

MEDICAL STAFF BYLAWS

**MINISTRY SAINT MICHAEL'S HOSPITAL
OF STEVENS POINT, INC.**

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MEDICAL STAFF BYLAWS

MINISTRY SAINT MICHAEL'S HOSPITAL OF STEVENS POINT, INC.

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of medical care provided at Ministry Saint Michael's Hospital and that it must accept and assume this responsibility subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Designated Administrative Officer and the Governing Body are necessary to fulfill the Hospital's obligations to its patients, the physicians, dentists, and podiatrists practicing in Ministry Saint Michael's Hospital hereby organize themselves into a self-governing medical staff in conformity with these Bylaws.

DEFINITIONS

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

1. The term “admit” or “admission” for purposes of patient care means registration of a patient as a Hospital patient for the purpose of treatment on either an outpatient or inpatient basis, but does not include registrations solely for the purpose of outpatient laboratory and x-ray diagnostic testing not requiring the presence or supervision of the ordering professional.
2. The term "Allied Health Professional" means an individual, other than a licensed physician, dentist or podiatrist, who is: admitted to practice in the Hospital either through the Medical Staff Bylaws process or an alternate approval process per Medical Staff policy; who is either licensed, certified or registered in the state or who is trained and qualified in a recognized health care discipline to exercise various degrees of judgment within the areas of his professional competence; and who is qualified to render direct or indirect medical care under the supervision of a Practitioner who has been accorded privileges to provide such care in the Hospital. As used in these Bylaws, the term "Allied Health Professional" includes midlevel providers (advanced practice clinicians) and paramedical affiliates (authorized providers) as defined per Medical Staff policy.
3. The term “anniversary date” shall be the date on which the Practitioner’s appointment is scheduled to expire. The Executive Committee shall determine anniversary dates based on objective criteria designed to foster an efficient and practical system for reviewing applicants for reappointment.
4. The “annual meeting” of the Medical Staff shall be the meeting whereby officers of the Medical Staff are elected and annual business conducted.
5. The term "business days" shall mean days on which the Hospital's administrative offices are open and, therefore, does not include Saturdays, Sundays or holidays.
6. The term “clinical privileges” means the authorization granted by the Governing Body to a Practitioner to provide specific patient care services in the Hospital within defined limits, based on an individual Practitioner’s license, education, training, experience, competence, health status, and judgment.
7. The term “Code of Ethics” means the code of ethics promulgated by the professional society or association applicable to the individual’s profession (such as the American Medical Association for physicians).

8. The term “completed application” means a fully-filled out, signed and dated application form accompanied by primary source verification of licensure, education, training, practice history (including all hospital affiliations and department Chair verification from each hospital where the applicant held active or, as appropriate, other staff or locum tenens status), professional liability coverage and claims history, applicable board certifications, Background Information Disclosure form, OIG exclusions, professional references and such other information as is requested by the Hospital.
9. The term "Credentials Committee" shall mean the credentials committee of the Medical Staff, a "professional review body," as defined in Section 431(11) of the Health Care Quality Improvement Act of 1986 and a review body as referenced in Sections 146.37 and 146.38 of the Wisconsin Statutes.
10. Unless specifically identified otherwise, the term “days” shall mean calendar days.
11. The term “Executive Committee” shall mean the Executive Committee of the Medical Staff unless specific reference is made to the executive committee of the Governing Body. This committee is a “professional review body,” as defined in Section 431(11) of the Health Care Quality Improvement Act of 1986 and a review body as referenced in Sections 146.37 and 146.38 of the Wisconsin Statutes.
12. The term “Designated Administrative Officer” means the Chief Executive Officer appointed by the Governing Body to act on its behalf in the overall management of the Hospital or his designee.
13. The term “ex officio” means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.
14. The term “Governing Body” shall mean the board of directors of Ministry Saint Michael’s Hospital of Stevens Point, Inc. except that, to the extent authorized in the Hospital’s corporate bylaws, the Governing Body may delegate its authority to act on Medical Staff matters (including but not limited to Medical Staff appointments and the grant of clinical privileges) to one of its committees, subject to subsequent ratification by the Governing Body. The Governing Body and committees thereof will be a "professional review body," as defined in Section 431(11) of the Health Care Quality Improvement Act of 1986 and a review body as referenced in Sections 146.37 and 146.38 of the Wisconsin Statutes as a part of the Hospital's program organized and operated to help improve the quality of health care and their activities will be conducted in a manner consistent with these provisions of the law. The protections of these statutes, including the protection of the confidentiality of committee records and proceedings, are intended to apply to all activities of the Governing Body and its committees and

include activities of the individual members as well as other individuals designated to assist in carrying out the duties and responsibilities.

15. References to "HCQIA" means the Health Care Quality Improvement Act of 1986, 42 USC §11101, et seq.
16. The term "health status" means the physical, emotional, and mental health status and stability of an individual.
17. The masculine pronoun wherever used in these Bylaws shall refer equally to both sexes.
18. The term "Hospital" means, unless the context requires otherwise, Ministry Saint Michael's Hospital of Stevens Point, Inc.
19. The term "in good standing" for the purpose of these Bylaws will mean an individual who at the time the issue with respect to his standing is raised, is current on the payment of dues and has not in the previous twelve (12) months, received a summary or automatic suspension for any reason, including medical records compliance. Precautionary suspensions are not summary or automatic suspensions for these purposes. Only members in good standing shall be eligible to vote for the election of officers, or for any other matters which are presented for vote at a departmental, committee or general meeting of the Medical Staff.
20. The term "Medical Staff" means the Hospital's organized, self-governing component of physicians, podiatrists and dentists appointed by the Governing Body and granted specific clinical privileges for the purpose of providing medical, podiatric and dental care for the patients of the Hospital.
21. The term "Medical Staff member" or "Medical Staff membership" means the prerogative of Medical Staff participation and does not necessarily include as an incident thereto any clinical privilege whatsoever. The Medical Staff is a "professional review body" as that term is defined in Section 431(11) of the Health Care Quality Improvement Act and a review body as referenced in Sections 146.37 and 146.38 of the Wisconsin Statutes.
22. "Medical Staff Year" means the 12-month period commencing the 1st day of January and ending on the 31st day of December of each year.
23. The term "oral surgeon" means an Oral and Maxillofacial Surgeon. These individuals have graduated from dental school with a Doctor of Dental Surgery ("DDS") or Doctor of Dental Medicine ("DMD") degree. They have trained an additional four (4) to six (6) years in a hospital setting along with medical interns, residents and fellows in various disciplines of medicine and surgery. A significant amount of the oral surgeon resident's training has been spent on medical and surgical rotations in areas such as internal medicine, emergency medicine,

anesthesiology, neurosurgery, cardiology, plastic surgery, otolaryngology, general surgery, pulmonary medicine, radiology and trauma surgery.

24. The term “patient” means an individual who receives preventative, diagnostic or therapeutic services relating to the patient’s health from individuals authorized to provide such services by the Hospital and utilizing Hospital resources in the provision of the services. The term “patient” applies to all individuals described above from the point in time that they begin receiving the services or are admitted for services, whether on an inpatient or outpatient basis, whichever occurs first, and continues until they are discharged or stop receiving services (whichever occurs last).
25. The term “Plan” shall mean the “Corrective Action Procedures and Fair Hearing Plan Addendum” to the Medical Staff Bylaws of Ministry Saint Michael’s Hospital of Stevens Point, Wisconsin, which is incorporated herein.
26. The term “Practitioner” means an appropriately licensed medical or osteopathic physician or an appropriately licensed dentist or podiatrist.
27. The term “Provider” means all Allied Health Professionals and Practitioners granted clinical privileges and/or Medical Staff membership by the Hospital.
28. The term “special notice” means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee.

SECTION 1 - NAME

The name of this organization shall be the Ministry Saint Michael's Hospital Medical Staff.

SECTION 2 - PURPOSES AND RESPONSIBILITIES

2.1 The purposes of the Medical Staff are:

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

2.2 The responsibilities of the Medical Staff are:

- (a) To provide an appropriate level of professional performance of all members of the Medical Staff authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each member may exercise in the Hospital and through an ongoing review and evaluation of each member's performance in the Hospital.
- (b) To provide a continuing education program fashioned, at least in part, on the needs demonstrated through the patient care audit and other quality assessment and improvement programs.
- (c) To provide a utilization review program to allocate inpatient medical and health services based upon determinations of patients' medical, social and emotional needs consistent with sound health care resources utilization management.
- (d) To provide an organizational structure that allows continuous monitoring of patient care practices.

- (e) To conduct reviews and evaluation of the quality of patient care through quality assessment and improvement activities.
- (f) To recommend to the Governing Body action with respect to appointments, reappointments, staff category, department assignment, clinical privileges and corrective action.
- (g) To assure the Governing Body that appropriate clinical procedures have been delineated.
- (h) To account to the Governing Body for the quality and efficiency of patient care rendered to patients at the Hospital through regular reports and recommendations.
- (i) To initiate and pursue corrective action with respect to members when warranted.
- (j) To develop, administer, and seek compliance with these Bylaws, the Rules and Regulations of the Medical Staff, and other patient care related Hospital and Medical Staff policies.
- (k) To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.
- (l) To conduct all its affairs involving the Medical Staff, patients, and employees in a manner and an atmosphere free of unlawful discrimination because of age, sex, creed, national origin, race, religion, handicap, disability, color, ancestry, religion, sexual orientation, mental status, newborn status, source of payment or any other unlawful basis.
- (m) To carry out such other responsibilities as may reasonably be delegated to the Medical Staff by the Governing Body.

2.3 **The obligations of Medical Staff members include:**

Each member of the Medical Staff, regardless of membership category, and each Practitioner exercising clinical privileges under these Bylaws, by accepting such appointment, reappointment, or privileges, agrees:

- (a) To provide patients with care at the generally recognized professional level of quality and efficiency.
- (b) To abide by these Bylaws, the Rules and Regulations, and by all other applicable standards, policies, procedures, rules, and regulations of the Hospital and the Medical Staff.

- (c) To discharge the staff, committee, department, and Hospital functions for which he is responsible, whether by membership category, appointment, election, or otherwise.
- (d) To appear for a personal interview at any reasonable time requested by the President of the Medical Staff, the Executive Committee, a Medical Staff committee, the Designated Administrative Officer or the Governing Body.
- (e) To provide data, written information or other documents (such as, but not limited to, physical or mental health information) when requested by the Designated Administrative Officer, President of the Medical Staff, Executive Committee or the Governing Body, in a manner and to the extent permitted by applicable laws and regulations.
- (f) If granted privileges, to complete and document a medical history and appropriate physical examination in the patient's medical record no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. If the history and physical examination is completed within thirty (30) days before admission or registration, an update note will be completed and documented in the patient's medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
- (g) To attempt to secure autopsies in all cases of unusual deaths and/or medical-legal and educational interest as further set forth in the Rules and Regulations and/or Hospital policy.
- (h) To always report to the Hospital fit for duty.
- (i) To submit to and cooperate with focused, ongoing and any other professional practice evaluations or other review requested or directed by the Executive Committee.
- (j) To keep timely, accurate and complete medical records during his membership, in anticipation of a leave of absence and when his Hospital practice is ending or has ended.
- (k) To practice within the scope of his license, experience and abilities and to seek consultation whenever necessary.
- (l) To obtain proper informed consent as a prerequisite to any procedure requiring informed consent.
- (m) To attend, without compensation or remuneration, an orientation program for new members, training regarding compliance issues, such as, but not

limited to, HIPAA, OSHA, etc., and other meetings as directed by the Executive Committee.

- (n) To notify the Medical Staff Services Office immediately upon a change of home or office address, telephone, email or other contact information.
- (o) To maintain all of the qualifications of appointment throughout his membership.

SECTION 3 - MEMBERSHIP

3.1 Membership a Privilege

Membership on the Medical Staff of Ministry Saint Michael's Hospital is a privilege which shall be extended only to those Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Rules and Regulations, who possess the character, competence, training, experience and judgment needed to provide high-quality, safe patient care, and for whom the Hospital is able to provide adequate facilities and/or supportive services for the Practitioner and his patients. Appointment to and membership on the Medical Staff shall confer on the Practitioner only such clinical privileges and prerogatives as have been granted by the Governing Body in accordance with these Bylaws.

3.2 Qualifications

- (a) Only Practitioners licensed in the State of Wisconsin and whose background, experience and training assures, in the judgment of the Governing Body, that any patient treated by them in the Hospital will be given quality medical care, shall be qualified for clinical privileges or membership on the Medical Staff. No Practitioner shall be entitled to membership of the Medical Staff, or to the enjoyment of particular privileges, merely by virtue of the fact that he is duly licensed to practice medicine, dentistry or podiatry in this or in any other state, or by virtue of the membership in any professional organization, or past or present privileges at another hospital.
- (b) Practitioners must provide evidence of graduation from an approved medical or approved osteopathic school meeting the standards of the Accreditation Council of Graduate Medical Education or the American Osteopathic Association, an approved dental school meeting the standards of the Council on Dental Education of the American Dental Association, or an approved school of podiatry meeting the standards of the Council on Education of the American Podiatry Association. Practitioners must meet the continuing education hours required for state licensure in their profession.

- (c) All prospective member physicians must be either board certified or board admissible doctors of medicine or osteopathy. Acceptable Board Certification/Admissibility includes: the American Board of Medical Specialties and the American Osteopathic Association. All prospective member podiatrists must be either board certified or board admissible with the American Board of Podiatric Surgery. All prospective member dentists must have completed an approved post-graduate training program or be pursuing board certification as may be required by the Credentials Committee and the Governing Body.

If the applicable board admissibility requirements include the successful completion of a residency program, this residency program must be completed through an approved postgraduate training program. In the event that the board admissibility requirement includes a post-residency practice requirement, this requirement may be met at the Hospital provided that all other requirements for Medical Staff membership are met.

Continued Medical Staff membership will require a physician who is board admissible to obtain board certification in the proposed area of practice within five (5) years of initially becoming board admissible. Notwithstanding the foregoing, the Governing Body has the power to waive the board certification requirement, upon recommendation of the Credentials Committee and approval of the Executive Committee, when the prospective member has demonstrated that he has obtained the training requisite to board certification in the area of proposed practice and there is documentation both of the need for the talents of the prospective member (prepared by the Executive Committee for review and recommendation by the Credentials Committee and for review and action by the Governing Body) and where either (i) the prospective member has been licensed to practice medicine in the United States for at least three (3) years or (ii) the prospective member has achieved extraordinary recognition in the field of medicine as evidenced by nationally or internationally recognized awards or appointments.

For purposes of this Section, an “approved” post-graduate training program for physicians is a residency program fully accredited throughout the time of the prospective member’s training by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. An approved post-graduate training program for podiatrists is one fully accredited throughout the time of the prospective member's training by the Council on Podiatric Medical Education of the American Podiatric Medical Association. An approved post-graduate training program for dentists is one fully accredited throughout the time of the prospective member's training by the Commission on Dental Accreditation.

The requirements outlined in these Bylaws for satisfactory completion of approved postgraduate training, and the general board certification or admissibility requirements, will be waived for any member who was a member in good standing of the Medical Staff for three (3) continuous years immediately prior to March 29, 2011.

- (d) Practitioners shall provide evidence of their background, experience, judgment, training and demonstrated current competency in their specialties for all privileges requested as demonstrated by peer data references and otherwise. All Practitioners shall participate in and be subject to the quality assessment and improvement activities of the Hospital and the Medical Staff.
- (e) Practitioners shall provide evidence of their adherence to the ethics of their profession, their good reputation and character, and to the appropriate utilization of Hospital resources as determined through quality assurance and utilization review activities.
- (f) Practitioners shall provide evidence of their ability to work competently and cooperatively with their peers, other Practitioners, Allied Health Professionals, members of the supporting staff and Hospital administration.
- (g) 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 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 provide high quality, safe care and supervision for patients. Similarly, the Governing Body may precondition appointment, reappointment, or the continuing exercise of any or all clinical privileges upon the Practitioner undergoing a mental or physical health examination by a physician acceptable to the Governing Body to support such certification.

Each initial applicant to the Medical Staff, in the year prior to appointment, shall have a complete physical examination. The Executive Committee may require that a member of the Medical Staff, including a limited Medical Staff member, submit to a mental or physical examination by an appropriate physician at such other times as the committee determines to be appropriate. The presence of a physical or mental condition which can reasonably be accommodated shall not constitute a bar to the grant of Medical Staff membership or clinical privileges, provided the Practitioner can safely perform the clinical privileges requested and provide safe, high quality care and supervision for patients. Each of the requirements of this Section 3.2(g) shall be applied according to applicable state and federal law.

- (h) Practitioners must submit and maintain on file at all times current evidence of unlimited and current licensure in the state of Wisconsin, unlimited DEA registration (if applicable) and hold current professional liability insurance in which coverage pertains to services to be provided by Practitioners at the Hospital and meets minimum requirements specified by Section 655.23 of the Wisconsin Statutes, as amended from time to time, and for participation in the Wisconsin Injured Patients and Families Compensation Fund. This requirement may be satisfied by submitting copies of the Practitioner's current license, DEA registration and insurance certificate at appointment and each time these documents change or are updated. Failure to do so may result in denial of appointment/reappointment or automatic suspension under the Plan.

