

THE BYLAWS, RULES AND REGULATIONS
OF
THE MEDICAL STAFF

SAINT JOSEPH'S HOSPITAL

MARSHFIELD, WISCONSIN

Revised April 1993
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PREAMBLE

WHEREAS, Saint Joseph's Hospital is a non-profit corporation under the laws of the State of Wisconsin; and

WHEREAS, its purpose is to serve as a general type of Hospital providing patient care, education, research, and promotion of health and wellness; and

WHEREAS, it is recognized that the Governing Body has delegated to the Medical Staff the responsibility for the quality of medical care in the Hospital, which must accept and discharge this responsibility, subject to the ultimate authority of the Governing Body, and that the cooperative efforts of the Medical Staff, the President and the Governing Body are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the physicians, dentists, and podiatrists practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

DEFINITIONS

1. The term "*Medical Staff*" means the Hospital's organized component of Practitioners appointed by the Governing Body of Saint Joseph's Hospital and granted specific medical privileges for the purpose of providing appropriate medical, dental and podiatric care to patients in the Hospital.
2. The term "*Governing Body*" means the Board of Trustees of Saint Joseph's Hospital.
3. The term "*Medical Staff Executive Committee*" or "*Executive Committee*" means the Executive Committee of the Medical Staff unless specific reference is made to the executive committee of the Governing Body.
4. The term "*President*" means the individual appointed by the Governing Body to act in its behalf in the overall management of the Hospital.
5. The term "*Practitioner*" means an appropriately licensed medical physician, osteopathic physician, dentist, or podiatrist.
6. The term "*Physician*" as used in these Bylaws, Rules and Regulations means a doctor of medicine or doctor of osteopathy possessing an unrestricted license issued by the State of Wisconsin.
7. The term "*Medical Staff Year*" as used in these Bylaws, Rules and Regulations commences on the 1st day of February and ends on the 31st day of January of each year.
8. The term "*Hospital*" as used in these Bylaws, Rules and Regulations means Saint Joseph's Hospital of Marshfield, Inc.

9. The term “*Special Notice*” as used in these Bylaws, Rules and Regulations means written notice personally delivered to the recipient or by certified mail, return receipt requested.

ARTICLE I. NAME

The name of this organization shall be the *Medical Staff of Saint Joseph’s Hospital*.

ARTICLE II. PURPOSES

The purposes of this organization are:

1. To provide systems so that all patients admitted to or treated in any of the facilities, departments, or services of the Hospital shall receive quality care.
2. To insure a high level of professional performance of all Practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each Practitioner may exercise in the Hospital and through an ongoing review and evaluation of each Practitioner’s performance in the Hospital.
3. To provide an appropriate educational setting that will maintain scientific standards, lead to continuous advancement in professional knowledge and skill, and encourage and cooperate in approved research.
4. To continue high levels of competence in formal education of nurses, allied health personnel, medical affiliates, and to cooperate with area medical schools in undergraduate and graduate education.
5. To initiate and maintain rules and regulations for self governance of the Medical Staff.
6. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body, and the President and/or designee.
7. To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs; and
8. To conduct all its affairs involving the Medical Staff, patients and employees in a manner and an atmosphere free of discrimination because of age, sex, creed, national origin, race, handicap, or financial status.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

Section A. Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, requirements and ethical directives set forth in these Bylaws. Appointment to and membership on the Medical Staff shall confer on the Practitioner only such clinical privileges as have been granted by the Governing Body in accordance with these Bylaws.

Section B. Qualifications for Membership

1. Only Practitioners licensed to practice in the State of Wisconsin, who can provide documentation of continued DEA registration if applicable and who can document their background, experience, training, and demonstrate competence, an ability to perform the privileges requested, adherence to the ethics of their profession, and their ability to work with others competently and cooperatively to assure the Medical Staff and Governing Body that any patient treated by them in the Hospital will be given quality medical care, shall be qualified for membership on the Medical Staff. No Practitioner shall be entitled to membership on the Medical Staff or to exercise particular clinical privileges in the Hospital merely by virtue of being duly licensed to practice medicine, dentistry, or podiatry in this or any other State, or because of membership on any professional organization, or in the past or present having had such privileges at another hospital.
 - a. To qualify for membership on the Medical Staff, the individual must not be barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code.
 - b. No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid is eligible or qualified for Medical Staff membership.
2. As a part of their appointment and reappointment to the Medical Staff, or at any other time upon the request of the Governing Body or Medical Staff Executive Committee, Practitioners must certify 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, and 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 Executive Committee or the Governing Body. The presence of a physical or mental condition which can reasonably be accommodated shall not constitute a bar to the granting of Medical Staff membership or clinical privileges.
3. Practitioners must submit and maintain on file at all times current evidence of continued licensure, DEA registration if applicable and financial responsibility in amounts which shall be determined by the Governing Body after consultation with the Executive Committee, 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 certificate each time these documents change or are updated.

4. As part of their appointment and reappointment to the Medical Staff, Practitioners have a continuing obligation to promptly notify the President of, and to provide such additional information as may be requested regarding each of the following:
 - a. the revocation, limitation 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;
 - b. loss of staff membership or privileges at any hospital or other health care institution whether temporary or permanent, including all suspensions;
 - c. limitation, restriction or reduction in one or more clinical privileges that arose as a result of quality concerns;
 - d. cancellation or change of professional liability insurance coverage;
 - e. 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 peer review organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin;
 - f. receipt of notice of the filing of any suit against the Practitioner alleging professional liability in connection with the treatment of any patient in or at the Hospital;
 - g. 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;
 - h. any proposed or actual exclusion from any federally-funded health care program, any notice to the individual or his representative of proposed or actual exclusion or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid; and
 - i. receipt of notice of the filing of any suit against the Practitioner alleging professional liability in connection with the treatment of any patient in or at the Hospital

5. No person who is otherwise qualified shall be denied Medical Staff membership or privileges by reason of race, age, color, creed, handicap, disability, sex or national origin; or on the basis of any other criterion unrelated to the delivery of good patient care in the Hospital, to professional qualifications, to the Hospital's purposes, needs and capabilities, to community need, or to any requirements set forth in these Bylaws.
6. As part of their appointment and reappointment to the Medical Staff, Practitioners have a continuing obligation to comply with federal and state laws and regulations applicable to the practice of their profession, including, but not limited to proof of immunity against rubella, mumps and varicella zoster, compliance with bloodborne pathogen standards, and annual tuberculosis testing.
7. The Governing Body shall solely determine whether to select or reject Medical Staff based on the limitations of facilities, services, staff, support capabilities or any combination thereof. Decisions not to appoint or reappoint or grant privileges to an otherwise qualified Practitioner in accord with criteria of a Medical Staff development plan or due to the existence of any contracts for exclusive provision of clinical services shall be made by the Governing Body.
8. The foregoing qualifications shall not be deemed exclusive by other qualifications and conditions deemed by the Hospital and the Medical Staff to be relevant in considering an applicant's application for exercising privileges in the Hospital.

Section C. Responsibilities of Medical Staff Membership

Each member of the Medical Staff shall:

1. Provide their patients with care at the generally recognized professional level of quality, efficiency and safety.
2. Participate in the care of indigent and needy patients.
3. Abide by the Medical Staff Bylaws, Rules and Regulations and by all other adopted standards, policies, rules and procedures of the Hospital and Medical Staff.
4. Fulfill such staff, department, committee, and Hospital functions for which the member is responsible by staff category assignment, appointment, election or otherwise.
5. Prepare and complete the patient medical records in a timely manner for all patients they admit or in any way provide care to in the Hospital.
6. Participate in Hospital peer review activities.

7. Agree to subject their performance to and faithfully participate in the Hospital's quality improvement programs as the same may from time to time be in effect in accordance with requirements of external regulatory agencies.
8. Abide by the Ethical and Religious Directives for Catholic Health Care Services and by the ethical principles of the Practitioner's profession.
9. Recommend to the Governing Body short and long-range planning activities, to assist in identifying community health needs, and to suggest to the Governing Body appropriate institutional policies and programs to meet those needs.
10. Attendance at Medical Staff and department meetings is encouraged but not required.
11. Discharge such staff, service, committee and Hospital functions for which he or she is responsible by staff status, assignment, appointment, election or otherwise.
12. Work with and relate to other Practitioners, medical affiliates, members of professional review organizations and accreditation bodies in a manner essential for maintaining a hospital.
13. Pledge not to receive from or pay to another Practitioner, either directly or indirectly, any part of any fee received for professional services not actually rendered personally or at the Medical Staff member's direction.
14. Provide for continuous care and supervision of patients, and refrain from delegating the responsibility for diagnosis or care of Hospital patients to any individual who is not qualified to undertake the responsibility and who is not adequately monitored.
15. Promptly notify the President of revocation, limitation or suspension of his/her professional license or DEA registration, or the imposition of terms of probation or limitation of practice by any state, or of his or her loss of staff membership, privileges or a limitation, restriction or reduction in one or more clinical privileges that arose as a result of quality concerns at any hospital or other health care institution, or of the cancellation of his or her professional liability insurance coverage, or the commencement of a formal investigation, or the filing of charges by the Department of Health and Human Services, or any law enforcement agency, or health regulatory agency of the United States or the State of Wisconsin.
16. Accept committee and consultation assignments as may be required by these Bylaws, Rules and Regulations.
17. Discharge such other responsibilities as may be required by the Medical Staff, subject to the Governing Body's approval.

Section D. The Dental Staff Functions.

1. Dentists granted membership on the Medical Staff in accordance with the procedures set forth in Article V may be members of any category of the Medical Staff for which they qualify and shall be assigned to the Department of Oral Surgery.
2. Patients admitted to the Hospital for dental care shall be given the same medical appraisal as those admitted for other services. Admission of a dental patient shall be the dual responsibility of the dentist and a physician member of the Medical Staff. The physician shall be responsible for the care of any medical problems that may be present on admission including any needed history and physical for the patient, or other needs that may arise during the hospitalization of a dental patient (unless the dentist is an oral maxillofacial surgeon).
3. Dentists shall conform to the Bylaws, Rules and Regulations of the Medical Staff with the following additions:
 - a. Patients may be admitted for dental services by a dentist after obtaining the concurrence of the admitting physician.
 - b. Surgical procedures performed by dentists shall be done under the overall supervision of the Chair of Oral & Maxillofacial Surgery or his or her designee.
 - c. At the time of surgery scheduling and at the time of admission, the name of the attending physician must appear on the appropriate forms. This physician shall be responsible for pre and post-operative medical evaluation and care of the patient.
 - d. The dentist may discharge the patient after obtaining the concurrence of the attending physician.
 - e. Complete records, both dental and medical, shall be required on each patient and shall be part of the Hospital record.

Section E. The Podiatric Staff Functions

1. Podiatrists granted membership on the Medical Staff in accordance with the procedures set forth in Article V may be members of any category of the Medical Staff for which they qualify and shall be accordingly assigned to the Department of Orthopedic Surgery.
2. Patients admitted to the Hospital for podiatric care shall be given the same medical appraisal as those admitted for other services. Admission of a podiatric patient shall be the dual responsibility of the podiatrist and a physician of the Medical Staff. The physician shall be responsible for the care of any medical problems that may be present on admission, including any needed history and physical for the patient, or other needs that may arise during the hospitalization of a podiatric patient.

3. Podiatrists shall conform to the Bylaws, Rules and Regulations of the Medical Staff with the following additions:
 - a. Patients may be admitted for podiatric services by a podiatrist after obtaining the concurrence of the physician.
 - b. Surgical procedures performed by podiatrists shall be done under the overall supervision of the Department Chair of Orthopedic Surgery or his or her designee.
 - c. At the time of surgery scheduling and at the time of admission, the name of the physician must appear on the appropriate forms. The physician shall be responsible for pre-and post-operative medical evaluation and care of the patient.
 - d. The podiatrist may discharge the patient after obtaining the concurrence of the physician.
 - e. Complete records, both podiatric and medical, shall be required on each patient and shall be part of the Hospital record.

Section F. Conditions and Duration of Appointment

1. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Medical Staff Executive Committee as provided in these Bylaws; provided that in the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the Medical Staff.
2. By the end of six months after initial appointment, the Practitioner's performance and clinical competence shall be evaluated via specific proctoring process within his/her department as defined by the Credentials Committee. The department chairperson or designee, and the department chairpersons will provide written documentation to the Credentials Committee on the Practitioner's performance.
3. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Body upon the recommendations of the Medical Staff Executive Committee, in accordance with these Bylaws.
4. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's obligations to provide continuous care and supervision of their patients, to abide by the Medical Staff Bylaws, Rules and Regulations, to accept committee assignments,

to accept consultation assignments and to participate in quality improvement activities.

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF, HOUSE STAFF AND ALLIED HEALTH

Section A. The Medical Staff

The Medical Staff shall be divided into Active, Active/Provisional, Associate, Courtesy, Limited, and Consultant Active. There shall also be House Staff and Allied Health Staff. These categories are not categories of the Medical Staff, but are adjunct categories of Hospital staff that are subject to the provisions of these Bylaws, Rules and Regulations.

Section B. The Active Medical Staff

The Active Medical Staff shall consist of Practitioners who regularly care for patients in the Hospital. They shall be responsible for the continuous care of their hospital patients. They assume all the functions and responsibilities of membership on the Active Medical Staff including, where appropriate, emergency service care and consultation assignments. Active Medical Staff shall participate in call arrangements and follow all other policies of their department.

Members of the Active Medical Staff shall be appointed to a specific department, shall be eligible to vote, to hold office, and to serve on Medical Staff committees, and be encouraged to attend the Annual Medical Staff meetings.

