) A written report of all matters considered in each practitioner's periodic reappointment appraisal must be made a part of the permanent files of the Hospital.
- (j) Aggregate Data considered in the periodic appraisal include but are not limited to:
  - (1) Number of operative and other procedures performed or major diagnoses made;
  - (2) Rates of undesirable outcomes, such as complications, compared with those of others doing similar procedures; and
  - (3) Use of blood and blood components
  - (4) Criteria for autopsies
  - (5) Findings and conclusions of review by peers (please refer to Medical Staff PI Policy approved by MEC and Board of Directors);
- (k) Prior to the last scheduled governing body meeting before the expiration of the practitioner's current appointment, the MEC shall make its recommendations to the governing body, through the CMO, concerning the reappointment or non-reappointment and the continuation or alteration of privileges for the ensuing term of each member of the Medical Staff applying for reappointment. In all cases where non-reappointment or a change in staff status or clinical privileges is recommended, the reasons for the recommendation shall be stated and documented.
- (l) When the recommendation of the MEC constitutes a professional review action giving rise to hearing rights as specified in the Plan, then prior to any referral of the recommendation to the governing body for action, the CMO shall give the practitioner involved special notice of the recommendation, and the practitioner shall be given an opportunity either to exercise the procedural rights set forth in the Plan or to accept the recommendation.
- (m) Thereafter, the procedure provided in Section 4.3 relating to recommendations on applications for initial appointments shall be followed.
- (n) If, for any reason, the reappointment process has not been fully completed by the end of the current appointment, the applicant's staff appointment and clinical privileges will automatically cease. No temporary privileges will be extended.

The burden is on the applicant to provide the necessary documentation and verifications to complete the reappointment process.

- (o) Each member of the Medical Staff is responsible for advising the CMO and their Service Chief(s) of any current physical or mental condition that may limit the individual's ability to safely exercise his or her clinical privileges. A referral to the Professional Activities Committee shall follow. The Professional Activities Committee may require the individual to submit evidence of his or her current physical and/or mental status, as determined by a physician acceptable to the Professional Activities Committee.
- (p) If as a result of the practitioner's self-reporting of a disability, the Professional Activities Committee submits a recommendation for modification of membership status or privileges and the MEC adopts such recommendation, the affected practitioner shall be notified by special notice of the recommendation. The recommendation shall not be considered a professional review action unless and until the practitioner chooses to exercise the right to hearing available under the Plan, and the notice shall so state. If the MEC recommends modification of membership status or privileges due to a condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional review action without regard to whether or not the practitioner exercises the hearing rights available under the Plan.

#### 4.5 **Reapplication After Adverse Action.**

- (a) An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both and who did not exercise any of the hearing rights provided in the Plan shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of six months from the date of final adverse action or until he or she completes training identified by the Medical Staff as a prerequisite for the privileges, whichever is longer.
- (b) An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both and who exercised some or all of the hearing rights provided in the Plan shall not be eligible to reapply for the membership status that were the subject of the adverse action for a period of two years from the date of final adverse action.
- (c) Any reapplication under this Section shall be processed as an initial application, but the applicant shall submit additional information as the Medical Staff or governing body may require in demonstration that the basis for the earlier adverse action no longer exists.
- (d) If the recommendation of the Medical Staff or the action proposed by the governing body upon reapplication continues to be adverse, the scope of the hearing to which the practitioner is entitled shall be limited to consideration of

the sufficiency of the additional information submitted in demonstration that the basis for the earlier adverse action no longer exists.

4.6 **Time Periods For Processing.**

Applications for appointment or reappointment shall be considered in a timely and good faith manner by all individuals and groups who are required by these Bylaws to act on such applications and, except for good cause, shall be processed within the time periods specified in Section 4. However, the time periods specified are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the practitioner to have his or her application processed within those periods nor to create a right for a staff member to be automatically reappointed for the coming term.

**SECTION 5 – PRIVILEGES**

5.1 **Delineation of Clinical Privileges.**

- (a) A practitioner or Allied Health provider providing clinical services in the Hospital by virtue of the Medical Staff Bylaws process or alternate approval process per Medical Staff policy shall be entitled to exercise only those clinical privileges specifically granted by the governing body or the CMO pursuant to the procedures set forth in these Bylaws and other applicable Medical Staff policies.
- (b) Evaluation of privileges for initial appointment and for new, extended or increased privileges shall be based upon the applicant's education, training, experience, references, demonstrated current ability, other relevant information as identified in the Peer Review Policy, the recommendation of the MMT or the chair of the applicable department and/or section. The Service Chiefs, working with the MMT, also shall make recommendations for specific criteria for granting privileges, which shall be approved by the MEC. The applicant shall have the burden of establishing his or her qualifications and competency in the clinical privileges requested.
- (c) Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the criteria set forth in Section 5.1(b) above and the observation of care provided, the health status of the practitioner, review of the records of patients treated in this or other hospitals or clinical practice setting and review of the records of the Medical Staff documenting the member's participation in the delivery of medical care, including training, experience, current competence and satisfactory exercise of clinical privileges to date.
- (d) Privileges granted to oral surgeons, dentists and podiatrists should be based on their training, experience and demonstrated current competence and judgment. The scope and extent of surgical procedures that each oral surgeon, dentist or podiatrist may perform must be specifically defined and recommended in the same manner as all other surgical privileges. The oral surgeon, dentist or podiatrist is responsible for the oral surgery, dental or podiatric care of the patient, including the oral surgery, dental or podiatric history and physical

examination, discharge summary and all appropriate elements of the patient's record.

- (e) Oral surgeons, dentists and podiatrists may write orders within the scope of their license, as limited by the applicable statutes and as consistent with the Medical Staff regulations. Oral surgeons, dentists and podiatrists shall agree to comply with all applicable Medical Staff Bylaws, Rules and Regulations at the time of application for clinical privileges.
- (f) All individuals who are not members of the Medical Staff but who are granted clinical privileges through the Medical Staff process shall, as a condition of the grant of clinical privileges, be subject to the conditions set forth in Section 2.4, except the requirement in Section 2.4(e) pertaining to a list of alternatives.

## 5.2 **Temporary Privileges.**

- (a) The granting of temporary privileges is not encouraged and shall be limited to:
  - (i) Periods of time pending review and approval of a completed application, or
  - (ii) Where it is deemed necessary or beneficial to the Hospital to meet important patient care needs.

Practitioners applying for temporary privileges under this section must be licensed in Wisconsin and have a sponsor on the Medical Staff who is willing to assume responsibility for the practitioner. Additionally, the practitioner must satisfy the requirements regarding professional liability insurance, health status and the Wisconsin caregiver background check as described in these Bylaws.