- (i) As part of their appointment and reappointment to the Medical Staff and as a condition of the grant of clinical privileges, Practitioners have an obligation to inform the Hospital at initial appointment, of the following. As part of their appointment and reappointment to the Medical Staff, and as a condition of the grant of clinical privileges, Practitioners also have a continuing obligation to immediately notify the Designated Administrative Officer of, and a duty to provide such additional information as may be requested regarding, each of the following:
 - (1) the revocation, suspension, reduction, limitation, denial or voluntary relinquishment of his professional license or DEA registration, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to his professional license, or the imposition of terms of probation or limitation by any state;
 - (2) denial, voluntary or involuntary loss, relinquishment or restriction of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;
 - (3) loss, cancellation or change of professional liability insurance coverage;
 - (4) receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges regarding health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or the any state;
 - (5) any criminal conviction or pending criminal charge, including but not limited to any findings by a governmental agency that the

Practitioner has been found to have abused or neglected a child or patient, or has misappropriated a patient's property;¹

- (6) any proposed or actual exclusion from any federally-funded health care program, any notice to the Practitioner or his representative of proposed or actual exclusion or any pending investigation of the Practitioner from any health care program funded in whole or in part by the federal government, including Medicare and Medicaid;
 - (7) settlement of a claim by a payment from an insurance company (or by the Practitioner or any other party), or any agreement that results in a release from liability being given by a patient to the Practitioner;
 - (8) receipt of notice of the filing of any suit against the Practitioner, submission of a request for mediation, or a submission of adversity to the Wisconsin Injured Patients and Families Compensation Fund alleging professional liability in connection with the treatment of any patient in or at the hospital;
 - (9) any notification by any quality improvement organization or a third party payor reimbursement program concerning any negative quality of care review or sanction imposed;
 - (10) any circumstance(s) or change in circumstance(s), including, but not limited to health status, that would materially affect his ability to perform essential functions of the Medical Staff or to exercise the clinical privileges granted, or that may put patients or Hospital staff at risk; and
 - (11) to promptly notify the Designated Administrative Officer of, and to provide such additional information as may be requested regarding any required report made by a physician about the conduct of another physician with clinical privileges at the Hospital to the Wisconsin Medical Examining Board.
- (j) No person who is otherwise qualified shall be denied appointment, reappointment or privileges by reason of race, color, creed, age, handicap, disability, sex, religion, sexual orientation, national origin or any other unlawful basis.
- (k) As part of their appointment and reappointment to the Medical Staff and as a condition of the grant of any clinical privileges, Practitioners have a continuing obligation to comply with federal and state laws and regulations applicable to the practice of their profession and applicable standards

¹ A criminal conviction or pending criminal charge is not necessarily a bar to appointment, reappointment or the granting of privileges.

established by The Joint Commission, the Medicare Conditions of Participation, and other accreditation and government agencies.

- (l) As part of their appointment and reappointment to the Medical Staff and as a condition of the grant of any clinical privileges, Practitioners have a continuing obligation to comply with health requirements established by the infection control and Executive Committees of the Medical Staff.
- (m) As a condition of appointment and reappointment to the Medical Staff and the grant of any clinical privileges, all Practitioners granted clinical privileges to provide patient care in the Hospital acknowledge they participate in the organized health care arrangement comprised of all clinically integrated settings at the Hospital ("OHCA") and agree to follow the privacy practices of that OHCA with respect to protected health information received through the OHCA.²
- (n) No Practitioner who is currently barred from providing services in the Hospital under Chapter DHS 12 of the Wisconsin Administrative Code is eligible or qualified for Medical Staff membership or the grant of clinical privileges.
- (o) The Governing Body may consider 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 also be made by the Governing Body. To the extent the geographic location of the applicant and his practice affects the ability of the Practitioner to provide effective continuity of care for Hospital patients, it shall also be a consideration.
- (p) No applicant who is currently or has been sanctioned by, denied, limited, restricted, suspended or 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 or for the grant of clinical privileges.

² Under the Health Insurance Portability and Accountability Act (HIPAA), a clinically integrated care setting in which individuals typically receive health care from more than one health care provider is an OHCA by definition. Since all of the entities that will be subject to these Medical Staff Bylaws are such clinically integrated settings, they are OHCAs for purposes of disclosing protected health information to and among otherwise unrelated health care providers for the health care operations of the OHCA, without requiring patient authorization. This allows, for example, Medical Staff members not employed by the Hospital to perform peer review for the OHCA even though the reviewing member had no relationship with the patient whose record is being reviewed.

3.3 **Ethics and Ethical Relationships**

- (a) By accepting membership on the Medical Staff or the grant of clinical privileges, a Practitioner specifically agrees to abide by the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops and the applicable Code of Ethics. Should there be a conflict between any provisions of the applicable Code of Ethics and the Ethical and Religious Directives, the latter shall prevail.
- (b) All members of the Medical Staff shall pledge that they shall not receive from or pay to another physician, dentist, podiatrist or psychologist, either directly or indirectly, any part of a fee received for professional services, or accept or make other inducements relating to patient referral. Further, all members shall pledge that they will provide continuous care for their patients, seek consultation when necessary, and refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a Provider who is not qualified to undertake the responsibility and is not adequately supervised. The member must agree to furnish the Hospital with a current list of alternates with a comparable scope of clinical privileges, in accordance with departmental policy or practice, or a telephone answering service number, which then can supply the name of the available alternate when the attending Practitioner is unavailable. Further, all Active staff and all Provisional staff seeking advancement to the Active staff, must provide emergency specialty call coverage as established by each specialty service, approved by the Executive Committee and the Governing Body, within their scope of privileges, without regard to source of payment or ability to pay. Practitioners must maintain a call response time of fifteen (15) minutes or less when on call.
- (c) Practitioners shall work collaboratively in a professional and collegial manner with other Practitioners, Allied Health Professionals and Hospital employees in the best interest of patient care. Each Practitioner will refrain from disruptive behavior as defined by Medical Staff policy.
- (d) The professional conduct of members of the Medical Staff shall at all times be governed by applicable Wisconsin and federal laws. In the event the provisions of these Bylaws or the Rules and Regulations promulgated hereunder shall not be in conformity with any Wisconsin or federal law or regulation, these Bylaws and Rules and Regulations shall be deemed automatically amended to comply with such law or regulation. As soon thereafter as may be practicable, such change shall be made in writing in the Bylaws or Rules and Regulations.

3.4 **Term of Appointment**

- (a) All initial appointments to the Medical Staff shall be made by the Governing Body of the Hospital upon the recommendation of the Executive Committee and shall be for a period extending to the Practitioner's anniversary date following the first twelve months of the initial appointment. Reappointments of all members of the Medical Staff shall be for a period up to but not more than two (2) years. Reappointments for a period of less than two (2) years are not adverse actions and not subject to the rights of hearing or appeal under the Plan.
- (b) The Governing Body shall not take unilateral action contrary to the Executive Committee's recommendation on an application for appointment or reappointment, or cancel an appointment previously made, without prior conference and consultation with the Executive Committee. However, in the event of unwarranted delay, the Governing Body may take action on the basis of the Practitioner's professional and ethical qualifications obtained from reliable sources. Prior to taking such action, however, the Governing Body shall notify the Executive Committee of its intent, and shall designate an action date prior to which the Executive Committee may fulfill its responsibility. For purposes of this Section, unwarranted delay generally means one hundred (100) days from the date that the fully completed application has been received by the Medical Staff. Nothing in this Section 3.4(b) is intended to preclude the Governing Body from ultimately taking action contrary to the Executive Committee's recommendation.
- (c) Appointments to the Medical Staff shall confer on appointees only such privileges as are specified in the notice of appointment in conformity with these Bylaws, Rules and Regulations.
- (d) As a condition of appointment, members shall act consistently with the Hospital's mission statement and written corporate compliance plan, but these documents shall not operate to deprive any member of the rights available under these Bylaws.

3.5 **Resignation from the Medical Staff**

- (a) Any Practitioner may resign his membership and privileges at any time by providing written notice to the Designated Administrative Officer and President of the Medical Staff. However, resignations taken without a minimum of two (2) weeks' notice may be considered to be resignations not in good standing and reported as such to inquiring entities. See also Section 6.7.
- (b) Unless on an approved leave of absence, resignation will be deemed to have occurred when a Practitioner has relocated his practice outside the

Hospital's service area and has not provided care to Hospital patients for sixty (60) days or more.

- (c) Resignation will be also be deemed to have occurred (and to have occurred not in good standing) when a Practitioner no longer meets the qualification of membership or eligibility for privileges, is absent without notice for two (2) consecutive scheduled procedures/call coverage/shifts, fails to complete his application for reappointment within required time frames, or fails to return from an automatic suspension under the Plan.
- (d) A Practitioner is expected to have completed all clinical and record-keeping responsibilities, and made arrangements for all immediate call and round obligations (defined, for these purposes, as scheduled within two (2) weeks of the resignation date) at the time of resignation. A Practitioner who resigns without having completed and signed medical records and fulfilled other clinical responsibilities as described herein will be considered to have resigned not in good standing.
- (e) Provisions of these Bylaws relating to hearings and appellate review shall not apply to a determination of a designation of "not good standing" based upon a Practitioner's resignation.

3.6 **Allied Health Professionals**

The Governing Body, upon recommendation of the Executive Committee, may grant Allied Health Professionals ("AHPs") appropriate clinical privileges to practice at the Hospital consistent with applicable Medical Staff policies. AHPs are not members of the Medical Staff and do not have the same rights and responsibilities provided to or required of Medical Staff members.

AHPs are health care providers who are not physicians, podiatrists or dentists, but by virtue of their special training, are able to provide services to the Hospital or its Medical Staff. AHPs perform specified patient care services under Medical Staff supervision or collaboration and pursuant to written guidelines. Scope of practice is determined for each individual by his/her supervising/collaborating physician with approval of the Credentials Committee, the Executive Committee and as applicable, the Governing Body and consistent with state law.

AHPs may be employed by the Hospital, employed by another entity or individual or, except in the case of Physician Assistants, may be independent practitioners. Physician Assistants may not be self-employed. All AHPs must have a sponsoring member of the Medical Staff who works with the AHP in a supervisory or collaborative relationship, as set forth in state law.

In requesting that an AHP be authorized to practice in the Hospital, the sponsoring Medical Staff member agrees:

- (a) To accept responsibility for the AHP's performance in the Hospital with respect to patients under his supervision/collaboration;
- (b) To accept responsibility for the proper conduct of the AHP within the Hospital, and for the AHP's observation of all bylaws, policies and rules and regulations of the Hospital and Medical Staff (including the maintenance of professional liability insurance coverage);
- (c) To abide by all bylaws, policies, rules, regulations and laws governing the use of AHPs in the Hospital including refraining from requesting that the AHP provide services beyond, or what might reasonably be construed as being beyond his authorized scope of practice in the Hospital;
- (d) To immediately notify the Executive Committee in the event any one of the following occurs:
 - (1) The physician modifies or terminates his supervisory or collaborative agreement with the AHP;
 - (2) Notification is given of the investigation of either the supervisory or collaborative physician or the AHP by any state or federal agency or authority;
 - (3) The employment status or the authorized scope of practice of the AHP or the supervising or collaborating physician changes;
 - (4) Professional liability insurance coverage is changed insofar as coverage of the acts of the AHP is concerned.

SECTION 4 - CATEGORIES OF THE MEDICAL STAFF

4.1 The Medical Staff

The Medical Staff shall be divided into Provisional, Active, Limited, Courtesy, Consulting and Telemedicine staffs. The Medical Staff will assess dues annually according to its needs. Staff dues shall be determined by a majority vote of the Executive Committee. Dues will be designated for use by the Executive Committee, consistent with the purposes and responsibilities of the Medical Staff and the mission and philosophy of the Hospital.

4.2 The Provisional Medical Staff

- (a) The Provisional Medical Staff shall consist of all newly appointed Practitioners and those who have been reappointed to provisional membership for an additional period after completion of the initial term. The staff category to which Practitioner will be seeking to advance must be specified at the time of application.

- (b) The Provisional Medical Staff member will be expected to have fulfilled the responsibilities and abided by the restrictions applicable to the staff category designated for advancement, as a condition of advancement upon completion of the provisional term. However, Provisional Medical Staff members shall not be eligible to: (1) vote in the election of officers or the amendment or adoption of Bylaws or Rules and Regulations; (2) serve on the Executive or Credentials Committees; or (3) hold office.
- (c) Provisional Medical Staff members shall be assigned to departments and shall have their performance monitored and reviewed by the Chair(s) of these departments or his representative, as appropriate to their staff membership category.
- (d) A member of the Provisional Medical Staff who does not qualify at the end of his initial term of appointment for advancement to the staff category designated may be scheduled for a personal interview with the Credentials Committee at the time of reappointment to discuss the status of his continued interest in membership on the Medical Staff of the Hospital. The Credentials Committee, after consultation with the Chair of the department(s) involved, will recommend continuation on the Provisional staff for a specified period not to exceed a single appointment term, appointment to the Active, Courtesy, Limited or Consulting Medical Staff, or non-reappointment to the Medical Staff. In the case of non-reappointment, the Practitioner shall be entitled to the procedural rights set forth in the Plan.
- (e) The factors to be considered in whether to recommend advancement shall be those identified in Sections 3.2 and 5.3, of these Bylaws and a demonstrated ability to meet the requirements and responsibilities of the staff category to which the Practitioner seeks to advance. Continuation of Provisional status may be recommended in lieu of non-reappointment where the Practitioner either fails to meet the criteria for advancement or has not experienced a sufficient volume of cases for such a determination to be made and there is a reasonable expectation that he will be eligible for advancement by the end of a second provisional appointment.
- (f) If the Practitioner fails to meet the requirements or responsibilities of the staff category to which he was initially designated to advance (e.g., Active staff), the Practitioner may be advanced to any other staff category for which he qualifies (e.g., Courtesy or Limited staff), if approved by the Governing Body.

4.3 **The Active Medical Staff**

- (a) The Active Medical Staff shall consist of those Practitioners who regularly admit patients to, or are otherwise regularly involved in the care of patients in the Hospital (including the Hospital-based clinic), who are located close

enough to the Hospital to provide proper care to their patients, and who assume all the functions and responsibilities of membership on the Active Medical Staff, including providing emergency care and emergency consultation as established by the specialty service and approved by the Executive Committee and the Governing Body, within the scope of their privileges for patients admitted to the Hospital and presenting to the Hospital's Emergency Department.

- (b) Each Active Medical Staff member must provide continuous care for his patients, and refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a Provider who is not qualified to undertake the responsibility and is not adequately supervised. The member must agree to furnish the Hospital with a current list of alternate Practitioners, in accordance with departmental policy or practice, or a telephone answering service number, which then can supply the name of the available alternate when the attending Practitioner is unavailable. Further, all Practitioners must provide emergency specialty call coverage as established by each specialty service and provide, within their scope of privileges, such emergency care without regard to source of payment or ability to pay. Practitioners must maintain a telephone response time of fifteen (15) minutes or less when on call.
- (c) For purposes of this Section, a Practitioner will be considered to be located close enough to the Hospital to provide proper care if the Practitioner:
 - (1) Maintains his professional office and usual overnight location within a geographic proximity that permits arrival within thirty (30) minutes of being called in; or
 - (2) Specific arrangements have been made to transfer care responsibilities to an alternative Practitioner who is properly privileged at Hospital, qualified and willing to cover for the individual, and such alternative can arrive at the Hospital within thirty (30) minutes of being called in.
- (d) New members of the Active Medical Staff must have been members of the Provisional Medical Staff or the Courtesy Medical Staff and regularly involved in the care of twelve (12) or more patients at the Hospital for a period of at least one (1) year, which requirement may be waived in unusual circumstances by the Executive Committee and the Governing Body. They must have attained acceptable qualifications in their field of practice according to current national standards and have an active interest in the operation of the Hospital.
- (e) Members of the Active Medical Staff shall promote the quality of medical care in the Hospital, offer sound counsel to the Designated Administrative

Officer and the Governing Body and participate in the internal government of the Medical Staff according to these Bylaws.

- (f) Members of the Active Medical Staff shall:
 - (1) Be eligible to vote, hold office, and serve on the Executive and Credentials committees;
 - (2) Be required to serve on Medical Staff committees and attend department and committee meetings as provided in Section 12 of these Bylaws.

4.4 **The Limited Medical Staff**

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

judgment. Members of the Limited Medical Staff must reasonably comply with all requests for such practice information, data, or reports.