Section C. The Consultant Active Staff

It is recognized that there are Practitioners who may not be permanently located in this area, but are willing to practice here for limited periods of time to meet specific needs as specified by the Medical Staff. These Practitioners would become members of the Consultant Active Staff.

The Consultant Active Staff shall consist of Practitioners who provide a specific service to St. Joseph's Hospital patients. They have privileges limited to their specific area of service, and limited call responsibility.

They shall be responsible for developing a sufficient plan for continuous care of their patients when they are not in the area.

Members of the Consultant Active Staff shall be appointed to a specific department, but they shall not be eligible to vote or hold office.

Section D. The Associate Medical Staff

1. The Associate Medical Staff shall consist of Residents who are Independent Contractors. They shall be appointed to a specific department and shall be responsible for the continuous care of their hospital patients either personally or through arrangements with another qualified provider. They shall not be eligible to vote at general staff meetings nor to hold office. They shall agree to abide by the Bylaws and Rules and Regulations of the Medical Staff.
2. Throughout the period of associate appointment, it will be the responsibility of the chairperson of the appropriate department to orient the Practitioner to the department, and to oversee performance and quality.

Section E. The Courtesy Medical Staff

The Courtesy Medical Staff shall consist of Practitioners who treat a maximum of 12 patients per year in the hospital. Courtesy Medical Staff members shall be appointed to a specific department, but shall not be eligible to vote or hold office in this Medical Staff organization or departments. The Courtesy Medical Staff may be assigned to serve as members of Medical Staff committees as determined by the Chief of Staff. They shall be encouraged to attend the Annual Medical Staff Meeting. They shall be responsible for the continuous care of their hospital patients. Members of the Courtesy Medical Staff shall be restricted to treating a maximum of 12 patients per year. If this number is exceeded at any time during the Medical Staff Year, the member must apply for an advancement of membership. A member of the Courtesy Medical Staff must be a member of the active or provisional medical staff of another hospital where he or she is subject to peer review process and other quality assessment and improvement activities similar to those required of the Medical Staff of this Hospital. If the practitioner is not a member of an active staff at another hospital their quality will be assessed through peer review.

Section F. House Staff Membership

1. It is the policy of the Hospital to promote and encourage continuing medical education at the medical student and residency level. Members of this category are not members of the Medical Staff. House Staff shall function as defined in the Rules and Regulations of the Medical Staff or any educational affiliation agreement approved by the Medical Staff and Governing Body.
2. House Staff memberships include:
 - a. Extern and Clinical Clerkship: Externs, Preceptors and Medical Students shall be under the direction of a member of the Active or Active/Provisional Medical Staff.
 - b. Residents: Resident Staff includes the full-time Post Graduate (PG) staff in training having assigned responsibility for patient care under an Active or Active/Provisional Medical Staff member. Resident Staff physicians do not have sole responsibility for patient care and have no direct admitting privileges, except through an Active Medical Staff member.

Section G. Allied Health Staff

1. The Allied Health Staff consist of those allied health professionals who participate in Hospital patient care and are not employees of the Hospital. Members of this category are not members of the Medical Staff.
2. The Allied Health Staff shall consist of Independent Allied Health Staff.

This category of allied health shall consist of psychologists, speech pathologists, PAs, CRNAs, advanced registered nurse practitioners, social workers, professional counselors, marriage and family counselors, optometrists, certified nurse midwives and dieticians who are licensed, registered or certified in the State of Wisconsin. Independent Allied Health Staff may provide patient care services without Active, Courtesy, or Consultant Active Medical Staff supervision within the limits of their delineated privileges established by their department.

3. An individual applying as Allied Health Staff must be recommended to the Governing Body by an Active, Courtesy, or Consultant Active Medical Staff member, the Credentials Committee and the Medical Staff Executive Committee.
4. These applications for appointment shall be processed through the same channels as those for Medical Staff membership and privileges. If the applicant is a nurse, the Vice President of Patient Care Services reviews and signs off on the application.
5. Scope of Practice

All individuals who are determined by the Credentials Committee as appropriate for categorization as Allied Health Staff shall complete an individual application form as is approved by the Medical Staff Executive Committee and the Governing Body and submit a copy of same to the President of the Hospital or designee. After verification of the information on the application form, the application and privilege lists for Independent Allied Health Staff shall be reviewed by the appropriate Medical Staff department chairperson in the department in which the Allied Health Staff or responsible staff member is assigned. The department chairperson shall submit a recommendation as to privileges to the Credentials Committee. In determining the extent of privileges, the following criteria shall be considered by the department chairperson and Credentials Committee.

- a. The exercising of independent judgment within their areas of competence provided always that an Active, Courtesy or Consultant Active member of the Medical Staff should have ultimate responsibility for the care of the patient.

- b. Participating in the management of patient care under the supervision and direction of a member of the Active, Courtesy or Consultant Active Medical Staff.
- c. The writing of orders and entering of notations on patients' charts shall be permitted to the extent allowed by governing Wisconsin law and such appropriate Rules and Regulations of the Medical Staff.

Upon approval by the Credentials Committee, the application shall be submitted to the Executive Committee and Governing Body of the Hospital for their respective approvals.

6. Responsibilities and Prerogatives.

Allied Health Staff members have neither the duties nor rights as are required of members of the Medical Staff. Such individuals may, with the approval of the Chief of Staff or Medical Staff committee chairperson, serve on Medical Staff committees if appointed or on departmental committees. Allied Health Staff are encouraged to attend such Medical Staff meetings in which matters of interest in their profession may be discussed, and may be required to attend such meetings of the Medical Staff or its committees which entail a discussion or review of cases in which they participated in clinical care. All Allied Health Staff members are subject to biennial review. No Allied Health Staff members may admit or discharge patients from the Hospital.

7. Removal for Cause.

The privileges of an Allied Health Staff member may be terminated or suspended by the Chief of Staff or the Hospital President. Upon such termination or suspension, they:

- a. Shall receive notice of the adverse decision.
- b. Shall receive a statement of the basis for the decision.
- c. Shall, within 10 days of receiving notice of an adverse decision, have an opportunity to request to present evidence on their own behalf to an ad-hoc committee of the Medical Staff Executive Committee. Such Committee will consist of three Active Medical Staff members appointed by the Chief of Staff, and shall exclude the Department Chair of the Medical Staff Department to which the Allied Health Practitioner belongs.
- d. The Ad-Hoc Committee will communicate their decision to the Chief of Staff.
- e. The Allied Health Practitioner may, within 10 days of receipt of an adverse decision by the Ad-Hoc Committee, request appeal of the decision to the Medical Staff Executive Committee.

8. Should any member of the Medical Staff whose duties or responsibilities include the direct supervision and responsibility of an Allied Health Staff member be terminated or suspended, the Allied Health Staff member shall be terminated or suspended

summarily from their duties unless and until the Allied Health Staff member's status is restored by a decision of the President and Chief of Staff of the Hospital and supervision responsibility transferred to another member of the Medical Staff.

Section H. The Limited Medical Staff

1. The Limited Medical Staff shall consist of those practitioners who are members of the active staff of another hospital where the practitioner actively participates in a quality assessment and improvement activities similar to those required of the members of the active staff of this hospital and who seek medical staff membership for the limited purpose of performing admitting history and physicals or to refer patients for admission. If the practitioner is not a member of an active staff at another hospital their quality will be assessed through peer review.
2. Members of the Limited Medical Staff shall:
 - a. Not be eligible to serve on Medical Staff committees;
 - b. Not be eligible to vote at general staff meetings or departmental meetings;
 - c. Not be eligible to hold office;
 - d. Not be required to attend general medical staff meetings or departmental meetings, but may do so, except they 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;
 - e. Not have admitting or treating privileges;
 - f. May order but not perform outpatient diagnostic procedures.
 - g. Limited Medical Staff Members will be assigned to a Medical Staff Department.
3. Individuals desiring appointment to the Limited Medical Staff shall complete an individual application form approved by the Medical Staff Executive Committee and the Governing Body, and submit a copy of same to the President of the Hospital or designee. The applicant shall also submit:
 - a. Evidence of current Wisconsin licensure
 - b. Information pertaining to any sanctions against their Wisconsin license, and
 - c. Evidence of current professional liability insurance.

After verification of the information on the application form, the application and privilege list shall be reviewed by the appropriate Medical Staff department chairperson. The department chairperson shall submit a recommendation as to privileges to the Credentials Committee.

Upon approval by the Credentials Committee, the application shall be submitted to the Medical Staff Executive Committee and Governing Body of the Hospital for their respective approvals.

**ARTICLE V. PROCEDURE FOR APPOINTMENT
AND REAPPOINTMENT**

Section A. Application for Appointment and Initial Granting of Clinical Privileges

1. Practitioners desiring appointment to the Medical Staff shall obtain an application and privilege request form from the President or his or her designee who will, in addition to the forms, supply the applicant with a copy of the Hospital Bylaws, Medical Staff Bylaws, and Rules and Regulations. A copy of the principles of medical ethics of the American Medical Association, Notice of Privacy Practices and the Ethical and Religious Directives for Catholic Health Care Services.

2. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the Medical Staff Executive Committee. The application shall require:
 - a. detailed information concerning the applicant's professional qualifications,
 - b. the name of at least two persons who have had extensive experience in observing and working with the applicant
 - c. written references pertaining to the applicant's professional competence and ethical character,
 - d. a listing of all hospital medical staff memberships held within five years prior to the application
 - e. information as to whether the applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced or not renewed at any other hospital or institution, or whether the applicant resigned or voluntarily reduced privileges as a result of a peer evaluation
 - f. whether or not the applicant has ever been refused liability insurance or had same cancelled;
 - g. information as to any past or pending involvement in any quality inquiry, sanction action or formal investigation by a Medicare peer review organization;
 - h. information as to whether membership in local, state or national medical societies, or license to practice any profession in any jurisdiction, has ever been suspended, terminated, or subject to any terms of probation or limitation and
 - i. 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.

3. 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.

4. The applicant shall also provide information as to any currently pending challenges to any licensure or registration of the applicant or the voluntary relinquishment of such license or registration, and as to the applicant's ability to safely exercise the privileges requested.
5. Information on current health status will be obtained on a separate form and will not be reviewed or considered until after a preliminary recommendation to appoint is made by the Medical Staff Executive Committee unless the applicant elects to volunteer health information at an earlier point.
6. In order to determine the applicant's current level of competency, professional references must have had direct contact with the applicant within the preceding 24 months. Such references must have personal knowledge of the applicant's scope of performance, current clinical competence (including clinical judgment and technical skills), ethical character, and ability to work cooperatively with others and be willing to provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time and at least one must have had organizational responsibility for supervision of the applicant's performance as a department chair, service chief, training program director, or similar role. Professional references from residents and fellows in training programs, and relatives of the applicant are not acceptable as references. Reasonable effort (two written requests) will be made to secure replies from individuals/institutions listed on the application. It is the applicant's responsibility to secure the necessary references within 60 days after notification of deficiencies in the application. Exceptions may be made when information is not otherwise available. If the requested information is still not received at the end of the 60 day period, the application will be considered withdrawn and will not be processed further.
7. The completed application shall provide a full summary of the applicant's education and training, documented experience including all pertinent hospital and clinic practice affiliations, past and present state licensure, professional liability claims history, board certification and recertification, and professional references.
8. Applicants shall promptly notify the Chief of Staff and the Hospital President of the revocation or suspension of their professional license, the imposition of terms of probation or limitation of practice by any state, the loss of their staff membership or loss or restriction of privileges at any hospital or other health care institution, the filing of charges by the Department of Health and Human Services, voluntary accrediting or registering bodies or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin.

9. 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 competence, references and other relevant information including an appraisal by the clinical department in which such privileges are sought. The applicant shall have the burden of establishing both qualifications and competency in the clinical privileges requested.
10. The applicant shall supply evidence of minimum liability insurance in such amounts as required by the state. Upon initial application to the Medical Staff, the applicant must report any professional liability cases in which payment has been made on their behalf, either as a settlement, or as the outcome of a court action. Applicants must also report any pending cases at the time of initial application. Such cases will be reported on the application form, with a description of the case and outcome.
11. The applicant shall have the burden of producing adequate information for a proper evaluation of current clinical competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. Failure to adequately complete the application form, the withholding of requested information, omitting material information necessary for a complete assessment of the applicant's qualifications, or providing false or misleading information shall be a basis for denial of membership on or removal from the Medical Staff.
12. The completed application shall be submitted to the Hospital President/designee. After collecting the references and other materials deemed pertinent, the President/designee shall transmit the application and all supporting materials to the Credentials Committee for evaluation.
 - a. The Medical Staff Office may administratively reject an application for appointment to the medical staff or for clinical privileges without forwarding the application to the Credentials Committee, if it determines that the applicant does not hold a valid Wisconsin license, does not have adequate professional liability insurance, is not eligible to receive payment from the Medicare or Medical Assistance Program, is currently excluded from any health care program funded in whole or in part by the federal government, or is barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code. Applicants who are administratively denied under this Section do not have a right to a fair hearing under Article VIII of these Bylaws but may submit evidence to the Medical Staff Office to refute the basis for the administrative denial.
13. By applying for appointment to the Medical Staff, the applicant thereby signifies willingness to appear for interviews in regard to the application; authorizes the Hospital to consult with any and all members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on competence, character, experience and ethical

qualifications; consents to the Hospital's inspection of all records and documents that may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested as well as moral and ethical qualifications for staff membership; releases from any liability all representatives of the Hospital and its Medical Staff for acts performed in good faith and without malice in connection with evaluating the applicant's credentials; and releases from any liability all individuals and organizations who provide information at the request of the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

14. Applicants agree that any lawsuit brought by the applicant against an individual or organization providing information to a Hospital representative, or against any Hospital representative, shall be brought in a court, federal, or state, in the state in which the defendant resides or is located. For purposes of this section, the term "representative of the Hospital" includes the Governing Board and its members and committees; the Hospital President; the Medical Staff organization; all staff members, departments, and committees which have responsibility for collecting, evaluating, or acting upon the applicant's credentials or application; and any authorized representative of any of the foregoing.
15. The application form shall include a statement that the applicant agrees to provide continuous care to his or her patients and that the applicant has received and read the Bylaws, Rules and Regulations of the Medical Staff and agrees to be bound by the terms thereof if granted membership and/or critical privileges, and to be bound by the terms thereof in all matters relating to consideration of the application, whether or not the applicant is subsequently granted membership and/or clinical privileges.

