

**BYLAWS OF THE MEDICAL STAFF
OF
GOOD SAMARITAN HEALTH CENTER, INC.
MERRILL, WISCONSIN**

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**BYLAWS OF THE MEDICAL STAFF
OF
GOOD SAMARITAN HEALTH CENTER, INC.**

PREAMBLE

Good Samaritan Health Center, Inc. of Merrill, Wisconsin, is a not-for-profit corporation organized under the laws of the State of Wisconsin, and its purpose is to serve as a general hospital, providing health care services to the general community. Recognizing that the best interests of patients are served by ongoing cooperation among Hospital Administration, the Medical Staff and the Hospital Governing Body, the Practitioners practicing in the Hospital hereby organize themselves to carry out the functions delegated to the Medical Staff by the Governing Body in conformity with the Medical Staff Bylaws, subject to the ultimate authority of the Governing Body.

DEFINITIONS

1. **“Allied Health Professional”** or **“AHP”** means a health care professional (other than a Practitioner) who is licensed, certified or registered in the state to exercise a degree of independent judgment within his area of professional competence and who is qualified and has been granted Privileges to render direct or indirect medical care under the supervision of or collaboration with a physician Member of the Medical Staff. Such AHPs shall include, without limitation, clinical psychologists, nurse clinicians/practitioners, physician assistants, qualified therapists (e.g., occupational, physical, respiratory, audiologists), certified alcohol counselors and members of the Academy of Certified Social Workers.
2. **“Hospital President”** means the individual appointed by the Governing Body to act on its behalf in the overall management to the Hospital.
3. **“Chief of Service”** means the Medical Staff Member duly appointed, in accordance with these Bylaws, to serve as the head of a Service.
4. **“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).
5. **“Days”** means calendar days unless denoted otherwise. **“Business Days”** means those days the administrative offices of the Hospital are staffed (so does not, for example, include weekends or holidays).
6. **“Executive Committee”** or **“MEC”** means the Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Governing Body.
7. **“Ex-officio”** means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

8. **“Fair Hearing Plan”** or **“Plan”** means the “Corrective Action Procedures and Fair Hearing Plan Addendum to the Medical Staff Bylaws” of the Hospital.
9. **“Governing Body”** means the board of directors of the Hospital.
10. **“Health Status”** means the physical, emotional and mental health status (including stability) of an individual.
11. **“Hospital”** means the health care facility known as Good Samaritan Health Center, Inc.
12. **“In good standing”** for the purpose of these Bylaws means an individual who, at the time the issue of standing is raised, has not been suspended in the previous twelve (12) months for any purpose excluding precautionary suspension or medical records compliance, and has for the previous twelve (12) months met the meeting attendance requirements set forth in these Bylaws. When granted voting rights, only Members in good standing shall be eligible to vote for the election of officers, or for any other matter presented for vote at a special or general meeting of the Medical Staff .
13. **“Interactive Telemedicine”** for purposes of these Bylaws consists of responsibility (either total or shared) for patient care, treatment and services (as evidenced by having the authority to write orders and direct care, treatment and services) through a telemedicine link.
14. **“Interpretive Telemedicine”** for purposes of these Bylaws consists of providing official readings of images, tracings or specimens through a telemedicine link, but not engaging in Interactive Telemedicine.
15. **“Medical Staff”** means the Hospital’s organized component of physicians, podiatrists and dentists approved by the Governing Body of Good Samaritan Health Center, Inc. and granted specific Clinical Privileges for the purpose of providing adequate medical, podiatric and dental care for the patients of the Hospital.
16. **“Medical Staff Year”** shall be a twelve (12) month period commencing the first day of April, through the thirty-first day of March.
17. **“Member”** or **“Membership”** means the Prerogative of Medical Staff participation and does not necessarily include, as an incident thereto, any Clinical Privilege whatsoever.
18. **“Practitioner”** means an appropriately licensed medical or osteopathic physician, dentist or podiatrist.
19. **“Prerogative”** means a participatory and conditional right granted, by virtue of staff category or otherwise, to a staff Member and exercisable subject to the conditions imposed in these and the Hospital Bylaws and in other Hospital and staff policies.
20. **“President of the Medical Staff”** means the chief elected official and chief medical officer elected annually by the voting Members of the Medical Staff and approved by the Governing Body.

21. **“Privileges”** or **“Clinical Privileges”** mean the permission granted to a Practitioner or an AHP or other designated healthcare provider to render specific diagnostic, therapeutic, medical, podiatric, dental or surgical services, which may or may not include permission to admit patients.
22. **“Quality Improvement Officer”** or **“QI Officer”** means the active Medical Staff Member selected and appointed by the Governing Body on the advice of the President of the Medical Staff to oversee the quality assessment and improvement functions of the Medical Staff, and to coordinate Medical Staff quality assessment and improvement activities with the Hospital-wide quality assessment and improvement activities.
23. **“Service”** means that group of Practitioners who have Clinical Privileges in one of the general areas of medicine, surgery or emergency medicine. **“Special Notice”** means written notification sent by certified or registered mail, return receipt requested, or hand delivered to the addressee.
24. The masculine pronoun wherever used in these Bylaws or the Medical Staff Rules and Regulations shall refer equally to both sexes.

ARTICLE 1

NAME

The name of this organization shall be the Medical Staff of Good Samaritan Health Center, Inc.

ARTICLE 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 all those with Privileges 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.
- (e) To cooperate with medical schools and other educational institutions in undergraduate, graduate, post-graduate and continuing education programs.

2.2 Basic responsibilities of the Medical Staff are:

- (a) To provide an appropriate level of professional performance of all Practitioners, and all those authorized to practice in the Hospital through the appropriate delineation of the Clinical Privileges that each individual may exercise in the Hospital and through an ongoing review and evaluation of each individual's performance in the Hospital.
- (b) To provide a continuing education program fashioned, at least in part, on the needs demonstrated through the patient care audit and other quality assessment and improvement programs.
- (c) To provide a utilization review program to assure that medical and health care services rendered at the Hospital are appropriately employed for meeting patients' medical, social and emotional needs consistent with sound health care resources utilization practices.
- (d) To provide an organizational structure that allows continuous monitoring of patient care practices.
- (e) To conduct retrospective 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, 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 adhere to and abide by the applicable Code of Ethics; the standards of The Joint Commission; and the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops.
- (l) To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

- (m) To conduct all its affairs involving the Medical Staff, patients, employees and the public in a manner and an atmosphere free of unlawful discrimination because of age, sex, creed, national origin, race, handicap, disability, color, ancestry, religion, sexual orientation, marital status, newborn status, source of payment or any other unlawful basis.
- (n) To cooperate with and assist the Hospital in achieving accreditations.
- (o) To assist the Hospital in the development of an annual budget and in operating the Hospital in a cost effective manner.
- (p) To exercise the authority granted by these Bylaws as necessary to adequately fulfill the responsibilities of the Medical Staff.
- (q) To abide by the Corporate Integrity Program, including without limitation, the Hospital's Standards of Conduct and any related education and training requirements.
- (r) 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.
- (s) To carry out such other responsibilities as may be delegated by the Governing Body.

ARTICLE 3

MEMBERSHIP

3.1 Membership a Privilege

Membership on the Medical Staff of the Hospital is a Prerogative which shall be extended only to those Practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and Membership on the Medical Staff shall confer on the Practitioner only such Clinical Privileges and Prerogatives as have been granted by the Governing Body in accordance with these Bylaws.

3.2 Qualifications

- (a) To be qualified for Medical Staff Membership, Practitioners must:
 - (1) Be licensed to practice medicine, dentistry or podiatry in the State of Wisconsin;

- (2) Document and support their background, character, training, experience, current competence, clinical judgment, their adherence to the ethics of their profession, their good reputation and ability to work competently with other Practitioners, support staff and patients, with sufficient adequacy to demonstrate to the Medical Staff and the Governing Body that they will provide care to patients at a generally recognized level of quality, in an economically efficient manner, taking into account patient needs, available Hospital facilities and resources and utilization standards in effect at the Hospital;
- (3) Provide evidence of graduation from an approved medical or 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 Commission on Dental Education of the American Dental Association or an approved school of podiatry meeting the standards of the Council on Podiatric Medical Education of the American Podiatric Medical Association and meet the continuing education hours required for state licensure in their profession;
- (4) Submit and maintain on file at all times current evidence of continued licensure, DEA registration (if applicable) and financial responsibility in amounts which shall be determined by the Governing Body after consultation with the Executive Committee, which responsibility may be satisfied by participation in the Wisconsin Injured Patients and Families Compensation Fund and malpractice insurance coverage meeting the requirements of Chapter 655 of the Wisconsin Statutes. This requirement may be satisfied by submitting copies of the Practitioner's current license, DEA registration and insurance certificate each time these documents change or are updated;
- (5) Subject to applicable law, as part of their appointment and reappointment to the Medical Staff, certify annually, or at any other time upon request of the Governing Body or the Executive Committee, that their current Health Status does not in any way impair their ability to safely exercise the Clinical Privileges requested or to care for patients, and the Governing Body may precondition appointment, reappointment, or the continuing exercise of any or all Clinical Privileges upon the Practitioner undergoing a health examination by a physician acceptable to the Governing Body or upon submission of any other reasonable evidence of current Health Status that may be requested by the Executive Committee or the Governing Body. Medical Staff Membership and Clinical Privileges will not be denied on the basis of disability if, with or without reasonable accommodation, the Practitioner can safely perform the Clinical Privileges requested and safely care for patients;
- (6) Be able to render continuous care and supervision of their patients admitted to the Hospital and, if required by their Service pursuant to

approved Service rules, to provide emergency care and emergency consultation within the scope of their Privileges for patients admitted to or treated at the Hospital;

- (7) Be willing to participate in the discharge of Medical Staff Service, committee and Hospital functions for which he is responsible by staff status, assignment, appointment, election or otherwise and discharge such other responsibilities as may be required by the Medical Staff, subject to Governing Body approval;
- (8) Participate in and be subject to the quality assessment and improvement activities of the Hospital and the Medical Staff;
- (9) Prepare and complete in a timely fashion the required medical, patient and Hospital records for all patients he admits or in any way provides care to in the Hospital;
- (10) Eligible to receive payment from Medicare and Medicaid and not excluded from any health care program funded in whole or in part by the Federal Government;
- (11) Not be barred from providing services in the Hospital under Chapter DHS 12 of the Wisconsin Administrative Code; and
- (12) 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 promptly, but in no case more than fifteen (15) days after the triggering event, notify the Hospital President of, and to provide such additional information as may be requested regarding, each of the following:
 - (a) the revocation, limitation, reduction, denial, voluntary relinquishment, or suspension 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 by any state;
 - (b) denial, restriction, voluntary or involuntary loss of staff membership or clinical privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;
 - (c) loss, cancellation or change of professional liability insurance coverage;
 - (d) receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal

investigation or the filing of charges relating to health care matters by a Medicare quality improvement organization, the Department of Health and Human Services or any law enforcement agency or health regulatory agency of the United States or of any State;

- (e) receipt of notice of the filing of any suit against the Practitioner or submission of a request for mediation alleging professional liability in connection with the treatment of any patient;
 - (f) settlement of a claim by a payment from an insurance company (or by the applicant or any other party), or any agreement that results in a release from liability being given by a patient to the applicant;
 - (g) subject to applicable law, any criminal conviction or pending criminal charge, any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient or has misappropriated a patient's property;
 - (h) proposed or actual exclusion from any federally funded health care program, any notice to the individual or his representative of proposed or actual exclusion and/or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid; and
 - (i) any notification by any quality improvement organization or a third party payor reimbursement program concerning any utilization or quality of care review or sanction imposed.
- (b) No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff or Allied Health Professional Staff membership or for any Clinical Privileges.
- (c) No Practitioner shall be entitled to Membership on 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 membership in any professional organization, or past or present Privileges at another hospital.
- (d) No person who is otherwise qualified shall be denied Privileges by reason of race, color, creed, handicap, disability, sex or national origin or on the basis of any other criterion unrelated to the delivery of quality patient care in the Hospital, to professional qualifications, to the Hospital's purposes, needs and capabilities, to community need, or to any requirements set forth in these Bylaws.
- (e) The Governing Body shall have the ultimate responsibility to determine whether to select or reject Medical Staff based on the limitations of facilities, services, staff, support capabilities or any combination thereof. Decisions not to appoint or reappoint or grant

Privileges to an otherwise qualified Practitioner in accord with criteria of a Medical Staff development plan or due to the existence of any contracts for exclusive provision of clinical services, shall be made by the Governing Body. 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.