4.5 **The Courtesy Medical Staff**

- (a) The Courtesy Medical Staff shall consist of Practitioners who desire to treat patients in the Hospital but who are unable to participate actively in the functions of the Medical Staff. New members of the Courtesy Medical Staff must have been members of the Provisional Medical Staff, the Active Medical Staff or the Consulting Medical Staff for a period of at least one (1) year before being eligible for the Courtesy Medical Staff.
- (b) Members of the Courtesy staff shall not be required to, but may attend general Medical Staff meetings or departmental meetings.
- (c) Members of the Courtesy staff shall not be eligible to vote at general staff or departmental meetings, hold office or serve on the Executive, Credentials committees, but may be required to serve on any other Medical Staff committee, with voting rights on the committee.
- (d) Members of the Courtesy staff shall be restricted to admitting (outpatient or inpatient) twelve (12) patients per year. If this number is exceeded at any time during the Medical Staff Year, the member will automatically be considered to have applied for an advancement of membership. Additionally, if the Courtesy staff member is a member of a group practice where no member of the group is on the Active Medical Staff, admission of more than twenty-four (24) patients of the group (even when no single member of the group admits more than twelve (12) patients) will result in all members of the group on the Courtesy staff being considered to have applied for an advancement of membership.
- (e) A member of the Courtesy Medical Staff must be a member of the Active or Associate Medical Staff of another hospital where he actively participates in a patient care audit program and other quality assessment and improvement activities similar to those required of the Active Medical Staff of Hospital. This requirement may be waived by the Executive Committee in the case of a Practitioner who does not maintain either an active outpatient or inpatient practice but who otherwise would qualify for membership. In the event of waiver, all of that Courtesy staff member's cases will be reviewed by the President of the Medical Staff or his designee. Members of the Courtesy staff must reasonably comply with all requests for information, data or reports sought by the Medical Staff for evaluation of the member's professional competence and judgment.
- (f) Courtesy Medical Staff who do not admit any patients in a one (1)-year period may be deemed ineligible for reappointment, without a right to hearing or appeal under the Plan.

4.6 **The Consulting Medical Staff**

- (a) The Consulting Medical Staff shall consist of recognized specialists who are active in their specialties and have signified a willingness to accept such appointment to the Medical Staff. Members of the Consulting staff shall be members of specialty boards, diplomats of one of the national boards of medical specialties, or other practitioners who, in the opinion of the Credentials Committee and the Executive Committee, are qualified for consultation work in their specialty. Membership on the Consulting staff shall not, per se, qualify the member for Active staff membership.
- (b) Members of the Consulting staff shall provide their services in the care of patients in the Hospital at the request of any member of the Medical Staff as well as in circumstances where consultation is required by the Rules and Regulations of the Medical Staff. Consulting staff members may admit patients on their own initiative for observation during a non-surgical treatment or for radiation or chemotherapy, provided they remain available for call during the admission or an Active staff member is qualified, properly privileged, available and agrees to provide coverage in the event of unavailability of the Consulting staff member during the patient's stay.
- (c) Members of the Consulting staff shall have no assigned duties and shall not be eligible to vote or hold office, but may serve on Medical Staff committees, except the Executive and Credentials committees and may vote at committee meetings.
- (d) Members of the Consulting staff may attend general Medical Staff meetings and departmental meetings but are not required to do so.
- (e) Members of the Consulting staff shall have such clinical privileges as may be granted by the Governing Body in accordance with these Bylaws. All surgical privileges require Active or Courtesy staff membership or Provisional staff membership with advancement to either of these two Medical Staff categories designated. For purposes of defining the scope of Consulting staff privileges only, procedures such as endoscopy, colonoscopy, angiography, and angioplasty are not considered surgical privileges.
- (f) A member of the Consulting staff must be a member of the Active or Associate staff of another hospital where he actively participates in a patient care audit program and other quality assessment and improvement activities similar to those required of the members of the Active staff of Hospital. Members of the Consulting staff must reasonably comply with all requests for information, data or reports sought by the Medical Staff for evaluation of the member's professional competence and judgment.

4.7 **The Telemedicine Medical Staff**

The Telemedicine Medical Staff shall consist of those physicians who meet the qualifications for Medical Staff membership but provide services to Hospital patients exclusively via telemedicine. For the purposes of these Bylaws, telemedicine shall mean the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services. The Medical Staff shall recommend to the Governing Body which clinical services may be delivered appropriately via telemedicine. Telemedicine Medical Staff members shall not be entitled to hold office, vote, admit patients, or have any other assigned duties or responsibilities unless deemed necessary by the Executive Committee. Telemedicine Medical Staff members shall not be required to pay dues.

4.8 **The Dental and Podiatric Staff Functions**

- (a) Dentists and podiatrists granted membership on the Medical Staff in accordance with the procedures set forth in Section 5 may be members of any category of the Medical Staff for which they qualify and shall be assigned to the Department of Surgery.
- (b) Except as provided in Section 4.8(d) below, patients admitted to the Hospital for dental or podiatric care shall be given the same medical appraisal as those admitted for other services. Admission of a dental or podiatric patient shall be the dual responsibility of the dentist or podiatrist and a physician member of the Medical Staff. The physician shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of a dental or podiatric patient.
- (c) Subject to Section 4.8(d) below, dentists and podiatrists shall conform to the Bylaws, Rules and Regulations of the Medical Staff with the following additions:
 - (1) Patients may be admitted for dental or podiatric services by a dentist or podiatrist after obtaining the concurrence of the admitting physician.
 - (2) Surgical procedures performed by dentists and podiatrists shall be done under the overall supervision of the Chief of Surgery or his designee.
 - (3) At the time of surgery scheduling and at the time of admission, the name of the medical consultant must appear on the appropriate forms. This consultant shall be responsible for pre- and post-operative medical evaluation and care of the patient, except as provided in Section 4.8(d) below.

- (4) The dentist or podiatrist may discharge the patient after obtaining the concurrence of the attending physician.
 - (5) Complete records, both dental or podiatric and medical, shall be required on each patient and shall be part of the Hospital record.
- (d) Privileges granted to oral surgeons shall be based upon their training, experience, demonstrated competence, judgment and current capability. The scope and extent of surgical procedures that each oral surgeon may perform shall be specifically delineated. Qualified oral surgeons who have been granted clinical privileges to do so may admit and discharge patients without medical problems without first obtaining the concurrence of a physician member of the Medical Staff, but such oral surgeons must designate a physician member of the Medical Staff with appropriate clinical privileges to be responsible for the care of any medical problem that may arise. If qualified and granted clinical privileges to do so, oral surgeons may, in lieu of a physician member of the Medical Staff, perform the admission history and physical examination and assess the medical risks of the proposed surgical procedures on those patients admitted without medical problems. Criteria to be used in identifying such qualified oral surgeons shall include, but shall not necessarily be limited to, successful completion of training requirements for certification by the American Board of Oral and Maxillofacial Surgery.

4.9 **Provisional Appointments and New Clinical Privileges-Monitoring-Protocol**

- (a) During the term of any appointment to the Provisional Medical Staff, it will be the responsibility of the Chair or his designee(s) of the appropriate department(s) to orient the Practitioner to the department(s), and establish and oversee a monitoring protocol as set forth in Medical Staff policy. See Appendix B.
- (b) The initial cases in which a member of the Provisional staff admits and treats, or participates as a non-admitting Practitioner, and the initial cases in which any Medical Staff member exercises new or increased clinical privileges, shall be reviewed by means of the monitoring protocol. Each department shall recommend in advance either a fixed number of cases or a fixed time period in which all cases will be reviewed for the individual member subject to review according to the volume of cases in which the Practitioner is expected to participate so that a sufficient number of cases will have been performed for the Chair to make a determination about the need for continued review. For candidates for Medical Staff categories other than the Active Medical Staff, the applicable departments may review cases from other hospitals where the Practitioner has privileges or from the Practitioner's office records to obtain the specified volume of cases necessary for the Chair to make a determination about the need for

continued review. The Practitioner shall have the burden of assuring access to records requested for this purpose.

- (c) At the conclusion of the cases or period of time established by the applicable department(s), the Chair of the department(s) shall recommend to the Credentials Committee that the monitoring be terminated or that an additional period of monitoring be established. The Credentials Committee shall consider the issue and make its recommendation to the Executive Committee. Should the Executive Committee extend the monitoring of a Practitioner for an additional period, such may be done with no further action being required by the Governing Body. Further, the Practitioner shall not be entitled to a hearing or review on such a decision in accord with the Plan established in the Medical Staff Bylaws. Any decision to extend the monitoring protocol beyond the term of the next renewal appointment following the initial provisional appointment or of the first grant of the new or increased clinical privileges must, however, be ratified by the Governing Body. Such decision is not subject to review in accord with the Plan.
- (d) At the time of the grant of the clinical privileges that will be subject to monitoring, the departments responsible for monitoring the privileges at issue will be designated, according to the areas of practice to which the clinical privileges relate. If more than one department is designated, the Chair of each such department shall be responsible for implementing the monitoring for the clinical privileges within the purview of his department. The Executive Committee shall base its determination in this Section 4.9(d) upon the recommendation of each department Chair responsible for monitoring.
- (e) During the provisional appointment, the monitoring protocol shall afford the Hospital and the Practitioner the following:
 - (1) The ability to establish pretreatment consultation requirements.
 - (2) A current review of the clinical abilities of a Practitioner.
 - (3) A resource person or committee to whom the Practitioner can or must seek voluntary or required consultation.
 - (4) A resource in the form of a mentor with whom other staff members or Hospital personnel may confer concerning the Practitioner on interim status, and with whom the Practitioner may confer concerning Hospital practices and policies, bylaws and rules and regulations.
 - (5) A basis for recommending privileges at the completion of the provisional appointment.

SECTION 5 - PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 Application for Appointment

- (a) Practitioners desiring appointment to the Medical Staff shall obtain an application and privilege request form from the Medical Staff Services Office who will, in addition to the forms, supply or make available to the applicant a copy of the Medical Staff Bylaws, Rules and Regulations, the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops, the Medicare Notice to Physicians acknowledgment form, and the Hospital mission statement. A copy of the Code of Ethics applicable to the applicant's profession shall be made available for Practitioner review upon request.
- (b) All applications for appointment to the Medical Staff shall be presented in writing on a form prescribed by the Executive Committee. The completed application shall be signed and dated by the applicant and provide a full summary of the applicant's education, institutional positions held, the dates of commencement and completion of each service, practice affiliations (hospital and clinic), date and number of past and present state licensure, date and number of board certification, and information regarding insurance coverage and registration with the DEA, ECFMG, Medicare and Medicaid and other certifications, as applicable, and such other information as may be relevant to the applicant's qualifications for appointment. The Hospital is responsible for verifying the information provided but the applicant has a continuing obligation to update the application and facilitate the release of information necessary for verification and evaluation of the applicant's credentials. The Hospital will verify that the applicant is the same practitioner identified in the credentialing documents by viewing one of the following: a current picture hospital identification card or a valid picture identification issued by a state or federal agency.
- (c) The applicant shall sign a statement that he agrees to provide continuous care to his patients and that the applicant has received and read the bylaws of the Hospital and the Bylaws, Rules and Regulations of the Medical Staff and agrees to be bound by their terms if granted membership or clinical privileges and to be bound by their terms relating to consideration of his application without regard to whether or not the applicant is ultimately granted membership or clinical privileges.
- (d) The application shall include information as to whether the applicant's membership and/or clinical privileges have ever been revoked, suspended, reduced, not renewed, denied, investigated, voluntarily relinquished or subjected to probationary conditions; whether proceedings towards any of those ends have been instituted or recommended; and

whether he has been subject to any other disciplinary action or sanction at any other hospital or institution, by any specialty board, by any local, state or national medical organization or other professional society, or by any employer of the applicant in a clinical position or practice arrangement. The application shall also include information as to whether or not the applicant has ever been refused liability insurance or renewal or had it canceled, or limitations placed on scope of coverage, had coverage rated up because of unusual risk or been notified of any intent by any insurer to do so. The applicant shall also include information as to any involvement in any professional liability action, information as to any past or pending involvement in any quality inquiry, sanction action or formal investigation by Medicaid or a Medicare peer review or quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state, and information as to whether any license or registration of the applicant has ever been suspended or revoked, and whether the applicant has ever been reprimanded or otherwise disciplined by any state or federal governmental agency relating to the practice of his profession. The applicant shall also include information as to any currently pending challenges to any licensure or registration of the applicant and a statement as to the applicant's ability to safely exercise the privileges requested. The application shall include information as to whether the applicant has any criminal conviction or pending criminal charge, or any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated the property of any patient. The applicant must provide, or cause to be provided, professional practice review data by an organization with which he is currently privileged (if available). The applicant must also 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 DHS 12 of the Wisconsin Administrative Code and other information as the Hospital may require.

- (e) The applicant must submit current evidence of professional liability insurance in the minimum amounts required by the Wisconsin Department of Regulation and Licensing and for participation in the Wisconsin Injured Patients and Families Compensation Fund under Chapter 655 of the Wisconsin Statutes.
- (f) The application shall identify at least two (2) references from peers in the same profession as the applicant who have recently worked with the applicant and directly observed his professional performance over a reasonable period of time and who can and will provide reliable information regarding the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, relevant training and/or experience, current competence, fulfillment of obligations as a member of the medical

staff, interpersonal skills, communication skills, professionalism, and any effect of health status on the applicant's ability to practice medicine or the privileges recommended. These references must be peers who are practitioners in the same or a related professional discipline as the applicant.

- (g) 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.
- (h) The applicant shall have the burden of producing timely and adequate information for a proper evaluation of his competence, character, ability to work with other health care professionals, health status, ethics, and other qualifications and for resolving any doubts about such qualifications. Failure to adequately complete the application form, withholding requested information, providing false or misleading information (whether intentional or not), or omitting material information necessary for a full picture of the applicant's professional history can be a basis for denial of membership on or removal from the Medical Staff.
- (i) The completed application form shall be presented to the Medical Staff Services Office which, after collecting the references and other materials deemed pertinent, shall transmit the application and all supporting materials to the Credentials Committee. Such collection shall include, but is not limited to, written verification from the primary source, whenever feasible, or from a credentials verification organization, the applicant's current licensure, relevant training and current competence.
- (j) Additional details regarding the applicant's health status shall be obtained following a favorable recommendation for appointment by the Executive Committee.
- (k) Any Practitioner by applying for appointment or reappointment, does thereby signify a willingness to appear and be interviewed in regard to the application. The applicant by signing the application authorizes the Hospital to consult with any and all members of medical staffs of other hospitals and clinical entities with which the applicant has been associated, or with prior employers, professional review service organizations, as well as with others who may have information bearing on the competence, practice patterns and appropriate utilization of facility resources, character, health status, conduct, and ethical qualifications of the applicant and to inspect such records and documents as shall be material to an evaluation of stated professional qualifications, and

competence to carry out the clinical privileges requested as well as the applicant's moral and ethical qualifications and health status. By so applying, the applicant also releases all individuals who submit information, including otherwise privileged and confidential information, at the request of the Hospital to facilitate the assessment of his qualifications for staff appointment and clinical privileges, from any liability for their statements made and releases from any liability the Hospital and all representatives of the Hospital (including the Medical Staff) for their acts performed in connection with evaluating the applicant.

- (l) The Hospital retains the right not to process applications for appointment or reappointment until all documents and information required have been provided. The applicant shall be notified of any missing information or verifications and it shall be the responsibility of the applicant to have any missing information sent to the Medical Staff Services Office. If the applicant fails to provide any information or verification within thirty (30) days after being requested to do so, the application shall be automatically deemed to be withdrawn, unless the time to obtain the information is extended by the Medical Staff President and the Hospital Designated Administrative Officer. An application deemed withdrawn pursuant to this Section is an administrative denial, is not a professional review action and does not provide the applicant the right to hearing or appeal under the Plan.

5.2 **Administrative Denial**

The Medical Staff Services Office may, with the approval of the Credentials Committee Chair, deny an application for appointment or reappointment to the Medical Staff or for clinical privileges without further review, if it determines any of the following about the applicant: (1) the applicant does not hold a valid Wisconsin license and no application is pending; (2) the applicant does not have adequate professional liability insurance; (3) the applicant is not eligible to receive payment from the Medicare or Medicaid program or is currently excluded from any health care program funded in whole or in part by the federal government; (4) the applicant is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code; or (5) the applicant has requested clinical privileges that have been exclusively granted to another Medical Staff member or group of members pursuant to a written contract then in effect without notice from any party to the contract of intent to terminate, which contract covers all of the privileges being requested by the applicant. Applicants who are administratively denied under this Section do not have a right to a fair hearing or appeal under the Plan but may submit evidence to the Medical Staff Services Office to refute the basis for the administrative denial.