Section B. Appointment Process

1. Within 180 days after the Credentials Committee receives the completed applications for membership, the Credentials Committee shall make a written report of its investigation to the Medical Staff Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, licensure, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including an appraisal from the clinical department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested as set forth in Article VI of these Bylaws. Every department in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific, written recommendations for delineating the applicant's clinical privileges and these recommendations shall be made part of the report. Together with its report, the Credentials Committee shall transmit to the Medical Staff

Executive Committee, through the Chief of Staff, the completed application and a recommendation that the applicant be either appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration.

2. While the recommendation on appointment to the Medical Staff is based primarily on the professional competence of the applicant, the Governing Body may also consider 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, and the geographic location of the applicant and his or her practice to the extent it affects the applicant's ability to provide effective continuity of care for Hospital patients.
3. In circumstances where the Credentials Committee recommendation is favorable to the Practitioner, and there is no Medical Staff Executive Committee meeting scheduled within the next seven days, the Chief of Staff, acting on behalf of the Medical Staff Executive Committee, may determine whether to refer the application for consideration by the Medical Staff Executive Committee or to recommend to the Governing Body initial appointment to the Medical Staff. All recommendations to appoint must also specifically recommend the clinical privileges to be granted. When the recommendation of the Credentials Committee or that of the Chief of Staff is to refer the application for further consideration, to recommend privileges qualified by probationary conditions, or to recommend denial of membership or privileges, the Chief of Staff shall forward the recommendation to the Medical Staff Executive Committee for consideration.
4. At its next regular meeting after receipt of the Credentials Committee's or Chief of Staff's recommendation, the Medical Staff Executive Committee shall determine whether to defer the application for further consideration or to recommend to the Governing Body appointment of the Practitioner to the Medical Staff or rejection of the Practitioner for Medical Staff appointment. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges. When the recommendation of the Medical Staff Executive Committee is to defer the application for further consideration, the recommendation shall state the basis for deferral and shall specify the date of the meeting at which the application will be reconsidered.
5. Any recommendation for appointment will be conditioned upon the applicant's completing documentation of his or her current physical, mental and emotional ability to safely perform the clinical privileges requested, with or without accommodation. Such documentation will be completed by the applicant and assessed by the Chief of Staff or Medical Staff Executive Committee, as appropriate, prior to any referral of the recommendation to the Governing Body. The Practitioner, upon request of the Governing Body, the Chief of Staff, or the Medical Staff Executive Committee, may be required to undergo such physical

examinations as are deemed necessary to show that the Practitioner's mental, or physical health will not negatively impact the Practitioner's ability to provide an adequate level of patient care. When so requested, a Practitioner shall authorize the reviewing committees, Chief of Staff and Governing Body of the Hospital to have full access to any and all medical records or treatment information concerning his or her health status.

6. Unless the health information obtained requires further evaluation and reconsideration, when the recommendation of the Medical Staff Executive Committee or Chief of Staff, as appropriate, continues to be favorable, the President shall promptly forward the recommendation, together with all supporting documentation, to the Governing Body. A copy of any favorable recommendations from the Chief of Staff to the Governing Body shall be forwarded to the members of the Medical Staff Executive Committee. If a member of the Medical Staff Executive Committee files a written objection to the recommendation with the Governing Body prior to the date the Governing Body acts on the recommendation, the Governing Body must return the application to the Executive Committee for further consideration in accordance with the provisions of this Section B.
7. In circumstances where the Chief of Staff reviews the health information and determines further evaluation and consideration is warranted, the Chief of Staff shall refer the application to the Medical Staff Executive Committee. Unless the Medical Staff Executive Committee determines that the health information obtained requires further evaluation and consideration, if the Medical Staff Executive Committee's recommendation is favorable, the President shall promptly forward the recommendation, together with all supporting documentation, to the Governing Body.
8. If the health information obtained reveals a condition that warrants further investigation or evaluation, the Medical Staff Executive Committee shall refer the application back to the Credentials Committee. The Credentials Committee shall investigate the matter and report its findings back to the Medical Staff Executive Committee with any change in its recommendation on appointment or privileges within 60 days. The Medical Staff Executive Committee shall then affirm or revise the previous recommendation.
9. When the recommendation of the Medical Staff Executive Committee is unfavorable to the Practitioner, either in respect to appointment or clinical privileges as identified in Article VIII of the Bylaws, the President shall promptly notify the Practitioner by Special Notice. The adverse recommendation shall be forwarded to the Governing Body, but the Governing Body shall not take any action on the recommendation until after the Practitioner has exercised or been deemed to have waived his or her right to a hearing as provided in Article VIII of these Bylaws.

10. At its next regular meeting after receipt of a final recommendation from the Medical Staff Executive Committee or the Chief of Staff, as applicable, after a Practitioner has waived or exhausted his or her appeal rights, the Governing Body shall act on the matter. All decisions to appoint shall include a delineation of the clinical privileges the Practitioner may exercise.
11. The President shall notify the Chief of Staff, the Department Chairperson concerned, and, by Special Notice, the applicant, of the Governing Body's final decision. If the applicant is granted membership and/or clinical privileges, the notice shall state the specific Medical Staff category and privileges granted.
12. To help ensure that all individuals with clinical privileges provide services within the scope of privileges granted, information regarding credentials and privileges will be added to the Provider Credentials screen available through the hospital intranet that is accessible to all units.
13. In circumstances where all information regarding an applicant for Limited Medical Staff membership is favorable to the Practitioner, the Chief of Staff or his or her designee, acting on behalf of the Medical Staff Executive Committee, may determine whether to refer the application for consideration by the Medical Staff Executive Committee or to recommend to the Governing Body appointment to the Medical Staff. All recommendations to appoint will limit the recommendation for clinical privileges to be granted to performing admitting histories and physicals. When the recommendation of the Chief of Staff is to refer the application for further consideration, the Chief of Staff shall forward the application and supporting materials to the Medical Staff Executive Committee for consideration.

Section C. Reappointment Process and Renewal of Clinical Privileges

1. Each member of the Medical Staff and individuals with clinical privileges will be provided with a reappointment form applicable to their medical staff category at least 90 days prior to expiration of the member's current reappointment date. Each staff member who desires reappointment shall submit the completed reappointment form within 45 days of receipt. Failure, without good cause, to return the completed application for reappointment within 45 days may be deemed a voluntary resignation resulting in automatic termination of membership effective at the expiration of his or her current term. Such voluntary resignation shall not entitle the member to the procedural rights set forth in the Fair Hearing Plan.
2. A Practitioner's reappointment year will occur biennially. After initial applicants have completed their first six-month period, an evaluation will be conducted of their clinical performance by their respective department chairperson.
3. The Credentials Committee shall review all pertinent information available on each Practitioner scheduled for periodic appraisal, for the purpose of determining its recommendations for reappointments to the Medical Staff and for the granting

of clinical privileges for the ensuing period, and shall transmit its recommendations, in writing, to the Medical Staff Executive Committee, through the Chief of Staff. Where non-reappointments or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

4. In circumstances where the Credentials Committee recommendation is favorable to the Practitioner with no change to the clinical privileges requested, and there is no Medical Staff Executive Committee meeting scheduled within the next seven days, the Chief of Staff, acting on behalf of the Medical Staff Executive Committee, shall review the application for reappointment.
5. Reappointment will be based upon current licensure and DEA registration, if applicable, board certification/recertification, professional performance, professional liability coverage, current health status as it relates to the Practitioner's ability to safely perform the privileges requested, participation in continuing education, the maintenance of timely, accurate and complete medical records, service on staff and Hospital committees when requested, and the individual's patterns of care, based on such reliable information as may be available. It will also be based on the individual's ethics and conduct, cooperation with Hospital personnel, use of the Hospital's facilities for patients, relations with other Practitioners and the Practitioner's general attitude toward patients, the Hospital and its staff. The applicant for reappointment and renewal of clinical privileges is required to submit any reasonable evidence of current health status relevant to the performance of duties that may be requested by the Medical Staff Executive Committee or Chief of Staff.
 - a. The Medical Staff Office may administratively reject an application for reappointment to the Medical Staff or for clinical privileges without forwarding the application to the Credentials Committee, if it determines that the applicant does not hold a valid Wisconsin license, does not have adequate professional liability insurance, is not eligible to receive payment from the Medicare or Medical Assistance Program, is excluded from any healthcare program funded in whole or in part by the federal government, or is barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code. Applicants who are administratively denied under this Section do not have a right to a fair hearing under Article IX of these Bylaws but may submit evidence to the Medical Staff Office to refute the basis for the administrative denial.
6. Prior to reappointment to the Medical Staff, the applicant must report 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:
 - a. 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, whether voluntary or involuntary;

- b. Suspension or revocation of any licensure or registration (state or DEA) or any reprimand or imposition of sanctions, or suspension or revocation of membership or imposition of other sanctions by any local, state or national professional society;
 - c. Any malpractice claims, suits, settlements or judgments, whether pending or finally determined and any refusal or cancellation of professional liability insurance;
 - d. Any additional training, education or experience relevant to the privileges sought on reappointment;
 - e. Any criminal conviction or pending criminal charges;
 - f. Current evidence of licensure and DEA registration and of professional liability insurance coverage;
 - g. 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;
 - h. 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. ; and
 - i. A statement that the applicant is not currently excluded from any healthcare program funded in whole or in part by the federal government
7. Where the review is conducted by the Chief of Staff, the Chief of Staff shall summarize and provide recommendations from the evaluation of the department chairperson of each department on its individual members, and shall make written recommendations regarding the application. Where the Chief of Staff recommends reappointment without a change of the clinical privileges recommended, the written recommendations shall be forwarded to the Governing Body, through the President. In all other cases, the Chief of Staff will refer the application to an ad-hoc committee of the Medical Staff Executive Committee, which consists of five members of the Medical Staff Executive Committee. If the recommendation of the ad-hoc committee is unfavorable to the practitioner, the practitioner can appeal through the Medical Staff Executive Committee.
8. At its next meeting following receipt of the report from the Credentials Committee or Chief of Staff, the Medical Staff Executive Committee shall summarize and provide recommendations from the evaluation of the department chairperson of each department on its individual members, and shall make written recommendations to

the Governing Body, through the President, concerning the reappointment, non-reappointment and/or clinical privileges of each Practitioner then scheduled for periodic appraisal. Where non-reappointment or a change in clinical privileges is recommended, the reasons for such recommendations shall be stated and documented.

9. Thereafter, the procedures in Section B of this Article V relating to recommendations on applications for initial appointment shall be followed.
10. In circumstances where all information regarding an applicant for limited medical staff membership is favorable to the Practitioner, the Chief of Staff or his or her designee, acting on behalf of the Medical Staff Executive Committee, may determine whether to refer the application for consideration by the Medical Staff Executive Committee or to recommend to the Governing Body reappointment to the Medical Staff. All recommendations to appoint will limit the recommendation for clinical privileges to be granted to performing admitting histories and physicals. When the recommendation of the Chief of Staff is to refer the application for further consideration, the Chief of Staff shall forward the application and supporting materials to the Medical Staff Executive Committee for consideration.

Section D. Continuing Medical Education

1. Applicants for Medical Staff Privileges shall satisfy the continuing education requirements established by the State of Wisconsin by completing 30 hours of AMA Category I or equivalent continuing medical education every two years as applicable to their medical staff category.
2. Each individual's participation in continuing education is documented and considered at the time of reappointment to the Medical Staff and/or renewal or revision of individual clinical privileges.

Section E. Modification of Membership Status or Privileges

A member of the Medical Staff may, either in conjunction with the reappointment process or at any other time, request modification of staff category, department assignment, or clinical privileges by submitting a written application on the prescribed forms. Such application shall be processed in the same manner as provided in Article V. Section C. Any granting of new, extended or increased clinical privileges shall be subject to evaluation as set forth in Article VI.