- (b) Upon the basis of information then available which may reasonably be relied upon as to the current competence and ethical standing of the applicant, temporary clinical privileges (non-membership) may be granted by the CEO upon recommendation of the CMO or his or her designee, for the care of a specific patient, to a practitioner who is not an applicant for membership, provided that the practitioner first acknowledges in writing that he or she has received and read copies of the Medical Staff Bylaws, Rules and Regulations, Medical Staff Code of Conduct and applicable policies and agrees to be bound by their terms in all matters relating to temporary clinical privileges. Temporary privileges for a non-applicant practitioner shall be limited to situations where there is an important patient care need that mandates an immediate authorization to practice before all credentials information can be verified and approved. Temporary privileges for a non-applicant practitioner shall be restricted to the treatment of not more than two patients in any one year by any practitioner, after which the practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

- (c) Temporary clinical privileges for up to 120 days are available for applicants with a completed application awaiting review and approval of the governing body. Before temporary privileges can be granted under this section, the applicant must have submitted a completed application showing no current or previously successful challenges to a licensure or registration; no involuntary termination of Medical Staff membership at another organization; and no prior involuntary limitation, reduction, denial or loss of clinical privileges elsewhere. Additionally, temporary privileges cannot be granted under this section without first obtaining at least telephone verification of current licensure, relevant training or experience, current competence, demonstration of ability to perform the privileges requested, proof of insurance, absence of any bar from providing direct patient care under Wisconsin's caregiver misconduct laws, absence of exclusion from any federally-funded health care program, and receipt of the results of the National Practitioner Data Bank inquiry. The governing body shall complete processing such applications in accordance with these Bylaws.
- (d) The CMO may permit a practitioner serving as a "Locum Tenens" for a member of the Medical Staff to attend patients without applying for membership on the Medical Staff for a period not to exceed 45 days per year, provided all credentials have first been approved by the CMO and the member engaging the locum tenens has filed a letter requesting temporary privileges for the locum tenens, acknowledging responsibility for his or her actions and quality of practice.
- (e) Special requirements of supervision and reporting may be imposed by the CMO on any practitioner granted temporary privileges. Temporary privileges may be immediately terminated by the CMO, upon notice of any failure by the practitioner to comply with the special conditions.
- (f) The CMO may at any time, upon the recommendation of the service chief concerned, terminate a practitioner's temporary privileges effective as of the discharge of the practitioner's patient(s) then under his or her care in the Hospital. However, when it is determined that the life or health of the patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a suspension pursuant to the Plan, and the same shall be effective immediately. The appropriate committee chairperson or, in his or her absence, the CMO shall assign a member of the Medical Staff to assume responsibility for the care of the practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered when feasible in the selection of a substitute practitioner. The termination or modification of temporary privileges shall not entitle the practitioner involved to the procedural rights set forth in the Plan.
- (g) Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested. Before temporary privileges are granted, the practitioner must acknowledge in writing that he or she received and read the Bylaws, Rules and

Regulations, Medical Staff Code of Conduct and applicable Medical Staff policies, and that he or she agrees to be bound by the terms thereof in all matters relating to his or her temporary privileges.

- (h) No practitioner is entitled to temporary privileges as a matter of right. A practitioner shall not be entitled to the procedural rights afforded by the Plan because of his or her inability to obtain temporary privileges or because of any termination, modification or suspension of temporary privileges.

### 5.3 **Emergency Privileges.**

In the case of any emergency, any practitioner, to the degree permitted by his or her license, and regardless of department or staff status, or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must then request the privileges necessary to continue to treat the patient, or in the event such privileges are denied or he or she does not desire to request the privileges, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this Section, an “emergency” is defined as a condition which could result in serious permanent damage to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

### 5.4 **Disaster Credentialing.**

The CMO, or in his or her absence, the vice chief of staff, and/or the CEO and/or COO shall have the power to grant emergency privileges to physicians, physician extenders, ancillary and nursing staff, and will assign them to work under the general direction of an identified Medical Staff member. Privileges may be granted to these individuals in areas of their individual expertise to assist in times of disasters such as public health threats and emergencies that involve mass casualties, pursuant to protocols and conditions set forth in Medical Staff policy approved by the MEC. See the Disaster Credentialing Policy approved by the MEC and Board of Directors for more detail.

### 5.5 **Telemedicine Privileges.**

- (a) Interpretive telemedicine privileges:

An applicant based at a distant site, whose practice at the Hospital will be limited to interpretive telemedicine only, may apply for telemedicine privileges or be allowed to perform telemedicine privileges through one of the following mechanisms, as selected by the MMT either for the individual or for a designated class of applicants per policy decision of the MMT:

- (1) If the applicant will be providing the interpretive telemedicine services pursuant to a written contract, and the services are under the control of a

JCAHO-accredited organization: by submission of an application containing at least the following information (and verification of the information with either the distant JCAHO-accredited site or a primary source):

- (i) Medical Staff status at distant site and scope of clinical privileges currently held.
  - (ii) Wisconsin licensure.
  - (iii) Evidence of liability insurance meeting requirements for applicants for Medical Staff membership.
  - (iv) Existence of any of the events or circumstances outlined in Section 2.4(b).
  - (v) Request for the specific telemedicine privileges desired.
  - (vi) Acknowledgment that the applicant is subject to (1) Section 6 of the Bylaws in all respects in connection with the application for or exercise of clinical privileges; and (2) the conditions of appointment outlined in Section 2.4 of the Bylaws.
- (2) If the telemedicine services are being provided by contract with a JCAHO-accredited organization: by a written contractual commitment with the JCAHO-accredited distant site that it will ensure that all services provided by individuals under the contract will be provided only by practitioners licensed to practice independently in Wisconsin: (a) who are in good standing on the distant site entity's active Medical Staff and are acting within the scope of privileges granted by the distant site; (b) who carry adequate professional liability insurance; and (c) who are not excluded or proposed to be excluded from any federally-funded health care program; or
- (3) By submission of the same application required of all other applicants for Medical Staff membership or clinical privileges.
- (b) Interactive telemedicine privileges:

Applicants based at distant sites requesting any form of interactive telemedicine privileges may apply for privileges through one of the following mechanisms as selected by the MMT either for the individual applicant or for a designated class of applicants per policy decision of the MMT:

- (1) By submission of the same application required of all other applicants for Medical Staff membership or clinical privileges;

- (2) The practitioner may be privileged at the originating site using credentialing information from the distant site if the distant site is JCAHO accredited. (see the Telemedicine Policy approved by the MEC and Board of Directors).
- (3) The originating site may use the privileging and credentialing information provided by the distant site if all of the following requirements are met:
  - (i) The distant site is Joint Commission-accredited
  - (ii) The practitioner is privileged at the distant site for those services to be provided at the originating site
  - (iii) The originating site has 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. At a minimum, this information includes all adverse outcomes related to sentinel events\* considered reviewable by the Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site.
  - (iv) Wisconsin licensure is provided
  - (v) Evidence of professional liability insurance meeting requirements for applicants for Medical Staff membership is provided
  - (vi) Existence of any of the events or circumstances outlined in Section 2.4(b) is communicated
  - (vii) Request for the specific telemedicine privileges desired
  - (viii) Acknowledgment that the applicant is subject to (1) Section 6 of the Bylaws in all respects in connection with the application for or exercise of clinical privileges; and (2) the conditions of appointment outlined in Section 2.4 of the Bylaws.
- (c) In processing requests for clinical privileges, the Hospital may rely upon credentialing information obtained and verified in accord with JCAHO standards by a JCAHO-accredited distant site where the applicant currently holds Medical Staff membership or clinical privileges rather than directly obtaining primary source verification of the information supplied by the applicant.