5.3 **Appointment Process**

- (a) The Medical Staff Services Office will obtain verifying information from the National Practitioner Data Bank, the appropriate state licensure boards and other related sources. If required, the applicant will authorize any special releases that may be required.
- (b) If the application and verifying information obtained reveal no signs of possible problems (such as but not limited to those listed in subsection (c) or (d) below), the application will be classified as a Type I application and be eligible for expedited processing.
- (c) Any one of the following may preclude expedited processing:
 - (1) Inexperienced Practitioner (e.g., out of training for less than five (5) years).
 - (2) Multiple, non-concurrent prior hospital appointments.
 - (3) Multiple state licenses scattered throughout the country.
 - (4) Letters of reference that were returned late or suggest that the Practitioner may have problems in getting along with others.
 - (5) The Practitioner's requested privileges deviate from those generally requested by others in that specialty.
 - (6) Prior but few malpractice actions.
- (d) Applications showing evidence such as, but not limited to the following shall be classified as a Type II application and will not be eligible for expedited processing:
 - (1) Applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial or loss of clinical privileges at another organization.
 - (2) Applicant is, or has been, under investigation by a state medical board or has had prior disciplinary actions or legal sanctions.
 - (3) Applicant has had either an unusual pattern of, or an excessive number of, professional liability actions.
 - (4) Applicant changed medical schools or residency programs or has unexplained gaps in training or practice.
 - (5) Applicant has one or more references that raise more than minor concerns or questions.

- (6) Discrepancy found between information received from the applicant and references or verified information.
 - (7) Applicant has an adverse National Practitioner Data Bank report.
 - (8) Applicant has been removed from a managed care panel for reasons of unprofessional conduct or quality.
 - (9) Applicant submitted an incomplete application.
 - (10) Letters of reference were not returned, returned only after multiple requests, or did not address all the questions asked.
 - (11) Applicant's requested clinical privileges deviate substantially from those generally associated with the specialty.
- (e) The Credentials Committee chair, in consultation with the President of the Medical Staff, shall classify completed and verified applications as either Type I or Type II applications. Classification of the application is not professional review action and does not create a right to hearing or appeal under the Plan. Type I applications will be eligible for the following expedited process:
- (1) The application and all supporting materials will be forwarded to the Chair of the clinical department in which privileges are sought, for appraisal and recommendation.
 - (2) If the department Chair recommends approval of the application and clinical privileges requested without recommending any special conditions, the application and all supporting materials will be forwarded to the Credentials Committee chair or his designee for review and recommendation. The Credentials Committee chair or his designee shall perform the functions assigned to the Credentials Committee in subsections (f) through (j).
 - (3) If the Credentials Committee chair or his designee recommends approval of the application and clinical privileges requested without recommending any special conditions, the application and all supporting materials will be forwarded to the Executive Committee for review and recommendation pursuant to subsection (k).
 - (4) A Type I application will be reclassified to Type II status and subjected to the process applicable to Type II applications at any stage of the process when the body then considering the application proposes to recommend imposing special conditions or to recommend denial of the application or of any clinical privilege requested or for any other reason. However, reclassification will not require resubmission to the department, but will require referral

back to the Credentials Committee for processing according to subsection (f).

- (f) Approximately sixty (60) days after receipt of a completed Type II or a non-expedited Type I application for membership (including all references, reports and other supporting data requested of the applicant), the Credentials Committee should make a written report of its recommendations to the Executive Committee. In preparing this report, the Credentials Committee shall examine the character, ability to work with other health care professionals, current professional competence, qualifications, practice patterns, health status, professional sanctions and ethical standing of the applicant and shall verify, through information contained in references given by the applicant and from other sources available to the committee, including an appraisal from the clinical department in which privileges are sought, and the applicant's National Practitioner Data Bank report (if available), that the applicant meets and has established all the necessary qualifications for the category of staff membership and the clinical privileges requested as set forth in Section 6 of these Bylaws.
- (g) As part of this process, the Credentials Committee shall specifically assess competence in six (6) care areas:
 - (1) Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
 - (2) Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
 - (3) Patient-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
 - (4) Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams. Absorb
 - (5) Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and responsible attitude toward their patients, their profession, and society.

- (6) System-Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.
- (h) The recommendations of the clinical department are advisory to the Executive Committee and do not themselves constitute professional review action such that the applicant has no right to hearing or appeal under the Plan based upon the recommendation. While the recommendation and the appointment to the Medical Staff shall be based primarily on professional competence and conduct of applicants, other factors may also be considered such as: the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his patients; need for additional staff members with the applicant's skill and training; the Hospital's needs; the composition of the Medical Staff and other factors. To the extent the geographic location of the applicant and his practice affects the ability of the applicant to provide effective continuity of care for Hospital patients, it shall also be a consideration.
- (i) The Governing Body or any Medical Staff committee or department may, at any time, request additional information in connection with a completed application, and the processing of the application shall be suspended for 60 days or until the applicant has provided the information requested or satisfactorily explains his failure to do so, whichever occurs first. If the applicant fails to respond in any manner, the application will be deemed withdrawn as described further in Section 5.1(l).
- (j) The Credentials Committee:
 - (1) Shall confirm the validity of the current medical license, residency training, or other post graduate education of the applicant, particularly as they apply to the privileges requested. The committee shall also verify, through references and other sources, that the applicant meets and has established all basic qualifications and criteria set forth in these Bylaws.
 - (2) May require that the applicant appear for an interview with the Chair of the department in which privileges are requested and/or the President of the Medical Staff or their designees, who must be Medical Staff members, and/or the Designated Administrative Officer.
- (k) The Credentials Committee shall submit a written report to the Executive Committee, which may be in the form of the committee's minutes with attachments.

- (1) The written report shall state the applicant's qualifications, other hospital affiliations, interest in the Hospital, and the committee's opinion in regard to the applicant's professional competence and conduct, character, and physical, mental and emotional ability to safely perform the clinical privileges requested, with or without reasonable accommodation, and thereafter, recommend that the applicant be accepted, deferred or rejected.
 - (2) The Credentials Committee report shall include a recommendation as to a delineation of privileges to be extended and any limitations or restrictions thereto, based upon a recommendation from the respective department Chair(s). Any recommendations as to limitations or restrictions, if temporary, shall specify the conditions required and time period necessary to remove such limitations or restrictions. If there are differences in privilege recommendations between departments, both recommendations shall be submitted with each department's reasons set forth.
 - (3) Each recommendation for initial appointment shall be for assignment to the Provisional Medical Staff. The initial period of time on the Provisional staff shall be twelve (12) months, at which time the applicant will be considered eligible for advancement to the category of the Medical Staff that was requested on the original application.^{cc}
 - (4) When a recommendation to defer is made, the recommendation shall state the basis for deferral and shall specify the date of meeting at which the application will be recommended for acceptance or rejection.
 - (5) While the Credentials Committee's recommendation and the appointment to the Medical Staff shall be based primarily on professional competence and conduct of applicants, the Hospital's ability to provide adequate facilities and supportive services to the applicant and his patients, the need for additional staff members with the applicant's skill and training, composition of the Medical Staff, present and future, the Hospital's needs, and other factors shall also be considered.
 - (6) The recommendations of the Credentials Committee are advisory to the Executive Committee and do not of themselves constitute professional review action such that an applicant does not have the right to hearing or appeal under the Plan based upon the recommendation.
- (l) The Executive Committee shall at its next meeting after the receipt of the report of the Credentials Committee:

- (1) Give careful consideration to the new applicant in reference to professional competence, ethical conduct and willingness to contribute toward meeting the educational and professional needs of the Hospital.
- (2) Decide by a majority vote to recommend to approve, defer or reject the applicant and submit its recommendation to the Governing Body through the President of the Medical Staff. Any recommendations for appointments may include probationary conditions relating to clinical privileges. A recommendation by the Executive Committee to defer for further consideration or investigation must be followed up within three (3) months by a recommendation for appointment to the Medical Staff with specified privileges or for rejection of staff membership.
- (3) When the recommendation of the Executive Committee is negative or not in accord with the staff status or privileges requested by the applicant, prior to any referral of the recommendation to the Governing Body for action, the Practitioner involved should be notified of the recommendation pursuant to the Plan and when such are applicable, given an opportunity either to waive any procedural rights which are contained in the Plan by accepting the recommendations or to exercise such review rights as are set forth in the Plan.
- (4) When the recommendation of the Executive Committee is favorable, additional information regarding the applicant's current health status shall be obtained prior to forwarding the recommendation to the Governing Body for action. Upon receipt of the completed health assessment questionnaire, the President of the Medical Staff shall determine whether further investigation and review is warranted.
 - (i) If the President of the Medical Staff determines that the information may affect the Practitioner's ability to safely perform the privileges requested, the matter will be referred to the Practitioners' Advisory Committee for further investigation and review. Following review, the Practitioners' Advisory Committee may recommend affirmation, modification or reversal of the Executive Committee's recommendation and submit a report to that effect to the Executive Committee for processing in accord with this Section.
 - (ii) If the President of the Medical Staff determines that the information does not affect the Practitioner's ability to safely perform the privileges requested, the Executive Committee's

recommendation shall be forwarded to the Governing Body for action. This Section shall not preclude referral to the Practitioners' Advisory Committee for recommendation for monitoring.

- (m) The Governing Body, at its next regular meeting after receipt of the recommendation of the Executive Committee following receipt of the health assessment questionnaire (provided all procedural rights to hearing and appellate review have either been waived or exhausted), shall:
 - (1) Accept the recommendation; or
 - (2) Refer the matter back to the Executive Committee with a request for reconsideration or additional information, indicating reasons for non-acceptance.
- (n) If the Governing Body's final action is a denial of the application, the Designated Administrative Officer shall notify the applicant, in writing, of the decision, the reason for the denial, and as applicable, his right to hearing and review under the Plan, with a copy to the applicant's record.
- (o) If the Governing Body's final action is an approval of the application, the Designated Administrative Officer shall notify the applicant in writing.
- (p) No person who is otherwise qualified shall be denied appointment or reappointment to the Medical Staff, or the exercise of clinical privileges, on the basis of age, sex, race, creed, color, handicap, national origin, religion, disability, sexual orientation, or on the basis of any other criterion unrelated to quality of health care treatment or services.
- (q) The decision to grant, deny, revise or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities.

5.4 **Procedure for Reappointment**

- (a) The Medical Staff Services Office will provide each staff member scheduled for reappointment with a reappointment application form no more than one hundred twenty (120) days prior to expiration of the member's current appointment. Each staff member who desires reappointment shall submit his completed reappointment form to the Medical Staff Services Office within forty-five (45) days of receipt. Failure without good cause to timely return the form shall be deemed a voluntary resignation from the staff and shall result in automatic termination of membership at the expiration of the member's current term. A Practitioner whose membership is so terminated shall be entitled to the procedural rights provided in the Plan for the sole purpose of determining the issue of good cause.

- (b) The reappointment application form shall include all information necessary to update the information contained in the applicant's initial application for appointment since the last time such information was supplied including, without limitation:
- (1) Changes in Medical Staff membership or clinical privileges at any other hospital or institution, including, without limitation, any revocation, suspension, reduction, limitation, denial or non-renewal thereof, whether voluntary or involuntary;
 - (2) Suspension or revocation of licensure or registration (state, district or DEA) or any reprimand or imposition of sanctions related thereto or suspension or revocation of membership or imposition of other sanctions by any local, state or national professional society;
 - (3) Any malpractice claims, suits, settlements or judgments, whether pending or finally determined and any refusal or cancellation of professional liability insurance;
 - (4) Any additional training, education or experience relevant to the privileges sought on reappointment;
 - (5) Any criminal conviction or pending criminal charges;
 - (6) Current evidence of licensure and DEA registration and of professional liability insurance coverage;
 - (7) Documentation of the health assessment required under state regulations for persons providing direct patient services in the Hospital and reporting of any adverse findings relevant to the applicant's exercise of clinical privileges;
 - (8) Any proposed or actual exclusion from any health care program funded in whole or in part by the federal government; or 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;
 - (9) Receipt of a quality inquiry letter, an initial sanction notice or notice of proposed sanction or of the initiation of a formal investigation or the filing of charges relating to health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or any state;
 - (10) Updated information regarding any findings by a governmental agency that the applicant has been found to have abused or

neglected a child or patient or has misappropriated the property of any patient including a fully completed Background Information Disclosure form; and

- (11) Such other information about the applicant's ethics, qualifications, and ability as may be relevant to his ability to provide quality patient care at the Hospital including, without limitation, a current NPDB report.
- (c) All promotions in or changes in Medical Staff category or scope of clinical privileges shall be subject to the procedures in the Bylaws applicable to initial appointments.
- (d) Prior to the last scheduled Governing Body meeting before expiration of the Practitioner's current appointment, the Credentials Committee shall complete its review of all pertinent information available on each Practitioner applying for reappointment for the purpose of determining its recommendations for reappointments to the Medical Staff and for the granting of clinical privileges for the ensuing term and shall transmit its recommendations, in writing, to the Executive Committee.
- (e) Each recommendation concerning reappointment of Medical Staff members and clinical privileges to be granted upon reappointment shall be based upon such individual's current professional competence and conduct, and his clinical performance, including his patterns of practice, based at least in part on the findings of quality assurance measures such as: medical audits; utilization review; medical record review; peer review; infection control activities; tissue review; Practitioner-specific data as compared to aggregate data; morbidity and mortality data; and pharmacy and therapeutics activities. Consideration also includes: current privileges and the basis for any requested modifications; core privilege or special privilege ongoing requirements; current health status; current liability insurance coverage and any filed, settled or pending professional liability claims or actions; current and past professional sanctions, participation in relevant continuing educational programs; timely completion of medical records; attendance at medical staff, department and committee meetings; participation in staff affairs; compliance with the Medical Staff Bylaws and policies; ethical compliance; use of the Hospital for his patients; cooperation and relations with other Practitioners and Hospital personnel; and any other information the Credentials Committee or Executive Committee deems necessary and appropriate for a proper evaluation of a Practitioner's continued status and clinical privileges.
- (f) The assessment of the Chair of each department in which the applicant for reappointment will exercise clinical privileges shall be considered.

- (g) The results of quality assessment and improvement activities, and the monitoring performed during a term of provisional appointment or grant of additional privileges, if applicable, shall be considered in the appraisal of the applicant's professional performance, judgment and technical and/or clinical skills.
- (h) A written report of all matters considered in each Practitioner's periodic reappointment appraisal must be made a part of the permanent files of the Hospital.
- (i) Factors considered in the periodic appraisal include but are not limited to:
 - (1) Number of procedures performed or major diagnoses made;
 - (2) Rates of undesirable outcomes, such as complications compared with those of others doing similar procedures; and
 - (3) Findings and conclusions of review by peers;
- (j) Prior to the last scheduled Governing Body meeting before the expiration of the Practitioner's current appointment, the Executive Committee shall make its recommendations to the Governing Body, through the President of the Medical Staff, concerning the reappointment or non-reappointment and the continuation or alteration of privileges for the ensuing term of each member of the Medical Staff applying for reappointment. In all cases where non-reappointment or a change in staff status or clinical privileges is recommended, the reasons for the recommendation shall be stated and documented.
- (k) When the recommendation of the Executive Committee constitutes a professional review action giving rise to hearing rights as specified in the Plan, prior to any referral of the recommendation to the Governing Body for action, the Designated Administrative Officer shall give the Practitioner involved special notice of the recommendation, and the Practitioner shall be given an opportunity either to utilize the procedural rights which are contained in the Plan or to accept the recommendation.
- (l) Thereafter, the procedure provided in Sections 5.3(m), 5.3(n) and 5.3(o) relating to recommendations on applications for initial appointments shall be followed.

5.5 **Modification of Membership Status or Privileges**

- (a) Subject to Sections 5.2 and 5.6, a member of the Medical Staff may, either in connection with the reappointment process or at any other time, request modification of his staff category, department assignment, or clinical privileges by submitting a written request to the Designated Administrative Officer. Requests for additional clinical privileges shall include:

- Documentation of training and experience for the privilege(s) being requested;
 - Outline of course curriculum, if applicable;
 - Applicable guidelines and standards from recognized specialty boards, societies, etc.;
 - Patient outcome information if available; and
 - Letter from proctor/Chair/etc. attesting to competency to perform the procedure/privilege being requested.
- (1) Such requests shall be processed in a similar manner as provided in Section 5.4 for reappointment. Any grant of new, extended or increased clinical privileges shall also be subject to evaluation as set forth in Sections 6.1(d) and 6.1(e) and to monitoring as set forth in Section 4.9.
 - (2) Requests for privileges that involve either technology or procedures new to the Hospital shall not be processed until the process for approving new technology and/or new procedures, as established by Medical Staff policy, has been completed.
- (b) Each member of the Medical Staff is responsible for advising the President of the Medical Staff, their department Chair, or the Designated Administrative Officer of any current health status that may limit the individual's ability to safely exercise his clinical privileges. A referral to the Practitioners' Advisory Committee shall follow. The Practitioners' Advisory Committee may require the individual to submit evidence of his current health status, as determined by a physician acceptable to the Practitioners' Advisory Committee, in a manner and to the extent permitted by law.
 - (c) If as a result of the Practitioner's self-reporting of a disability, the Practitioners' Advisory Committee submits a recommendation for modification of membership status or privileges and the Executive Committee adopts such recommendation, the affected Practitioner shall be notified by special notice of the recommendation. The recommendation shall not be considered a professional review action unless and until the Practitioner chooses to exercise the right to hearing available under the Plan, and the notice shall so state. If the Practitioner accepts the recommendation of the Executive Committee and waives rights to hearing under the Plan, the Executive Committee will confirm such in writing and forward the recommendation to the Governing Body.
 - (d) If the Executive Committee recommends modification of membership status or privileges due to a condition initially discovered by means other than self-reporting, such recommendation shall constitute a professional

review action without regard to whether or not the Practitioner exercises the hearing rights available under the Plan.