ARTICLE VI. CLINICAL PRIVILEGES

Section A. Delineation of Clinical Privileges

1. Every Practitioner at this Hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Body, except as provided in Sections B and D of this Article VI.
2. At no time shall a Practitioner provide patient care within the hospital without Temporary, Locum Tenens, Courtesy, Active, Active/Provisional, Consultive Active, Limited or Associate privileges.
3. It is the Practitioner's responsibility to provide documentation to support the request and to practice within the accepted standards through:
 - written verification of residencies or fellowships
 - valid certificates of specialty board recognition
 - certification from applicable educational institutions
 - valid and current license to practice in the State of Wisconsin
 - written verification of other employment, appointments, or memberships
4. Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. Determination of initial privileges shall be based upon an applicant's training, experience, demonstrated ability, references and other relevant information. The applicant shall have the responsibility to establish his or her qualifications and competency for the clinical privileges requested.
5. Each department shall be responsible for developing the category of privileges to be practiced within the department and criteria for extending privileges for each of those categories. Such criteria are subject to the approval of the Medical Staff Executive Committee and the Governing Body. The department shall provide each applicant a list of potential specific procedures, treatments or privileges they may provide in the specific clinical service.
6. A Practitioner may request an increase or decrease in privileges at any regular meeting of the Credentials Committee. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the criteria set forth in subparagraph 3 and on the evaluation of care provided, review of the records of patients treated in this or other hospitals, clinics or offices, and review of the records of the Medical Staff.
7. The exercise of clinical privileges within any department is subject to the rules and regulations of the department and to the authority of the department chairperson.
8. 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 Rules and Regulations. Dentists and podiatrists shall agree to comply with all

applicable Medical Staff Bylaws, Rules and Regulations at the time of application for clinical privileges.

Section B. Temporary Privileges

1. Upon receipt of an application for Medical Staff membership from an appropriately licensed and insured Practitioner, the President may, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the departmental chairperson concerned and of the Chief of Staff, grant temporary admitting, clinical or other appropriate privileges to the applicant. However, in exercising such privileges the applicant shall be responsible to the respective department chairperson or his or her designee.
2. Temporary clinical privileges may be granted by the President, provided the Practitioner first signs a statement acknowledging the Practitioner has received and read copies of the Medical Staff Bylaws, Rules and Regulations and agrees to be bound by their terms in all matters relating to the temporary clinical privileges. Additionally, the Practitioner must satisfy the requirements regarding professional liability insurance, health status and, the Wisconsin Caregiver Background check law as delineated in these Bylaws. The circumstances for which the granting of temporary privileges are acceptable are to fulfill an important patient care, treatment and service need also when a new applicant with a complete application that raises no concerns is awaiting review and approval of the medical staff executive committee and the governing board. Such temporary privileges may be granted for a 120-day period.
3. Special requirements of supervision and reporting may be imposed by the departmental chairperson concerned on any Practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the President upon notice of any failure by the Practitioner to comply with such special conditions.
4. The President may at any time, upon the recommendation of the Chief of Staff or the department concerned, terminate a Practitioner's temporary privileges effective as of the discharge from the Hospital of the patient(s) then under the Practitioner's care in the Hospital. However, where it is determined that the life or health of such patient(s) would be compromised by the continued treatment by the Practitioner, the termination may be imposed by the department chairperson, the Chief of Staff or the President or any person entitled to impose a summary suspension pursuant to Section B.1 of Article VII of these Bylaws, and which termination shall be immediately effective. The appropriate departmental chairperson, or the Chief of Staff, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until the patient(s) are discharged from the Hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute Practitioner.

5. No Practitioner is entitled to temporary privileges as a matter of right. A Practitioner shall not be entitled to the procedural rights afforded by Article IX because of his or her inability to obtain temporary privileges or because of any termination, modification or suspension of temporary privileges.

Section C. Locum Tenens Privileges

1. The President may permit a physician serving as a locum tenens to attend patients without applying for membership on the Medical Staff for a period not to exceed 120 calendar days, providing all credentials have first been approved by the departmental chairperson concerned and by the Chief of Staff. Continued credentialing beyond the 120 days will require application to Active/Provisional Staff.
2. Locum tenens clinical privileges may be granted by the President, Department Chair and the Chief of Staff, provided that there shall first be obtained such Practitioner's statement acknowledging receipt of and reading copies of the Medical Staff Bylaws, Rules and Regulations; and agreement to be bound by the terms thereof in all matters relating to the locum tenens clinical privileges. Additionally, the Practitioner must satisfy the requirements regarding professional liability insurance, health status and, the Wisconsin Caregiver Background check law as delineated in these Bylaws. The practitioners must also possess a valid Wisconsin license.
3. No Practitioner is entitled to locum tenens privileges as a matter of right. A Practitioner shall not be entitled to the procedural rights afforded by Article IX because of his/her inability to obtain locum tenens privileges or because of any termination, modification or suspension of locum tenens privileges.

Section D. Special Case Privileges

1. A special case privilege will be granted in urgent cases and if no Medical Staff member in good standing is qualified or available to render the necessary treatment or consultation.
2. The President shall have the approval to grant a one-case privilege in the event of a life-threatening event.
3. The National Practitioner's Data Bank will be queried. Wisconsin license verification obtained and the practitioner will provide professional liability insurance face sheet and copy of DEA Certificate. A telephone verification shall be obtained from the hospital where the practitioner has active staff privileges.
4. Practitioners who have been granted a special case privilege are not eligible to admit a patient. They shall work in conjunction with the Medical Staff Member who admitted the patient.

5. Practitioners who have been granted a special case privilege shall not be considered to be members of the Medical Staff, and shall not be entitled to vote or have any of the rights, such as the rights to a hearing or appeal, afforded to members of the Medical Staff.

Section E. Leave of Absence

Leave of absence of more than 90 days, up to 18 months, may be granted by the Credentials Committee, upon written application of the staff member for the following reasons: 1) educational leave; 2) medical leave; 3) military leave; and 4) personal leave. Return from any leave of absence may subject the Practitioner to the full or a partial credentialing process at the discretion of the Credentials Committee. Failure to return from a leave of absence constitutes a 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 the staff member so terminated may be submitted and processed in the manner specified in Article V, Section C.

Section F. Emergency Privileges

In the case of emergency, any Practitioner, to the degree permitted by his or her license and regardless of service 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 consultant necessary or desirable as long as an emergency situation continues to exist. For the purpose of this Section, an “emergency” is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section G. Withdrawal of Privileges

1. Any member of the staff may voluntarily withdraw any clinical privilege at any time upon written notice. Such action, unless as a result of disciplinary action or investigation or in lieu thereof, shall not create a right of hearing under the Fair Hearing Plan nor generate any reporting requirements under Wisconsin Statutes 50.36 or the federal Health Care Quality Improvement Act.
2. Any clinical privileges granted to a member of the Medical Staff may be involuntarily reduced or withdrawn, in whole or in part, upon demonstrated lack of competence, ability, training, or experience as observed from patient care provided, a review of the records of patients treated in this or other hospitals and a review of the records of the Medical Staff which document the evaluation of the individual’s participation in the delivery of medical care, or as otherwise provided in these Bylaws. Any such involuntary action shall entitle the staff member to the rights of review set forth in the Fair Hearing Plan.

ARTICLE VII. PEER REVIEW

Section A. Summary Statement

Saint Joseph's Hospital will conduct peer review and evaluation of the quality of patient care provided by or the conduct of a Medical Staff member through quality assessment and improvement activities.

The peer review activities identified in this section are a major component in the hospital's program organized and operated to help improve the quality of health care in the hospital and those activities will be conducted in a manner consistent with the provisions of secs. 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of peer review records and proceedings, are intended to apply to all peer review activities and include activities of the individuals involved in the peer review activities as well as other individuals designated to assist in carrying out the peer review duties and responsibilities.

Section B. Definitions

Any terms used in this policy have the same meaning and definition as those terms that are defined in the Medical Staff Bylaws. In addition, for the purpose of this Policy, the following words or phrases are defined:

1. "Peer" means a Medical Staff member.
2. "Peer review" means the study, review, investigation, evaluation or assessment of the training, experience, skill, professional conduct, qualifications or current competence of one or more Medical Staff members by one or more of his peers.
3. "External peer review" means the study, review, investigation, evaluation or assessment of the training, experience, skill, professional conduct, qualifications or current competence of one or more Medical Staff members referred to an individual or individuals who are not Medical Staff members but who have the same professional licensure (e.g. physician, dentist, podiatrist) as the review subject and who are in the same or a similar specialty as the review subject or are in a different specialty but where the individual's core or specialized training significantly overlaps the primary elements of the type of care or technique that will be subject to review.
4. "Review subject" means the Medical Staff member whose services or conduct are being reviewed.

Section C. Procedures

Any person may forward for peer review any issues or concerns relating to a Medical Staff member's training, experience, skill, professional conduct, adherence to SJH

Hospital policies and procedures, qualifications or current competence to any appropriate Department Chair, Medical Staff committee member or the Chief of Staff.

If the initial peer review is conducted by a body whose membership does not contain a peer who is in the same or a similar specialty as the review subject, or who is in a different specialty but where the peer's core or specialized training significantly overlaps the primary elements of the type of care or technique that will be subject to review, and the initial peer review could result in a professional review action against the review subject, further peer review will be undertaken involving at least one peer who meets the above qualifications.

A peer may decline to participate in peer review only if the Chief of Staff recuses him from service. The Chief of Staff may also consider requests by the individual being reviewed to exclude specific individuals from the peer review panel.

Peer review will be based upon medical records and reports, and other information as determined necessary or relevant by the peer review body.

Unless it is decided to submit the matter to external peer review, the peer review will generally be completed within 60 days of having the matter referred to it. This timeframe may be used as a general guide, but may also be expanded on a case by case basis subject to the particular case in review.

A written report containing findings and conclusions shall be made and filed in the practitioner's quality assurance file for all focused peer review. Conclusions should reference, as appropriate, any literature and relevant clinical practice guidelines upon which the peer review body based its decision. Majority and minority opinions of the peer review body, if any, will be considered and included in the report.

When follow-up actions by another body may be warranted, the report will also be forwarded to the appropriate person or committee for follow-up as is deemed appropriate.

Section D. Routine Peer Review

Routine peer review will be accomplished by the Quality Review process outlined in the Quality Improvement Plan of Saint Joseph's Hospital.

Section E. Focused Peer Review

Focused peer review is conducted whenever a question arises as to whether the care provided by or the conduct of a Medical Staff member meets professional standards. Generally, focused peer review is conducted through the Quality Improvement Committee of the Medical Staff.

Common circumstances which trigger focused peer review include but are not limited to:

1. cases referred by a Medical Staff Department, as a result of routine peer review;

2. cases referred by a Medical Staff member, hospital staff member or patient complaint;
3. any sentinel event involving a Medical Staff member; and
4. a pattern of cases or circumstances potentially indicative of a problem with a Medical Staff member's clinical judgment, expertise or professional conduct.

Section F. External Peer Review

1. External peer review will be sought when an insufficient number of appropriate peers are available or able to serve as reviewers, or the Medical Executive Committee or Chief of Staff believes a potential exists that the peer review subject may assert bias on the part of any internal review body.
2. Because an external peer review is conducted by an individual who is not a member of the Medical Staff, the timing within which an external peer review will be completed will be determined on a case by case basis, depending upon the availability of the external reviewer, the scope of the review and other relevant factors.

Section. G. Physicians' Health Committee

The Physicians' Health Committee is the Medical Staff Committee that will provide identification and management of individual physician health issues separate from the Medical Staff disciplinary function. Its purpose is to maintain and improve quality of care of patients, to assist in the maintenance of appropriate standards of personal performance, to educate staff about illness and impairment issues specific to physicians and to protect patients from harm.

The focus of the Physicians' Health Committee is to compassionately attend to the needs of a physician who is, or is perceived to be, impaired by a physical or mental illness. The Physicians' Health Committee does not take disciplinary action, but instead serves as an advisor to the referral source and to the physician in question. The Committee shall respond and make recommendations to the referral source and to the physician in question. If a physician's impairment threatens patient care, the Committee will refer the issue to an ad-hoc committee comprised of the Chief of Staff, Hospital President or designee, Chairperson of the Credentials Committee and Hospital Risk Manager.

For purposes of this policy "impaired" or "impairment" is defined as "the inability to practice medicine with reasonable skill and safety to patients by reason of physical or mental illness, including but not limited to use or abuse of drugs or alcohol and deterioration through the aging process".

The responsibilities of the Physicians' Health Committee include:

- a. To assess and make recommendations regarding the health, well-being or impairment of a Medical Staff member with possible impairment issues, and assist staff members in the maintenance of appropriate standards of performance;
- b. To be identified as a Committee within the Hospital where information and concern about the health of an individual physician can be delivered for consideration, whether by the physician, another staff member, or pursuant to a complaint by a patient, hospital personal or parties outside of the hospital.
- c. To receive, consider and evaluate the credibility of the information, to seek corroboration and additional information, to investigate and, ultimately, to develop recommendations for monitoring plans and monitoring agreements as necessary;
- d. To provide advice, recommendations and assistance to the physician in question and to the referring source, provide recommendations for treatment, monitoring and/or education and provide assistance in obtaining what is recommended;
- e. To monitor physicians for compliance with the terms of a monitoring agreement;
- f. To provide general education for members of the Medical Staff about:
 - physician illness and impairment recognition issues;
 - appropriate responses to different levels and kinds of distress and impairment;
 - the responsibilities of the Medical Staff in response to concerns about a physician's health;
 - available resources for prevention, treatment and rehabilitation; and
 - the role and function of the Physicians' Health Committee.
- g. To monitor physicians' compliance with any special conditions imposed pursuant to a rehabilitation approval under Chapter HFS 12 of the Wisconsin Administrative Code or by the Medical Staff when a physician is granted privileges notwithstanding a record of a substantially related crime; and
- h. To refer appropriate cases to the Medical Executive Committee for corrective action when warranted by a physician's condition or a physician's failure to comply with a monitoring agreement or to Hospital Administration or other committees as designated by the Medical Executive Committee.

3. Membership

The Physicians' Health Committee, appointed by the Chief of the Medical Staff in consultation with the Hospital President and Medical Executive Committee, shall consist of no fewer than three members of the Medical Staff representing, where practicable, various specialties. Appointments to the Committee will be staggered three-year terms.