- (f) As a condition of appointment and reappointment to the Medical Staff or the grant of any Clinical Privileges, all individuals 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 (the Good Samaritan Health Center OHCA) and agree to follow the privacy practices of that OHCA with respect to protected health information received through the OHCA.
- (g) As part of their appointment and reappointment to the Medical Staff and as a condition of the grant of any Clinical Privileges, all individuals granted privileges have a continuing obligation to comply with federal and state laws and regulations applicable to the practice of their profession and applicable standards established by The Joint Commission and other accreditation agencies as recognized and approved by the Medical Staff and Governing Body.
- (h) As part of their appointment and reappointment to the Medical Staff and as a condition of the grant of any Clinical Privileges, all individuals granted Privileges have a continuing obligation to comply with health requirements established by the Executive Committee.

3.3 Ethics and Ethical Relationships

- (a) By accepting Membership on the Medical Staff, a Practitioner specifically agrees to abide by the Medical Staff Bylaws, and all other adopted standards, policies, rules, regulations and procedures of the Medical Staff and the Hospital, 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 provision of the applicable Code of Ethics and the Ethical and Religious Directives, the latter shall prevail.
- (b) The professional conduct of Members of the Medical Staff shall at all times be governed by applicable state 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 applicable state 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 Basic Responsibilities of Individual Medical Staff Members

Each Member of the Medical Staff shall:

- (a) Provide his patients with care at the generally recognized professional level of quality and efficiency.
- (b) Abide by the Medical Staff Bylaws, the Rules and Regulations, and all other adopted standards, policies, rules and procedures of the Hospital and Medical Staff.
- (c) Willingly and collegially discharge such staff, Service, committee and Hospital functions for which he is responsible by staff status, assignment, appointment, election or otherwise.
- (d) Prepare and complete in a timely fashion the required medical, patient and Hospital records for all patients he admits or in any way provides care to in the Hospital.
- (e) Abide by the:
 - (1) Ethical and Religious Directives for Catholic Health Care Services;
 - (2) Recognized Code of Ethics applicable to the Practitioner's profession;
 - (3) Ethical principles adopted by the Hospital; and
 - (4) Requirements for accreditation of The Joint Commission.
 - (5) Corporate Integrity Program, including without limitation the Hospital's Standards of Conduct and any related education and training requirements.
- (f) Work with and relate to other Practitioners, residents, students, AHPs, Hospital staff, members of professional review organizations and accreditation bodies in a manner essential for maintaining a hospital.
- (g) Pledge not to receive from or pay to another Practitioner, either directly or indirectly, any part of any fee received for professional services.
- (h) Provide for continuous care and supervision of patients, and refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a Practitioner or AHP who is not qualified to undertake the responsibility, who is not adequately monitored, or who is not privileged to do so.
- (i) Agree to furnish the Hospital with a current list of alternates, in accordance with the Rules and Regulations of the Service to which the Practitioner has been assigned, **or the telephone answering service number** which then can supply the name of the available alternate when the Practitioner is unavailable. Further, all Practitioners must provide emergency specialty call coverage as such is established by each Service pursuant to Service rules approved by the Executive Committee and the Governing

Body. Medical Staff Members who participate in call coverage will assure availability of emergency medical care to patients who may present to the Hospital for care related to the Member's specialty and within the capacity of the Hospital. Further, all Practitioners must provide emergency specialty call coverage, without regard to sources of payment or ability to pay, as such is established by each Service pursuant to Service rules approved by the Executive Committee and the Governing Body.

- (j) Promptly, but in no case more than fifteen (15) days after the triggering event, notify the Hospital President of, and to provide such additional information as may be requested regarding, each of the following:
- (1) the revocation, limitation or suspension 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 by any state;
 - (2) loss of staff membership or privileges at any hospital or other health care institution, whether temporary or permanent, including all suspensions;
 - (3) cancellation or change of professional liability insurance coverage;
 - (4) receipt of a quality inquiry letter, an initial sanction notice, notice of proposed sanction or of the commencement of a formal investigation, or the filing of charges relating to health care matters, by a Medicare quality improvement organization, the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or of any State;
 - (5) receipt of notice of the filing of any suit against the Practitioner or submission of a request for mediation alleging professional liability in connection with the treatment of any patient;
 - (6) settlement of a claim by a payment from an insurance company (or by the applicant or any other party), or any agreement that results in a release from liability being given by a patient to the applicant;
 - (7) subject to applicable law, any criminal conviction or pending criminal charge, any findings by a governmental agency that the applicant has been found to have abused or neglected a child or patient, or has misappropriated a patient's property; and
 - (8) proposed or actual exclusion from any federally funded health care program, any notice to the individual or his representative of proposed or actual exclusion and/or any pending investigation of the individual from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

- (k) Accept committee and consultation assignments as may be required by these Bylaws or the Rules and Regulations.
- (l) Comply on a continuing basis with federal and state laws and regulations applicable to the practice of their profession, including, but not limited to, proof of immunity against rubella and compliance with blood borne pathogen standards and periodic tuberculosis testing.
- (m) Discharge such other responsibilities as may be required by the Medical Staff, subject to the Governing Body's approval.

3.5 Exclusive Contracts

The Hospital may enter into contracts with a Practitioner or group of Practitioners for the provision of certain Hospital based services such as, but not limited to, radiology, pathology, anesthesiology or emergency room services. Where the contracts grant the contracting Practitioners the exclusive right to provide the services at issue, all Medical Staff Members or other Practitioners who are not parties to the contracts shall automatically lose the right to exercise those Clinical Privileges exclusively granted to the contracting parties, without right to any hearing or appeal. Applicants not affiliated with the contracting party for Clinical Privileges shall be denied, consistent with the exclusivity granted to the contracting party, without right to any hearing or appeal.

ARTICLE 4

CATEGORIES OF THE MEDICAL STAFF

4.1 The Medical Staff Categories

The Medical Staff shall be divided into provisional, active, courtesy, consulting, associate, limited and honorary staff categories. The Allied Health Professional Staff shall be affiliated with and shall be subject to applicable portions of the Bylaws and Rules and Regulations of the Medical Staff. Allied Health Professionals shall not be Members of the Medical Staff and shall have no Medical Staff responsibilities or rights.

4.2 The Provisional Medical Staff

- (a) The provisional Medical Staff shall consist of newly appointed Practitioners (except honorary Medical Staff Practitioners) and those who have been reappointed to provisional Membership for an additional twelve (12)-month period after completion of their initial term. The staff category to which Practitioner will be seeking to advance must be specified at the time of application. Except as set forth in this Section 4.2, the Prerogatives of the staff category to which the Practitioner is seeking to advance will apply while the Practitioner is part of the provisional staff. Provisional Medical Staff Members shall be assigned to one or more clinical Services, shall have

their Clinical Privileges delineated and shall have their performance evaluated by the President of the Medical Staff.

- (b) During the first six (6) months of the provisional appointment, it will be the responsibility of the Chief of the appropriate Service to orient the Practitioner to the Service, and it shall be the responsibility of the President of the Medical Staff to establish and oversee a monitoring protocol.
- (c) During the monitoring period, the monitoring protocol shall afford the Hospital and the Practitioner the following:
 - (1) The ability to establish pretreatment consultation requirements;
 - (2) A current review of the clinical abilities of the Practitioner;
 - (3) A resource person or committee to whom the Practitioner can or must seek voluntary or required consultation;
 - (4) A resource in the form of the monitor or monitoring committee with whom other staff Members or Hospital personnel may confer concerning the Practitioner on interim status; and
 - (5) A basis for recommending Privileges at the completion of the interim status.
- (d) At the conclusion of the initial monitoring period as set forth in (b) above, or upon completion of the review and satisfactory evaluation of the Practitioner's initial fifteen (15) cases, the President of the Medical Staff shall recommend that the interim monitoring process be terminated or that an additional interim period of monitoring be established. Should the Executive Committee determine to extend the interim monitoring of a Practitioner for a second period, not to exceed six (6) months, 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 decision in accord with the Fair Hearing Plan.
- (e) A Practitioner may be reappointed to provisional Membership after completion of the initial term for an additional twelve (12)-month period, may be recommended for advancement or may be recommended for denial of reappointment/advancement. A Practitioner who does not qualify for promotion to the regular Medical Staff within two (2) full calendar years should be scheduled for a personal interview with the Executive Committee to discuss the status of his continued interest in Membership on the Medical Staff of the Hospital. The Executive Committee, after consultation with the Chief of the Service involved, will recommend continuation on the provisional staff, advancement to the active, courtesy or consulting staff, or non-reappointment to the Medical Staff. In the latter case, the Practitioner may be entitled to the procedural rights set forth in the Fair Hearing Plan.