- (e) Thereafter, the procedure provided in Sections 5.3(m), 5.3(n) and 5.3(o) relating to recommendations or initial appointments shall be followed.^{cc}

5.6 **Reapplication After Adverse Action**

- (a) An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both and who did not exercise any of the hearing rights provided in the Plan shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action for a period of six (6) months from the date of final adverse action or until he completes training identified by the Medical Staff as a prerequisite for the privileges, whichever is longer.
- (b) An applicant who has received a final adverse professional review action regarding appointment or clinical privileges or both and who exercised some or all of the hearing rights provided in the Plan shall not be eligible to reapply for the membership status or clinical privileges that were the subject of the adverse action for a period of two (2) years from the date of final adverse action.
- (c) Any reapplication under this Section shall be processed as an initial application, but the applicant shall submit additional information as the Medical Staff or Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.
- (d) If the recommendation of the Medical Staff or the action proposed by the Governing Body upon reapplication under Section 5.6(b) continues to be adverse, the scope of the hearing to which the Practitioner is entitled shall be limited to consideration of the sufficiency of the additional information submitted in demonstration that the basis for the earlier adverse action no longer exists.

5.7 **Time Periods For Processing**

Applications for appointment or reappointment shall be considered in a timely and good faith manner by all individuals and groups who are required by these Bylaws to act on such applications and, except for good cause, shall be processed within the time periods specified in Section 5. However, the time periods specified are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the Practitioner to have his application processed within those periods nor to create a right for a staff member to be automatically appointed, reappointed for the coming term or granted requested privileges.

SECTION 6 - PRIVILEGES

6.1 Delineation of Clinical Privileges

- (a) Except as provided in Sections 6.2, 6.3 and 6.4, a Practitioner providing clinical services in the Hospital by virtue of the Medical Staff Bylaws process shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body for a period not to exceed two (2) years.
- (b) The Credentials Committee shall be responsible for establishing written criteria for the granting of clinical privileges at the Hospital. From time to time the Credentials Committee will solicit recommendations from the clinical departments and committees of the Medical Staff and the Hospital to establish certain written criteria for each position to be recommended by the Credentials Committee and provided to the Executive Committee and the Governing Body for approval.
- (c) Each application for appointment to the Medical Staff must contain a request for specific clinical privileges. Evaluation of initial requests for clinical privileges shall be conducted by the Credentials Committee by first comparing such request against the criteria established by the Credentials Committee and approved by the Executive Committee and the Governing Board. Evaluation of initial requests for privileges will follow the process set forth herein for initial appointment, and, when applicable, run concurrently with the review for appointment, such that an individual's request for appointment and privileges is first reviewed by the Credentials Committee whose recommendation is reviewed by the Executive Committee. Final determination of all requests for privileges rests with the Governing Body.
- (d) Evaluation of privileges for initial appointment and for new, extended or increased privileges shall be based upon the applicant's education, current licensure, specific and relevant training, experience, evidence of physical ability to perform the requested privilege(s), peer references, professional practice review data from an organization that currently privileges the applicant (if available), demonstrated ability, judgment and other relevant information and where applicable per Medical Staff policy, the recommendation to the Credentials Committee or its Chair by the applicable department. The applicant shall have the burden of establishing his qualifications and competency in the clinical privileges requested.
- (e) Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the criteria set forth in subsection (d) above and the observation of care provided, the health status of the practitioner, as permitted by law, review of the records of patients treated in this or other hospitals or clinics/offices and review of the records of the

Medical Staff which document the evaluation of the member's participation in the delivery of medical care, including training, experience, current competence and satisfactory exercise of clinical privileges in the period first completed. Where applicable per Medical Staff policy, the recommendations of the Chair of each department in which the applicant for reappointment exercises clinical privileges shall also be considered in the periodic redetermination of clinical privileges.

- (f) The scope and extent of surgical procedures that each dentist and podiatrist may perform must be specifically defined and recommended in the same manner as all other surgical privileges. Surgical procedures performed by dentists or podiatrists shall be under the overall supervision of the Chief of Surgery. All dental or podiatric patients must receive the same basic medical appraisal as patients admitted to other services, except for patients without medical problems admitted by oral surgeons with privileges to medically appraise these patients. A physician member of the Medical Staff must be responsible for the general care of the patient during hospitalization. The dentist or podiatrist is responsible for the dental or podiatric care of the patient, including the dental or podiatric history and physical examination, discharge summary, and all appropriate elements of the patient's record.

6.2 **Temporary Privileges**

The granting of temporary privileges is not encouraged and shall be done only in circumstances where it is deemed necessary or beneficial to the Hospital to meet important patient care needs. Privileges under this Section are limited as follows:

- (a) Practitioners applying for temporary privileges under this clause must be currently licensed in Wisconsin, be currently competent, and meet at least one of the following criteria:
 - (1) be an active staff member in good standing at another health care facility;
 - (2) have a sponsor on the Medical Staff who is willing to assume responsibility for the Practitioner; or
 - (3) be in an approved residency program.

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.

- (b) Temporary privileges will not be granted to applicants for Medical Staff membership during the pendency of their applications, except in unusual circumstances but in no case for more than one hundred twenty (120)

days and only following submission of a complete application and after verification of: (1) current licensure; (2) DEA certification; (3) relevant training or experience; (4) current competence, including peer references; (5) ability to perform the privileges requested; (6) NPDB information; (7) no current or previously successful challenge to licensure or registration; (8) no prior involuntary termination of medical staff membership at another organization; and (9) no prior involuntary limitation, reduction, denial or loss of clinical privileges. Such applicants are required to submit a completed application at least 90 days in advance to allow full review prior to the contemplated date of beginning practice.

- (c) Temporary privileges may be granted to a Practitioner only by the Executive Committee in concurrence with the Designated Administrative Officer, allowing him to attend or consult upon a specific patient in the Hospital, provided an Active staff member is responsible for admission and general care of the patient. Such temporary privileges shall be limited by the Executive Committee to a specified number of patients or specific period of time in any staff year, after which the Practitioner shall be required to apply for Medical Staff membership. Practitioners may be denied temporary privileges and be required to apply for Medical Staff membership. Such temporary privileges may be granted for a maximum of sixty (60) days.
- (d) A Practitioner who contemplates serving as locum tenens (whether to fill in for a specified Medical Staff member or because of the temporary loss or unavailability of candidates for Medical Staff membership in the needed specialty) must complete an application as if he were applying for Medical Staff membership and must be reviewed, approved, and have privileges delineated according to these Bylaws. The Practitioner or entity engaging the locum tenens Practitioner must, at least thirty (30) days prior to the period of temporary privileges requested, file a letter requesting temporary privileges for the locum tenens Practitioner, and identifying one or more Medical Staff members who accept responsibility for his actions and quality of practice. Temporary privileges may be granted for the locum tenens Practitioner for a period not to exceed sixty (60) days. Such privileges may be granted after review of the Practitioner's credentials by the Executive Committee, subject to the approval of the Governing Body.
- (e) All Practitioners exercising temporary privileges shall do so under the supervision of the President of the Medical Staff or his designee.
- (f) No practitioner is entitled to temporary privileges as a matter of right. A Practitioner shall not be entitled to the procedural rights afforded by the Plan because of his inability to obtain temporary privileges or because of any termination, modification or suspension of temporary privileges.

- (g) Temporary privileges may be terminated at any time at the direction of the Designated Administrative Officer on the recommendation of the President of the Medical Staff or the Chair of the department concerned when the conduct of the Practitioner exercising such privileges so indicates. Such termination shall not be subject to the procedural rights afforded by the Plan. In cases where it is deemed necessary to permit the Practitioner holding temporary privileges to continue treating a patient then under his care, the Practitioner shall be permitted to care for the patient until discharge of the patient. Where it is determined that the life or health of the patient would be endangered by the continued treatment by a Practitioner whose temporary privileges have been terminated, the Chair of the applicable department or, in his absence, the President of the Medical Staff shall assign a member of the Medical Staff to assume responsibility for the care of the patient until the patient is discharged from the Hospital. The wishes of the patient shall be considered if feasible in selecting a substitute Practitioner.
- (h) Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, ability and judgment to exercise the privileges requested. Special requirements of consultation and reporting may be imposed by the Chair of any department responsible for supervision of the Practitioner granted temporary privileges. Before temporary privileges are granted, the Practitioner must acknowledge in writing that he has received and read the Medical Staff Bylaws, Rules and Regulations and that he agrees to be bound by the terms thereof in all matters relating to his temporary privileges.
- (i) Temporary privileges may be granted to visiting faculty for the purpose of actual consultation or demonstration with one or more physician members of the Medical Staff, as permitted by the Wisconsin Medical Examining Board, upon primary verification of licensure in another state or country, proof of insurance in an amount acceptable to the Hospital and primary verification of faculty status in good standing with the institution where the Practitioner serves as a faculty member. Such temporary privileges may be granted for a maximum of sixty (60) days.

6.3 **Emergency Privileges**

In the case of any emergency, any Provider, to the degree permitted by his license, and regardless of department or staff status, or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Practitioner must then request the privileges necessary to continue to treat the patient, or in the event such privileges are denied or he does not desire to request the privileges, the patient shall be assigned to an appropriate

member of the Medical Staff. For the purpose of this Section, an “emergency” is defined as a condition which could result in serious permanent damage to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

6.4 **Disaster Privileges**

- (a) For the purpose of this Section, a disaster exists when the Hospital implements its Emergency Operations Plan, and the Hospital is unable to handle the immediate patient needs.
- (b) During a disaster and in the best interest of immediate patient care, the Designated Administrative Officer may, at his discretion, grant disaster privileges on a case-by-case basis to volunteer physicians upon presentation of the following:
 - (1) A valid government-issued photo identification (i.e., driver’s license or passport); and
 - (2) At least one of the following:
 - (i) A current picture hospital ID card/badge (a photocopy will be made when possible); or
 - (ii) A current license to practice (a photocopy will be made when possible); or
 - (iii) Identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, or the Emergency System for Advance Registration of Volunteer Health Professionals (a photocopy will be made when possible); or
 - (iv) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment or services in disaster circumstances; or
 - (v) Presentation by current Medical Staff member(s) with personal knowledge regarding the physician’s ability to act as a volunteer during a disaster.
- (c) The Designated Administrative Officer will have the overall responsibility for assignment of duties to any volunteer physicians that are granted disaster privileges.
- (d) As soon as possible, additional information will be gathered from the volunteer physicians on a “Disaster Privileges” form. Primary source verification of a volunteer’s license will begin as soon as the immediate

situation is under control and must be completed within seventy-two (72) hours from the time the volunteer begins to provide service at the Hospital. In extraordinary circumstances where primary source verification cannot be completed within seventy-two (72) hours, there must be documentation of the following: (1) the reason primary source verification could not be performed in the required time frame; (2) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (3) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

- (e) When the Hospital deems a disaster or emergency situation to no longer exist or to be under control:
 - (1) The disaster privileges shall expire. The expiration of such privileges is not a professional review action and does not entitle the physician to hearing or appeal under the Plan.
 - (2) The physicians who were granted disaster privileges must request Medical Staff membership and the clinical privileges necessary to continue to treat patients.
 - (3) In the event such privileges are denied or the voluntary physician does not desire such privileges, any patients still receiving care at the hospital shall be assigned to an appropriate Medical Staff member.
 - (4) After-the-fact/retroactive credentialing for temporary privileges will occur as soon as possible if feasible to cover the time period of the disaster.

6.5 **Telemedicine Privileges**

- (a) Subject to subsection (b) below, applicants based at distant sites whose practice at the Hospital will be limited to patient care, treatment and services via a telemedicine link (either as direct care or interpretive services) must apply for privileges by submission of the same application and subject to the processes required of all other applicants for Medical Staff membership and clinical privileges.
- (b) If the distant site is a Medicare-participating hospital, the Hospital's Medical Staff may use a copy of the distant site's credentialing packet for privileging purposes, but cannot use the privileging decision of the distant site.
- (c) Applicants for telemedicine privileges will be assigned to the Telemedicine Medical Staff category.

6.6 **Leave of Absence and Reappointment**

- (a) Any member of the Medical Staff may obtain a leave of absence from the Medical Staff for a period not to exceed his present term of appointment by submitting a written request to the Executive Committee and the Designated Administrative Officer. The request shall state the start and anticipated end date of the requested leave and the reasons for the leave (such as military duty, additional training, family matters or personal health). Failure of a Practitioner to return or apply for an extension of leave shall constitute a resignation from the Medical Staff, and shall not be subject to any hearing or appellate review. A request for Medical Staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for reappointments.
- (b) If the leave of absence was for medical reasons, then upon return the Practitioner must submit a report from his or her attending physician indicating that the Practitioner is physically and/or mentally capable of resuming a Hospital practice and exercising his clinical privileges competently and safely with or without reasonable accommodation. Subject to applicable laws, the Practitioner shall also provide such other information as may be requested by the Executive Committee or the Designated Administrative Officer at that time. After considering all relevant information, the Executive Committee shall then make a recommendation regarding reinstatement to the Governing Body for final action.
- (c) If a leave of absence is requested to take remedial training as a result of corrective action or probation, the Practitioner, after completion of the training, must present to the appropriate department Chair and to the Executive Committee satisfactory evidence that the special education/training corrected the deficiencies. The Practitioner shall also provide such other information as may be requested by the Executive Committee or Designated Administrative Officer at that time. The Executive Committee shall evaluate the evidence presented and shall make a recommendation to the Governing Body for final approval. Any monitoring, review or similar processes affecting the Practitioner prior to the leave of absence shall resume upon return of the Practitioner from the leave.
- (d) A member in good standing who is granted a leave of absence for special training in his specialty to acquire new knowledge and/or skills as a part of a request for additional privilege(s) shall present evidence of competence in the new or different procedure(s) to the department Chair and the Executive Committee. After review, the recommendations of the Executive Committee shall be forwarded to the Governing Body for appropriate action.

- (e) Subject also to the conditions set forth above for specific types of leave, at the conclusion of the leave of absence, the individual must request reinstatement by filing a written statement with the Executive Committee summarizing any relevant professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the Executive Committee at that time. Notice of the individual's intent to return from leave must be received a minimum of 10 days before the termination of the leave of absence. The Executive Committee will review the request and make a recommendation to the Governing Body regarding reinstatement. Reinstatement after a leave of absence is a matter of courtesy, not of right.
- (f) During the period of leave, the Practitioner shall not exercise clinical privileges at the Hospital and membership rights and responsibilities shall be inactive but the obligation to pay dues, if any, shall continue unless waived by the Executive Committee.
- (g) The Practitioner shall be responsible for obtaining coverage for his patients during the leave.
- (h) A leave of absence may not extend beyond the term of the Practitioner's current term of appointment. If the Practitioner is not ready to return from leave before his or her current appointment term is set to expire, any application for reappointment will be held in abeyance for up to two (2) years until the Practitioner identifies with reasonable certainty the date of anticipated return from leave. The Practitioner will then be required to supply interval data through the date of the notice of anticipated return from leave to begin the reappointment process. The Practitioner's Medical Staff membership shall be considered expired between the time of the expiration of the term in which the leave began and the date of reappointment.

6.7 **Withdrawal of Privileges**

Any member of the staff may voluntarily withdraw any clinical privilege at any time upon written notice to the Designated Administrative Officer and the President of the Medical Staff. Such action, unless it arises during the course of an investigation of professional competency or conduct, or in lieu thereof, should not generate any reporting requirements under HCQIA.

6.8 **Orders From Individuals Without Clinical Privileges or Medical Staff Membership**

The Hospital may accept and execute orders for outpatients from health care professionals who are not members of the Medical Staff and who have not been granted any clinical privileges at the Hospital only if all the following conditions are met:

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

6.9 **Focused Professional Practice Evaluation**

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

6.10 **Ongoing Professional Practice Evaluation**

- (a) A process of ongoing professional practice evaluation exists to continuously review Medical Staff members' care and to identify professional practice trends that impact on quality of care and patient safety.
- (b) The criteria used in the ongoing professional practice evaluation may include such factors as:

- (1) The review of operative and other clinical procedures performed and their outcomes;
 - (2) Patterns of blood and pharmaceutical usage;
 - (3) Requests for tests and procedures;
 - (4) Length of stay patterns;
 - (5) Morbidity and mortality data;
 - (6) Practitioner's use of consultants; and
 - (7) Other relevant factors as determined by the Medical Staff.
- (c) The information used to review the ongoing professional practice evaluation factors shall include, as appropriate, periodic chart reviews, direct observations, monitoring of diagnostic and treatment techniques and discussions with other individuals involved in the care of each patient, such as consulting Practitioners, assistants at surgery, nursing, and administrative personnel.
- (d) Relevant information obtained from the ongoing professional practice evaluation shall be integrated into Medical Staff performance improvement activities. Such information shall help determine whether existing privileges should be maintained, revised or revoked.