4. Meeting Frequency

The Physicians' Health Committee shall meet at the call of its Chair.

5. Maintain Records of Proceedings

The Committee shall maintain separate and confidential records of its proceedings and actions.

6. Confidentiality

All activities of the Committee are part of the Medical Staff's program organized and operated to help improve the quality of care at the Hospital, and will be conducted in a manner consistent with the provisions of secs. 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 Committee and include activities of the individual members of the Committee, as well as other individuals designated by the Committee to assist in carrying out the duties and responsibilities of the Committee including but not limited to participation in monitoring plans.

All contacts with the Committee are confidential to the fullest degree possible under the law. This shall not, however, operate to restrict the Committee from providing information to other committees of the Medical Staff participating in the Medical Staff's program organized to help improve the quality of care. Thus, if information received by the Committee demonstrates that the health or known impairment of a Medical Staff member poses a risk of harm to patients; such information shall be promptly referred to the President of the Medical Staff and the Medical Executive Committee for corrective action. Communications to and from the Committee shall be the responsibility of the Committee Chair or the authorized representative of the Committee Chair.

Due to the nature of the Committee's activities, its sources of information and potential role in addressing a staff member's problem, the proceedings, minutes, records and reports shall not be accessible to the hospital, medical or administrative staff as a whole or individual members. However, in the instance of Administrative Referral or when the safety of patient or practitioner is perceived to be at risk the Chairman of the Committee or designee shall meet with the Chief of Medical Staff or designee, the Chief Executive Officer or designee or

the Chair or acting Chair of the Credentials Committee to discuss matters under review. At such meetings, those involved shall have access to all information available to the Committee. The activities and reports of the Committee with respect to any individual staff member need not be made a part of the physician's file unless it relates to corrective action or steps taken to limit the physician's professional activity.

ARTICLE VIII. CORRECTIVE ACTION

Section A. Due Process Procedure

1. Whenever the professional activities or conduct of a Practitioner are considered to be unacceptable, or are judged to be disruptive of the operations of the Hospital, corrective action may be requested by any member of the Medical Staff or the senior administrative staff of the Hospital. Activities not involving clinical issues that are considered disruptive to the operations of the Hospital can consist of, but are not limited to:
 - a. Negligence or conduct which endangers patients such as abandonment, failure to respond to an emergency, refusal to accept a triaged patient, or refusal to accept a consult when on call;
 - b. Unauthorized access to or disclosure of patient information;
 - c. Sexual harassment or physical or verbal abuse of patients, staff or others;
 - d. Criminal, fraudulent or other improper business conduct relating to activities of the member in the Hospital;
 - e. Exercising privileges while the Practitioner's professional ability is impaired, whether through illness, accident, addiction, abuse, or from any other source;
 - f. Abusive or intimidating behavior;
 - g. Fighting or threatening violence in the work place;
 - h. Violation of Bylaws, Rules and Regulations of the Medical Staff, the applicable Code of Ethics or any policy of the Hospital; and
 - i. Commission of an offense that bars the Practitioner from providing services in the Hospital under Chapter HFS 12 of the Wisconsin Administrative Code.

All requests for corrective action shall be made in writing to the President, Chief of Staff, or respective Department Chairperson, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

2. The President, Chief of Staff or their designee(s) shall investigate and evaluate the complaint and meet and discuss with the Practitioner those areas where it is considered that the professional activities or conduct are unacceptable. If it is determined that the professional activities or conduct are, or have been unacceptable, the individual will be given a written directive to correct his or her activities or conduct by the Chief of Staff and/or President or designee.

3. If the Practitioner fails to correct his or her activities or conduct after being directed to do so by the President and/or Chief of Staff or where the activities or conduct were sufficiently serious as to warrant additional corrective action, the matter may be referred to the Medical Staff Executive Committee or a Disciplinary Review Committee (DRC). In general, matters relating to quality of practice will be referred to the Medical Staff Executive Committee for professional performance review, and matters of conduct or policy violation will be referred to the DRC.
4. In those cases where an individual is referred to the Medical Staff Executive Committee for a professional performance review, a special five member ad hoc committee from the Medical Staff Executive Committee shall be selected by lot by the Chief of Staff to evaluate the activities or conduct in question. The ad hoc committee shall: 1) investigate the facts relative to the activities or conduct in question; 2) assess the individual's current clinical competence; 3) assess any relevant physical, mental or emotional conditions which relate to the individual's ability to safely perform his or her duties for the Hospital; and 4) evaluate any other aspect of the individual's practice relevant to the activities or conduct in question. The individual staff member shall have an opportunity to meet with the committee to discuss, explain, or refute the activities or conduct in question. The meeting shall not constitute a hearing, is preliminary in nature, and none of the procedural rules provided in these Bylaws apply. This committee shall prepare a written report to the Medical Staff Executive Committee.
5. The Medical Staff Executive Committee shall receive the report from the ad hoc committee. The individual staff member shall have an opportunity to meet with the Medical Staff Executive Committee to discuss, explain, or refute the activities or conduct in question. The meeting shall not constitute a hearing, is preliminary in nature, and none of the procedural rules provided in these Bylaws apply. After hearing the evidence, the Medical Staff Executive Committee shall make a report and recommendation to the Governing Body.
6. The Medical Staff Executive Committee may determine that corrective action is not appropriate, or the Medical Staff Executive Committee may recommend sanctions including, but not limited to, requiring further professional training, limitation of privileges, supervision, a formal reprimand, termination from the Medical Staff, requiring a physical or mental examination and report by a physician or psychologist chosen by or acceptable to the Medical Executive Committee and compliance with any recommendations issued as a result of the examination, or other remedies or sanctions as appropriate.
7. The Medical Staff Executive Committee report and recommendation shall be received by the Governing Body. The individual staff member shall again have the opportunity to meet with the Governing Body to discuss, explain, or refute the activities or conduct in question. The Governing Body may accept the Medical Staff Executive Committee report and recommendations or it may, after hearing the evidence, prescribe other actions or interventions.

8. If the activities or conduct of the Practitioner are considered to be in violation of the Medical Staff Bylaws or administrative policy (as opposed to primarily matters of clinical competence), the Chief of Staff and/or President may, in accord with subparagraph 2, above, refer the matter to a DRC in lieu of the Medical Staff Executive Committee. Conduct appropriate for referral to the DRC includes, but is not limited to, sexual harassment, abuse of patients, staff or others, current substance abuse, or criminal, fraudulent or other improper business conduct. The DRC shall consist of the Hospital President or designee, the Chief of Staff, Medical Director of the service or Department Chair, Risk Manager, and Hospital Manager of the area. The individual staff member shall have an opportunity to meet with the DRC to discuss, explain, or refute the activities or conduct in question. The meeting shall not constitute a hearing, is preliminary in nature, and none of the procedural rules provided in these Bylaws apply.
9. The DRC may, after hearing the evidence, determine that corrective action is not appropriate, or it may impose corrective action, including but not limited to a fine, reprimand, or required counseling; or it may recommend to the Governing Body that the Practitioner's privileges be restricted, suspended or terminated.
10. The Practitioner may appeal the decision of the DRC to the Governing Body. The Practitioner shall again have the opportunity to meet with the Governing Body to discuss, explain, or refute the activities or conduct in question. The Governing Body may accept the DRC report and recommendations or it may, after hearing the evidence, prescribe other actions or interventions.
11. Any recommendation that is deemed a professional review action under Article VIII, Section B shall entitle the affected Practitioner to the procedural rights provided in Article IX of these Bylaws.
12. A report shall be submitted to the appropriate licensing body for transmission to the National Practitioner Data Bank within 15 days after the Governing Body has taken final action when required by law. The voluntary surrender or reduction of privileges by a Practitioner under investigation must be reported.

Section B. Summary Suspension

1. Any one of the following: the Chief of Staff, the chairperson of a clinical department, the President or designee, the Medical Staff Executive Committee or the Governing Body shall have the authority, whenever action must be taken in the best interest of patient care in the Hospital, to summarily suspend all or any portion of the clinical privileges of a Practitioner, and such summary suspension shall become effective immediately.
2. A Practitioner whose clinical privileges have been summarily suspended shall be entitled to request that the Medical Staff Executive Committee hold a hearing on the

matter as soon as practicable, but not later than five business days from the date of suspension.

3. The Medical Staff Executive Committee may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Medical Staff Executive Committee does not recommend immediate termination of the summary suspension, the affected Practitioner shall, in accordance with Article VIII, be entitled to submit a written appeal to the Governing Body, but the terms of the summary suspension as sustained or as modified by the Medical Staff Executive Committee shall remain in effect pending a final decision by the Governing Body.
4. Immediately upon the imposition of a summary suspension, the Chief of Staff or responsible departmental chairperson shall provide for alternative medical coverage for the patients of the suspended Practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative Practitioner.
5. A suspension of all privileges of a Practitioner may be imposed by the President or designee upon notification that a Practitioner:
 - a. Is under investigation for a serious crime, act or offense as defined in Chapter HFS 12 of the Wisconsin Administrative Code,
 - b. Is being investigated by a unit of government or an entity subject to HFS 12 for abuse or neglect of a patient or misappropriation of a patient's property,
 - c. Is being investigated under the Children's Code or an entity under HFS 12 for abuse or neglect of a child.

As soon as possible after such suspension, the Medical Executive Committee shall convene to review and consider the facts under which the individual was suspended and determine whether or not to continue the suspension pending the outcome of the investigation, terminate the suspension subject to monitoring or other safeguards pending the outcome of the investigation, or to take such further corrective action as is appropriate under the circumstances.

Section C. Automatic Suspension

1. Action by the applicable licensing board revoking or suspending a Practitioner's license, or placing the Practitioner on probation or limitation of practice, shall automatically suspend all of the Practitioner's clinical privileges. Action by the applicable licensing board placing a Practitioner on probation shall promptly be reviewed by the Medical Staff Executive Committee and it shall submit a recommendation to the Governing Body regarding the continuance of the suspension. In the event the Medical Staff Executive Committee does not discontinue the suspension and the restrictions are revised by the applicable licensing board, the Practitioner may reapply as per Article V and VI of these Bylaws.

2. Suspension, revocation, or restriction of a Practitioner's DEA registration shall automatically suspend all of the Practitioner's right to prescribe medications controlled by the number. Further, this shall constitute a suspension of any clinical privileges that require the ability to prescribe those medications.
3. Subject to proof of rehabilitation review approval, an automatic suspension of all privileges of a Practitioner shall be imposed upon notification received by the President that the Practitioner:
 - a. Has been convicted of a serious crime, act or offense or has pending charges for a serious crime, act or offense as defined in Chapter HFS 12 of the Wisconsin Administrative Code.
 - b. Has been found by a unit of government to have abused or neglected a patient or misappropriated a patient's property;
 - c. Has been determined under the Children's Code to have abused or neglected a child.

As soon as possible after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the individual was barred from providing services under Chapter HFS 12 of the Wisconsin Administrative Code. The Medical Executive Committee may then take such further corrective action as is appropriate under the circumstances. If the Practitioner provides evidence that rehabilitation review approval has been received, the Medical Executive Committee must determine whether the rehabilitation review approval in any way limits the Practitioner's ability to practice the privileges granted and/or if it wishes to retain the Practitioner on the Medical Staff. The Medical Executive Committee may then take such further corrective action as is appropriate under the circumstances.

4. An automatic suspension of all privileges of a Practitioner shall be imposed if the Practitioner is excluded from a federally funded health care program. If the Practitioner immediately notifies the President of any proposed or actual exclusion from any federally funded health care program as required by the Bylaws, a simultaneous request in writing by the Practitioner for a meeting with the President or his or her designee to contest the fact of the exclusion and present relevant information will be granted. This meeting shall be held as soon as practicable but not later than five business days from the date of the written request. The President or his or her designee shall determine within 10 business days following the meeting, and after such follow-up investigation as he or she deems appropriate, whether an exclusion has occurred, and whether the Practitioner's staff membership and privileges will be immediately terminated. The determination of the President or his or her designee regarding the matter shall be final, and the Practitioner will have no further procedural rights. The Practitioner will be given Special Notice of the termination decision.

5. An automatic suspension of all privileges may be imposed upon a Practitioner's failure to notify the President within five days of receipt by the Practitioner of an initial sanction notice of a gross and flagrant violation, or of the commencement of a formal investigation or the filing of charges, by a Medicare peer review organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of Wisconsin. The Medical Executive Committee shall promptly review the matter and submit a recommendation to the Governing Body regarding the continued Medical Staff status and clinical privileges of the Practitioner. The Medical Executive Committee shall, if the President concurs, be authorized to lift or modify any such automatic suspension pending final determination by the Governing Body.
6. An automatic suspension may be imposed upon a Practitioner's failure without good cause to supply information or documentation requested by any of the following: the President or his or her designee, the Credentials Committee; the Medical Executive Committee or the Governing Body. Such suspension shall be imposed only if: (1) the request for information or documentation was in writing, (2) the request was related to evaluation of the Practitioner's current qualifications for membership or clinical privileges, (3) the Practitioner failed to either comply with such request or to satisfactorily explain his or her inability to comply, and (4) the Practitioner was notified in writing that failure to supply the requested information or documentation within 15 days from receipt of such notice would result in automatic suspension. Any automatic suspension imposed pursuant to this paragraph may be a suspension of any portion or all of the Practitioner's privileges and shall remain in effect until the Practitioner supplies the information or documentation sought or satisfactorily explains his or her failure to supply it.
7. Automatic suspension activated pursuant to this Section C shall not be a professional review action and thus not give rise to any right of hearing or appellate review, including the maintaining of any suspension instituted as a result of licensing board action.
8. It shall be the duty of the Chief of Staff to cooperate with the President in enforcing all automatic suspensions.