- (f) The requirement to serve on the provisional staff may be waived only upon a three fourths vote of the Executive Committee and concurrence by the Governing Body by a three fourths vote. A waiver may be considered in the case of an extensively experienced Practitioner or where a Practitioner is to be appointed Chief of a Service of the Hospital.
- (g) Members of the provisional Medical Staff shall:
 - (1) Be eligible to serve on all Medical Staff committees, except the executive and quality assurance committees, and to vote on matters before such committees;
 - (2) Not be eligible to vote at general staff meetings, nor to hold office, nor to chair any committee;
 - (3) Carry out Membership responsibilities, including meeting attendance requirements, associated with the category of Medical Staff Membership that the Practitioner seeks to attain upon completion of the provisional period; and
 - (4) Agree to abide by the Bylaws and Rules and Regulations of the Medical Staff.
- (h) The factors to be considered in whether to recommend advancement shall be those identified in Section 5.5(e), 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 the 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.
- (i) 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 affiliated 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 at the Hospital, who are located close enough to the Hospital to provide proper and continuous care to patients, and who assume all the functions and responsibilities of Membership on the active Medical Staff.
- (b) For purposes of this Section, a Practitioner will be considered to be located close enough to the Hospital to provide proper care if the Practitioner meets the following on call requirements:

- (1) Maintains a telephone response time of fifteen (15) minutes or less; and
 - (2) Unless specific arrangements have been made to transfer care responsibilities to an alternative Practitioner qualified to cover for the individual, or to appropriately transfer patients to another facility that is equipped to handle the patients' emergency medical conditions, arrives at the Hospital within sixty (60) minutes of being called in; and
 - (3) Can arrive at the Hospital within sixty (60) minutes of being called in (day and night); or
 - (4) Is physically present at the hospital and on-duty for a regularly scheduled shift (i.e. emergency department, hospitalists).
- (c) Unless excepted under Section 4.2(f), above, new Members of the active Medical Staff must have been Members of the provisional Medical Staff or the courtesy Medical Staff and 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.
- (d) Members of the active Medical Staff shall promote the quality of medical care in the Hospital, offer sound counsel to the Hospital President and the Governing Body and participate in the internal government of the Medical Staff according to these Bylaws. The Members of the active Medical Staff shall, within the scope of their Privileges, provide emergency care as such is established by each Service pursuant to Service rules approved by the Medical Executive Committee and the Governing Body to patients without regard to source of payment or ability to pay.
- (e) Members of the active Medical Staff are:
- (1) Eligible to vote, hold office and serve on and chair all committees; and
 - (2) Unless expressly excepted by the Medical Executive Committee, required to serve on or chair Medical Staff and other committees as assigned, attend general Medical Staff meetings and service meetings as provided in Article 12 of these Bylaws.

4.4 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 and who only occasionally admit or attend patients in the Hospital.
- (b) New Members of the courtesy staff must have been Members of the provisional staff, the active Medical Staff or the consulting Medical Staff for a period of at least one year before being eligible for the courtesy Medical Staff, which requirement may be waived as provided in Section 4.2(f).

- (c) Members of the courtesy staff shall not be required to attend general Medical Staff meetings or service meetings, but are encouraged to do so.
- (d) Members of the courtesy staff shall not be eligible to vote, hold office or serve on the Medical Executive committee; however, Members may be attend, but may not chair or vote on other Medical Staff committees.
- (e) Members of the courtesy staff must be Members of the active or associate staff at another hospital where they actively participate in a peer review process or other quality assessment and improvement activities similar to those required of active staff of this Hospital.
- (f) Members must reasonably comply with all requests for practice information, data and/or reports if deemed needed by the Medical Staff to provide a basis for the evaluation of the Member's professional competence and judgment..

4.5 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 Executive Committee, are qualified for consultation work in their specialty. Membership on the consulting staff shall not, by itself, qualify the Practitioner for active staff Membership.
- (b) Members of the consulting staff shall provide their services in the care of patients in the Hospital at the request of any Member of the Medical Staff and in circumstances where consultation is required by the Rules and Regulations of the Medical Staff. Members of the consulting Medical Staff may only admit patients in conjunction with an active Medical Staff Member.
- (c) Members of the consulting staff shall not be eligible to vote, hold office or serve on the Medical Executive Committee. They may, however, attend other Medical Staff committees. However, Members of the consulting staff may not serve as chair of any committee.
- (d) Members of the consulting staff are encouraged to attend general Medical Staff meetings and service meetings but are not required to do so. Consulting Medical Staff shall not be eligible to attend and participate in those portions of meetings devoted to peer review of other Medical Staff members in other categories of the Medical Staff.
- (e) New Members of the consulting staff must have been Members of the provisional staff, the courtesy Medical Staff or the active Medical Staff for a period of at least one year, which requirement may be waived as provided in Section 4.2(f).
- (f) Members of the consulting staff must be members of the active or other category of staff at another hospital where they actively participate in a peer review process or other

quality assessment and improvement activities similar to those required of the active staff of this Hospital.

4.6 The Associate Medical Staff

The Associate Medical Staff shall consist of those Practitioners whose primary hospital affiliation is Good Samaritan Health Center, 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.

- (a) Members of the Associate Medical Staff shall:
 - (1) Be eligible to vote at general staff meetings or service meetings only if appointed and serving on Medical Staff committees or Medical Executive Committee;
 - (2) Be eligible to serve, with voting rights, on all Medical Staff committees, [including the Medical Executive Committee;]
 - (3) Be eligible to hold office and chair committees;
 - (4) Be eligible to attend general Medical Staff meetings or service 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 attending Privileges;
 - (6) May order, but not perform, outpatient diagnostic or therapeutic procedures that can be performed without their personal presence and that are within the scope of their practice to order; and
 - (7) May provide pre-procedural history and physical examinations.
- (b) Review of the office practice of Members of the Associate 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 Associate Medical Staff must reasonably comply with all requests for such practice information, data, and/or reports.

4.7 The Limited Medical Staff

- (a) The Limited Medical Staff shall consist of those practitioner who are only applying for history and physical privileges and do not have an active interest in the operation of the Hospital. Members of the Limited Medical Staff shall:
 - (1) Not be eligible to vote at general staff meetings or service meetings;

- (2) Not be eligible to serve on any Medical Staff Committees
- (3) Not be eligible to hold office or chair any committees
- (4) Not be required to, but may attend general Medical Staff meetings or services 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) May not have admitting or treating privileges;
- (6) May order, but not perform, outpatient diagnostic or therapeutic procedures that can be performed without their personal presence and that are within the scope of their practice to order, and
- (7) May provide pre-procedural history and physical examinations.
- (8) 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 and/or reports.

4.8 The Honorary Medical Staff

- (a) The honorary Medical Staff shall consist of Practitioners who are not active in the Hospital and who are honored by emeritus positions. These may be Practitioners who have retired from active Hospital service or who are of outstanding reputation, not necessarily residents of the community.
- (b) Honorary Medical Staff Members shall have no assigned duties and they shall not have Privileges to admit or treat patients to the Hospital. Honorary Medical Staff Members shall not be eligible to vote or hold office, but may serve on Medical Staff committees, except the executive and quality assurance committees. Honorary Medical Staff Members may not serve as chair of any committee.
- (c) Honorary Medical Staff Members are encouraged to attend general Medical Staff meetings and service meetings but are not required to do so.
- (d) Honorary Medical Staff Members are not required to apply for appointment or reappointment but instead shall be designated as honorary Medical Staff Members at the discretion of the Hospital.

4.9 Contracts with Practitioners

- (a) The Governing Body may employ Practitioners or otherwise contract with Practitioners to act as consultants to the Medical Staff, to staff, supervise and direct patient care in a particular Service of the Hospital.

- (b) Practitioners employed by the Hospital and those providing services under a contractual arrangement with the Hospital shall not be permitted to admit patients to the Hospital or attend patients, unless provision to the contrary is made in such contractual agreement with the Hospital, and then only if they apply for and obtain Clinical Privileges to do so. These Practitioners shall be considered for Clinical Privileges in accordance with the procedures set forth in these Bylaws for the delineation of Clinical Privileges for other Members of the Medical Staff.
- (c) Employed or contracted Practitioners may be required to be Members of the Medical Staff and to abide by the Bylaws and Rules and Regulations of the Medical Staff and shall be required to abide by these Bylaws and the Rules and Regulations and all relevant Hospital and Medical Staff policies, if their employment will involve the exercise of Clinical Privileges.
- (d) The Clinical Privileges and Medical Staff Membership of the Practitioner will cease upon the termination of such agreement or contract and the Practitioner shall not be entitled to the fair hearing procedures or appellate review set forth by these Bylaws through the Fair Hearing Plan, unless provision to the contrary is made in the Practitioner's contractual arrangement with the Hospital.

4.10 Dental and Podiatric Staff Functions

- (a) Dentists and podiatrists granted Membership on the Medical Staff in accordance with the procedures set forth in Article 5 shall be assigned to the surgery service.
- (b) 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 active 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) Dentists and podiatrists shall conform to the Bylaws and Rules and Regulations of the Medical Staff, including:
 - (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;
 - (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; and
- (6) Oral surgeons who have been granted Clinical Privileges to do so may admit and discharge patients without medical problems without first obtaining the concurrence of a physician Member of the Medical Staff, but such oral surgeons must designate a physician Member of the Medical Staff with appropriate Clinical Privileges to be responsible for the care of any medical problem that may arise. If granted Clinical Privileges to do so, oral surgeons may, in lieu of a physician Member of the Medical Staff, perform the admission history and physical examination and assess the medical, surgical and anesthesia risks of the proposed surgical procedures on those patients admitted without medical problems.

4.11 The Allied Health Professional Staff

(a) General

- (1) The Allied Health Professional Staff shall consist of those Allied Health Professionals who are admitted to practice in the Hospital through the Medical Staff credentialing process and are not employees of the Hospital, except that employees whose license permits them to practice independently will also be approved through the Medical Staff credentialing process. AHPs are not Members of the Medical Staff. Individuals who are not licensed to practice independently but who are authorized to participate in hospital care pursuant to a contractual arrangement with the Hospital under a detailed job description will not be considered Allied Health Professional Staff subject to these Bylaws unless the Executive Committee determines the Medical Staff credentialing process should be the mechanism under which the individual should be approved to practice in the Hospital.
- (2) The Allied Health Professional Staff shall be divided into two categories: independent Allied Health Professional Staff and dependent Allied Health Professional Staff.
- (3) Each individual in these categories will present his qualifications for review by the Medical Staff in accord with the procedures as set forth herein for the appointment of Practitioners to the Medical Staff. If approved, the Governing Body may grant such individual Privileges as restricted by Sections (b) and (c).
- (4) As a condition of appointment and the exercise of Clinical Privileges as an Allied Health Professional Staff Member, each individual must meet the conditions set forth for Practitioners in Article 3, Sections 3.2, 3.3 and 3.4, modified to apply to the applicable health discipline of the Allied Health Professional.

(b) Independent Allied Health Professionals

- (1) This category of Allied Health Professionals shall consist of the following persons:
 - (a) Individuals with a doctorate in psychology or its equivalent from an accredited college or university, and licensed in the State of Wisconsin;
 - (b) Privately practicing social workers certified by either the National Registry of Health Care Professionals in Clinical Social Work or the National Association of Social Workers Registry of Clinical Social Workers and licensed by the State of Wisconsin.
- (2) Independent Allied Health Professionals may provide patient care services within the limits of their professional skills and abilities and granted Clinical Privileges. The degree of participation of independent Allied Health Professionals in patient care shall be determined according to protocol or Privileges recommended and approved by the Governing Body.
- (3) Independent Allied Health Professionals shall:
 - (a) Only see patients referred by physician Members of the Medical Staff;
 - (b) Exercise independent judgment in their areas of competence, provided that an active or appropriate provisional physician Member of the Medical Staff shall have the ultimate responsibility for patient care;
 - (c) Participate directly in the management and care of patients under the general supervision or direction of an active or appropriate provisional physician Member of the Medical Staff;
 - (d) Record reports and progress notes on the patients' records and write orders for treatment to the extent established in the Rules and Regulations and other policies of the Medical Staff, provided that such orders are within the scope of his license, certificate or other legal credential;
 - (e) Not admit or discharge patients at the Hospital unless the AHP is within the Hospitalist Telemedicine Program;
- (4) Applications for appointment, reappointment and Clinical Privileges as an independent Allied Health Professional Staff member shall be processed in accordance with the procedures set forth in Article 5 of the Medical Staff Bylaws for Membership on the Medical Staff. An individual

applying for appointment as an independent Allied Health Professional must be recommended to the Executive Committee by an active or appropriate provisional Member of the Medical Staff or have as a reference such a Member of the Medical Staff; and

- (5) Such individuals may attend Medical Staff meetings, and as a condition of continued Privileges, may be required to attend meetings involving the clinical review of patient care in which they participated.