SECTION 7 - IMMUNITY FROM LIABILITY

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

- (a) Any act, communication, report, recommendation or disclosure, with respect to any individual, performed or made for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.
- (b) Such privileges shall extend to members of the Medical Staff and Governing Body, the Designated Administrative Officer and any of their designated representatives and to third parties who supply information to or receive information from any of the foregoing authorized to receive, release, or act upon the same. For the purposes of this Section, the term "third parties" means both individuals and organizations who have supplied information to or received information from an authorized representative of the Hospital (including the Governing Body or the Medical Staff) and includes but is not limited to individuals, health care

facilities, governmental agencies, quality improvement organizations and any other person or entity with relevant information.

- (c) There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.
- (d) Such immunity shall apply to all acts, communications, reports, or disclosures performed or made in connection with this or any other health care institution's activities related to, but not limited to:
 - (1) Applications for appointment or clinical privileges;
 - (2) Monitoring of members of the Provisional staff or of any Provider under the monitoring protocol established by the Medical Staff;
 - (3) Periodic reappraisals for reappointment or clinical privileges;
 - (4) Corrective action, including investigations and suspension;
 - (5) Hearings and appellate reviews;
 - (6) Medical care evaluations;
 - (7) Utilization reviews;
 - (8) Profiles and profile analysis;
 - (9) Malpractice loss prevention; and
 - (10) Other Hospital, departmental, service or committee activities related to quality patient care and interprofessional conduct.
- (e) The acts, communications, reports, recommendations and disclosures referred to in this Section may relate to an individual's professional qualifications, clinical competency, conduct, character, judgment, health status, ethics, or any other matter that might directly or indirectly have an effect on patient care.
- (f) Each individual who exercises clinical privileges or performs any service that is monitored under the monitoring protocols established under these Bylaws, as a condition of exercising the clinical privileges or performing the service, shall indemnify and hold harmless all members of the Medical Staff and Governing Body, the Designated Administrative Officer and their designated representatives, other Providers and Hospital staff from any liability arising from or out of the services performed by the individual being monitored, including but not limited to claims of malpractice,

negligent supervision, and any other basis. The exercise of clinical privileges or performance of any service that is monitored constitutes the individual's acceptance of the terms of this indemnification agreement.

- (g) To reaffirm the immunity intended by this Section, each individual shall, upon request of the Hospital, execute releases acknowledging the immunity and protections set forth in this Section in favor of the individuals and organizations specified in subsection (b) above, 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 such releases is not a prerequisite to the effectiveness of this Section.
- (h) The consents, authorizations, releases, rights, privileges and immunities provided by these Bylaws for the protection of this Hospital's Practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointments, shall also be fully applicable to the activities and procedures covered by this Section. All provisions in these Bylaws and in other forms used in the credentials process relating to authorizations, confidentiality of information and immunity from liability are in addition to and not in limitation of other immunities provided by law.

SECTION 8 - INTERVIEWS, HEARINGS AND APPELLATE REVIEW

8.1 Procedure and Process

All interviews, hearings and appellate reviews shall be conducted in accordance with the procedures set forth in the Plan appended to these Bylaws as Appendix A and incorporated into these Bylaws by reference.

8.2 Exceptions

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

8.3 Agreements with Practitioners

Notwithstanding any other provision of the Bylaws, the Hospital may provide by agreement that a Practitioner's membership on the Medical Staff and clinical privileges are contingent on terms therein and/or shall expire or terminate simultaneously with such agreement or understanding. In the event that an agreement has such a provision or there is such an understanding, the provisions of these Bylaws with respect to hearings, appeals, appellate review, etc., shall not apply.

SECTION 9 - OFFICERS

9.1 **Officers of the Medical Staff**

- (a) The officers of the Medical Staff shall be:
 - (1) President
 - (2) President-Elect
 - (3) Secretary-Treasurer

9.2 **Qualifications of Officers**

Officers must be members of the Active Medical Staff at the time of nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The officers shall be Practitioners with demonstrated competence in their fields of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and Medical Staff activities. The President of the Medical Staff must be an MD, DO, DDS or DMD.

9.3 **Election of Officers**

- (a) Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff in good standing shall be eligible to vote. Proxy votes will be acceptable, and a candidate in absentia may be nominated and elected provided that the staff member affirms his willingness to serve in writing.
- (b) The nominating committee shall be composed of the three (3) most recent past presidents, the chair being the individual farthest removed from the presidency in point of time. The Designated Administrative Officer shall be a non-voting member of the nominating committee. This committee shall offer one nominee for each office. Individuals nominated from the floor must receive at least three (3) seconds, and further must indicate a willingness to serve if elected.
- (c) Office holders shall be selected by majority vote of those present (either in person or by proxy) and entitled to vote and their selection shall be confirmed by the Governing Body. In the event there are more than two (2) candidates for an office and none receive a majority on the first ballot, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until a majority vote is obtained by one candidate.

9.4 **Term of Office**

All officers shall serve a two (2) year term or until a successor is elected, unless they are removed pursuant to Section 9.6. Officers shall take office on the first day of the Medical Staff Year after election. The President may not serve more than two (2) successive terms.

9.5 **Vacancies in Office**

Vacancies in office during the Medical Staff year, except for the presidency, shall be filled by the Executive Committee. If there is a vacancy in the office of President, the President-elect shall serve out the remaining term.

9.6 **Removal of Officers**

The Governing Body, by resolution, may remove an officer of the Medical Staff upon receipt of a recommendation of a two-thirds (2/3) majority of the members of the Active Medical Staff. Permissible bases for removal include, without limitation, failure to continuously meet the qualifications for office and failure to timely and appropriately perform the duties of the office held.

9.7 **Duties**

(a) **President**: The President shall serve as the chief administrative officer of the Medical Staff to:

- (1) Act in coordination with the Designated Administrative Officer of the Hospital in all matters of mutual concern within the Hospital;
- (2) Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
- (3) Be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations and policies, for implementation of sanctions where these are stipulated for non-compliance, and for presentation to the Executive Committee in those instances where corrective action may be recommended to the Governing Body;
- (4) Appoint committee members to all standing, special, and multi-disciplinary (combined) Medical Staff committees except the Executive Committee;
- (5) Serve as ex officio member of all Medical Staff committees and chair the Executive Committee;
- (6) Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and Designated Administrative Officer;

- (7) Serve as the responsible representative of the Medical Staff to receive, understand and interpret the policies of the Governing Body to the Medical Staff and to report and interpret to the Governing Body, in return, on the performance and maintenance of quality of its designated responsibility to provide medical care;
 - (8) Ensure, with the Designated Administrative Officer, that the Hospital's quality assurance program is implemented and effective for all patient care related services; that the findings of the program are incorporated into a well-defined method of accessing staff performance; and that the findings, actions and results of the program are reported to the Governing Body as necessary;
 - (9) Be responsible for the educational activities of the Medical Staff, subject to the policies of the Governing Body;
 - (10) Be the spokesperson for the Medical Staff in its external professional and public relations, or designate another physician to act in that capacity;
 - (11) Perform such other functions as may reasonably be delegated from time to time by the Medical Staff or the Governing Body; and
 - (12) Resolve disputes and address concerns between Medical Staff members, Allied Health Professionals and Hospital staff in consultation with the applicable Hospital vice president.
- (b) President-Elect: In the absence of the President, the President-Elect shall assume all the duties and have the authority of the President. The President-Elect shall automatically succeed the President when the latter fails to serve for any reason. The President-Elect shall be a member of the Executive and Credentials Committees and other committees as assigned, shall serve as Chair of the Credentials Committee, shall be responsible for resolving disputes between Hospital and Medical Staff if the department Chair is unavailable or unwilling to do so and shall function as liaison between the Credentials Committee and the Executive Committee. He shall perform such additional duties as may be assigned by the President of the Medical Staff, the Executive Committee or the Governing Body.
- (c) Secretary-Treasurer: The Secretary-Treasurer shall keep or provide for the taking of accurate and complete minutes of all meetings, call meetings on order of the President, attend to all correspondence, and perform such other duties as ordinarily pertain to his office. If there are funds, he shall also act as Treasurer.

SECTION 10 - CLINICAL DEPARTMENTS

10.1 Organization of Departments

- (a) Each department shall be organized as a separate division of the Medical Staff, and shall elect a Chair who shall be a member of and responsible to the Executive Committee and the President of the Medical Staff. The Chair shall be responsible for the functioning of the department, and shall have general supervision over the clinical work within the department.
- (b) The clinical departments of the Medical Staff shall be as follows: medicine, family medicine, surgery, obstetrics, pediatrics, Hospital-based clinic services, anesthesia, emergency services, radiology, and pathology.
- (c) The creation of additional departments or sections, or the termination of departments or sections, shall be accomplished as the need arises by the Executive Committee with the concurrence of the Governing Body. A department may be established if there are a sufficient number of physicians on the Medical Staff who are members of a recognized medical specialty, and if such physicians are willing to conduct audit and record reviews and educational programs.
- (d) A section is defined as a sub-group in a given department where there is a sufficient number of specialists or sub-specialists who wish to be recognized as a separate entity within that department.

10.2 Qualifications, Selection and Tenure of Department Chairs

- (a) The Chair shall be a member of the Active Medical Staff qualified by training and experience, and shall have demonstrated ability for the position.
- (b) The Chair shall be certified by one or more specialty boards that certify in a specialty that is relevant to the services provided in the department or have successfully completed specialty training in an approved residency program plus have three (3) years' experience within the relevant specialty.
- (c) Except for the Chair of the Hospital-based clinic services department, Chairs shall be elected prior to the annual meeting of the general staff by those Active Staff members assigned to the department, by simple majority vote of those voting in person or by proxy.
- (d) The regional vice president of Ministry Medical Group, Inc. ("MMG") as selected pursuant to bylaws adopted by MMG shall be the Chair of the Hospital-based clinic services department, on an ex officio basis with vote.

- (e) The length of term of office of a department Chair elected pursuant to Section 10.3(c) shall be two (2) years and shall begin on the first day of the Medical Staff Year. Such elected department Chairs may not serve more than two (2) consecutive terms unless the size of the department is so small as to not contain a qualified successor. The length of term of office of the Chair of the Hospital-based clinic services department shall be as prescribed in the MMG bylaws, provided the selected individual remains a member of the Medical Staff during the entire period.
- (f) Removal of the Chair of a department during a term of office other than the Chair of the Hospital-based clinic services department may be initiated by a two-thirds (2/3) majority vote of all active Medical Staff members of the respective department. A signed petition stating the reasons for the requested removal of the Chair shall be sent to the President of the Medical Staff who shall forward same to the Executive Committee. The Executive Committee shall hold an interview with the Chair of the department, after which it shall make its recommendation to the Governing Body. No such removal shall be effective unless and until it has been ratified by the Executive Committee and the Governing Body. The Executive Committee and the Governing Body may also remove the Chair of a department when doing so is deemed to be in the best interest of the Hospital. The Chair of the Hospital-based clinic services department may be removed in the circumstances and in the manner prescribed in the MMG bylaws, except that the Governing Body shall remove this Chair if he fails to remain a member of the Medical Staff.
- (g) In the event of a vacancy in the position of department Chair other than the Chair of the Hospital-based clinic services department, a successor shall be elected pursuant to the process set forth in these Bylaws for selection of a department Chair.

10.3 **Functions of Department Chairs**

Each department Chair shall:

- (a) Be accountable for all clinically related activities of the department to the Executive Committee, and all administrative activities of the department to the Designated Administrative Officer.
- (b) Be a member of the Executive Committee, giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding his own department in order to assure quality patient care.
- (c) Maintain continuing review of the qualifications and professional performance of all individuals with clinical privileges in the department and report regularly thereon to the Executive Committee and the Governing Body, as appropriate.

- (d) Be accountable for the continuous assessment and improvement of the quality of care, services, and treatment in the department.
- (e) Determine when consultation is being improperly withheld, inform the attending practitioner of this fact, and inform the Executive Committee of any ongoing problems which exist with members of the department.
- (f) Be responsible for enforcement of Medical Staff Bylaws, Rules and Regulations within the department.
- (g) Be responsible for implementation within the department of actions taken by the Executive Committee.
- (h) Transmit to the Executive Committee the department's recommendations and assessment concerning the staff classification, the reappointment, and the delineation of clinical privileges for all Practitioners and Allied Health Professional in his department.
- (i) Establish, together with the Medical Staff and administration, the type and scope of services required to meet the needs of the patients in the department and the Hospital.
- (j) Develop and implement policies and procedures that guide and support the provision of services in the department.
- (k) Recommend to the Executive and Credentials Committee the criteria for clinical privileges in the department.
- (l) Integrate the department into the primary functions of the Hospital.
- (m) Coordinate and integrate intradepartmental and interdepartmental services.
- (n) Recommend a sufficient number of qualified and competent persons to provide care, treatment and services.
- (o) Determine the qualifications and competence of Allied Health Professionals in the department.
- (p) Be responsible for maintaining quality control programs, as appropriate.
- (q) Be responsible for the orientation and continuing education of all persons in the department.
- (r) Recommend space, equipment, routine procedures, and other resources needed by the department and cooperate with the Hospital on purchases of supplies and equipment.

- (s) Be responsible for teaching, education and research in the department.
- (t) Be responsible for the preparation of periodic and annual reports of the department including budgetary planning as may be required for the Executive Committee, Designated Administrative Officer, Governing Body, and general Medical Staff.
- (u) Be responsible for recruitment of Practitioners for the department.
- (v) Be responsible for recommending the number of cases for monitoring new clinical privileges granted to practitioners in the department.
- (w) Assess and recommend to the relevant Hospital authority off-site sources for needed patient care treatment and services not provided by the department or the organization.
- (x) Resolve disputes and address concerns between Medical Staff members, Allied Health Professionals and Hospital staff in consultation with the applicable Hospital vice president.
- (y) Oversee services provided through any functional unit or clinical service within the department for which a medical director has been appointed and report on such unit or clinical service to the Executive Committee.
- (z) Maintain the quality of medical records.
- (aa) Arrange and implement inpatient and outpatient programs, which include organizing, engaging in educational activities, and supervising and evaluating the clinical work.
- (bb) Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by the President of the Medical Staff, the Executive Committee or the Governing Body.

10.4 **Functions of Departments**

The clinical department Chairs are essential elements in the line of authority within the Medical Staff organization, and are accountable to the Executive Committee and the President of the Medical Staff for all professional and Medical Staff administrative activities within their departments. Clinical 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 Sections 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 including but not limited to participating in monitoring plans. (See Medical Staff policies.) In fulfilling this responsibility, each clinical department shall:

- (a) Maintain continuing surveillance of the professional performance of all members of the Medical Staff with privileges in their department, and other individuals with privileges in the department, and must report regularly thereon to the Executive Committee.
- (b) Assure adherence to the Hospital and Medical Staff Bylaws, Rules and Regulations and policies by all Medical Staff members practicing in the department.
- (c) Transmit to the Credentials Committee the department's recommendations and assessment concerning the classification, the reappointment, and the delineation of clinical privileges for all members of the department.
- (d) Recommend to the Executive Committee the department's criteria for the granting of clinical privileges, and for the holding of office in that department.
- (e) Conduct a primary retrospective review of selected completed records of discharged patients and other pertinent sources of medical data relating to patient care. Each department shall also develop objective criteria that reflect current knowledge and clinical experience to be used in monitoring and evaluating patient care. Pursuant to these criteria, each department shall review and consider selected deaths, unimproved patients, patients with infections, complications, problems in diagnosis and treatment, and such other instances as are believed to be important, such as patients currently in the Hospital with unsolved clinical problems.
- (f) Meet separately on a regular basis to review and analyze on a peer group basis the clinical work of the department. Such meetings shall not release the Medical Staff members from their obligation to attend the general meetings of the Medical Staff as provided in Section 13 of these Bylaws.
- (g) Formulate policies relating to the functions of the department. Such policies shall be effective after approval by the department, the Executive Committee and the Governing Body.

10.5 **Assignment to Departments**

- (a) Assignments of members of all categories of the Medical Staff to clinical departments shall be made by the Governing Body on the recommendation of the Executive Committee pursuant to Section 5 of these Bylaws. While members of departments may not be required to be

certified board specialists, it is to be expected that they will be well qualified, as provided in Section 6 of these Bylaws, in the specialty to which they are assigned.

- (b) Practitioners shall have clinical privileges in one or more departments in accord with their experience and training, and shall be subject to all the rules of those departments and to the jurisdiction of the Chair of the clinical departments involved, and must fulfill the clinical review participation and meeting requirements for each department to which they are assigned, except that Practitioners assigned to the Hospital-based clinic services department will only be required to fulfill the participation and meeting requirements of that department if the Executive Committee designates it as a principal department for them at the time of appointment, reappointment or upon the grant of new clinical privileges.
- (c) Each Practitioner shall be assigned to each department in which the Practitioner has clinical privileges.