ARTICLE IX. HEARING AND APPEALS PROCEDURE

Section A. Right to Hearing

1. The following actions, if deemed a professional review action under Section A.2 below, entitle the affected Practitioner to a hearing upon a timely and proper request:

- a. Denial of initial Staff appointment.
 - b. Denial of reappointment.
 - c. Suspension of Staff membership except for automatic suspension under Article VII, Section C.
 - d. Revocation of Staff membership.
 - e. Denial of requested appointment to or advancement in Staff category.
 - f. Reduction in Staff category.
 - g. Limitation of the right to admit patients.
 - h. Denial of requested clinical privileges.
 - i. Involuntary reduction in clinical privileges.
 - j. Suspension of clinical privileges except for automatic suspension under Article VIII, Section D.
 - k. Revocation of clinical privileges.
2. An action listed above is a professional review action only when it has been:
 - a. Recommended by the Medical Staff Executive Committee.
 - b. Taken by the Governing Body under circumstances where no prior right to a hearing existed.
 - c. A summary suspension imposed pursuant to Article VIII, Section C.
 3. A warning or a letter of admonition or a letter of reprimand or imposition of terms of probation or requirement for consultation are not recommendations that will adversely affect the Practitioner's appointment to or status as an appointee of the Medical Staff or the Practitioner's exercise of clinical privileges and therefore are not professional review actions.
 4. All hearings shall be in accordance with the procedural safeguards set forth in this Article IX to assure that the affected Practitioner is accorded all rights to which he or she is entitled, unless a Practitioner then under suspension requests an expedited hearing, in which case time limits will be adjusted in accord with the Practitioner's request.

5. In formulating such action or recommendation, the acting body should conclude that:
 - a. there is a reasonable belief that the action is in furtherance of quality health care; and
 - b. reasonable efforts are taken to obtain the pertinent facts; and
 - c. a reasonable belief exists that the action is warranted by the facts.

Section B. Notice of Adverse Action

The President or the President's designee shall promptly give the Practitioner Special Notice of the action. The notice to the Practitioner shall:

1. Advise the Practitioner that a professional review action has been taken or proposed to be taken against the Practitioner, set forth the reasons for the action and, that the Practitioner has the right to request a hearing pursuant to the provisions of this Article.
2. Specify that the Practitioner has 45 days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Section C of this Article.
3. State that the Practitioner's failure to request a hearing within the 45-day time period and in the proper manner constitutes a waiver of rights to a hearing and any appeal on the matter.
4. Summarize the hearing procedure and the Practitioner's rights including:
 - a. The right to be represented by an attorney or other person of the Practitioner's choice;
 - b. The right to have a record made of the hearing proceedings, copies of which may be obtained by the physician upon payment of reasonable charges associated with the preparation of such copies;
 - c. To call, examine and cross-examine witnesses;
 - d. To present evidence and exhibits determined to be relevant by the hearing officer, or chair of the committee regardless of their admissibility in a court of law; and
 - e. To present a written statement at the close of the hearing.
5. State that the Practitioner will be notified of the date, time, and place of the hearing after making a timely and proper request.

6. Advise the Practitioner of the right to review the hearing record and report, if any, and to submit a written statement on his or her own behalf as part of the hearing.

Section C. Request for Hearing

The Practitioner must file a written request for a hearing within 45 days after receipt of the notice described in Section B above. The Practitioner's request must be sent to the President by Special Notice and must be received by the President within the 45-day period.

Section D. Waiver by Failure to Request a Hearing

A Practitioner who fails to request a hearing within the time specified in Section C of this Article is deemed to have waived all rights to any hearing to which he or she might otherwise have been entitled.

1. Such waiver in connection with an adverse action by the Governing Body constitutes acceptance of that action, which then becomes the final decision of the Governing Body.
2. Such waiver in connection with an adverse recommendation by the Medical Staff Executive Committee constitutes acceptance of that action, which then becomes and remains effective pending the final decision of the Governing Body.

Section E. Notice of Hearing

1. Within ten days after receipt of a timely and proper request for hearing, the Medical Staff Executive Committee or the Governing Body, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the President, notify the Practitioner of the hearing, by Special Notice. The hearing date shall be not less than 30 nor more than 60 days following the date the Practitioner is notified of the hearing.
2. The notice of hearing given to the Practitioner must include the following:
 - a. The place, time, and date of the hearing;
 - b. A preliminary list of the witnesses (if any) expected to testify at the hearing in support of the professional review action and a statement that each party must submit a final list of witnesses expected to testify at least 10 days prior to the hearing; and
 - c. A summary of the Practitioner's alleged acts or omissions or the other reasons forming the basis for the professional review action that is the subject of the hearing.

Section F. Composition of Hearing Committee

1. When a hearing relates to an adverse recommendation of the Medical Staff Executive Committee, the hearing shall be conducted by a special review committee appointed by the Chief of Staff, consisting of five members of the Active Medical Staff who have not previously participated in the formulation of the decision and who are not in direct economic competition with the Practitioner. For purposes of this Section, direct economic competition shall be defined to mean those Practitioners actively engaged in practice in the primary medical community of the affected Practitioner, and who practice in the same medical specialty or subspecialty as the affected Practitioner. The Hearing Committee may use, on a non-voting consulting basis, members of the same medical specialty or subspecialty.
2. When a hearing relates to an adverse decision of the Governing Body under circumstances where no prior right to a hearing existed, the Governing Body shall appoint a Hearing Committee to conduct the hearing and shall designate one of the members of this committee as chairperson.
3. As an alternative to a Hearing Committee, a sole hearing officer may be selected to conduct the hearing. The use and appointment of a hearing officer shall be determined by the chair of the body whose decision is being contested, after consultation with the President or his or her designee. The hearing officer shall act in an impartial manner as the Chair and presiding officer of the hearing.
4. A member of the Active Medical Staff or of the Governing Body shall not be disqualified from serving on a Hearing Committee because he or she has requested the corrective action or heard of the case or has knowledge of the facts involved, or what he or she supposes the facts to be, or has participated in the investigation of the matter at issue. All members of a Hearing Committee shall be required to consider and decide the case with good faith objectivity.

Section G. Conduct of Hearing

1. At least a majority of the members of the Hearing Committee must be present when the hearing and deliberations takes place, and no member may vote by proxy. If a committee member is absent for any significant part of the proceedings, he or she shall not be permitted to participate in the deliberations or decision.
2. An accurate record of the hearing must be kept. The mechanism shall be established by the hearing committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by taking of adequate minutes. The Practitioner may obtain copies of the record upon the payment of reasonable fee.
3. The Practitioner must personally appear at the hearing. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his or her rights in the same manner as provided in Section D of this Article and to have accepted the adverse recommendation or decision involved.

4. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the approval of the hearing committee for good cause shown.
5. The affected Practitioner shall be entitled to be accompanied by or represented at the hearing by a member of the Medical Staff in good standing or by a member of his or her local professional society.
6. Either a hearing officer, if one is appointed, or the chairperson of the hearing committee or his designee, shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.
7. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The affected Practitioner and the body taking or recommending the professional review action shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact. These memoranda shall become a part of the hearing record.
8. The Chief of Staff or designee, when the Medical Staff Executive Committee action has prompted the hearing, shall present the reasons for the recommended course of action and may present witnesses and other evidence in support of the adverse recommendation. The Governing Body, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the reasons for the recommended course of action and may present witnesses and other evidence in support of its adverse decision. The affected Practitioner shall thereafter be responsible for supporting his or her challenge to the adverse recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or any action based thereon is arbitrary or capricious.
9. During the hearing, each party has the right:
 - a. To have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation of such copies;
 - b. To call, examine, and cross-examine witnesses;
 - c. To present evidence and exhibits determined to be relevant by the hearing officer, or chair of the committee regardless of their admissibility in a court of law and to rebut the same; and

- d. To present a written statement at the close of the hearing.
10. Either side may formally request assistance of legal counsel or of some other person in these proceedings by giving the Hearing Committee notice at least 10 days prior to the hearing of such assistance. In such cases, the hearing committee chair or hearing officer may define the role of such legal counsel or other person, as a participant or strictly as an observer in the proceeding. Any Practitioner who incurs legal fees in his or her behalf shall be solely responsible for payment.
11. In reaching a decision, the hearing officer or hearing committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration. All other information that can be considered under these Medical Staff Bylaws in connection with credentials matters may also be considered.
12. The Practitioner has the burden of proving by clear and convincing evidence that the professional review action or recommendation lacks any substantial factual basis or that the conclusions drawn from the facts are arbitrary or capricious.
13. The hearing committee may, without notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee may then, at a time convenient to itself, conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened.

Section H. Hearing Committee Report and Further Action

1. Within 30 days after close of the hearing, the hearing committee or hearing officer shall submit a written report of its findings and recommendations to the body whose review action occasioned the hearing. The report must include a statement of the bases for the recommendation.
2. Within 30 days after receiving the recommendation of the Hearing Committee or hearing officer, the body whose review action occasioned the hearing shall consider the report and prepare its own report affirming, modifying, or reversing its previous action. This report must include a statement of the bases for the decision. If the recommendation resulted from Medical Executive Committee action and remains adverse to the Practitioner, the Practitioner will have ten days in which to submit a written appeal to the Governing Body.
3. When the hearing was as a result of an adverse recommendation of the Medical Staff Executive Committee, the Governing Body shall, within 45 days following receipt of the final Medical Staff Executive Committee recommendation, consider the Practitioner's appeal, if any, and render its final decision in the matter. The decision of the Governing Body shall be sent by Special Notice to the Practitioner involved by the President and shall not be subject to further review.

4. Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled as a right to more than one hearing on any matter which shall have been the subject of professional review action by the Medical Staff Executive Committee, or by the Governing Body, or by a duly authorized committee of the Governing Body, or by both.

Section I. Substantial Compliance

Technical or insignificant deviations from the procedures set forth in this Article IX shall not be grounds for invalidating action taken.

Section J. Waiver of Time Limits

Any time limits set forth in this Article IX may be extended or accelerated by mutual agreement of the Practitioner and the President or the Medical Staff Executive Committee. The time periods specified in this Article IX for action by the Medical Staff Executive Committee, the Governing Body, the President and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of the professional review action if the fair hearing process is not completed within the time periods specified.

ARTICLE X. OFFICERS

Section A. Officers of the Medical Staff

1. The Officers of the Medical Staff shall be:
 - a. Chief of Staff
 - b. Vice Chief of Staff

Section B. Qualifications of Officers

Officers must be members of the Active Medical Staff at the time of nomination and election and must remain member in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

Section C. Election of Officers

1. Officers shall be elected at the end of the incumbent's term. Only members of the Active Medical Staff shall be eligible to vote.
2. The Nominating Committee shall consist of three members of the Active Staff appointed by the Chief of Staff. This committee shall offer one or more nominees

for each office and the list of nominees posted at least seven days prior to the election.

3. Nominations from the Medical Staff at large will be accepted up to 10 days prior to the election.

Section D. Term of Office

Officers shall take office on the first day of the Medical Staff Year after the election. The terms of offices shall be three years unless the Officer is removed pursuant to Section G of this Article.

Section E. Vacancies in Office

Vacancies in office during the Medical Staff Year, except for the Chief of Staff, shall be filled by the Medical Staff Executive Committee with approval of the Governing Body. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve out the remaining term.

Section F. Duties of Officers

1. CHIEF OF STAFF: The Chief of Staff shall serve as the chief administrative officer of the Medical Staff to:
 - a. Act in coordination and cooperation with the President in all matters of mutual concern within the Hospital;
 - b. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and the Medical Staff Executive Committee;
 - c. Serve as ex officio member of all other Medical Staff committees without vote;
 - d. Be responsible for the procedural compliance, implementation and enforcement of Medical Staff Bylaws, Rules and Regulations;
 - e. Appoint committee members to all standing and special Medical Staff committees except as noted elsewhere in these Bylaws;
 - f. Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and President;
 - g. Receive, and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

- h. Review and sign all applications for appointment or reappointment to the Medical Staff.
 - i. Respond to external credentialing inquiries, including completion of forms and preparation of reference letters.
 - j. Speak on behalf of the Medical Staff in its external professional and public relations.
 - k. Facilitate TQM initiatives as required.
 - l. Review and sign Hospital policies relative to the Medical Staff.
 - m. Review and investigate all incidents and complaints relative to Medical Staff members and intervene as appropriate.
 - n. Address issues among Medical Staff departments when these cannot be disposed by the department themselves.
2. VICE CHIEF OF STAFF: The Vice Chief of Staff shall act in the absence of the Chief of Staff and assume all the duties and have the authority of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Staff Executive Committee. The Vice Chief of Staff shall automatically succeed the Chief of Staff when the latter fails to serve for any reason.

Section G. Removal of Officers

- 1. Any officer of the Medical Staff may be removed from office for any of the following reasons:
 - a. Failure to satisfactorily perform the duties of office.
 - b. Failure to abide by the Medical Staff Bylaws or current Hospital policy applicable to activities as a Medical Staff member or a Medical Staff officer.
 - c. Failure to remain a member in good standing of the Active Medical Staff.
- 2. Any officer may be temporarily removed from office by a majority vote of the Medical Staff Executive Committee. The temporary removal will be in effect until the following meeting of the Medical Staff at which time the temporary removal may be made permanent (subject to the provisions of these Bylaws) or removed.
- 3. A two-thirds vote of the Active Medical Staff is necessary to permanently remove an officer from office.