(c) Dependent Allied Health Professionals

- (1) This category of Allied Health Professional Staff members shall consist of advanced practice nurses, certified physician's assistants, certain registered or licensed practical nurses (i.e., surgical first assist), as well as those clinical technicians who are employees of a Member or Members of the Medical Staff, or who are engaged by the Hospital by contract to perform a portion of their professional responsibilities within the Hospital for whom no detailed job description exists and who the Executive Committee determines should be approved through the Medical Staff credentialing process.
- (2) The employer of the individual who is seeking appointment, reapproval or clinical privileges for a dependent Allied Health Professional Staff member shall present a written statement of the clinical duties and responsibilities of said individual to the Executive Committee for its review and approval prior to allowing the individual to perform any professional responsibilities within the Hospital. The individual applicant shall supply information regarding his character, judgment, qualifications, including but not limited to, education, licensure, professional training, experience, and current competence, to the Executive Committee for processing in accordance with the procedure set forth in Article 5 of these Bylaws.
- (3) The employer of the dependent Allied Health Professional shall assume full responsibility, and be fully accountable for, the conduct of the individual within the Hospital. It is the further responsibility of the employer of the dependent Allied Health Professional to acquaint the individual with the applicable rules and regulations of the Medical Staff and the Hospital, as well as appropriate Members of the Medical Staff and Hospital personnel with whom the individual shall have contact at the Hospital. The employer shall furnish evidence of professional liability insurance coverage for such individuals.
- (4) Where the employer of the dependent Allied Health Professional is a Member of the Medical Staff, the clinical duties and responsibilities of the Allied Health Professional within the Hospital shall terminate if the Medical Staff Membership of the employer is terminated for any reason or

if the employer's Clinical Privileges are curtailed to the extent that the professional services of the Allied Health Professional within the Hospital are no longer necessary or permissible to assist the employer.

- (5) The practice of a dependent AHP will, at all times, be governed by the laws of the State of Wisconsin, and the particular profession's scope of practice, such that a supervising or collaborating relationship with an appropriate Member of the Medical Staff may be required.

(d) Fair Hearing and Appeal of Termination of Privileges

- (1) The Hospital retains the right either through Administration or upon recommendation of the Executive Committee to suspend or terminate any or all of the Privileges or functions of any Allied Health Professional without recourse on the part of such person or others to the Fair Hearing Plan or any other review or appeals procedure of the Medical Staff Bylaws, except as provided in this Section.
- (2) Independent Allied Health Professionals whose Privileges are terminated or curtailed shall be told the reasons for such action and shall be entitled to have such action reviewed by the Executive Committee or a committee duly appointed by the Executive Committee, by submitting a written request for review to the Hospital President within fifteen (15) days of notification of the action. If review is requested, the independent Allied Health Professional will be provided with written notice of the date, time and place of the review meeting, which notice will include the basis for the action and whether the request for review will be considered to have stayed the action until a written decision following review is issued. At any review meeting, the individual shall be present and allowed to offer information to refute the action. Within a reasonable time after adjournment of the meeting, the review committee will issue a written decision indicating whether it agrees with the action. If the decision is to reverse or modify the action, the Hospital President may submit the matter for review by the Governing Body or a subcommittee of the Governing Body appointed for this purpose. If the decision is in agreement with the action, the Allied Health Professional may appeal the decision in writing within fifteen (15) days to the Hospital President whose decision will be final if it is to affirm the decision of the Committee. If the decision of the Hospital President does not affirm the Committee's decision, the matter may be submitted for review by the Governing Body or a subcommittee of the Governing Body appointed for this purpose.
- (3) Where the Privileges of a dependent Allied Health Professional are terminated or curtailed, the employer shall be notified as to the reasons for such action and the procedures in Section (d)(2) above will be followed.

- (4) Any Allied Health Professional whose Privileges are terminated shall not be eligible to reapply until the individual has taken effective action as determined by the Hospital to correct the conditions that resulted in termination.

4.12 Medical Student Affiliation

- (a) A medical student means an unlicensed person in a formal education program at a certified medical school. An application for affiliation with the Hospital will be completed by the student and physician preceptor and presented to the Hospital President or designee, for approval prior to rotation at the Hospital. The physician preceptor, who must be a Member of the Medical Staff, assumes responsibility for the medical student's actions in every situation which occurs within the confines of the Hospital. The determination of the specific level of involvement of medical students in patient care will be the responsibility of the physician preceptor.
- (b) Medical students are not Members of the Medical Staff but must adhere to the applicable Rules and Regulations and policies of the Medical Staff and the Hospital. Medical students are not entitled to procedural rights afforded by these Bylaws through the Fair Hearing Plan.
- (c) The President of the Medical Staff, the applicable Service Chief, or the President of the Hospital may summarily suspend the student's affiliation at the Hospital at any time.

ARTICLE 5

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

5.1 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 not to exceed twelve (12) months. Reappointments of all Members of the Medical Staff shall be for a period not to exceed 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 Fair Hearing Plan.
- (b) The Governing Body shall not take action on an application for appointment, reappointment or cancel an appointment previously made without prior conference and consultation with the Executive Committee. However, in the event of unwarranted delay on the part of the Executive Committee or a failure to act, the Governing Body may, without the prior recommendation of the Executive Committee, take action on the basis of documented evidence of the applicant's professional and ethical qualifications obtained from reliable sources. 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 and Rules and Regulations.

5.2 Application for Appointment

- (a) Except as set forth in Section 6.6, Practitioners desiring appointment to the Medical Staff shall obtain an application and privilege request form from the Hospital President who will, in addition to the forms, supply or make available to the applicant the Medical Staff Bylaws, Rules and Regulations, the applicable Code of Ethics and the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops, the Medicare Notice to Physicians acknowledgement form and the Hospital's mission statement.¹
- (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 by the applicant and shall provide a full summary of the applicant's education, institutional positions held (hospital and clinic), the dates of commencement and completion of each service, date and number of state licensures, date and number of DEA registration, date and number of board certification(s), and such other information as may be relevant to the applicant's qualifications for appointment.
- (c) The application shall include information as to whether the applicant's membership and/or clinical privileges have ever been, or are in the process of being revoked, suspended, reduced, not renewed, denied, investigated, voluntarily relinquished or subjected to probationary conditions, disciplinary action or sanctions at any other hospital or institution; whether the applicant resigned or voluntarily reduced or limited privileges as a result of a peer evaluation or investigation; and whether or not the applicant has ever been refused liability insurance or had it canceled. The applicant shall also include information as to any involvement in any past or pending professional liability action; information as to any confirmed or pending involvement in any quality inquiry, sanction action or formal investigation by 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 of any State, information as to whether his membership in local, state or national medical societies has ever been suspended or revoked and the applicant should include information as to whether any licensure 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 a statement as to the applicant's ability to safely exercise the privileges requested. 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 shall also include information as to any currently pending challenges to or disciplinary action proceedings relating to any licensure or registration of the applicant and as to the applicant's ability to safely perform the Privileges requested. The application shall include information as to whether the applicant has any criminal conviction, any findings by a governmental agency that the applicant has been found to have abused or

¹ Applicants for Telemedicine Privileges shall be credentialed and privileged according to Medical Staff Policy and as set forth in Section 6.6.

neglected a child or patient or has misappropriated the property of any patient. The applicant must provide a fully completed Background Information Disclosure form with the completed application and must cooperate with the Hospital in obtaining any additional information required for the Hospital to comply with the requirements of Chapter DHS 12 of the Wisconsin Administrative Code and other information as the Hospital may reasonably require.

- (d) The applicant shall supply evidence of minimum financial responsibility as required by Article 3, Section 3.2(a)(4) of these Bylaws.
- (e) The application shall include at least three (3) references from peers in the same profession 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, ethical character, 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 work with others, practice medicine or the privileges recommended, and any other factors as may be requested.
- (f) Every initial application for staff appointment must contain a request for the specific Clinical Privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references and other relevant information, including an appraisal by the Chief of each clinical Service in which such Privileges are sought. The applicant shall have the burden of establishing both qualifications and competency in the Clinical Privileges requested.
- (g) The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, 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), omitting material information necessary for a full picture of the applicant's professional history or failing to facilitate the release of pertinent information shall be a basis for denial of Membership on or removal from the Medical Staff.
- (h) The applicant shall sign and submit along with the completed application such other consents, authorizations and releases as may be required for the proper evaluation of the applicant's qualifications for Membership.
- (i) The application form shall include a statement that the applicant 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 and applicable policies of the Medical Staff, and agrees to be bound by their terms if granted Membership and/or Clinical Privileges, and to be bound by their terms without regard to whether or not he

is granted Membership and/or Clinical Privileges in all matters relating to consideration of his application.

- (j) The completed application shall be presented to the Hospital President who, after collecting the references and other materials deemed pertinent, shall transmit the application and all supporting materials to the Executive Committee. The Hospital is responsible for verifying the information provided, but the applicant has a continuing obligation to facilitate the release of information necessary for verification and evaluation of the applicant's credentials.
- (k) Additional details regarding the applicant's Health Status shall be obtained following a favorable recommendation for appointment by the Executive Committee.

5.3 Effect of Application

- (a) By applying for appointment to the Medical Staff, each applicant:
 - (1) Signifies his willingness to appear and be interviewed in regard to his application;
 - (2) Authorizes Hospital representatives to consult with any members of Medical Staffs of other hospitals and organizations with which the applicant has been associated, as well as with employers, professional review service organizations, others who may have information bearing on the competence, practice patterns, conduct, appropriate utilization of facility resources, character, Health Status and ethical qualifications of the applicant;
 - (3) Consents to and authorizes Hospital representatives to inspect all records and documents that may be material to an evaluation of the applicant's professional qualifications and competence to carry out the Clinical Privileges requested, as well as the applicant's moral and ethical qualifications and Health Status;
 - (4) Releases the Hospital from any liability for the acts performed in connection with evaluating the applicant and his credentials;
 - (5) Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for staff appointment and Clinical Privileges; and
 - (6) Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards and other organizations concerned with provider performance and the quality and efficiency of

patient care with information the Hospital may have concerning him, and releases Hospital representatives from liability for doing so.