SECTION 11 - MEDICAL DIRECTORS

11.1 Designation and Qualifications of Medical Directors

- (a) The Hospital, through the Designated Administrative Officer, may arrange for a member of the Active Medical Staff to serve as the Medical Director of a specific service or unit within the Hospital, such as but not limited to the emergency room, the dialysis unit, and the intensive care unit.
- (b) Medical Directors shall be certified by one or more specialty boards that certify in a specialty that is relevant to the services provided in the service or unit, unless the Executive Committee determines, through the privilege delineation process, that the candidate possesses comparable competence.
- (c) The term of office and specific duties of each Medical Director shall be determined by the agreement between the Hospital and the individual selected, and nothing in these Bylaws shall affect the terms and conditions of such agreements.

11.2 Responsibility of Medical Directors

The responsibilities of the Medical Director of a clinical service or unit shall be to:

- (a) Establish, together with the Medical Staff and administration, the type and scope of services required to meet the needs of the patients and the Hospital;
- (b) Develop and implement policies and procedures that guide and support the provision of services in the service or unit;

- (c) Recommend to the appropriate department, for recommendation to the executive and credentials committees, the criteria for clinical privileges in the service or unit when the department Chair has delegated this function to the Medical Director;
- (d) Recommend to the appropriate department Chair the clinical privileges for each person allowed to exercise clinical privileges in the service or unit;
- (e) Continue surveillance of the professional performance of all individuals with clinical privileges in the service or unit;
- (f) Continuously assess and improve the quality of care, services and treatment provided in the service or unit;
- (g) Integrate the service or unit into the primary functions of the Hospital;
- (h) Coordinate and integrate intradepartmental and interdepartmental services;
- (i) Recommend a sufficient number of qualified and competent persons to provide care and services;
- (j) Determine the qualifications and competence of Allied Health Professionals in the service or unit;
- (k) Maintain quality control programs, as appropriate;
- (l) Orient and educate all persons in the service or unit;
- (m) Recommend space and other resources needed by the service or unit; and
- (n) Be responsible for all clinically related activities and, unless otherwise provided for in the Hospital, all administratively related activities of the service or unit.

11.3 **Role of Medical Director**

Each Medical Director shall have a dual accountability both to the Designated Administrative Officer, as to fulfillment of the agreed-upon responsibilities of Medical Director, and to the Medical Staff through the Chair of the department affiliated with the Medical Director's service or unit as to the fulfillment of the responsibilities set forth in this Section.

SECTION 12 - COMMITTEES

All committees of the Medical Staff are a major component of the Hospital's program organized and operated to help improve the quality of health care in the Hospital and

their activities will be conducted in a manner consistent with the provisions of Sections 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 are intended to apply to all activities of the committees relating to improving the quality of health care and include activities of the individuals participating in and designated by the committee to assist in carrying out the duties and responsibilities of the committee including but not limited to those participating in monitoring plans, Medical Staff, Hospital administration and the Governing Body. Committees may also be a “professional review body” as defined in Section 431(10) of HCQIA and a review body as referenced in the Wisconsin Statutes.

12.1 **Standing Committees**

The members of all standing committees of the Medical Staff, except the Executive Committee, shall be appointed by the President of the Medical Staff and approved by the Executive Committee. A committee member shall serve in the same capacity until such time as he is replaced by a new appointee or until he is removed. Committee members may not resign their appointments without the approval of the President of the Medical Staff. The functions of the standing committees set forth in these Bylaws may be combined upon the approval of the Executive Committee, provided separate recording of each function is assured. Standing committees shall be:

(a) **The Executive Committee:**

- (1) **Composition.** The Executive Committee will be composed of the President, the immediate past President, the President-Elect, the Secretary-Treasurer, and the Chairs of the departments of surgery, medicine, family medicine, obstetrics, pediatrics, Hospital-based clinic services, anesthesia, emergency services, radiology, and pathology. The immediate past President shall serve as an ex officio voting member for a period of two (2) years. The President shall serve as Chair of the Executive Committee. The Designated Administrative Officer of the Hospital shall attend all meetings of this committee. In cases where one individual serves in more than one capacity, he shall be entitled to have only one (1) vote. The Executive Committee is empowered to act on behalf of the Medical Staff, and to coordinate the activities and general policies of the various departments and sections as indicated by the Medical Staff Bylaws, Rules and Regulations. The Executive Committee shall generally meet monthly, and maintain a permanent record of its proceedings and actions. The majority of the Executive Committee members must be fully licensed physicians who are members of the Active Medical Staff.
- (2) **Duties.** The duties of the Executive Committee shall be:

- (i) to represent the Medical Staff and to act on its behalf between meetings and as needed under such limitations as may be imposed by these Bylaws;
- (ii) to be regularly involved in Medical Staff management including the enforcement of Medical Staff Bylaws, Rules and Regulations, policies and committee and department affairs;
- (iii) to coordinate the activities and general policies of the various departments and sections as required;
- (iv) to receive and act upon department and committee reports and reports of other assigned activity groups;
- (v) to create, adopt and implement policies and procedures of the Medical Staff not otherwise the responsibility of clinical department personnel and to make recommendations to the Governing Body for approval and implementation of such policies and procedures;
- (vi) to take all reasonable steps to ensure professionally ethical conduct on the part of all members of the Medical Staff, and to initiate and/or participate in Medical Staff disciplinary or appeals measures as indicated;
- (vii) to provide liaison between Medical Staff and the Designated Administrative Officer and the Governing Body;
- (viii) to recommend action to the Designated Administrative Officer on matters of a medico-administrative nature;
- (ix) to make recommendations to the Governing Body, including long range planning;
- (x) to fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to the patients in the Hospital. The Executive Committee shall monitor all medical care quality assessment and improvement activities, make recommendations to the Governing Body on the organization of such activities and be responsible for taking any necessary and appropriate action or delegating the responsibility for such action to the appropriate Medical Staff or multidisciplinary committee or group;
- (xi) to ensure that the Medical Staff is kept abreast of the accreditation status of the Hospital;

- (xii) to provide for the preparation and presentation of all the programs of all meetings either directly or through delegation to a program committee or other suitable agent;
 - (xiii) to report at each general staff meeting;
 - (xiv) to review the credentials of all applicants and to make recommendations for Medical Staff membership, assignment to departments, and delineation of clinical privileges;
 - (xv) to review periodically all information available regarding the performance and clinical competence of Medical Staff members and others with clinical privileges;
 - (xvi) to consider amendments to the Bylaws and Rules and Regulations of the Medical Staff as necessary for the proper conduct of its work;
 - (xvii) to review and approve departmental Rules and Regulations;
 - (xviii) to be responsible for making recommendations to the Governing Body relating to the structure of the Medical Staff; the mechanism used to conduct, work at and revise the quality assessment and improvement activities of the Medical Staff; the mechanisms used to review credentials and delineate individual clinical privileges; the mechanisms by which memberships on the Medical Staff may be terminated; and the mechanism for fair hearing procedures;
 - (xix) to have overall responsibility for all Medical Staff accreditation policy and procedure. The Chair of this committee may delegate specific functions of this responsibility to appropriate Medical Staff members and committees; and
 - (xx) to perform such other functions as may from time to time be delegated by the Medical Staff or the Governing Body.
- (3) Removal of Executive Committee Members. An Executive Committee member shall be considered for removal from service by the Executive Committee. Upon written request of twenty percent (20%) of the Active Medical Staff directed to the chair of the Executive committee, or the Medical Staff President or the Designated Administrative Officer, or by certification by two (2) physicians with special qualification in the appropriate medical field(s) that the member cannot be expected to perform his duties because of illness for minimum of three (3) months. Such request

shall include a list of the allegations or concerns precipitating the request for removal.

- (i) Reasons for Removal.
 - removal from current office or Chair position;
 - loss or suspension of medical staff appointment.
 - (ii) Procedures. A member removed from service pursuant to this Section shall be so notified in writing by the Chair of the Executive Committee and advised of his rights to a review by the Executive Committee, if any. When the chair of the Executive Committee is the member in question, the immediate past-President of the Medical Staff shall carry out the duties of the chair during the removal process until the issue is resolved, at which time the chair (if not removed) will resume his duties or the President-Elect will take over the remaining term of the removed chair. The member in question will be relieved of his Executive Committee duties until the question is resolved.
 - (iii) Review Procedures. A meeting of the Executive Committee shall be called within seven (7) business days to consider the matter. A quorum of the Executive Committee must be present to act on the matter. The member in question shall have no vote in the matter and may be excluded from the meeting. The member in question shall be permitted to make an appearance before the Executive Committee prior to its taking final action on the request. A member may be removed by an affirmative vote of two-thirds (2/3) of the Executive Committee members present at a meeting at which there is a quorum. The final decision of the Executive Committee shall be given promptly to the member in question in writing by the chair of the Executive Committee.
- (4) Action Without Meeting. An action required or permitted to be taken at a meeting of the Executive Committee may be taken by written action signed by not less than two-thirds (2/3) of the Executive Committee. Any such written action is effective when signed by the required number of committee members. When any such written action is taken, all committee members must be notified immediately of its text and of its effective date and time.
 - (5) Use of Communication Equipment. The President of the Medical Staff may, in his discretion, permit any or all members of the Executive Committee to participate in a meeting of the committee by or through the use of any means of communication by which

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

(b) The Credentials Committee:

- (1) Composition. The Credentials Committee shall consist of representatives of the clinical departments of medicine, surgery, obstetrics, pediatrics, Hospital-based clinic services, and additional members of the Active staff selected by the President of the Medical Staff on an annual basis so as to insure representation of the major clinical specialties and the Hospital-based specialties. The Secretary-Treasurer shall be a member, and the President-elect of the Medical Staff shall be a member and function as the committee chair.
- (2) The duties of the Credentials Committee shall be:
 - (i) to investigate and review the credentials of all applicants for membership, as well as any Allied Health Professional designated by policy to be approved by the Medical Staff alternate approval process, and to make recommendations in compliance with Section 5 of these Bylaws. The established procedure must assure a fair evaluation of the qualifications and the competence of each applicant for appointment, and for periodic reappointment. The procedure shall be objective, impartial and fair, broad enough to recognize professional excellence and strict enough to safeguard patients. The selection of persons to be recommended for appointment shall depend upon a thorough study of the qualifications of each applicant.
 - (ii) to send a specific report to the Executive Committee on each applicant for Medical Staff appointment and clinical privileges, and each Allied Health Professional applicant for clinical privileges, including specific consideration of the recommendations from the department in which the candidate requests privileges;
 - (iii) to investigate any breach of ethics that is reported to it;

- (iv) to review all information available, including reports that are referred by the Executive and Quality Assurance Committees and by the President of the staff regarding the competence of the staff members, including but not limited to information on: meeting attendance, current health status, compliance with continuing education requirements, working relationships with Medical Staff members and Hospital personnel, and promptness of record completion;
 - (v) to arrive at a decision regarding the performance of the staff member and formulate a recommendation to the Executive Committee or other referring committee, or to refer the case to the full Active Staff if this is considered desirable;
 - (vi) to review all information available regarding the competence of staff members and as a result of such reviews, to make recommendations for the granting of privileges, reappointments, and the assignment of Providers to the various departments or sections as provided in Section 5 of these Bylaws.
- (3) Meetings. The Credentials Committee shall meet as necessary and within one (1) month after receiving a completed application for membership on the Medical Staff or privileges. The committee shall maintain a permanent record of its proceedings and actions.
- (c) The Committee for Continuing Medical Education (CME): The Director for Physician CME will work with the Department of Education at Ministry Saint Michael's Hospital to provide continuing physician medical education on a regular basis. The position of Director for Physician CME will be a two (2) year appointment, renewable at the option of the President of the Medical Staff and the Physician CME Director.

The Physician CME Advisory Committee will consist of six (6) to eight (8) staff physicians from a broad area of practice, with at least one (1) member specializing in family medicine (who shall be a member of the American Academy of Family Physicians). The Director of Physician CME will select these members in conjunction with the President of the Medical Staff and Hospital administration. Long-term service on this committee is encouraged for continuity, and members will be appointed to staggered terms. The committee will also be staffed by one (1) member of the Department of Education. Committee meetings will be on a semi-annual basis with additional meetings called as necessary. The goal of the Physician CME Advisory Committee is to provide programs of relevance and interest to the broad spectrum of medical practice. This will best be accomplished through Medical Staff committee input, needs assessments,

identified community needs, suggestions from Medical Staff members and quality assurance results.

(d) Practitioners' Advisory Committee:

- (1) Composition. The Practitioners' Advisory Committee shall consist of no fewer than three (3) members of the Medical Staff representing where practicable, various specialties. Long-term service on the committee is encouraged so as to provide continuity and development of expertise.
- (2) Duties. The duties of the Practitioners' Advisory Committee shall be:
 - (i) To be responsible for issues related to health, well-being or impairment of Medical Staff members in order to maintain and improve the quality of care and assist staff members in the maintenance of appropriate standards of performance;
 - (ii) To be the identified point within the Hospital where information and concern about the health of an individual Practitioner can be delivered for consideration;
 - (iii) To receive and consider information, to seek corroboration and additional information and to develop monitoring plans and monitoring agreements as necessary;
 - (iv) To provide advice, recommendations and assistance to the Practitioner in question and to the referring source; provide recommendations for treatment, monitoring and/or education and provide assistance in obtaining what is recommended;
 - (v) To monitor Practitioners for compliance with the terms of a monitoring agreement or plan;
 - (vi) To educate its members and members of the Medical Staff about Practitioner health, well-being and impairment; about appropriate responses to different levels and kinds of distress and impairment; about the responsibilities of the Medical Staff in response to concerns about a practitioner's health; and about appropriate resources for prevention, treatment and rehabilitation;
 - (vii) To monitor Practitioners' compliance with any special conditions imposed pursuant to a rehabilitation approval under Chapter DHS 12 of the Wisconsin Administrative Code or by the Medical Staff; and

- (viii) To refer appropriate cases to the Executive Committee for corrective action when warranted by a Practitioner's condition or for failure to comply with the monitoring agreement or plan or the conditions of appointment, or any activities of the Practitioner in violation of these Bylaws as it deems appropriate.
- (3) 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 for corrective action.
- (4) 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 staff as a whole or individual members. The Chair of the committee shall meet periodically, or on request, with the President of the Medical Staff, the Designated Administrative Officer and the 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 as respects any individual staff member will not be made a part of the Practitioner's Medical Staff file unless it relates to corrective action or steps taken to limit the Practitioner's professional activity.
- (5) Meetings. The Practitioners' Advisory Committee shall meet at the call of its Chair.

12.2 **Multidisciplinary Committees Involving Medical Staff**

The Medical Staff shall appropriately participate in the maintenance and improvement of high professional standards throughout the Hospital by maintaining physician representation on all multidisciplinary committees which relate to the safety of and the quality of care rendered to patients. Members of the Medical Staff shall be assigned to these committees on an annual basis by the President of the Medical Staff, who shall also appoint a chair of each committee.

Multidisciplinary committees shall meet as necessary to fulfill their purpose and to meet accreditation standards unless otherwise provided herein, and shall maintain a permanent record of their proceedings and actions. Voting privileges

are limited to members of the Medical Staff, except as otherwise stated in these Bylaws. These committees include but are not limited to:

- (a) Infection Control Committee: The Infection Control Committee shall be a Hospital committee whose membership shall consist of representatives of the Medical Staff, administration, nursing, employee health service, microbiology, and infection control departments. Additional representation from other departments involved with direct and indirect patient care shall be called upon when needed on a consultative basis. All members of the infection control committee shall be eligible to vote.

The role of Medical Staff members on the committee shall be to provide direction and strengthen the clinical aspects of the infection control program.

This committee shall meet at least quarterly and report its activities and recommendations to the Medical Staff through the Executive Committee, the Designated Administrative Officer, the vice president of nursing services, and the person responsible for Hospital-wide quality assessment and improvement activities.

The Infection Control Committee, through its Chair, physician members, or infection control coordinator, may institute any surveillance, prevention and control measures or studies when it is felt that there may be a danger to any patient or personnel. The Infection Control Committee shall be responsible for the surveillance of inadvertent Hospital infection potentials, review and analysis of actual infections and the promotion of a preventive and corrective program designed to minimize infection hazards.

- (b) Case Review Committee: The Case Review Committee shall consist of members of the Medical Staff, including representatives from the departments of medicine, surgery, anesthesia and pathology.

The Case Review Committee shall:

- (1) study the agreement or disagreement among the preoperative, postoperative and pathological diagnoses; determine whether surgical procedures in the Hospital were performed at the desired standard; and determine whether diagnostic procedures where biopsies were taken were performed at the desired standard;
- (2) review transfusions of blood and investigate all transfusion reactions and make recommendations to the Medical Staff regarding improvement in transfusion procedures; and
- (3) be responsible for the peer review function for the department of surgery.