4. The Governing Body may request that the Medical Staff take action to remove an officer of the Medical Staff for reasons outlined in Section G.1 above. In the event the Medical Staff fails to take action as required in this Article, and after notice to the Medical Staff Executive Committee from the Governing Body of at least 30 days to such effect, the Governing Body may upon its own initiative take action to remove the officer. In such event, the Medical Staff recommendation and views of the Medical Staff Executive Committee should be carefully considered by the Governing Body during its deliberations and in its actions.

ARTICLE XI. CLINICAL DEPARTMENTS

Section A. Organization of Clinical Departments

The Medical Staff shall be organized into departments. Each department shall be organized as a separate part of the Medical Staff and shall have a chairperson who shall be responsible for the overall supervision of the clinical work within the department.

Section B. Selection and Tenure of Department Chairpersons

1. Each department will elect a chairperson. Each chairperson shall be a member of the Active Medical Staff, elected by a majority vote of the department. The chairperson shall be certified by an appropriate specialty board or affirmatively established comparable competence through the Credentialing process.
2. An appropriate specialty board is one which is relevant to the services provided by the department and is recognized by a member in the American Board of Medical Specialties, the American Board of Oral and Maxillofacial Surgery, the Council on Post-Secondary Accreditation (in dentistry) or the American Osteopathic Association.
3. The department chairperson shall serve three-year terms commencing upon election and continuing until a successor for the position is chosen, unless an officeholder should resign or be removed from office. All positions are eligible for re-election or reappointment.
4. A department chairperson may resign at any time by giving notice to the Medical Staff Executive Committee. Removal of a chairperson may be effected by a two-thirds majority vote of the Medical Staff Executive Committee, subject to the approval of the Governing Body, or by a simple majority vote of the individual's department. Permissible grounds for removal include, but are not limited to:
 - a. Failure to perform the duties of the position held in a timely and appropriate manner; and
 - b. Failure to continuously satisfy the qualifications for the position.

5. The Governing Body may request that the Medical Staff Executive Committee take action to remove a department chairperson of the Medical Staff for reasons outlined in Section B.4 above. In the event the Medical Staff Executive Committee fails to take action as required in this Article, and after notice thereto by the Governing Body of at least 30 days to such effect, the Governing Body may upon its own initiative take action to remove the department chair. In such event, the recommendation and views of the Medical Staff Executive Committee should be carefully considered by the Governing Body during its deliberations and in its actions.

Section C. Responsibilities of Department Chairpersons

Each department chairperson shall:

1. Have general supervision over all clinical activity within the department including physicians-in-training and allied health professionals.
2. Be a member of the Medical Staff Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding the department in order to assist quality patient care;
3. Advise the Chief of Staff on matters of a professional nature affecting the department. The Chief of Staff shall in turn inform the President of matters affecting operations or patient care.
4. Continually evaluate the clinical activities of the department and make recommendations for improved patient care.
5. Assume responsibility for implementation of a planned and systematic process to monitor and evaluate the qualifications of members of the department and to monitor the appropriateness of care and treatment in the department.
6. Be responsible for enforcement of the Hospital Bylaws, Medical Staff Bylaws, and Rules and Regulations within the department;
7. Be responsible for implementation of actions taken by the Medical Staff Executive Committee within the department;
8. Prepare and transmit to the appropriate authorities, as required by the Medical Staff Bylaws, recommendations concerning appointment, reappointment, delineation of privileges, and corrective action with respect to Practitioners in the department.
9. Recommend to the Medical Staff the criteria for clinical privileges in the department.
10. Recommend clinical privileges for each member of the department.
11. Coordinate orientation for new Practitioners in the department.

12. Coordinate medical education activities for the department.
13. Participate in every phase of departmental administration through cooperation with the nursing service and the Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques, equipment, routine procedures and planning of Hospital facilities.
14. Assist in preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Staff Executive Committee, the President or the Governing Body.
15. Preside at monthly or special departmental meetings.
16. Provide for an accurate record of each department meeting submitted to the Medical Staff Executive Committee and kept with the permanent records of the Medical Staff.
17. The coordination and integration of department activity with other hospital services.
18. The implementation of policies and procedures that guide the provision of the department's services.
19. The determination of the qualifications and competence of department or services' personnel who are not licensed independent practitioners.

Section D. Functions of Departments

Departments are a major component in the Hospital's program organized and operated to help improve the quality of health care in the Hospital and its activities will be conducted in a manner consistent with the provisions of secs. 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of department records and proceedings, are intended to apply to all activities of the department relating to improving the quality of health care and include activities of the individual members of the department as well as other individuals designated by the department to assist in carrying out the duties and responsibilities of the department.

1. Granting of Clinical Privileges

Each clinical department shall establish its own criteria, consistent with the policies of the Medical Staff and of the Governing Body, for the granting of clinical privileges and for the holding of office in the department.

2. Quality Improvement Activities

Each clinical department shall be responsible for conducting a primary view for quality improvement activities through the use of medical information relating to patient care. This review will contribute to the continuing education of every Practitioner and to the process of developing criteria to assure appropriate patient care.

3. Peer Review

Each department shall review its clinical work through findings from ongoing monitoring and evaluation activities, and report its findings to the Medical Staff Executive Committee and Governing Body on a quarterly basis from the minutes of its Quality Improvement Activities.

4. Policies

Each department shall establish policies pertinent to the operation of their department, including identification of call participation requirements.

Section E. Department Quality Review Functions

1. Each department chairperson will be responsible to:

- a. Implement quality improvement and accountability functions, either for the department or in concert with other organizational components of the Medical Staff and Hospital.
- b. Monitor its members' performance, on a continuing basis for adherence to staff, Hospital, and department policies and procedures; for adherence to sound principles of clinical practice generally for appropriate surgical and other procedures; for unexpected clinical occurrences; as well as for patient safety; and use such quality improvement information for consideration for members' reappointment process.
- c. Establish such committees or other mechanisms as are necessary and desirable to properly perform the quality review functions assigned to it.

Section F. Assignment to Departments

The Medical Staff Executive Committee shall, after consideration of the recommendations of the clinical departments as transmitted through the Credentials Committee, recommend initial departmental assignments for all Medical Staff members and for all other approved Practitioners with clinical privileges. All individuals with delineated clinical privileges are assigned to and have clinical privileges in one clinical department and may be granted clinical privileges in other clinical departments.

Section G. Identification of Departments

For the purposes of these Bylaws, the following shall be considered clinical departments: Allergy, Anesthesiology, Cardiology, Cardiovascular and Thoracic Surgery, Clinical Research, Dermatology and Cutaneous Surgery, Emergency Medicine, Endocrinology and Metabolism, Family Medicine, Gastroenterology, General Internal Medicine, General Surgery, Infectious Disease, Clinical Oncology, Nephrology, Neurosciences, Neurosurgery, OB/GYN, Ophthalmology, Oral and Maxillofacial Surgery, Orthopedic Surgery, Otolaryngology-Head and Neck Surgery, Palliative Medicine, Pathology, Pediatrics, Physical Medicine & Rehabilitation, Plastic Surgery, Psychiatry and Behavioral Health, Pulmonary Medicine, Radiology, Rheumatology, and Urology.

Section H. Voting Privileges in Department Meetings

Only Active and Active/Provisional Staff members of the department may vote at department meetings. Simple majority vote prevails, except as otherwise provided in these Bylaws.

Section I. Rules and Regulations of the Department

Departments will establish departmental rules and policies for areas of the Hospital within their respective jurisdictions, and for the professional activities performed by department members. Such rules must be approved by the appropriate department, Medical Staff Executive Committee and Governing Body for inclusion in the Rules and Regulations of the Medical Staff of Saint Joseph's Hospital.

Section J. Creation of Departments

A department unit may be created when its members are willing to accept independent responsibility and accountability as a department under the terms of these Bylaws. To form a new department a majority of the prospective members should initiate a request. The matter should be discussed by the parent department and any other departments involved and then referred with recommendation to the Medical Staff Executive Committee. The Medical Staff Executive Committee should consider the matter and then refer with recommendations to the Governing Body for a final decision.

ARTICLE XII. COMMITTEES

The following committees are a major component in 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 secs. 146.37 and 146.38 of the Wisconsin Statutes: Medical Executive, Quality Improvement, Credentials, Medical Records, Pharmacy and Therapeutics, Infection Control, Operating Room, Risk Management, Safety, Critical Care and Cancer. 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 above committees relating to improving the quality of health care and include activities of the individual members of the committee as well as

other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee.

The following committees will be required to furnish reports at appropriate intervals to the Medical Staff Executive Committee:

- Credentials
- Emergency-Disaster Preparedness
- Infection Control
- Medical Records
- Medical Staff Bylaws
- Pharmacy & Therapeutics
- Quality Improvement
- Rehabilitation
- Risk Management
- Safety
- Cancer

Appointment to these Hospital Medical Staff committees will be submitted to the Medical Staff Executive Committee annually by the Chief of Staff and Hospital President for appointments for the following staff year.

Section A. Medical Staff Executive Committee

1. The Medical Staff Executive Committee shall be a standing committee empowered to act for the Medical Staff in the intervals between Medical Staff meetings and shall consist of the officers of the Medical Staff, the chairpersons of clinical departments, the Medical Director of Surgical Services, the Director of Trauma and the chairperson of the Quality Improvement Committee. The Chief of Staff shall be the presiding officer of the Medical Staff Executive Committee. The President of the Hospital or designee attends each Medical Staff Executive Committee meeting on an ex-officio basis without vote. The committee shall meet no less than quarterly, or more often at the request of the Chief of Staff.
2. The function of the Medical Staff Executive Committee shall be to:
 - a. Represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.
 - b. Coordinate the activities and general policies of the various departments.
 - c. Receive and act upon committee reports and recommendations from Medical Staff committees, clinical departments, and assigned activity groups.
 - d. Implement policies of the Medical Staff not otherwise the responsibility of the departments.

- e. Provide liaison between the Medical Staff, the President and the Governing Body.
- f. Recommend action to the President on matters of a medical administrative nature.
- g. Make recommendations on Hospital operational matters to the Governing Body through the President.
- h. Fulfill the Medical Staff's accountability to the Governing Body through the President and Medical Staff Executive Committee.
- i. Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation status of the Hospital.
- j. Provide for the preparation of all meeting programs, either directly or through delegation to a program committee or other suitable agent.
- k. Review the credentials and/or the Credentials Committee's reports of all applicants and to make recommendations directly to the Governing Body for staff membership, assignments to departments, and delineation of clinical privileges.
- l. Recommend the structure of the Medical Staff.
- m. Organize the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate and revise such activities.
- n. Establish a mechanism by which membership on the Medical Staff may be terminated.
- o. Establish a mechanism to review credentials and to delineate individual clinical privileges.
- p. Periodically review all information available regarding the performance and clinical competence of Staff Members and Allied Health Staff with clinical privileges; and, as a result of such reviews, to make recommendations to the Governing Body for reappointments and renewal or changes in clinical privileges.
- q. Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.

- r. Be responsible for the acquisition and maintenance of the accreditation of the Hospital as it relates to the Medical Staff. The Medical Staff Executive Committee may require annually that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey forms be used as a review method to estimate the accreditation status of the Hospital as it relates to compliance with the Medical Staff standards. The Medical Staff Executive Committee shall identify areas of suspected non-compliance with the Medical Staff standards of the JCAHO and shall make recommendations to the Medical Staff for appropriate action.
- s. Report activities at each Medical Staff meeting.
- t. Establish a mechanism for fair-hearing procedures.

Section B. Quality Improvement Committee

1. The members and chairperson for the Quality Improvement Committee will be appointed by the Chief of Staff and Hospital President. Ex-officio members will include an administrative representative. Additional committee members may be appointed at the discretion of the committee chairperson.
2. The Quality Improvement Committee shall:
 - a. Be responsible for general supervision of clinical appraisal mechanisms to assure appropriate standards of care.
 - b. Review the use of Hospital services, personnel, and equipment in clinical practice.
 - c. Report to the Medical Staff Executive Committee regarding the appraisal of medical care provided in the Hospital. These reports will then be forwarded to the Governing Board for its review.
 - d. Monitor and evaluate the quality and appropriateness of patient care rendered under the auspices of Saint Joseph's Hospital and the clinical performance of individuals with patient care responsibilities or granted delineated clinical privileges, utilizing Medical Staff monitoring functions, independent investigations or other methods of assessment.
 - e. Review reports and make recommendations regarding quality improvement functions relating to the Medical Staff or individuals with patient care responsibilities. This will include review of medical records, surgical care, blood utilization, antibiotic/drug monitoring, pharmacy/therapeutics, risk management, infection control, and ambulatory care.

- f. Review Medical Staff or patient care issues related to quality improvement.
- g. Recommend action regarding the establishment, maintenance and improvement of professional standards of care within the Hospital, including the recommendation of medical education programs as appropriate.
- h. Make recommendations for specific corrective actions, when necessary, to the Medical Staff Executive Committee, with simultaneous notification to the respective department chairperson.
- i. Review and monitor the indications for surgery and all cases in which there is a major discrepancy between the preoperative and postoperative diagnoses.