- (b) For purposes of this Section, the term “Hospital representative” includes the Governing Body and its committees and members, the Hospital President or his designees; the Medical Staff organization, and all staff committees which have responsibility for collecting or evaluating the applicant’s credentials or acting upon his application; and any authorized representative of any of the foregoing.
- (c) For purposes of these Bylaws, the application shall be considered ready for transmittal to the Chief of each clinical Service in which the applicant seeks Privileges, and to the Executive Committee when all information requested has been provided by the applicant, and all credentials have been verified, to the satisfaction of the Executive Committee, including all supporting reference letters and other supporting documents.

5.4 Appointment Process

- (a) The Hospital President (or throughout this section, his designee) will obtain verifying information from the National Practitioner Data Bank, the appropriate state licensure boards and related sources. The applicant must sign any special releases these agencies may require.
- (b) The applicant shall deliver the completed application to the Hospital President, who shall, in a timely fashion, seek to collect or verify the references, licensure, and other qualification data submitted. The Hospital President shall confirm the validity of the medical license, residency training or other post-graduate education of the applicant, particularly as they apply to the Privileges requested. The Hospital President shall also verify, through references and other sources, that the applicant meets and has established all basic qualifications set forth in these Bylaws. The Hospital President shall promptly notify the applicant of any issues in obtaining the information required, and it shall then be the applicant’s obligation to obtain the required information. If the applicant fails to supply the required information within a reasonable time frame to be defined at the time of notification, the application will be considered withdrawn and will not be processed further unless the applicant provides the information and establishes, to the satisfaction of the Hospital President, that he cannot/could not reasonably obtain the information. When collection and verification are accomplished and all information requested has been provided by the applicant to the satisfaction of the Executive Committee, including all supporting reference letters and other supporting documents, the Hospital President shall transmit the application and all supporting materials to the Chief of each clinical Service in which the applicant seeks Privileges, and to the Executive Committee. The Executive Committee may solicit opinions, comments and general information regarding the applicant from the Medical Staff.
- (c) Within thirty (30) days of receipt of the completed application for Membership and all supporting materials, the Chief of each affected Service shall review the application and supporting materials; conduct a personal interview with the applicant, if deemed

necessary, and transmit to the Executive Committee on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, as to staff category, Service affiliation, Clinical Privileges to be granted and any special conditions to be attached to the appointment. The Chief of Service, at his discretion, may delegate this review to another active Member of the Medical Staff if he feels such a review could be more appropriately accomplished by another staff Member.

- (1) The Chief of Service, or his designee, shall submit a recommendation to the Executive Committee as to whether the applicant should be accepted, deferred or rejected. The recommendation shall be based on the professional competence, character, ability to safely perform the Privileges requested, qualifications and ethical standing.
 - (2) The Chief of Service's recommendation shall include a delineation of Privileges to be extended and any limitations or restrictions. Any recommendations as to limitations or restrictions, if temporary, shall specify the conditions required and time period necessary to remove such limitations or restrictions.
 - (3) When a recommendation to defer is made, the recommendation shall state the basis for deferral and shall specify the date when the application will be recommended for acceptance or rejection.
 - (4) The recommendations of the Service Chief are advisory to the Executive Committee and do not constitute professional review action.
- (d) The Hospital President, the Executive Committee, the Chief of the affected Service or his designee may, at any time, request additional information in connection with the completed application, and the processing of the application shall be suspended for sixty (60) days or until the applicant has provided the information requested or satisfactorily explains his failure to do so, whichever occurs first.
- (e) At its next regular meeting after receipt of the Service Chief reports and recommendations, the Executive Committee shall consider the application, the supporting documentation, the Service Chiefs' reports and all other relevant information and shall:
- (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 Hospital President. Any recommendation to appoint must also specifically recommend the staff category, service affiliation, and Privileges to be granted, which may be qualified by probationary conditions. A recommendation by the Executive Committee to defer for

further consideration or investigation must be followed up within sixty (60) days 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 these Bylaws and given an opportunity either to waive any procedural rights, by accepting the recommendation, or to exercise such review rights as are set forth in the Fair Hearing Plan, as applicable;
 - (4) When the recommendation of the Executive Committee is favorable, additional information regarding the applicant's 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.
 - (a) If the President of the Medical Staff determines that the information may affect the applicant's ability to safely perform the Privileges requested with or without reasonable accommodation, the matter will be referred to the Executive Committee for further investigation and review. Following review, the Executive Committee may recommend affirmation, modification or reversal of its prior recommendation and submit a report to that effect to the Governing Body for action.
 - (b) If the President of the Medical Staff determines that the information does not affect the recommendation, the Executive Committee's recommendation shall be forwarded to the Governing Body for action. This Section shall not preclude referral to the Physician's Health Committee for a recommendation on monitoring or other appropriate action.
 - (5) The recommendations of the Executive Committee shall be reduced to writing and shall include the reasons for, and references in support of, each recommendation as contained in the application and any other documentation considered by it. Any minority views shall also be reduced to writing, supported by reasons and references and shall be transmitted with the Executive Committee report to the Hospital President.
- (f) After the applicant's rights, if any, to hearing and review have been exercised or waived, the Hospital President shall forward the Executive Committee's report, along with the application and supporting materials, to the Governing Body or, if applicable and consistent with Medical Staff policy, to an authorized committee of the Governing Body as set forth in Section 13.6.

- (g) The Governing Body shall at its next regular meeting after receipt of the recommendation of the Executive Committee, or upon its own initiative if the Executive Committee has failed to act on an application:
 - (1) Refer the application back to the Executive Committee, indicating the reasons for such referral back and setting a time limit within which a subsequent recommendation is to be made; or
 - (2) Accept and take final action on the application. If the Governing Body's proposed final action will be contrary to the Executive Committee's recommendation, the Governing Body shall submit the matter to a joint conference of the Executive Committee and the Governing Body for review before making its final decision.
- (h) While the recommendation and the appointment shall be based primarily on professional competence of applicants, the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his patients and patient care needs for additional staff Members with the applicant's skill and training shall also be considerations of the Governing Body in determining Medical Staff Membership. 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) After the Governing Body has made its final decision on the application, the Hospital President shall notify the applicant (by Special Notice), the President of the Medical Staff, and the Chiefs of Service of the decision. A notice of decision to appoint shall include designation of staff category, the Clinical Privileges granted and any special conditions attached to the appointment. Any notice of a decision constituting a professional review action, as defined in the Fair Hearing Plan, shall be accompanied by the reasons therefore and shall set forth the applicant's rights, if any, to hearing and review as detailed in the Fair Hearing Plan.

5.5 Reappointment Process

- (a) The Hospital President will provide each staff Member scheduled for reappointment with a reappointment application form at least ninety (90) days prior to the expiration of the Member's current appointment. Each staff Member who desires reappointment shall, at least sixty (60) days prior to such expiration date, submit his completed reappointment form to the Hospital President. Failure without good cause to return the form shall be deemed a voluntary resignation from the staff and shall result in automatic termination of Membership at the expiration of the Member's current term. A Practitioner whose Membership is so terminated shall be entitled to the procedural rights provided in the Fair Hearing Plan for the sole purpose of determining the issue of good cause.
- (b) To be eligible for reappointment to the Medical Staff of the Hospital, Practitioners must have provided patient care services or had clinical activity at the Hospital in the

preceding two (2) years, or be Members of a group in which Clinical Privileges are obtained for the purpose of providing specialty service cross coverage.

- (c) 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) As applicable, documentation of any health assessment required under state regulations on persons providing direct patient services in the Hospital and reporting of any adverse findings relevant to the applicant's exercise of Clinical Privileges;
 - (7) Current evidence of licensure and DEA registration and of financial responsibility in amounts which are determined by the Governing Body;
 - (8) Any exclusion 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, any 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. Reapplicants must submit a fully completed Background Information Disclosure form with the completed application; 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.
- (d) At least thirty (30) days prior to the last Governing Body meeting prior to expiration of any staff Member's appointment, the Executive Committee shall complete its review of all pertinent information available on each Practitioner applying for reappointment for the purpose of determining its recommendations for reappointment to the Medical Staff and for the granting of Clinical Privileges for the ensuing period and shall transmit its recommendations, in writing, to the Governing Body.
- (e) In arriving at recommendations for reappointment of each Medical Staff Member and the assignment of Privileges, specific consideration shall be given to the Practitioner's professional competency and clinical judgment in the treatment of patients 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; Practitioner-specific data as compared to aggregate data; and morbidity and mortality data, ethics and conduct; Health Status; attendance at Medical Staff meetings and participation in staff affairs; compliance with the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations (including timeliness of medical record completion) and policies; cooperation with Hospital personnel; efficient and economic use of the Hospital's facilities for patients; relations with other staff members; general attitude toward patients, the Hospital and the public, and other information as deemed relevant. The periodic appraisal of the professional activities of each Member of the Medical Staff, as well as periodic appraisal of Health Status will also be considered. 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.

The recommendation of the Chief of each Service in which the applicant for the reappointment will exercise Clinical Privileges shall be considered. The results of the Practitioner's specific information from quality assessment and improvement activities, compared to the aggregate information for the Practitioner's specialty, and the monitoring performed during a term of provisional appointment, if applicable, shall be considered in the appraisal of the applicant's professional performance, judgment, technical and clinical skills.

- (f) Factors considered in the periodic appraisal include, but are not limited to:
 - (1) Number of procedures performed or major diagnoses made;
 - (2) Rates of desirable and undesirable outcomes, such as complications compared with those of others doing similar procedures; and
 - (3) Findings and conclusions of reviews by peers.

- (g) At least thirty (30) days 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 Hospital President, concerning the reappointment or non-reappointment and the continuation or alteration of Privileges for each Member of the Medical Staff scheduled for reappraisal. 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.
- (h) When the recommendation of the Executive Committee constitutes a professional review action, as defined in the Fair Hearing Plan, prior to any referral of the recommendation to the Governing Body for action, the Hospital President shall give the Practitioner Special Notice of the proposed recommendation, and the Practitioner shall be given the opportunity to either exercise procedural rights in accord with the Fair Hearing Plan or to accept the recommendations in Sections 5.4(f) through 5.4(i).
- (i) Thereafter, the procedures provided relating to recommendations on applications for initial appointments shall be followed.

5.6 Modification of Membership Status or Privileges

- (a) 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, Service assignment, or Clinical Privileges by submitting a written request to the Hospital President, subject to the limitations of Section 5.7. Such written request shall be processed in the same manner as provided in Section 5.5 for reappointment.
- (b) 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.
- (c) It shall be the responsibility of all Members of the Medical Staff to bring to the attention of the President of the Medical Staff, their Chief of Service, or the Hospital President, any physical or mental disability that may limit their ability to safely exercise the Clinical Privileges granted them. A review of the individual's status by the Executive Committee shall follow, and the committee may require the individual to submit any required evidence of his current physical and/or mental status, consistent with applicable law.
- (d) If as a result of the Practitioner's self-reporting of a disability, the Executive Committee submits a recommendation for modification of Membership status or Privileges, 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 Fair Hearing Plan, and the notice shall so state. If the Executive Committee recommends modification of Membership status or Privileges due to a Practitioner's disability 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 Fair Hearing Plan.