The committee shall maintain written reports of conclusions, recommendations, actions taken, and the results of actions taken and regularly report on same to the Executive Committee through the Department of Surgery.

- (c) Pharmacy and Therapeutics Committee: The Pharmacy and Therapeutics Committee shall be responsible for the development and surveillance of the drug utilization policies and practices within the institution in order to assure optimum clinical results and a minimum potential for hazard. It represents the organizational line of communication and the liaison among the Medical Staff, nursing service and the pharmacist relative to all drug matters.

This committee shall consist of at least two (2) representatives from the Medical Staff and one (1) each from the nursing service and from Hospital management. A pharmacist shall be a member and shall act as the secretary of the committee.

The committee shall maintain a record of all activities relating to the pharmacy and therapeutics function, and submit periodic reports and recommendations to the Executive Committee.

The committee assists in the formulation, of broad professional policies and performs ongoing review regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital. It performs the following specific functions:

- (1) serves as an advisory group to the Hospital, Medical Staff and the pharmacist on matters pertaining to the choice of drugs;
- (2) makes recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- (3) develops and reviews periodically a formulary or drug list for use in the Hospital;
- (4) prevents unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;
- (5) evaluates clinical data concerning new drugs or preparations requested for use in the Hospital;

- (6) establishes standards concerning the use and control of investigational drugs and research in the use of recognized drugs where no Institutional Review Board is assigned this responsibility;
 - (7) reviews the appropriateness, safety and effectiveness of prophylactic, empiric, and therapeutic use of all types of drugs, including antibiotic drugs being used for antibiotic sensitivities in lab procedures, used in the hospital for all patient care, including all significant untoward drug reactions; and
 - (8) serves as a liaison between pharmacy, nursing and physicians in seeking to resolve questions or disagreements relative to drugs and pharmaceuticals.
- (d) Quality Assurance Committee: Overall responsibility for the evaluation of delivery of care within the Hospital shall be assigned to a multidisciplinary committee of the Medical Staff. It shall consist of the Medical Director of the Hospital-based clinic services department and representatives from the other major clinical departments, as well as representatives from administration, medical records, nursing service, quality assurance and utilization review.

The Quality Assurance Committee shall meet as a group as often as deemed necessary but not less than quarterly, and shall maintain a permanent record of its proceedings and actions. This committee shall report regularly to the Executive Committee regarding the results of the activities conducted by the committee. On an annual basis, or as otherwise stipulated by the Governing Body, it shall submit an overall report containing all information relevant to the appraisal of the medical care provided in the Hospital.

The Quality Assurance Committee shall be responsible for the following functions:

- (1) a program of concurrent review of admissions and continued stays of patients, in accordance with applicable statutes and regulations, utilizing utilization review department and physician advisor;
- (2) maintain coordination between prospective, concurrent and retrospective review and evaluation studies;
- (3) analyze the review findings and take appropriate action to further investigate or correct any deficiencies identified in the process, including recommending corrective action, and to recommend changes in Hospital procedures or Medical Staff practices where indicated;

- (4) review and act upon, on a regular basis, factors affecting the quality and efficiency of patient care provided in the Hospital;
- (5) assure that all medical records meet standards of completeness, timeliness and clinical pertinence; and
- (6) determine the format of the complete medical record and the forms used in the record.

A comprehensive discussion of the quality assurance and utilization review function is contained in the respective plan.

- (e) Bioethics Committee: The committee functions as a Hospital resource for education, consultation and the formulation of policies/procedures dealing with bioethical issues. The committee will be composed of physicians and other health care professionals. All committee members shall be eligible to vote. It performs the following specific functions:
- (1) Provides inservices to Medical and Hospital staff on selected bioethical issues.
 - (2) Acts as a resource to community groups and agencies regarding bioethical issues.
 - (3) Identifies bioethical issues on an institutional level and recommends a course of action.
 - (4) Serves in an advisory capacity to individuals involved in bioethical decision making.
 - (5) Serves as a resource for the development and implementation of policies/procedures related to bioethical issues.
 - (6) Reviews specific cases having potential bioethical implications and makes appropriate recommendations for follow up.

12.3 Special Committees

The President of the Medical Staff or the Executive Committee may establish such other special committees as may be required for the effective and efficient operation of the Hospital and for the proper discharge of the Medical Staff's responsibility for assuring optimum patient care in the Hospital. The President of the Medical Staff or the Executive Committee may also assign new functions to existing committees or make certain committee functions the responsibility of individual Medical Staff members or the Medical Staff as a whole. The President of the Medical Staff shall appoint members of the Medical Staff to special committees. Special committees may include, but are not limited to:

- Utilization Advisory Committee
- Bylaws, Rules and Regulations Committee
- Radiation Safety Committee
- Continuing Medical Education Committee

The President of the Medical Staff will designate a committee chairperson from the Active Medical Staff with a minimum of one (1) year's membership. Should the President of the Medical Staff desire to name a member with less than one (1) year's membership as Chairperson, approval of the Executive Committee and Designated Administrative Officer is required. The President of the Medical Staff and the Designated Administrative Officer may serve as ex officio members of all committees. The chairperson of the committee votes only in the event of a tie; the President of the Medical Staff and Designated Administrative Officer serve without a vote.

12.4 **Removal From Committees**

Committee members may be removed from their appointed positions at the discretion of the President of the Medical Staff. Permissible bases for removal may include but are not limited to loss of good standing, failure to appropriately discharge committee responsibilities, lengthy service on the committee, and the committee member's request to resign from the committee.

SECTION 13 - MEETINGS

13.1 **Staff Meetings**

There shall be an annual meeting of the general Medical Staff and other meetings as called by the President of the Medical Staff or Executive Committee. At the annual meeting, retiring officers and committee Chairs shall make reports as warranted. The officers of the Medical Staff shall be elected at this meeting, and the newly elected Chair of the departments will be announced.

The Executive Committee may provide for the holding of additional regular meetings of the Medical Staff for the purpose of transacting such business as may come before the meeting. All regular meetings shall be held at such day and hour as the President of the Medical Staff shall designate in the call and notice of the meeting.

13.2 **Special Meetings**

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, and shall be called at the written request of the Governing Body, the Executive Committee, or any five (5) members of the Active Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Notice of a special meeting shall be given to each member of the Medical Staff in writing (including email) or by telephone at

least forty-eight (48) hours before the time set for the special meeting. The special meeting shall be held within three (3) business days after the written request is presented to the President of the Medical Staff. A special departmental meeting may be called at the request of the Chair of the department or any two (2) members of the active Medical Staff in the department.

13.3 **Attendance at Meetings**

- (a) Active Medical Staff members and Provisional Active Medical Staff members are expected to attend all meetings of the general Medical Staff. They shall be required to attend at least fifty percent (50%) of the meetings of each department in which they hold clinical privileges (except the Hospital-based clinic services department unless it has been designated as a principal department for the member) and of each committee to which they are assigned, excluding committees meeting two (2) or fewer times per year. Failure to meet these attendance requirements in one (1) Medical Staff Year may be a basis for suspension or other corrective action by the Executive Committee, including imposition of a fine.
- (b) Members of the Courtesy, Limited and Consulting categories of the Medical Staff may attend meetings of the Medical Staff but are not required to do so, and shall not be eligible to attend and participate in those portions of meetings devoted to peer review of Medical Staff members in other categories of the Medical Staff, except as set forth in the following subsection.
- (c) A member of any category of the Medical Staff who has attended a case that is to be presented for discussion at any meeting shall be given special notice at least one (1) week prior to the meeting, and shall be required to be present. Unexcused absences will be referred to the Executive Committee for appropriate action. If the member's absence from any meeting at which a case that he attended is to be discussed is excused, the discussion will be postponed. In no case shall postponement be granted for a period of longer than until the next regular meeting.

13.4 **Quorum**

Thirty-three percent (33%) of the active Medical Staff shall constitute a quorum for general meetings of the Medical Staff. A quorum for committee and department meetings shall consist of fifty (50%) of the members of such committee or department who are entitled to vote, except that a quorum for a meeting of the Hospital-based clinic services department shall consist of fifty (50%) of the members for whom it has been designated a principal department. A quorum is necessary in order to hold a meeting.

13.5 **Eligibility to Vote**

- (a) **Medical Staff Matters.** To vote at a Medical Staff meeting on Medical Staff business other than the Medical Staff Bylaws and election of officers, a Medical Staff member must be a member of the Active or Provisional Active staff. Only members of the Active staff shall be eligible to vote on the Medical Staff Bylaws and the election of officers.
- (b) **Department Matters.** Only members of either the Active staff or the Provisional Active staff who have been assigned to the department that is conducting the business at issue shall be entitled to vote upon matters before that department. Only members of the Active staff shall be eligible to vote on the election of the department Chair.
- (c) **Committee Matters.** Except as otherwise stated in these Bylaws, only Medical Staff members appointed in accord with these Bylaws to the committee that is conducting the business at issue shall be entitled to vote upon matters before that committee.
- (d) **Good Standing.** In addition to the eligibility requirements set forth above, a Medical Staff member must be in good standing at the time of the vote for such vote to be counted.

13.6 **Minutes**

Minutes of each regular and special meeting of the Medical Staff, a Medical Staff committee or a department shall be prepared in a timely fashion and shall include a record of attendance of members and the vote taken on each matter. Copies of the minutes shall be submitted to those in attendance for approval, and the minutes shall thereafter be forwarded to the Executive Committee. The Medical Staff Services Office shall maintain a permanent file of the minutes of meetings. All Medical Staff members may have access to meeting minutes that are not otherwise privileged and confidential, upon request to the applicable committee or department Chair or the President of the Medical Staff.

13.7 **Conduct at Meetings**

All Medical Staff and Medical Staff Committee meeting attendees are expected to conduct themselves professionally, extending the courtesy of contributing and listening to all other attendees. Disruptive conduct such as yelling, interrupting, profanity, etc. will not be tolerated at any meeting. The President of the Medical Staff or the Committee Chair, as the case may be, in his sole discretion, may ask any attendee to leave the meeting at any time due to disruptive conduct. Confidential documents must be returned to the President of the Medical Staff/Committee Chair, if requested, prior to an attendee's exit. The inappropriate treatment of confidential documents or information (including, but not limited to

email distributions, careless disregard of printed materials, tape recordings, etc.) will be considered a violation of these Bylaws and will be addressed accordingly.

SECTION 14 - CONFIDENTIALITY

The Medical Staff recognizes that it is vital to maintain the confidentiality of certain information, for reasons of both law and policy. Practitioners participate in credentialing, peer review, and quality improvement activities, and others contribute to these activities, in reliance upon the preservation of confidentiality. The confidentiality of these activities, and of all Medical Staff records, is to be preserved and these communications, information and records will be disclosed only in the furtherance of credentialing, peer review, and quality improvement activities, and only as specifically permitted under the conditions described in these Bylaws and Medical Staff policy. This requirement of confidentiality extends to the records and minutes of all Medical Staff committees, to the records of all Medical Staff credentialing, peer review and quality improvement activities, to the credentials and peer review files concerning individual Practitioners, and to the discussions and deliberations which take place within the confines or under the aegis of Medical Staff committees.

Each member of the Medical Staff, by acceptance of appointment or reappointment, therefore pledges to: (a) maintain all such information and any and all discussions and deliberations regarding the same in strict confidence; (b) agree to make no disclosures of such confidential information outside of appropriate meetings, except when (i) the disclosures are to another authorized member of the Medical Staff or authorized employee of Hospital and are for the purposes of conducting legitimate Medical Staff affairs; (ii) the disclosures have been authorized, in writing, by the Designated Administrative Officer and the President of the Medical Staff; or (iii) as otherwise permitted by the Medical Staff policy. Any such disclosures shall be made only in a private setting for the specified purpose regarding the disclosure. Confidential documents may not be removed from Hospital premises without the express consent of the Designated Administrative Officer.

SECTION 15 - RULES AND REGULATIONS AND POLICIES

15.1 Medical Staff Rules and Regulations and Policies

The Medical Staff hereby delegates to the Executive Committee, the authority to make, adopt and amend such Rules and Regulations, and policies, as may be necessary for the proper conduct of its work and to implement more specifically the general principles set forth in these Bylaws.

The Rules and Regulations and policies should be reviewed periodically and revised as necessary. The review may be performed by the Medical Staff Bylaws Committee or a special committee appointed by the Medical Staff President. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, so that the Rules and Regulations and policies are of generally recognized quality, provide a basis for

acceptance by accreditation agencies, comply with supervising licensing authorities, and provide a system of ongoing effective professional review. When the committee has conducted such review, it will make its recommendations to the Executive Committee.

The Executive Committee will provide the Medical Staff with notice of proposed changes to Rules and Regulations prior to submitting to the Governing Body. Rules and Regulations and any amendments thereto shall become effective when approved by the Governing Body. Neither the Executive Committee nor the Governing Body may unilaterally amend the Rules and Regulations.

Should the need for an immediate amendment to the Rules and Regulations be necessary to comply with law, regulation, or accreditation requirement, the Executive Committee may provisionally adopt such amendment and the Governing Body may provisionally approve such amendment, without prior notification of the Medical Staff. In this circumstance, the Medical Staff will be immediately notified by the Executive Committee and have the opportunity for review and comment of the provisional amendment. If there is no conflict, the amendment stands. If there is conflict, the Conflict Resolution process described in Section 17 below, will be followed.

The Executive Committee will provide the Medical Staff with notice of newly adopted or amended policies. Policies shall become effective when approved by the Executive Committee.

Any member of the Medical Staff may propose amendments, additions and repeals of any rule, regulation or policy by submitting such request in writing to the Executive Committee. Moreover, the Medical Staff may prepare and present proposed amendments, additions and repeals of a rule, regulation or policy which are supported by the Medical Staff, as evidenced by a vote of the Medical Staff using the methodology described in Section 16.2, directly to the Governing Body.

15.2 **Department Rules and Regulations**

Each department shall adopt Rules and Regulations pertinent to the practice of medicine within their department, and these Rules and Regulations shall become effective when approved by the Executive Committee.

SECTION 16 - ADOPTION AND AMENDMENT OF BYLAWS

16.1 **Medical Staff Responsibility**

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Governing Body, Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Governing Body.

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

16.2 **Methodology**

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

- (a) The affirmative vote of two thirds (2/3) of the active staff who are present at a meeting at which a quorum is present and eligible to vote on this matter as set forth in Section 13.5, provided at least ten (10) days written notice, accompanied by the proposed Bylaws and/or alterations, has been given of the intention to take such action; and
- (b) The affirmative vote of a majority of the Governing Body.
- (c) In addition to the amendment process for the Bylaws as set forth herein, the Medical Staff may, upon a vote of the Medical Staff using the methodology described in this Section 16.2, recommend amendments to the Bylaws directly to the Governing Body, provided that the recommendation is first communicated to the Executive Committee. The timing and method of presentation to the Governing Body will be consistent with the Hospital's corporate bylaws.

16.3 **Effective Date**

These Bylaws shall be adopted at any regular meeting of the active Medical Staff, shall replace any previous Bylaws and shall become effective when approved by the Governing Body of the hospital. They shall, when adopted and approved, be equally binding on the Governing Body and the Medical Staff.

Errors, alterations or additions to these Bylaws shall be effected through the due process outlined in these Bylaws.

16.4 **Review and Revision**

The Medical Staff Bylaws shall be reviewed periodically and revised as necessary. The review shall be undertaken by a committee appointed by the President of the Medical Staff and any proposed amendments and revisions shall be adopted by the Medical Staff and Governing Body as provided herein.

SECTION 17 - CONFLICT RESOLUTION

In the event the Medical Staff has a concern regarding the Medical Staff Bylaws, Rules and Regulations, associated policies, Department Rules and Regulations, or any other conflict that cannot be resolved or otherwise appropriately managed through existing processes, representative members of the Active Medical Staff may request an opportunity to meet with the Executive Committee. If the members remain unsatisfied, they may prepare and present the issue at a regularly scheduled or specially-called Medical Staff meeting. If the issue is supported by the Medical Staff, as evidenced by a vote of the Medical Staff using the methodology described in Section 16.2, such issue may proceed directly to the Governing Body according to the Hospital's corporate bylaws.

SECTION 18 - GOVERNING LAW

These Bylaws shall be governed by, and construed in accordance with the Health Care Quality Improvement Act of 1986 and, to the extent not inconsistent therewith, the Wisconsin Statutes Sections 146.37 and 146.38, and to the extent not so governed, with the other laws of the State of Wisconsin without giving effect to its conflict of laws principles.

ADOPTED by the Active Medical Staff of Ministry Saint Michael's Hospital of Stevens Point, Inc.

Andrew J. Braun, MD
President of Medical Staff

March 25, 2011
Date

Todd M. Williams, MD
Secretary/Treasurer of Medical Staff

APPROVED by the Governing Body of Ministry Saint Michael's Hospital of Stevens Point, Inc.

March 29, 2011
Date

Mr. Joseph Kinsella
Chair of Board of Directors