Section C. Credentials Committee

1. The Credentials Committee will report directly to the Medical Staff Executive Committee. The Chief Staff shall appoint the members from among the Active Staff. The Chief of Staff may appoint three physicians at large from the Active Staff. The Hospital President will be an Ex-officio member.
2. The duties of the Credentials Committee shall be to:
 - a. Investigate and review each application for Medical Staff membership, appointment, reappointment and extension of privileges based on the Practitioner's responsibility to furnish documentation on the following:
 - current licensure
 - training and experience
 - liability insurance and experience
 - current clinical competence
 - participation in quality improvement
 - current physical and mental health as related to the Practitioner's ability to safely perform the privileges requested
 - ethical practice
 - b. Make a report to the Medical Staff Executive Committee on each applicant for Medical Staff membership or clinical privileges, including specific consideration of the recommendations from the departments in which such applicant requests privileges;
 - c. Make recommendations regarding the reappointment, departmental assignment and professional privileges of members of the Medical Staff within the provisions of the Bylaws;

- d. Review reports that are referred by the Medical Staff Executive, Medical Record and Quality Improvement Committees and by the Chief of Staff; and
 - e. Review credentials of Allied Health Staff.
3. Meetings: The Credentials Committee shall meet as required to conduct its business, and shall maintain a permanent record of its proceedings and actions.

Section D. Bylaws Committee

The Bylaws Committee will consist of three or more members of the Active or Associate Staff appointed by the Chief of Staff for a one-year term and will meet as needed and will make a report of its deliberations and of appropriateness of Bylaws to the Medical Staff Executive Committee. The Bylaws Committee will meet on call to formulate any suggested revisions of the Bylaws, Rules and Regulations and policies of the Medical Staff. Ex-officio members will be one member of Administration and the Director of Quality Improvement.

Section E. Medical Record Committee

1. The Medical Record Committee membership should consist of at least two or preferably four members of the medical staff appointed by the Chair of the Medical Record Committee, the Chair being appointed by the Chief of Staff. It should also include one representative each from nursing service, hospital administration, hospital medical records, clinic health information management, hospital information systems, clinic information systems, hospital clinical informatics and hospital transcribing. A medical record manager shall be designated to act as the committee secretary and coordinator of meeting agendas. The committee should meet monthly and maintain a permanent record of its findings, proceedings, and actions, and forward a copy of the report to the Medical Staff Executive Committee.
2. The duties of the Medical Record Committee shall be to:
 - a. Provide guidance and oversight of the development and maintenance of the medical record at SJH both paper and electronic.
 - b. Assure an appropriate record review program.
 - c. Review reports of record reviews and make recommendation for additional action that may need to be taken.
 - d. Approve existing and new documents that are or will be a permanent part of the hospital medical record.
 - e. Approve medical record storage and retention practices.
 - f. Assure systems are in place to assure that medical record documentation is timely, accurate, complete, reflects care and treatment given, supports continuity of patient care, supports legal documentation and reimbursement.
 - g. Assists in assuring compliance with The Joint Commission, State and CMS regulations.

Section F. Pharmacy and Therapeutics Committee

1. Membership shall consist of representatives of the Medical Staff appointed by the Chief of Staff, and one each from Hospital pharmacy, nursing service, Clinic pharmacy and administration. A Hospital pharmacist shall act as secretary for the committee.
2. The Pharmacy and Therapeutics Committee shall:
 - a. Be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard.
 - b. Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety, procedures, and all other matters relating to drugs in the Hospital.
 - c. Serve as an advisory group to the Medical Staff and the pharmacy on matters pertaining to the choice of available drugs;
 - d. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
 - e. Develop and review periodically a formulary or drug list for use in the Hospital;
 - f. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;
 - g. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital; and
 - h. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
 - i. Meet at least bimonthly and send periodic reports to the Medical Staff Executive Committee regarding its activities.
 - j. Perform regular review of adverse drug reactions reported to have occurred to hospitalized patients, and inform the Medical Staff and FDA of drug reactions of significance.

Section G. Infection Control Committee

1. Medical Staff representatives shall be appointed by the Chief of Staff. Hospital representatives shall be appointed by the President.

2. The Infection Control Committee shall:
 - a. Be responsible for the investigation, control, and surveillance of infections within the Hospital.
 - b. Formulate policies concerning the admission and isolation of patients with infections, advise on policies concerning Hospital staff and personnel with overt infections and advise on technical matters and procedures relating to infection control.
 - c. Through its chairperson, take whatever emergency action it deems appropriate in the interest of patient and/or personnel safety. These actions may include, but not be limited to, ordering of special studies, closing patient units, or the isolation of selected patients.
 - d. Report quarterly to the Medical Staff Executive Committee, Medical Staff, and Governing Body.

Section H. Operating Room Committee

1. The operating Room Committee shall consist of the chairpersons of the surgical departments, the chairperson of the Anesthesia Department, and Hospital personnel designated by the President. The Committee shall be chaired by the Medical Director of Saint Joseph's Hospital Operating Room Services, who shall be jointly appointed by the Hospital President (or designee) and the Chief of Staff, and who shall also serve on the Medical Staff Executive Committee.
2. The Committee shall be responsible for general supervision and oversight of clinical activity within the operating rooms (see O.R. Policy Manual).

Section I. Cancer Committee

1. Membership shall consist of representatives of the Medical Staff appointed by the Medical Director of Oncology, Chief of Staff or designee and shall be multidisciplinary. The representatives shall include, but not limited to: Administration, Surgery, Hematology/Oncology, Nursing, Palliative Care, Pathology, Quality Assurance, Radiation Oncology, Radiology, Social Work or Case Management and Cancer registry.
2. An Oncology specialist, appointed by the Medical Director of Oncology, Chief of Staff or designee will chair the Cancer Committee.
3. The Cancer Committee structure includes designated leadership roles for Cancer Conference, quality control of Cancer Registry data, quality improvement and community outreach. A Cancer Liaison Physician (appointed by the chair of the

Cancer Committee) will provide a relationship with the American College of Surgeons: Commission on Cancer.

4. The Cancer Committee will meet at least quarterly. (Minutes of the meetings will be maintained.)
5. The Cancer Committee shall be responsible for:
 - a. Developing and overseeing all aspects of the comprehensive cancer program.
 - b. Meeting or exceeding current Commission on Cancer program standards.
 - c. Promoting a coordinated multidisciplinary approach for patient care at all levels.
 - d. Verification of an active support system for patients, families, and staff.
 - e. Patient care audits.
 - f. Assurance that education and cancer conferences cover all major types of cancer and that issues of cancer care are addressed.
 - g. Cancer registry (accurate, timely abstracting, staging, and reporting of data).
 - h. Evaluation of the effectiveness of program quality improvement activities.
 - i. Assurance of regular attendance by the majority of participating physicians at cancer conferences.
 - j. Promoting clinical research.
 - k. Overseeing preparation and publication of the annual committee report.
 - l. Upholding medical ethical standards.

Section J. Special Committees

The Medical Staff shall appoint and develop committees to direct, review, and analyze hospital services. These include, but are not limited to, the following committees:

1. Rehabilitation Committee.

The Rehabilitation Committee shall develop, monitor, and review the activities of the rehabilitation program.

2. Emergency Department-Disaster Preparedness Committee. The Emergency Department-Disaster Preparedness Committee is responsible to discuss, propose, and implement items pertinent to emergency care and disaster planning. The everyday functioning of the Emergency Department as it relates to good patient care is an item of continued discussion. In addition, the Emergency Department-Disaster Preparedness Committee shall adopt and periodically review a written plan for the care, reception, and evacuation of mass casualties, and shall assure that such a plan is coordinated with the inpatient and outpatient services of the Hospital, that the plan adequately reflects developments in the Hospital community and the anticipated role of the Hospital in the event of disasters in nearby communities, and that the plan is rehearsed by key personnel at least twice yearly.

3. Medical Education Committee. The Medical Education Committee shall be responsible for the formulation of education policies and procedures for the medical educational programs, medical student services, medical residency programs, and fellowship programs, and shall send periodic reports to the Medical Staff Executive Committee.
4. Critical Care Committee. The Critical Care Committee shall monitor and review the intensive treatment of critically ill patients. It shall set standards, protocols, and procedures for the handling of the critically ill patient. An on-going responsibility shall be the review of the admission and transfer of critically ill patients and the updating of protocols for the handling of critically ill patients.
5. Radiation Safety Committee. The Radiation Safety Committee is responsible to be certain that all activities involving nuclear materials, and irradiation technique, comply with the Code of Federal Regulations and the Wisconsin Administrative Code.

ARTICLE XIII. MEDICAL STAFF MEETINGS

Section A. Regular Meetings

There will be at least one annual meeting of the Medical Staff during the year.

Section B. Special Meetings

The Chief of Staff or Medical Staff Executive Committee may call a special meeting of the Medical Staff at any time. The Medical Staff Executive Committee shall designate the time and place of any special meeting.

Section C. Quorum

The presence of 40 percent of the voting members of the Active Staff at any regular or special meeting shall constitute a quorum. At all meetings of the staff, departments, and committees, "Robert's Rules of Order" shall prevail unless otherwise specified in the Medical Staff Bylaws and Rules and Regulations Manual.

Section D. Agenda

The agenda of staff meetings will be determined by the President and Chief of Staff and distributed prior to the meeting.

ARTICLE XIV. COMMITTEE AND DEPARTMENT MEETINGS

Section A. Regular Meetings

Departments shall hold regular meetings at least quarterly to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients, and to conduct such other business as may be necessary.

Section B. Special Meetings

A special meeting of any committee or department may be called by or at the request of the chairperson of the committee or department, by the Chief of Staff, or by one-third of the group's then members, but not less than two members.

Section C. Notice of Meetings

The chairperson sets the time and place of meetings and posts an agenda in advance. However, if good cause exists, the chairperson may call an emergency meeting without a posted agenda.

Section D. Quorum

Quorum of the Medical Staff Executive Committee shall be 50 percent of the membership. For all other committees, clinical departments, or sections, 40 percent of the voting members shall constitute a quorum, but in no event shall quorum be less than two members.

Section E. Manner of Action

1. The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote at any meeting.
2. No person may represent another person's vote by proxy on a special issue unless expressly allowed by the department or committee and upon the consent of the Chief of Staff and President.

Section F. Rights of Ex-Officio Members

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members, excluding the right to vote, except as otherwise provided in these Bylaws.

Section G. Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and maintained. Minutes shall be forwarded to the Medical Staff Executive Committee for review and approval. Each committee and department shall maintain a permanent file of the minutes of each meeting.

ARTICLE XV. IMMUNITY FROM LIABILITY

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

First, any act, communication, report, recommendation, or disclosure, with respect to any individual, performed or made in good faith and without malice and at the request of any authorized representative for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

Second, the privilege shall extend to members of the Hospital Medical Staff and Governing Body, its Practitioners and employees, its President and representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XV, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Governing Body or of the Medical Staff.

Third, there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

Fourth, the immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities, related, but not limited to: (1) applications for appointment or clinical privileges; (2) periodic reappraisals for reappointment or clinical privileges; (3) corrective action, including summary suspension; (4) hearings and appellate reviews; (5) medical care evaluations; (6) utilization reviews; and (7) other Hospital, departmental or committee activities related to quality patient care and professional conduct.

Fifth, the acts, communications, reports, recommendations and disclosures referred to in this Article XV may relate to an individual's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

Sixth, in furtherance of the foregoing, each individual shall upon request of the Hospital execute releases in accordance with the tenor and import of this Article XV in favor of the individuals and organizations specified in the second paragraph, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this State. Execution of a release is not a prerequisite to the application of this Article.

Seventh, the consents, authorizations, releases, rights, and privileges and immunities provided by Sections A and B of Article V 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 appointment, shall also be fully applicable to the activities and procedures covered by this

Article XV. 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.

ARTICLE XVI. RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner in the Hospital. Such Rules and Regulations shall be a part of these Bylaws, except that they may be amended or repealed by the Medical Staff Executive Committee. Such changes shall become effective when approved by the Governing Body. Rules and Regulations governing activities within departments need be approved by the department, the Medical Staff Executive Committee, and the Governing Body.

ARTICLE XVII. GENERAL PROVISIONS

Technical or insignificant deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken. Any time limits set forth in these Bylaws may be extended or accelerated by mutual agreement of the Practitioner and the Credentials Committee, the Medical Staff Executive Committee, Governing Body or President. The time periods specified in these Bylaws for action by the Credentials Committee, the Medical Staff Executive Committee, Governing Body or President and any other committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of any action taken by those bodies if such action is not completed in the time periods specified.

ARTICLE XVIII. AMENDMENTS

These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. To be adopted, an amendment shall require a simple majority vote of the Active Medical Staff when a quorum is present. Amendments so made shall be effective when approved by the Governing Body. The Bylaws may not be amended or adopted by unilateral action of the Medical Staff or Governing Body. In the event the Bylaws must be amended and the Medical Staff either will not or cannot effectuate amendments, the Governing Body could do so after consultation with the Medical Staff Executive Committee.

ARTICLE XIX. ADOPTION

These Bylaws together with the appended rules and regulations, shall be adopted at any regular or special 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. These Bylaws together with the appended rules and regulations, shall be reviewed on an annual basis. They shall

be, when adopted and approved, equally binding on the Governing Body and the Medical Staff.

ARTICLE XX. REPEALING

These Bylaws together with the appended Rules and Regulations or any part of such may be repealed at any regular or special meeting of the Active Medical Staff. The repealing of the Bylaws and/or the Rules and Regulations shall require a two-thirds vote of the Active Medical Staff present. Repeals or revisions shall be effective when approved by the Governing Body.

ADOPTED by the Active Medical Staff on April 30, 2008.

Chief of the Medical Staff

APPROVED by the Governing Body on April 30, 2008.

Chairman of the Governing Body