5.7 Reapplication After Adverse Action

- (a) An applicant who has received a final adverse professional review action regarding appointment, reappointment and/or Clinical Privileges and who did not exercise any of the hearing rights provided in the Fair Hearing 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 Executive Committee as a prerequisite for the Privileges, whichever is longer.
- (b) An applicant who has received a final adverse professional review action regarding appointment, reappointment and/or Clinical Privileges and who exercised some or all of the hearing rights provided in the Fair Hearing 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 two years from the date of final adverse action.
- (c) Any reapplication under this Section 5.7 shall be processed as an initial application, but the applicant shall submit such additional information as the Executive Committee or Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists.
- (d) If the recommendation of the Executive Committee or the action proposed by the Governing Body upon reapplication under Section 5.7(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.

5.8 Leave of Absence and Reappointment

- (a) Any Member of the Medical or Allied Health staffs may request a leave of absence from the Medical Staff for a period of time not to exceed his present term of appointment by submitting a written request to the Executive Committee and the Hospital President. The request shall state the start and anticipated end dates of the leave and the reasons for the leave (such as military duty, additional training, family matters or personal health). The request should be received by the Executive Committee or Hospital President at least two (2) weeks prior to the desired commencement except in emergency circumstances. [
- (b) If the leave of absence was for personal medical reasons, then prior to his return, the Practitioner must submit a report from his attending physician indicating that the Practitioner is physically and/or mentally capable of resuming a hospital practice and exercising the Clinical Privileges requested competently and safely with or without reasonable accommodation. The Practitioner shall also provide such other information as may be requested by the Executive Committee or the Hospital President 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, probation or has been otherwise required by the Hospital, the Practitioner, after completion of the training, must present to the Chief of the applicable Service, and to the Executive Committee, satisfactory evidence that the special education/training corrected the deficiencies in clinical performance. 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) The Practitioner shall be responsible for obtaining coverage for his patients during the leave.
- (e) 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 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 and Privileges shall be considered expired between the time of the expiration of the term in which the leave began and the date of reappointment.
- (f) Subject also to the conditions set forth above for specific types of leave, at the conclusion of a leave of absence, the Practitioner may request reinstatement by filing a written statement with the Chief of the Service involved and the Executive Committee, summarizing any relevant professional activities undertaken during the leave. The request for reinstatement should be filed thirty (30) days before the anticipated end of the leave. The Practitioner may be required to submit such additional information as may be relevant to his request for reinstatement, including interval status information. The Executive Committee and the Chief of Service will review the request. Thereafter, the process for reappointment specified in Sections 5.5(e) through 5.5(i) shall be followed.
- (g) The failure of a Practitioner to return from an approved leave of absence or apply for an extension of the leave shall constitute a resignation from the Medical Staff, and shall not be subject to any hearings or appellate review. A request for Medical Staff Membership subsequently received from a Medical Staff Member so terminated shall be submitted and processed in the manner specified in these Bylaws for applications for reappointments.

5.9 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 Article 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.

5.10 Administrative Denial

The Medical Staff Office may, upon the approval of the Hospital President and Medical Staff President, refuse to process an application for appointment or reappointment to the Medical Staff or for Clinical Privileges without further review, if it determines any of the following: (1) the applicant does not hold a valid Wisconsin license and no such 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 Medical Assistance 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; (5) the applicant has only requested Clinical Privileges: (a) in a field of practice that has been closed pursuant to any Medical Staff development plan adopted by the Hospital or (b) that have been exclusively granted to another Practitioner or group of Practitioners pursuant to a written contract then in effect without notice from either party to the contract of intent to terminate, which contract covers all the Clinical Privileges being requested by the applicant; or (6) has been denied medical staff membership (or denial has been or is being recommended at the MEC level or higher) at any other facility within the Ministry Health Care, Inc. system. Applicants who are administratively denied under this Section do not have a right to a fair hearing under the Fair Hearing Plan, but may submit evidence to the Medical Staff Office to refute the basis for the administrative denial.

ARTICLE 6

PRIVILEGES

6.1 Delineation of Clinical Privileges

- (a) Each Practitioner or other health care professional providing clinical services in the Hospital by virtue of Medical Staff Membership or otherwise shall be entitled to exercise only those Clinical Privileges specifically granted by the Governing Body pursuant to the procedures set forth in these Bylaws, except as provided in Sections 6.2, 6.5 and 6.7 of this Article.

- (b) The Executive Committee shall be responsible for establishing criteria for the granting of clinical privileges at the Hospital. From time to time the Executive Committee will solicit recommendations from the clinical Services and committees of the Medical Staff and the Hospital to establish certain criteria for each position to be recommended by the Executive Committee and the Governing Body for approval.
- (c) Evaluation of Privileges for initial appointment and for new, extended or increased Privileges shall be based upon the applicant's education, specific and relevant training, experience, evidence of physical ability to perform the requested privileges, peer references, professional practice review data from an organization that currently privileges the applicant (if available), demonstrated ability, current licensure, judgment and other relevant information and the recommendation to the Executive Committee by the Chief of each applicable Service. The applicant shall have the burden of establishing his qualifications and competency in the Clinical Privileges requested.
- (d) Periodic redetermination of Clinical Privileges and the increase or curtailment of same shall be based upon the criteria set forth in Section 6.1(c) and the observation of care provided, the Health Status of the individual, 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 individual's participation in the delivery of medical care, including training, experience, current competence and satisfactory exercise of Clinical Privileges on the period first completed. The recommendations of the Chief of each Service in which the applicant for reappointment exercises Clinical Privileges shall also be considered in the periodic redetermination of Clinical Privileges. Whether the individual has actually exercised all the requested Privileges with sufficient frequency since the time of last appointment to indicate current proficiency shall also be a factor in the redetermination process.
- (e) A Practitioner seeking additional surgical Privileges at the Hospital will be required to present documented evidence of training and expertise in the Privileges being sought, as well as serve a surgical probationary period of six (6) months. During this period, the surgical expertise of the Practitioner will be observed by the Chief of Surgery or his designee. Following the probationary period, the Chief of Surgery will forward to the Executive Committee a review of the Practitioner's surgical performance, including information obtained from other sources, if such is available.
- (f) The scope and extent of surgical procedures that each dentist or 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 podiatric and dental 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.

- (g) Dentists and podiatrists may write orders within the scope of their licenses, as limited by applicable law and as consistent with the Medical Staff regulations.
- (h) Privileges granted to Allied Health Professionals shall be based upon the applicant's training, experience, demonstrated competence and judgment. Determination, extension or reduction of further Privileges shall also be based on these criteria, which shall be evaluated by review of the applicant's credentials, direct observation by the active Medical Staff and review of the reports of the committees of the staff.
- (i) All requests for Clinical Privileges shall be processed pursuant to the procedures outlined in Article 5, except that Allied Health Professionals shall not be entitled to the hearing and appellate review rights offered to Practitioners.

6.2 Temporary Privileges

- (a) Upon receipt of an application for Medical Staff Membership from an appropriately licensed Practitioner, the Hospital President may, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant and with the written concurrence of the Chief of the Service concerned or of the President of the Medical Staff, grant temporary admitting and Clinical Privileges for a period of up to one hundred twenty (120) days; but in exercising such Privileges the applicant shall act under the supervision of the Chief of the Service to which he is assigned. The following must be verified before temporary Privileges may be granted under this Section:
 - (1) Current licensure and DEA registration.
 - (2) Adequate malpractice insurance coverage.
 - (3) No history of or current exclusion from participation in any federally-funded health care program.
 - (4) National Practitioner Data Bank query.
 - (5) Current competence and ability to perform the Privileges requested, as evidenced by at least one current peer reference (oral or written).
 - (6) Relevant training or experience.
 - (7) No current or previously successful challenge to licensure or DEA registration.
 - (8) No history of involuntary termination of Medical Staff Membership at another organization.
 - (9) No history of involuntary limitation, reduction, denial or loss of Clinical Privileges.

- (b) Temporary Clinical Privileges may be granted by the Hospital President, on the recommendation of the President of the Medical Staff, for the care of a specific patient to a Practitioner who is not a applicant for Membership when this is necessary to meet an important patient care need in the same manner and upon the same conditions as set forth in Section 6.2(a), provided the Practitioner acknowledges in writing that he has received and read copies of the Medical Staff Bylaws and Rules and Regulations, and that he agrees to be bound by the terms thereof in all matters relating to his temporary Clinical Privileges, except that only items (1) through (5) need to be verified in advance. Such temporary Privileges shall be restricted to not more than forty-five (45) days and not more than two (2) patients, after which the Practitioner shall be required to apply for Membership on the Medical Staff before being allowed to attend additional patients.
- (c) The Hospital President may permit a physician serving as a “locum tenens” for a Member of the Medical Staff to attend patients without applying for Membership on the Medical Staff for a period not to exceed forty-five (45) days providing his credentials have first been approved by the Chief of the Service concerned and by the President of the Medical Staff and the Hospital President, as set forth in Section 6.2(a).
- (d) After receipt of an application for Medical Staff appointment by a physician in a contractual relationship with the Hospital in the emergency department, the Hospital President may grant temporary Privileges for an initial period of not more than one hundred twenty (120) days, providing his credentials have first been approved by the President of the Medical Staff, as set forth in Section 6.2(a).
- (e) Special requirements of supervision and reporting may be imposed by the Chief of the Service concerned on any Practitioner granted temporary Privileges. Temporary Privileges may be immediately terminated by the Hospital President upon notice of any failure by the Practitioner to comply with such special conditions.
- (f) The Hospital President may at any time, upon the recommendation of the Chief of Service concerned or the Executive Committee, terminate a Practitioner’s temporary Privileges effective as of the discharge from the Hospital of the Practitioner’s patient(s) then under his care in the Hospital. Where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the Practitioner, the termination may be imposed by any person entitled to impose a suspension under these Bylaws and the same shall be immediately effective. The Chief of the appropriate Service, 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 terminated Practitioner’s patient(s) until they are discharged from the Hospital. The wishes of the patient(s) shall be considered if feasible in selecting a substitute Practitioner.
- (g) 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 Fair Hearing Plan because of his inability to obtain temporary Privileges or because of any termination, modification or suspension of temporary Privileges.

6.3 Withdrawal of Privileges

Any Member of the staff may voluntarily withdraw any Clinical Privilege at any time upon written notice to the Hospital President and the President of the Medical Staff. Such action, unless the withdrawal occurs during the course of an investigation, as a result of an investigation or corrective action, or in lieu thereof, shall not entitle the Practitioner to any hearing under the Fair Hearing Plan nor require reporting under Section 50.36 of the Wisconsin Statutes or the Health Care Quality Improvement Act.