## 5.6 **Leave of Absence and Reappointment.**

Individuals appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Board for a definite, stated period of time. A leave of absence is an excused absence of a member of the Medical Staff from responsibilities, duties, and privileges for a specified period of time of sixty (60) days but not exceeding twelve (12) months or beyond the present term of the practitioner's appointment.

- (a) Absence for longer than the period of time granted or longer than twelve (12) months shall constitute voluntary resignation of Medical Staff appointment and clinical privileges unless an extension is requested in writing at least thirty (30) days prior to the end of the leave and granted by the Board upon recommendation of the Medical Executive Committee.
- (b) Extensions will be considered only in extraordinary cases of hardship and when extension of a leave is found to be in the best interest of the Hospital.
- (c) Requests for leave of absence shall state the start and anticipated end date of the requested leave and the reasons for the leave (such as military duty, additional training, family matters or personal health). Failure of a practitioner to return or apply for an extension of leave shall constitute a voluntary resignation from the Medical Staff, and shall not be subject to any hearing or appellate review. A request for Medical Staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for reappointment.
- (d) If the leave of absence was for medical reasons, then upon return the practitioner must submit a report from his or her attending physician indicating that the practitioner is physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested competently and safely. The practitioner shall also provide such other information as may be requested by the MMT or MEC at that time. All information shall be forwarded by the CMO to the MMT. After considering all relevant information, the MMT shall then make a recommendation regarding reinstatement to the MEC which shall make recommendation to the governing body for final action.
- (e) If a leave of absence is requested to take remedial training as a result of corrective action or probation, the practitioner, after completion of the training, must present to the appropriate Service Chief and to the MMT satisfactory evidence that the special education/training corrected the deficiencies in clinical performance. The MMT shall evaluate the evidence presented and shall make a recommendation to the MEC. The MEC will act upon that recommendation and forward its recommendation to the governing body for final approval. Any monitoring, review or similar processes affecting the practitioner prior to the leave of absence shall resume upon return of the practitioner from the leave.

- (f) A member in good standing who is granted a leave of absence for special training in his or her specialty to acquire new knowledge and/or skills shall present evidence of competence in the new or different procedure(s) to the department chair and the MMT. After review, the recommendations of the MMT shall be forwarded to the MEC and the governing body for appropriate action.
- (g) Subject also to the conditions set forth above for specific types of leave, at the conclusion of the leave of absence, the individual may request reinstatement by filing a written statement with the CMO summarizing any relevant professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the MMT at that time. Notice of the individual's intent to return from leave must be received a minimum of 30 days before the termination of the leave of absence. The MMT will review the request and make a recommendation to the MEC and to the governing body regarding reinstatement. Reinstatement after a leave of absence is a matter of courtesy, not of right.
- (h) During the period of leave, the practitioner shall not exercise clinical privileges at the Hospital and membership rights and responsibilities shall be inactive but the obligation to pay dues, if any, shall continue unless waived by the MEC.
- (i) The practitioner shall be responsible for obtaining coverage for his or her patients during the leave.
- (j) A leave of absence may not extend beyond the term of the practitioner's current term of appointment. If the practitioner is not ready to return from leave before his or her current appointment term is set to expire, any application for reappointment will be held in abeyance for up to two years until the practitioner identifies with reasonable certainty the date of anticipated return from leave. The practitioner will then be required to supply interval data through the date of the notice of anticipated return from leave to begin the reappointment process. The practitioner's Medical Staff membership shall be considered expired between the time of the expiration of the term in which the leave began and the date of reappointment.

#### 5.7 **Orders From Individuals Without Clinical Privileges or Medical Staff Membership.**

The Hospital may accept and execute orders for outpatients from health care professionals who are not members of the Medical Staff or the Allied Health provider staff and who have not been granted any clinical privileges at the Hospital 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 any state in a field of practice recognized by Wisconsin law and, upon the Hospital's

request, provides evidence satisfactory to the Hospital 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 or herself out to be associated or affiliated with the Hospital or its Medical Staff.
- (f) Refer to the policy on Verification of Non-Affiliated Providers approved by the MEC and Board of Trustees.

## **SECTION 6 – IMMUNITY FROM LIABILITY**

6.1 The following shall be express conditions to any individual’s application or reapplication for, or exercise of, clinical privileges or Medical Staff membership at the Hospital:

- (a) Any act, communication, report, recommendation or disclosure, with respect to any individual, performed or made for the purpose of achieving and maintaining quality patient care and patient safety in this or any other health care facility, shall be privileged to the fullest extent permitted by law;
- (b) Such privileges shall extend to members of the Medical Staff, administration and the governing body, the CMO and any of their designated representatives and to third parties who supply information to or receive information from any of the foregoing authorized to receive, release, or act upon the same. For the purposes of this Section, the term “third parties” means both individuals and organizations who have supplied information to or received information from an authorized representative of the Hospital (including the governing body, the Medical Staff, or administration) and includes but is not limited to individuals, health care facilities, governmental agencies, quality improvement organizations and any other person or entity with relevant information;
- (c) 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;
- (d) Such immunity shall apply to all acts, communications, reports, or disclosures performed or made in connection with this or any other health care institution’s activities related to, but not limited to:
  - (1) Applications for appointment or clinical privileges;

- (2) Monitoring of members of the provisional staff or of any other practitioner or affiliated provider;
  - (3) Periodic reappraisals for reappointment or clinical privileges;
  - (4) Corrective action, including suspension;
  - (5) Hearings and appellate reviews;
  - (6) Medical care evaluations;
  - (7) Utilization reviews;
  - (8) Profiles and profile analysis;
  - (9) Malpractice loss prevention; and
  - (10) Other hospital, departmental, service or committee activities related to quality, safe, and efficient patient care and professional conduct.
- (e) The acts, communications, reports, recommendations and disclosures referred to in this Section may relate to an individual's professional qualifications, clinical competency, character, health status, ethics, or any other matter that might directly or indirectly have an effect on patient care;
- (f) Each individual who exercises clinical privileges or performs any service that is monitored as a condition of exercising the clinical privileges or performing the service, shall indemnify and hold harmless all members of the Medical Staff and governing body, the CMO and their designated representatives from any liability arising from or out of the services performed by the individual being monitored, including but not limited to claims of malpractice, negligent supervision, and any other basis. The exercise of clinical privileges or performance of any service that is monitored constitutes the individual's acceptance of the terms of this indemnification agreement;
- (g) To reaffirm the immunity intended by this Section, each individual shall, upon request of the Hospital, execute releases acknowledging the immunity and protections set forth in this Section in favor of the individuals and organizations specified in Section 6.1(b). Execution of such releases is not a prerequisite to the effectiveness of this Section; and
- (h) The consents, authorizations, releases, rights, privileges and immunities provided by Section 4 of these Bylaws for the protection of this Hospital's practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointments, shall also be fully applicable to the activities and procedures covered by this Section. All provisions in these Bylaws and in other forms used in the credentials process relating to authorizations,

confidentiality of information and immunity from liability are in addition to and not in limitation of other immunities provided by law.

## **SECTION 7 – INTERVIEWS, HEARINGS AND APPELLATE REVIEW**

### **7.1 Interviews.**

- (a) When the MEC or the governing body is considering initiating a professional review action concerning a practitioner (other than immediate suspension) and the practitioner has not previously been afforded an opportunity for an interview with any preliminary investigating body as to the subject matter forming the basis of the professional review action, the practitioner shall be afforded an interview with the body initiating the professional review action. Such interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of this interview shall be made.
- (b) For the purposes of this Section 7.1, a preliminary investigating body may be a Service Chief, a committee or committee chair, the MMT, or the CMO or any other designees acting in the official capacities who provided information or a recommendation to the MEC or governing body upon which the MEC's or governing body's professional review action is based.

### **7.2 Hearings and Appellate Review.**

- (a) When any practitioner receives notice of a professional review action of the MEC, the practitioner shall be entitled, upon request, to a hearing before a hearing committee of the Medical Staff, as outlined in the Plan. If the recommendation of the MEC following such hearing is still adverse to the practitioner, the practitioner shall then be entitled, upon request, to an appellate review by the governing body before a final decision is rendered.
- (b) When any practitioner receives written notice of a professional review action by the governing body taken contrary to a favorable recommendation by the MEC where no right to a hearing existed, such practitioner shall be entitled, upon request, to a hearing before a hearing committee appointed by the governing body, as outlined in the Plan. If such hearing does not result in a favorable recommendation, the practitioner shall then be entitled, upon request, to an appellate review by the governing body before a final decision is rendered.

### **7.3 Procedure and Process.**

All hearings and appellate reviews shall be in accordance with the procedures set forth in the Plan appended to these Bylaws as Appendix A and incorporated into these Bylaws by reference. The MEC shall have the authority to recommend amendments to the Plan, which amendments shall become effective when approved by the governing body.

#### 7.4 **Exceptions.**

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges, nor the extension of monitoring or provisional status, or any other action except those specified in the Plan shall give rise to any right to a hearing or appellate review.

#### 7.5 **Removal of Hospital Employed Physician.**

Removal from office of a Hospital employed physician or termination of a contract for exclusive privileges may be accomplished in accordance with the terms of such individual's contractual agreement. Removal or termination of a contract that provides for the exclusive exercise of clinical privileges by the contracting entity shall terminate the clinical privileges covered by the contract and the termination shall not create any right to a hearing under the Plan. If the termination of an exclusive contract terminates all the clinical privileges held by the practitioner, the practitioner's Medical Staff membership shall also be considered terminated but such termination shall not create any right to a hearing under the Plan.

### **SECTION 8 – MEDICAL STAFF STRUCTURE**

#### 8.1 **Inaugural Medical Executive Committee.**

- (a) **Hospital Start-Up.** The Hospital was formed in 2002 with an anticipated opening date in 2005. A core group of practitioners interested in being members of the active Medical Staff has agreed to serve as the "Inaugural MEC" during the initial start-up period once appointed to active Medical Staff membership by the governing body. During this initial start-up period and for a period of two years from the formal opening of St. Clare's Hospital, the Inaugural MEC will perform the functions of the MEC as identified in these Medical Staff Bylaws, and the provisions set forth in Section 8.2 below relating to the composition, nomination, and selection and removal process shall not apply until the Inaugural MEC is inactivated as described in Section 8.1(g).
- (b) **Composition.** The Inaugural MEC shall be composed of those practitioners invited to serve on the Inaugural MEC by the governing body and appointed to membership on the active Medical Staff, not to exceed 18 practitioners, plus the CMO. In addition, the COO and the CEO or their specified designees shall meet with the Inaugural MEC as non-voting members.
- (c) **Term of Office.** The members of the Inaugural MEC shall serve as members of that body for two years from the date the first practitioner (other than the CMO) is appointed to the Inaugural MEC.
- (d) **Removal and Replacement of Inaugural MEC Members.** The governing body may remove a member of the Inaugural MEC at any time and appoint a replacement to complete the remainder of the individual's unexpired term, as well as fill any other vacancies on the Inaugural MEC. Reasons for removal include:

- (1) failure to adequately discharge or carry out with good faith objectivity the duties of the position;
  - (2) actions contrary to the philosophies, policies or mission of the Hospital; and
  - (3) failure to meet the conditions of and qualifications for membership on the active Medical Staff.
- (e) The CMO shall serve as chair of the Inaugural MEC. The CMO must fulfill the contractual obligations and duties as stipulated by the governing body, in consultation with the CEO, COO and the Inaugural MEC, and consistent with these Bylaws.
  - (f) All members of the Inaugural MEC shall be required to sign the Hospital's Conflict of Interest Statement and Confidentiality Agreement.
  - (g) Inactivation of Inaugural MEC. Once the initial terms of appointment to the Inaugural MEC of the practitioners appointed to that body end, the Inaugural MEC shall cease to exist and shall be replaced by MEC selected and operating pursuant to Section 8.2 below. The decisions, recommendations and actions of the Inaugural MEC made or taken prior to its replacement by the MEC described in Section 8.2 shall remain in full force and effect until or unless the MEC modifies or repeals them, subject to governing body approval of the modification and repeal.
  - (h) The responsibilities of the Inaugural MEC are the same as the MEC listed in 8.3.

## 8.2 Medical Executive Committee.

- (a) Composition. The MEC shall be composed of nine persons all of whom are active members of the Medical Staff. In addition, the COO and CEO or their specified designees shall meet with the MEC as a non-voting member.
- (b) Nomination and Selection of Members:
  - (1) Five of the members of the MEC will consist of the CMO and the employed medical directors who shall also serve as Service Chiefs. These five members shall be selected and directly appointed by the governing body, shall have full voting rights, and shall be called the Medical Management Team (MMT). The four remaining members of the MEC shall be selected by a vote of the general Medical Staff from a slate of active Medical Staff members nominated pursuant to Section 8.2(b)(2).
  - (2) The Professional Activities Committee shall serve as the Hospital's nominating committee and shall convene on or before August 1st yearly. The Professional Activities Committee shall consider the authority, duties and responsibilities of the MEC, as outlined by these Bylaws, when considering active staff members for nomination as an at-large member of

the MEC. The Professional Activities Committee shall develop a process of solicitation and input into potential candidates for nomination and recommend to the governing body by September 1st yearly at least four active staff members to be nominated for election by the active Medical Staff to serve as at-large members of the MEC. If the governing body rejects any recommended nominee, the Professional Activities Committee shall propose one or more replacement candidates until at least four candidates have been approved. Prior to October 1st yearly, the Professional Activities Committee also will develop a slate of potential candidates for any anticipated vacancies of the elected members of the MEC.