6.4 Orders From Individuals Without Clinical Privileges or Medical Staff Membership

- (a) The Hospital may accept and execute orders from health care professionals who are not members of the Medical Staff or the Allied Health Professional Staff and who have not been granted any Clinical Privileges at the Hospital only if all the following conditions are met:
 - (1) The order is within the scope of practice, as established by state law, of the ordering professional;
 - (2) The ordering professional provides evidence satisfactory to the Hospital of licensure, certification or registration in accord with state law on the regulation of the individual's profession;
 - (3) The order can be executed within the standards of the applicable discipline under which the order is to be performed without the presence or supervision of the ordering professional;
 - (4) The ordering professional is eligible to receive payment from Medicare and Medicaid and not excluded from any healthcare program funded in whole or in part by the Federal Government; and
 - (5) The ordering professional does not hold himself out to be associated or affiliated with the Hospital or its Medical Staff.
- (b) If upon execution of the order, a significant abnormality, urgent need for treatment or other aberrant result is noted by any Practitioner or Hospital personnel, both the patient and the ordering professional will be notified and advised of the need for follow up.

6.5 Emergency Privileges

In the case of any emergency, any Practitioner, to the degree permitted by his license, and regardless of service affiliation 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.

6.6 Telemedicine

(a) Interpretive Telemedicine Privileges

Applicants based at distant sites whose practice at the Hospital will be limited to Interpretive Telemedicine only may apply for telemedicine Privileges through one of the following mechanisms, as selected by the Executive Committee either for the individual or for a designated class of applicants per policy decision of the Executive Committee:

- (1) If the applicant will be providing the Interpretive Telemedicine services pursuant to a written contract and the services are under the control of a JCAHO-accredited organization, by submission and processing according to these Bylaws of a telemedicine privileges application containing at least the following information (and verification of the information with either the distant JCAHO accredited site or a primary source):
 - (a) Medical Staff status at distant site and scope of clinical Privileges currently held.
 - (b) Wisconsin licensure.
 - (c) Evidence of insurance meeting requirements for applicants for Medical Staff Membership.
 - (d) Existence of any of the events or circumstances outlined in Section 3.2(a)(12).
 - (e) Request for the specific telemedicine Privileges desired.
 - (f) Acknowledgment that the applicant is subject to these Bylaws in all respects in connection with the application for or exercise of clinical Privileges; or
- (2) By submission of the same application required of all other applicants for Medical Staff Membership or Clinical Privileges, to be processed pursuant to the application process described in these Bylaws.

(b) Interactive Telemedicine Privileges

Applicants based at distant sites requesting any form of Interactive Telemedicine Privileges may apply for Privileges through one of the following mechanisms as selected by the Executive Committee either for the individual applicant or for a designated class of applicants per policy decision of the Executive Committee:

- (1) By submission of the same application required of all other applicants for Medical Staff Membership or Clinical Privileges, to be processed pursuant to the application process described in these Bylaws.
- (2) If the applicant is a Member of the Medical Staff of, or has been granted Clinical Privileges at, a distant site that is JCAHO-accredited, by submission of a copy of the most recently completed application for Medical Staff Membership or Clinical Privileges at the distant site, provided the applicant supplies any supplemental information required by the Hospital that is not contained on the distant hospital's form, with the information to be processed pursuant to the application process described in these Bylaws.
- (3) By submission and processing according to these Bylaws of a telemedicine privileges application containing at least the following information (with evidence that the information has been verified by the distant JCAHO-accredited site), along with verification by the JCAHO-accredited distant site that the applicant has been granted, at a minimum, the same privileges being requested at the Hospital as telemedicine privileges:
 - (a) Medical staff status at distant site and scope of Clinical Privileges currently held.
 - (b) Wisconsin licensure.
 - (c) Evidence of insurance meeting requirements for applicants for Medical Staff Membership.
 - (d) Existence of any of the events or circumstances outlined in Section 3.2(a)(12).
 - (e) Request for the specific telemedicine Privileges desired.
 - (f) Acknowledgment that the applicant is subject to the Bylaws in all respects in connection with the application for or exercise of Clinical Privileges.
- (4) In processing requests for Clinical Privileges, the Hospital may rely upon credentialing information obtained and verified in accord with JCAHO standards by a JCAHO-accredited distant site where the applicant currently holds Medical Staff Membership or Clinical Privileges rather than directly obtaining primary source verification of the information supplied by the applicant.
- (5) Applicants for telemedicine Privileges may be assigned to the consulting Medical Staff category or may be granted Clinical Privileges without

Medical Staff Membership and any of the rights, responsibilities and Prerogatives of such Membership.

6.7 Mass Casualty Event Privileges

The Hospital President and the President of the Medical Staff (or in his absence, the vice president) have the authority to grant mass casualty event, or “disaster” Privileges to Practitioners in their individual areas of expertise to assist in times of public health threats and emergencies that involve mass casualties. Privileges will extend for the length of the proclaimed local disaster as determined by relevant authority . Disaster Privileges will be granted in accord with a disaster privileging policy as approved and periodically amended by the Executive Committee. Allied Health Professionals may be assigned disaster responsibilities consistent with policy as approved and periodically amended by the Executive Committee.

6.8 Focused Professional Practice Evaluation

- (a) A period of focused professional practice evaluation shall be implemented in accordance with policy:
 - (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.

6.9 Ongoing Professional Practice Evaluation

- (a) A process of ongoing professional practice evaluation exists to continuously review Practitioners’ 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.

ARTICLE 7

IMMUNITY FROM LIABILITY

- 7.1** The following shall be express conditions to any individual's application or reapplication for, or exercise of, Clinical Privileges and/or Medical Staff Membership at the Hospital:
- (a) Any act, communication, report, recommendation or disclosure, with respect to any Practitioner or other individual, performed or made at the request of an authorized representative of this or any other health care facility for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.
 - (b) This Privilege shall extend to Members of the Medical Staff, the Governing Body, the Hospital's other Practitioners and personnel, including the administrative staff and designated representatives, and to third parties who supply information to or receive information from any one at this Hospital authorized to receive, release, or act upon such information. For the purpose of this Article 7, the term "third parties" means both individuals and organizations from whom information has been requested by or who have received information from an authorized representative of the Hospital (including the governing body and the medical staff), and includes individuals, health care institutions, governmental bodies, 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) Periodic reappraisals for reappointment or Clinical Privileges;
 - (3) Monitoring of Members of the provisional staff or of any other Practitioner or Allied Health Professionals under the monitoring protocol established by the Medical Staff;
 - (4) Corrective action, including suspension;
 - (5) Hearings and appellate reviews;
 - (6) Medical care evaluations;
 - (7) Utilization reviews;
 - (8) Profiles and profile analyses;
 - (9) Malpractice loss prevention; and
 - (10) Other Hospital, service or committee activities related to maintaining quality and efficient patient care and appropriate professional conduct.
- (e) The acts, communications, reports, recommendations and disclosures, referred to in this Article may relate to an individual's professional qualifications, clinical competency, character, conduct, 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 the Governing Body, the Hospital President and their designated representatives from any liability arising from or out of the services performed by the individual being monitored, including, but not limited to, claims of malpractice, negligent supervision, and any other basis. The exercise of Clinical Privileges or performance of any service that is monitored constitutes the individual's acceptance of the terms of this indemnification agreement.
- (g) To reaffirm the immunity intended by this Section, each individual shall, upon request of the Hospital, execute releases acknowledging the immunity and protections set forth in

this Article in favor of the individuals and organizations specified in Section 7.1(b), subject to such requirements, including 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 Article.

- (h) The consents, authorizations, releases, rights, Privileges and immunities provided by Section 5.3 of these Bylaws for the protection of this Hospital's Practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointments, shall also be fully applicable to the activities and procedures covered by this Article. 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 other immunities provided by law and not in limitation of such immunities.

ARTICLE 8

INTERVIEWS, CORRECTIVE ACTION AND HEARING RIGHTS

8.1 Interviews

- (a) When the Executive Committee or the Governing Body is considering initiating a professional review action concerning a Practitioner (other than precautionary suspension) and the Practitioner has not previously been afforded an opportunity for an interview with any preliminary investigating body as to the subject matter forming the basis of the professional review action, the Practitioner shall be afforded an interview with the body initiating the professional review action. Such interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearings. The Practitioner shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of this interview shall be made.
- (b) For the purposes of this Section 8.1, a preliminary investigating body may be a Chief of Service, a committee or committee chair, the Hospital President or any other designees acting in the official capacities who provided information or a recommendation to the Executive Committee or Governing Body upon which the Executive Committee's or Governing Body's professional review action is based.

8.2 Corrective Action

All Medical Staff Members shall be subject to corrective action. The grounds for requesting corrective action, actions that may be taken in response to the request, when the action is deemed adverse and when the Practitioner is entitled to a fair hearing, are set forth in the Fair Hearing Plan. The Executive Committee is the disciplinary body and all requests for corrective action shall be directed to that body in the manner and according to the limits set forth in the Fair Hearing Plan.

8.3 Exceptions

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

8.4 Hearings and Appellate Review

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

8.5 Procedure and Process

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

8.6 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.

ARTICLE 9

OFFICERS

9.1 Officers of the Medical Staff

The Medical Staff shall be governed by one officer who shall be the President of the Medical Staff. The Vice President shall be designated to serve as President of the Medical Staff in the event the President is unavailable or unable to serve for any reason.

9.2 Qualifications

The President of the Medical Staff must be a physician Member of the active or associate Medical Staff at the time of nomination and election, and must be and remain a Member in good standing during his term of office. Failure to maintain such status shall immediately create a vacancy in the office. The President shall be a physician with demonstrated competence in his field of practice and demonstrated qualifications on the basis of experience and ability to direct the medico-administrative aspects of Hospital and Medical Staff activities.

9.3 Nomination and Election of President

- (a) At the regular staff meeting immediately preceding the annual staff meeting, the President of the Medical Staff shall appoint a nominating committee comprised of Members of the active Medical Staff. The Hospital President shall be an Ex-Officio Member of the nominating committee.
- (b) The nominating committee shall present one or more nominees for the office to the Medical Staff at the annual meeting. Nominations from the floor will also be accepted provided each nomination receives at least two (2) seconds and the individual nominated indicates a willingness to serve if elected.
- (c) Elections shall occur at the annual meeting. Only Members of the Active and Associate Medical Staff shall be eligible to vote. Voting will be by secret written ballot and voting by written proxy will be permitted. 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. If there are more than two (2) candidates for the office and none receives a majority on the first ballot, a runoff election will immediately be held between the two (2) candidates receiving the highest number of votes.

9.4 Term of Office

The President shall take office on the first day of the Medical Staff Year after election and shall serve a one year term from their election date or until a successor is elected unless sooner removed.

9.5 Vacancies in Office

Vacancies in office during the Medical Staff Year shall be filled by a special election conducted as soon as practicable after notice of the vacancy. Pending the outcome of the special election, the Vice President shall serve out the remaining term.

9.6 Removal of President

The Medical Staff may remove the President of the Medical Staff by a two thirds majority of the Members of the active and associate Medical Staff eligible to vote. Permissible bases for removal include, without limitations, failure to continuously meet the qualifications for office and failure to timely and appropriately perform the duties of the office held as described in these Bylaws.