#### Professional Activities Committee

The duties of the Professional Activities Committee shall be to:

- (a) Approve bylaws, policies rules and procedures governing professional services provided by the Hospital;
  - (b) Monitor all matters required by governmental or private agencies including JCAHO and other accrediting agencies;
  - (c) Approve clinical privileges for individual professionals and provide oversight as to the quality and scope of clinical practice of those professionals affiliated with the Hospital;
  - (d) Approve medical staff membership for individual professionals and monitor the application of the credentialing process of the Hospital;
  - (e) Monitor and report to the Board of Directors regarding the scope and quality of the clinical practice affiliates;
  - (f) Review and approve employee competencies;
  - (g) Approve medical staff and hospital quality of care plans for the Hospital; and
  - (h) Perform such other duties related to the medical staff and patient care activities as may be assigned to it by the Board of Directors
- (c) Membership Requirements. Active Medical Staff members may be considered eligible for appointment or election to the MEC if they maintain an active clinical practice at the Hospital, unless administrative duties require more than 75% of their professional time, and if they:
- (1) Demonstrated ability to establish professional and collegial relationships;
  - (2) Are committed to the mission, vision, values and strategic plan of the Hospital;

- (3) Demonstrate commitment to the continuous performance improvement activities of the Medical Staff and the Hospital;
  - (4) Are respected by their peers; and
  - (5) Are aware of and willing to enforce compliance with these Bylaws, the Medical Staff Code of Conduct and Conflict of Interest Policy and the Ethical & Religious Directives for Catholic Health Care Services. This enforcement applies only to the Hospital proper and not to other locations and programs not under the Hospital's control or ownership.
- (d) Selection of At-Large Members. The Medical Staff shall select from among the active members nominated by the Professional Activities Committee four individuals to serve as at-large members of the MEC. They shall be selected by means of a written ballot from the slate nominated by the Professional Activities Committee and approved by the governing body. The official ballot will be mailed on or before October 1st to the preferred mailing address identified by the active staff member and supplied to the Medical Staff office. If an active staff member has not indicated a preferred address, the ballots will be sent to the active staff member's office address currently on record. The elected members of the MEC shall be selected by majority vote of the official ballots returned to the Medical Staff office by October 21st.
- (e) Removal and Replacement of Members. The governing body may discontinue the services of an appointed member of the MEC at any time consistent with the terms of their employment contract. Contract termination in accord with this Section shall not automatically revoke existing clinical privileges of the MEC member. In the event of any vacancy, for any reason, on the MMT, the Chair of the governing body, or his or her designee, shall promptly fill the position with a qualified physician after consultation with the COO (and the CMO, if it is not the CMO position). MEC members appointed in this fashion shall have a term equal to the remainder of the term of the member they are replacing.
- (f) The governing body also retains the prerogative to remove an elected member of the MEC at any time. The MEC will recommend to the governing body and Medical Staff, subject to ratification of the Medical Staff, a replacement to complete the remainder of the term for elected members of the MEC removed in this manner and for other vacancies in the elected members of the MEC.
- (g) The active staff members may also remove any member of the MEC except the CMO, if 15% of the active staff members sign a petition calling for the removal of an MEC member, and a two-thirds majority of all the active staff members vote for removal. Any resulting vacancy shall be filled by an election or appointment of a replacement in a manner as determined by the MMT, subject to governing body approval. A person so removed shall not be eligible for re-election for a period of two years following removal.

- (h) Reasons for removal of a member of the MEC include but are not limited to:
  - (1) failure to adequately discharge or carry out with good faith objectivity the duties of the position;
  - (2) actions contrary to the philosophies, policies or mission of the Hospital; and
  - (3) failure to meet the conditions of and qualifications for membership on the active Medical Staff.
- (i) The CMO shall serve as Chair of the MEC and the MMT. The CMO must fulfill the contractual obligations and duties as stipulated by the governing body, in consultation with the CEO, COO and the MEC, and consistent with these Bylaws.
- (j) The appointed and elected MEC members shall contract with the Hospital to perform the duties required for the proper operation of the MEC and MMT. Such contracts shall be for the length of the term of office of the MEC member, as stipulated in the Bylaws.
- (k) The terms of the elected and appointed MEC members shall be two years unless the members are selected to fill a vacancy. Office terms also may be shorter than two years to achieve appropriate staggering of terms as determined by the MMT and the governing body. Prior to the end of the contracted term of office of the appointed members of the MEC, the governing body shall authorize the Professional Activities Committee to review the performance of these members and supply recommendations to the governing body regarding renewal of the contracts of the appointed MEC members.
- (l) All members of the MEC, whether elected or appointed, shall be required to sign the Hospital's Conflict of Interest Statement and Confidentiality Agreement.

### 8.3 **Duties and Responsibilities of the MEC.**

- (a) The elected and appointed members of the MEC shall meet as often as necessary (which generally will be monthly), shall have full voting authority on matters presented to the MEC, and shall perform other duties and functions as the MEC and the governing body shall so determine from time to time. The members of the MEC will be expected to participate in training and fulfill the additional expectations and requirements of MEC membership as outlined under Section 8.2(c) above. The Hospital shall provide MEC members with training and leadership skill development in order to permit MEC members to perform their required tasks. The appointed members of the MEC shall have additional duties as outlined under Sections 8.5 through 8.7 of these Bylaws.

- (b) The MEC shall be delegated sufficient authority and responsibility by the governing body to fulfill the requirements set forth in these Bylaws or as may be otherwise assigned by the governing body.
- (c) The MEC shall be responsible for:
  - (1) assuring that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital receive appropriate, safe and quality medical care;
  - (2) serving as the primary means for providing assurances to the governing body as to the appropriateness of the professional performance and ethical conduct of its members and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available;
  - (3) providing a means through which the Medical Staff may participate in the Hospital's policy-making and planning process;
  - (4) developing and implementing policies, procedures, rules and regulations governing the Medical Staff;
  - (5) developing, administering and monitoring compliance with these Bylaws, the rules and regulations of the Medical Staff, Medical Staff policies and other patient care related Hospital policies;
  - (6) making recommendations to the governing body related to the appointment of active members and Allied Health providers;
  - (7) making recommendations to the governing body related to the granting and re-granting of the clinical practice privileges of each active member and Allied Health provider;
  - (8) taking appropriate corrective or disciplinary action regarding active members and Allied Health providers;
  - (9) implementing the hearing and review process as outlined in the Plan;
  - (10) the Medical Staff peer review and performance improvement plans, including formulation, effective implementation, maintenance and annual review of these plans;
  - (11) formulation, effective implementation, maintenance and annual review of the Hospital's utilization and case management plans;
  - (12) establishing and maintaining a physician health committee;

- (13) evaluating for quality and utilization of the provider based and contracted services, including but not limited to radiation therapy, radiology, pathology, hospitalist, anesthesiology, emergency and outpatient services;
  - (14) working with the Hospital in obtaining and maintaining all accreditations, including radiation safety;
  - (15) assisting the governing body in identifying community health needs, in setting appropriate institutional goals and in implementing programs to meet these needs.
- (d) The MEC shall recommend an annual budget for the performance of the department functions. The proposed budget shall be submitted to the COO for evaluation and recommendation to the governing body.
  - (e) The MEC may create regular or special committees of the active staff members and staff as required to perform department functions. The resolution creating such committees shall include the purpose of the committee, the reporting responsibility of the committee, and the authorized duration of the committee not to exceed 12 months. All committees so authorized will be reviewed at least once yearly and may be authorized for additional duration at the discretion of the MEC. Standing committees identified in these Bylaws are not subject to this provision.
  - (f) The MEC shall implement a program of regular communication with the active staff members and staff of the Hospital. This can include, but is not limited to scheduled periodic meetings of all active members, e-mail communications, distribution of reports, minutes and meetings of the department sections.
  - (g) When outside federal or state agencies or governing law define activities and responsibilities as functions which are to be provided or performed by a Medical Staff as a whole or a medical MEC, or other committee of a Medical Staff of a hospital, absent action by the governing body assigning such functions to another committee or entity of the Hospital, the MEC shall be authorized to, and will undertake to perform or arrange for the performance of all such functions.

#### 8.4 **Meeting and Procedural Rules of the MEC.**

- (a) The MEC shall meet as often as necessary, which generally will be monthly. The MEC may take action at any meeting if six of the voting members are present.
- (b) The majority of the members present will constitute the action of the MEC, unless otherwise stipulated in these Bylaws.
- (c) The MEC may take action without a meeting if a written consent which sets forth the action to be taken is unanimously approved and signed by all members of the MEC. Any or all members of the MEC may participate in a meeting of the MEC

by or through the use of any means of communication by which either of the following occurs: (a) all participating members may simultaneously hear each other during the meeting, or (b) all communication during the meeting is immediately transmitted to each participating member, and each participating member is able to immediately send messages to all other participating members. A member participating in such a meeting is deemed to be present in person at the meeting.

- (d) Special meetings of the MEC can be called at any time by the CMO or any three members. A 48-hour notice is required.
- (e) The MEC shall establish and adhere to regular meetings, maintain complete minutes of its activities, and provide written reports and agendas to the active members of the Medical Staff and governing body.
- (f) An active staff member can arrange, upon notice to the CMO, to meet and confer with the MEC at any regularly scheduled meeting, contingent upon CMO approval and with at least 48 hours advance notice to the MEC.
- (g) The following actions require MEC participation and cannot be delegated to another committee or subcommittee:
  - (1) Amendments to the Bylaws
  - (2) Approval of Medical Staff Policies and Procedures
  - (3) Recommendations concerning individual practitioners with respect to corrective action or quality/utilization review activities
  - (4) Recommendation of denial or approval of affiliation and clinical privileges of individual practitioners
- (h) Policies and procedures adopted by the MEC shall be forwarded to the COO for approval and will be shared with the medical staff for information purposes only. Policies involving appointment, reappointment, and clinical privileges and suspension, restriction, or termination of membership or privileges require governing body approval.

#### 8.5 **Duties & Responsibilities of the MMT.**

- (a) The Medical Management Team (MMT) shall be composed of the CMO and the four other appointed members of the MEC. Each of the appointed members of the MMT, other than the CMO, shall also serve as a Service Chief. The Service Chief shall be certified or otherwise qualified in an appropriate medical specialty and exhibit clinical skills and professional judgment suitable to the expectations of the position. The MMT shall also include the CEO, COO, and other administrators chosen by the CMO, as non-voting members.

- (b) The MMT shall meet as a subcommittee of the MEC, or in conjunction with the full MEC (generally twice monthly). Additional meetings may be called at the discretion of the CMO or as determined by the MEC.
- (c) The MMT may take action at any meeting as long as four members are present. An affirmative vote of three members of the MMT will be required.
- (d) The MMT shall be responsible for and recommend to MEC the following actions:
  - (1) coordinating activities of the hospital departments and Service Chiefs and addressing any interdepartmental issues;
  - (2) credentialing functions, including reviewing and recommending to the MEC the appointment of all new applicants, and coordinating with the Service Chiefs in the reappointment process;
  - (3) evaluating on an ongoing basis any concerns regarding provider competency that are raised by the Service Chiefs, appropriate committees, quality process or peer review process;
  - (4) review and revision of credentialing and privileging criteria as are recommended by the Quality Department and Service Chiefs;
  - (5) implementation of the performance improvement plan for the Medical Staff as approved by the MEC and the governing body;
  - (6) establishing committees as required to perform functions;
  - (7) working with the Hospital's Medical Staff and Clinical Quality Department to review the quality data and assign specific concerns to the appropriate departments for further investigation and recommendation including focused review, when necessary, as defined by the Peer Review Policy.
  - (8) reviewing the yearly plan for performance improvement recommended by each hospital department and Service Chief before final approval by the MEC and the governing body, and receiving periodic progress reports from the departments concerning these quality action plans;
  - (9) serving as the Medical Staff Peer Review Steering Committee;
    - (i) Peer review issues will be reviewed by the MMT after review by the appropriate Service Chief or hospital department or when the appropriate Service Chief fails or refuses to address a peer review issue after being given the opportunity to do so;

- (ii) The recommendations of the department and/or Service Chief will then be reviewed by the MMT before a final report is made to the MEC;
- (10) assuring the quality and timely completion of medical records;
- (11) assuring that the Education & Development Shared Service Operation, which manages continuing medical education functions, is aware of issues of special concern identified by the CMO and Quality Management Department, the MMT, the MEC or Service Chiefs which might benefit from specific CME programs;
- (12) reviewing the Bylaws periodically;
- (13) making recommendation for revisions in the Bylaws to the MEC;
- (14) working with the Hospital leadership to ensure the coordinated, safe, and effective operations of the Hospital and all related patient care services; some of these functions may be delegated to specific standing committee or to ad hoc committees as determined by the MEC, MMT, COO or CMO.

#### 8.6 **Officers of the Medical Staff.**

- (a) The officers of the Medical Staff shall be the CMO, who serves as the Chief of Staff and Chair of the MEC, and the Vice-Chief of Staff/Vice-Chair of the MEC. The duties of the Chair of the MEC are as listed below. The Vice-Chair of the MEC shall assume the duties of the Chair in his or her absence. The Vice-Chair of the MEC shall be nominated by the CMO in his or her capacity as Chair of the MEC from among the MEC members, shall be ratified by the MEC and shall be approved by the governing body.
- (b) The Chair of the MEC is the Medical Staff's advocate and representative in its relationships to the governing body of the Hospital and the administration of the Hospital. The Chair of the MEC, jointly with the MMT, 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:
  - (1) call and preside at all general and special meetings of the Medical Staff;
  - (2) serve as chair of the MEC and MMT, and as a non-voting member of all other Medical Staff committees;
  - (3) participate, without voting privileges on the governing body and its committees;
  - (4) enforce bylaws, rules and regulations, policies and procedures of the Medical Staff and Hospital;

- (5) appoint committee chairpersons and all members of the Medical Staff standing and ad hoc committees, in consultation with the COO and MMT. Committee chairpersons will be asked for their input concerning membership before final recommendations are made. Committee memberships shall be subject to MMT review and final approval;
- (6) support and encourage Medical Staff leadership in and participation on interdisciplinary clinical performance improvement teams;
- (7) report to the governing body on the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges, and corrective action with respect to practitioners and allied health providers who are applying for appointment or privileges, or who are granted privileges or providing services in the Hospital;
- (8) continuously evaluate and annually report to the MEC, MMT and the governing body regarding the effectiveness of the credentialing and privileging processes;
- (9) review compliance with and enforcement of the Ethical & Religious Directives for Catholic Health Care Services among the members of the Medical Staff in their relations with each other, the governing body, the Hospital leadership, other professional and support staff, and the community the Hospital serves;
- (10) communicate and represent the opinions and concerns of the Medical Staff and its individual members on matters affecting the Hospital operations to the COO, the MEC and the Professional Activities Committee;
- (11) ensure that the decisions of the governing body are communicated to and implemented by the Medical Staff; and
- (12) perform such other duties and exercise such authority commensurate with the office as are set forth in these Bylaws.

#### 8.7 **Service Structure.**

- (a) The Medical Staff shall be non-departmentalized. Leadership and coordination of required activities within and between services and hospital departments will be responsibility of the Chief Medical Officer and Service Chiefs: Surgical/Anesthesia, Women and Families, Emergency/Diagnostics & Therapeutics, Medicine/Hospitalist.
- (b) The Chief Medical Officer shall be responsible for:
  1. Overseeing and manages the functions of the Medical Staff and associated committees. Ensures adherence to Medical Staff processes.

2. Overseeing medical quality initiatives and programs for Saint Clare's Hospital. Assesses the quality of medical care to patients, identifies areas that need improvement, and develops and implements systems for improvement. Participates in clinical practice guideline development and implementation.
3. Directing utilization management efforts for Saint Clare's Hospital, including prospective, concurrent, and retrospective assessment of patient care. Makes recommendations as to the dissemination of medical resources.
4. Serving as liaison between the various hospital medical directors and medical staff and administrative personnel. Serves as liaison between the various systems inside and outside the organization, including other medical organizations in the community, consumers, and other systems that may affect the business of the group.
5. Developing in conjunction with Chief Operating Officer and implements a quality management and risk management program. Reviews information collected and passes along to appropriate parties for feedback to physicians.
6. Managing the process for dealing with impaired professionals.
7. Mediating professional disputes and interdepartmental problems involving physicians, as needed and presents issues(s) to the appropriate governing body of the hospital.
8. Resolving grievances from or involving physicians through the medical staff governance structure. Ensures appropriate processes are in place for handling grievances against physicians, nurses, other staff, etc. Responds to complaints in a timely fashion and in accordance with established guidelines.
9. Monitoring patient care and standards of care in the hospitals throughout the organization in order to ensure that the medical staff efforts meet or exceed the standards of the various accrediting organizations. Responsible for seeing that the organization is prepared for all audits or accreditation visits by any state, federal, or accrediting bodies.
10. Monitoring medical compliance programs.

(c) The Service Chiefs shall be responsible for:

- (1) Clinically related activities of the service.
- (2) Administratively-related activities of the service, unless otherwise provided by the hospital.
- (3) Ongoing surveillance of the professional performance of all individuals exercising privileges within the service.

- (4) Recommending to the MMT the criteria for clinical privileges that are relevant to the care provided in the service.
  - (5) Recommending clinical privileges for each member within the service.
  - (6) Assessing and recommending to the MEC and COO off-site sources for needed patient care, treatment, and services not provided by the service or the organization.
  - (7) The integration of the service into the primary functions of the organization.
  - (8) The coordination and integration of hospital interdepartmental and intradepartmental services.
  - (9) Intraservice and interservice coordination and integration.
  - (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 licensed independent practitioners 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 within the service.
  - (16) Recommending space and other resources needed by the service.
  - (17) Participating in the peer review process as related to the members exercising privileges within the service as directed by the MMT or CMO, the MEC, or COO.
- (d) The Service Chief shall recommend to the MEC those other committee assignments needed to comply with the assigned functions of the service.

#### 8.8 **Medical Staff/Hospital Board Liaison Committee.**

Disagreements between the MEC and the governing body shall be referred to the Medical Staff/Hospital Board Liaison Committee for further discussion and action. The Committee shall meet on an as needed basis and shall consist of the three MEC members chosen by the CMO and three members of the governing body chosen by the chair of the

governing body. The members of the governing body shall include the chair of the governing body, or designee. The CEO and COO shall also be invited as non-voting members. The Committee shall review all the pertinent information and make a recommendation to the governing body for final action.

#### 8.9 **Standing Committees.**

- (a) The MEC, at its discretion, may establish committees of the active staff members as indicated in Section 3. Furthermore, the MEC shall establish the Infection Control Committee, Pharmacy and Therapeutics Committee, Physician Health Committee, as Standing Committees of the Medical Staff. The Chairs of the Standing Committees shall be appointed by the CMO, in consultation with the COO. The members of the Committees shall be selected by the Chair of the Committees, in consultation with the CMO and the COO. Appointment of an active staff member to a Standing Committee is for a two-year term which can be renewed at the discretion of the Committee Chair and the CMO. Committee members may be removed at any time, at the discretion of the Chair of the Committee or the CMO. The Standing Committees shall meet on a regularly scheduled basis and as necessary to carry out their responsibilities, shall record minutes of all meetings, and shall report to the COO and the MMT. All Standing Committees are responsible for participating in and monitoring quality improvement activities. The composition and function of each Standing Committee is detailed in a policy statement. All members are eligible to vote.
- (b) The MEC, the Medical Staff/Hospital Board Liaison Committee, the Professional Activities Committee and the Standing Committees are major components of the Hospital's program, organized and operated to help improve the quality of health care in the Hospital, and their activities will be conducted in a manner consistent with the provisions of §§ 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of committee records and proceedings, are intended to apply to all activities of the committees relating to improving the quality of health care and include activities of the individual members of the committees, as well as other individuals designated by the committees to assist in carrying out the duties and responsibilities of the committees, including but not limited to participating in monitoring plans.
- (c) Infection Control Committee shall
  - (1) Be responsible for surveillance of the Hospital for potential and actual infections, promotion of preventive or process improvement programs designed to minimize the risk of infection and the supervision of infection control processes in all areas of the Hospital, including the operating rooms, delivery rooms, recovery rooms, and special care units; and
  - (2) Supervise sterilization procedures, isolation procedures, procedures aimed at reducing cross infection by anesthesia apparatus or inhalation therapy,

procedures for testing the Hospital or its personnel for carrier status, procedures and processes for disposal of infectious materials, and any other infection related processes as requested by the COO or the MEC.

- (d) Pharmacy and Therapeutics Committee shall:
  - (1) Be responsible for the development of a formulary and policies and procedures concerning drug utilization within the Hospital in order to obtain the best clinical results at the least potential for hazard; and
  - (2) Work with the Hospital leadership to develop a process, which includes ongoing monitoring and process improvement activities, to reduce medication errors, especially adverse drug reactions.
- (e) Physician Health Committee. The Physician Health Committee shall be composed of at least three members of the Medical Staff appointed by the CMO. The Committee's role is to provide compassionate assistance to Medical Staff members and those concerned about these members because of problems of health which might impair the member's ability to practice medicine. The policy governing the function and scope of the Committee will be reviewed by the MMT on an annual basis and be approved by the governing body.

## **SECTION 9 – MEETINGS**

### **9.1 Staff Meetings.**

There shall be regular meetings of the Medical Staff at least once a year. At the annual meeting, retiring officers and committee chairs shall make reports.

### **9.2 Special Meetings.**

Special meetings of the Medical Staff may be called at any time by the CMO, and shall be called at the written request of the governing body, the MEC or at least 25% of the active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Notice of a special meeting shall be given to each member of the Medical Staff in writing, electronically or by telephone at least 48 hours before the time set for the special meeting. The special meeting shall be held within 10 business days after the written request is presented to the CMO. A special departmental meeting may be called at the request of the chair of the department or a majority of the active Medical Staff in the department.

### **9.3 Attendance at Meetings.**

- (a) Active Medical Staff members and provisional active Medical Staff members are expected to attend all meetings of the general Medical Staff. They shall be required to attend at least 50% of the meetings of each department in which they hold clinical privileges and of each committee to which they are assigned, excluding committees meeting two or fewer times per year. Failure to meet

these attendance requirements in one Medical Staff year will be reviewed by the MMT in considering the practitioner's suitability for reappointment and/or advancement.

- (b) Members of the honorary, Allied Health, courtesy and consulting categories of the Medical Staff may attend meetings of the Medical Staff but are not required to do so, and shall not be eligible to attend and participate in those portions of meetings devoted to peer review of Medical Staff members in other categories of the Medical Staff, except as set forth in the following paragraph.

#### 9.4 **Quorum.**

Thirty percent of the total membership of the active Medical Staff shall constitute a quorum for general meetings of the Medical Staff. A quorum for committee and department meetings shall consist of 50% of the members of such committee or department who are entitled to vote. A quorum is necessary in order to hold a meeting.

#### 9.5 **Eligibility to Vote.**

- (a) Medical Staff Matters. To vote at a Medical Staff meeting on Medical Staff business, a Medical Staff member must be a member of the active staff.
- (b) Committee Matters. Except as otherwise stated in these Bylaws, only Medical Staff members appointed in accord with these Bylaws to the committee that is conducting the business at issue shall be entitled to vote upon matters before that committee.
- (c) Good Standing. In addition to the eligibility requirements set forth above, a Medical Staff member must be in good standing at the time of the vote for such vote to be counted.

#### 9.6 **Minutes.**

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of attendance of members and the vote taken on each matter. The minutes shall be filed electronically with review available to medical staff members on the hospital intranet. The minutes shall thereafter be forwarded to the MEC. Each committee shall maintain a permanent electronic file of the minutes of each meeting. All Medical Staff members may have access to meeting minutes that are not otherwise privileged and confidential, by accessing them on the hospital intranet.

### **SECTION 10 – RULES AND REGULATIONS**

#### 10.1 **Staff Rules and Regulations.**

The Medical Staff shall adopt such Rules and Regulations that are recommended by the MEC as may be necessary for the proper conduct of the work of the Medical Staff and to implement more specifically the general principles set forth in these Bylaws. Such Rules

and Regulations shall be a part of these Bylaws. Rules and Regulations may be amended or repealed at any regular meeting of the Medical Staff upon the recommendation of the MEC by a majority vote of a quorum of the Medical Staff, provided at least ten days notice, accompanied by the proposed Rule or Regulation and/or alterations has been given of the intention to take such action. Such changes shall become effective when approved by the governing body.

## **SECTION 11 – ADOPTION AND AMENDMENT OF BYLAWS**

### **11.1 Medical Staff Responsibility.**

The MEC shall have the initial responsibility to formulate the Medical Staff Bylaws, Rules and Regulations and any amendments, and to present them to the Medical Staff for adoption and recommendation to the governing body. Such Medical Staff Bylaws, Rules and Regulations, and amendments shall be effective when approved by the governing body.

Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, so as to have Bylaws, Rules and Regulations of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review.

### **11.2 Methodology.**

Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

- (a) The affirmative vote of two-thirds of the active staff eligible to vote on this matter as set forth in Section 9.5, who are present at a meeting at which a quorum is present, provided at least ten days written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action;
- (b) In the event that a quorum is not present to act on an amendment or in the event that it is necessary for the staff to act on an amendment without being able to meet, the voting staff may be presented with the proposed amendment by mail and their votes returned to the CMO by mail.
  - (1) Ballots will be distributed to the Medical Staff and include the proposed amendment, a section to indicate their vote, instructions for return and a deadline for return of 14 days after the date of ballot distribution.
  - (2) A minimum of 30% of the Active Staff, eligible to vote, shall be required to return ballots before votes will be tallied for amendments recommended by the MEC and a minimum of 60% for amendments not recommended by the MEC.

- (3) To be adopted, a two-thirds affirmative vote from the ballots received shall be required.
  - (4) If the minimum percentage specified of the Active Staff ballots are not received by the deadline, the deadline shall be extended seven days. If by that deadline the minimum return threshold is not achieved, then the amendment shall be deemed adopted for amendments recommended by the MEC and shall be deemed rejected for amendments not recommended by the MEC.
- (c) Amendments adopted by the Medical Staff shall be effective when approved by the governing body.
  - (d) These Bylaws may not be unilaterally amended. In the event that the Medical Staff shall fail to exercise its responsibility and authority as required by Section 11.1 of this section, and after notice from the governing body to such effect, including a reasonable time for response, the governing body may, upon its own initiative, formulate amendments to these Bylaws. In such event, Medical Staff recommendations and views will be carefully considered by the governing body during its deliberations and in its actions.

### 11.3 **Effective Date.**

These Bylaws, together with the appended Rules and Regulations, shall be adopted at any regular meeting of the active Medical Staff, shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the governing body of the Hospital. They shall, when adopted and approved, be equally binding on the governing body and the Medical Staff.

### 11.4 **Review and Revision.**

The Medical Staff Bylaws, Rules and Regulations, and policies shall be reviewed periodically and revised as necessary. The review shall be undertaken through a procedure designated by the CMO and any proposed amendments and revisions of the Bylaws shall be adopted by the Medical Staff and governing body as provided in Section 11.2.

**ADOPTED** by the active Medical Staff of Saint Clare's Hospital of Weston, Inc.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chief of Medical Staff

**APPROVED** by the governing body of Saint Clare's Hospital of Weston, Inc.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chair of Governing Body of Directors