9.7 Duties

- (a) The President shall serve as the chief administrative officer of the Medical Staff and as the chief medical officer of the Hospital and shall:
 - (1) Act in coordination and cooperation with the Hospital President 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 the Medical Staff Bylaws, Rules and Regulations and policies, for implementation of sanctions where these are indicated for non-compliance, for presentation to the Executive Committee in those instances where corrective action may be recommended to the Governing Body and for compliance with the procedural requirements set forth in these Bylaws and the Fair Hearing Plan;
 - (4) Appoint Service Chiefs, a Quality Officer, Vice President and a sufficient number of at-large members to achieve a seven (7) member Medical Executive Committee and, unless otherwise expressly provided, appoint committee members to all standing, special and multi-disciplinary Medical Staff committees.
 - (5) Serve on the Executive Committee of the Medical Staff as its chairman;
 - (6) Serve as Ex-Officio member of all other Medical Staff committees;
 - (7) Represent the views, policies, needs and grievances of the Medical Staff to the Governing Body and Hospital President;
 - (8) 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 and efficiency in its designated responsibility to provide medical care;

- (9) Be responsible for the educational activities of the Medical Staff, subject to the policies of the Governing Body;
 - (10) Be the spokesman for the Medical Staff in its external professional and public relations, or designate another physician to act in that capacity; and
 - (11) Resolve disputes and address concerns between Medical Staff Members, Allied Health Professionals and Hospital staff in consultation with Administration.
 - (12) Perform such other functions as may from time to time be delegated by the Medical Staff or the Governing Body.
 - (13) Cause proper notice to be given of all staff meetings on order of the appropriate authority.
 - (14) Ensure the preparation of accurate and complete minutes of all meetings.
 - (15) Supervise the collection and account for any funds that may be collected in the form of staff dues, assessments or application fees.
 - (16) Ensure, with the Hospital President, 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.
- (b) In the temporary absence of the President and the Vice President, the chain of command shall be as follows:
- (1) Chief of Medicine;
 - (2) Chief of Surgery; and
 - (3) Chief of Emergency Services.

ARTICLE 10

CLINICAL SERVICES

10.1 Organization of Services

There shall be Services of medicine, surgery, and emergency medicine. Each Service shall be headed by a Chief of Service and shall function under the Executive Committee.

When appropriate, the Executive Committee and the Governing Body, by their joint action, may create, eliminate, subdivide or combine the clinical services or may reorganize the staff into a departmental structure.

10.2 Qualifications, Selection and Tenure of Service Chiefs

- (a) Each Service Chief shall be a Member of the active Medical Staff, qualified by training, experience and demonstrated ability for the position, with demonstrated ability in the Service's clinical area, and be willing and able to faithfully discharge the functions of Service Chief.
- (b) Each Chief shall be selected by the President of the Medical Staff subject to the approval of the Governing Body. The term of office shall be for one Medical Staff Year or until a successor is appointed unless the Chief sooner resigns or is removed from office. A Service Chief shall be eligible to succeed himself.
- (c) Removal of a Chief during his term of office may be initiated by a two thirds majority vote of either all active staff Members of the respective Service, by the Executive Committee or by the Governing Body, but no such removal shall be effective unless and until it has been ratified by the Executive Committee and by the Governing Body. Bases for removal include, without limitation, failure to timely and appropriately perform the functions of a Service Chief.
- (d) In the event of a vacancy in the position of Service Chief, a successor shall be selected and appointed pursuant to the process set forth in these Bylaws for selection of a Service Chief.

10.2 Functions of Service Chiefs

Each Chief of a Service shall:

- (a) Be accountable for all clinically related activities of the Service to Executive Committee, and all administrative activities of the Service to the Hospital President; represent the Service in a medical advisory capacity to administration and the Governing Body.
- (b) Give guidance to the Executive Committee on the overall medical policies of the Hospital and make specific recommendations and suggestions regarding the Service, including formulation of special rules and policies of the Service, in order to assure quality patient care.
- (c) Maintain continuing review of the professional performance of all individuals with Clinical Privileges in the Service, maintain aggregate information by specialty and regularly report to the Executive Committee and the quality and assessment and improvement programs as appropriate.
- (d) 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 Service.

- (e) Be responsible for enforcement of the Hospital Bylaws and of the Medical Staff Bylaws, Rules and Regulations and policies within the Service and Allied Health Professionals in the Service.
- (f) Be responsible for implementation within the Service of actions taken by the Executive Committee, by the Medical Staff and by the Governing Body.
- (g) Transmit to the Executive Committee his recommendations concerning the staff classification, reappointment, and delineation of Clinical Privileges for all individuals in the Service.
- (h) Be responsible for orientation, teaching, education and any research program in the Service.
- (i) Participate in every phase of administration of the Service through cooperation with the nursing Service and the Hospital Administration in matters affecting patient care, including personnel, supplies, equipment, special regulations, standing orders and techniques.
- (j) Assist in the preparation of such annual reports, including budgetary planning pertaining to the Service, as may be required by the Executive Committee, the Hospital President or the Governing Body.
- (k) Appoint such committees as are necessary to fulfill the functions of the Service as specified in Section 10.3.
- (l) Participate in initiating and investigating requests for corrective action as appropriate for individuals in the Service.
- (m) Maintain quality control programs, including oversight of the quality of medical records, as appropriate.
- (n) Recommend space and other resources needed by the Service.
- (o) Recommend to the Executive Committee the criteria for Clinical Privileges that are relevant to care provided in the Service.
- (p) Assess and recommend to Administration off-site sources for needed patient care, treatment, and services not provided by the Hospital.
- (q) Be responsible for the integration of the Service into the Hospital's primary functions.
- (r) Formulate recommendations as to the sufficient number of qualified and competent persons to provide patient care, treatment, and services in the Service.
- (s) Be accountable for the continuous assessment and improvement of the quality of care, treatment, and services in the Service.

- (t) Arrange and implement inpatient and outpatient programs.
- (u) 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 Medical Staff, the Executive Committee or the Governing Body.

10.3 Functions of Clinical Services

The primary responsibility delegated to each clinical Service is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Service. Clinical Services, whether acting through their Service Chiefs, subcommittees, or as a whole, 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 Service records and proceedings are intended to apply to all activities of the Service relating to improving the quality of health care and include activities of the individual Members of the Service as well as other individuals designated by the Service Chief to assist in carrying out the duties and responsibilities of the Service including, but not limited to, participating in monitoring plans. Most functions of the clinical Services can be accomplished by the Service Chiefs, as coordinated through the Executive Committee, at the Executive Committee's regular meetings. To carry out this responsibility, each Service, acting through its Service Chief or such subcommittee as the Service Chief may appoint, shall:

- (a) conduct retrospective patient care reviews for the purpose of analyzing, reviewing and evaluating the quality of care within the Service, using selected completed records of discharged patients and other pertinent sources of medical data relating to patient care. Each Service Chief 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 Service 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. The number of such reviews to be conducted during the years shall be as determined by the Executive Committee, but shall not be less than any number required by the Joint Commission or by law, whichever is higher. Each Service shall review all clinical work performed under its jurisdiction whether or not any particular Practitioner whose work is subject to such review is a Member of that Service, except that the clinical work of the Service Chief shall be reviewed by another Member of the Service or by a Practitioner selected for this purpose by the Executive Committee.
- (b) establish guidelines for the granting of Clinical Privileges and the performance of specified services within the Service and submit recommendations regarding classifications, the reappointment and delineation of Clinical Privileges each staff

Member or applicant in the Service may exercise and the specified services each Allied Health Professional in the Service may provide.

- (c) conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and to findings of review, evaluation and monitoring activities.
- (d) formulate policies relating to the functions of the Service. Such policies shall be effective after approval by the Executive Committee and the Governing Body.
- (e) monitor, on a continuing and concurrent basis, adherence to staff and Hospital policies and procedures; requirements for alternate coverage and for consultations; sound principles of clinical practice; and fire and other regulations designed to promote patient safety.
- (f) coordinate the patient care provided by the Service's Members with nursing and ancillary patient care services and with administrative support services.
- (g) report to the Executive Committee on a regularly scheduled basis concerning:
(1) findings of the Service's review, evaluation and monitoring activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving care; and (3) such other matters as may be requested from time to time by the Executive Committee.
- (h) provide updates to its Members on the results of the Service's review, evaluation and monitoring activities and of reports on other Service and staff functions.
- (i) establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

10.4 Assignment to Clinical Services

Each Member of the staff and each Allied Health Professional shall be assigned to at least one clinical Service for purposes of participating in the required functions of the Services and of the Medical Staff or Allied Health Professional Staff, but may be granted Membership and/or Clinical Privileges or specified services in one or more of the other Services. Assignment shall be made by the Governing Body on the recommendation of the Executive Committee. The exercise of Clinical Privileges or the performance of specified services within any Service shall be subject to the Rules, Regulations and policies of the Hospital and of that Service and the authority of the Service Chief.

ARTICLE 11

COMMITTEES

11.1 Executive Committee

- (a) **Composition.** The Executive Committee shall consist of the President of the Medical Staff, Vice President, Quality Officer and the Chiefs of the medicine, surgery, and emergency services and one at large active or associate Medical Staff member. The immediate past President of the Medical Staff may serve as a voting Ex-Officio member. The Hospital President shall be an Ex-Officio member without vote, and other administrative representatives may attend with the permission of the voting members. The Executive Committee is empowered to act on behalf of the Medical Staff, and to coordinate the activities and general policies of the various clinical Services as indicated by these Medical Staff Bylaws. Committee members may be removed by the Hospital President or the Governing Body. Permissible bases for removal may include but are not limited to loss of good standing, failure to appropriately discharge committee responsibilities, and the committee member's request to resign from the committee.
- (b) The Executive Committee is 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 committee records and proceedings are intended to apply to all activities of the committee relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans.
- (c) **Duties.** The duties of the Executive Committee shall be:
- (1) 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;
 - (2) to be regularly involved in Medical Staff management including the enforcement of Medical Staff Rules and Regulations, policies, and committee and Service affairs;
 - (3) to coordinate the activities and general policies of the various clinical Services as required;
 - (4) to receive and act upon reports and recommendations from the Service Chiefs and the President of the Medical Staff;
 - (5) to create, adopt, and implement Rules and Regulations and policies of the Medical Staff not otherwise the responsibility of clinical Service personnel

and to recommend such to the Governing Body for approval and implementation;

- (6) 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;
- (7) to provide liaison between Medical Staff, the Hospital President and the Governing Body;
- (8) to recommend action to the Hospital President on matters of a medico-administrative nature;
- (9) to make recommendations on Hospital management matters to the Governing Body, including long range planning;
- (10) 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, 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;
- (11) to ensure that the Medical Staff is kept abreast of the accreditation status of the Hospital;
- (12) 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;
- (13) to report at each general staff meeting;
- (14) to investigate and review the credentials of all applicants and to make recommendations for Medical Staff Membership, Allied Health Professional status, assignment to Services, and delineation of Clinical Privileges;
- (15) to review periodically all information available regarding the performance and clinical competence of Medical Staff Members and others with Clinical Privileges and to make recommendations for reappointment;
- (16) to consider and approve amendments to the Medical Staff Rules and Regulations and Medical Staff policy, as necessary for the proper conduct of the Medical Staff;
- (17) to review and approve Service Rules, Regulations and policies, subject to the approval of the Governing Body;

- (18) to be responsible for making recommendations to the Governing Body relating to the structure of the Medical Staff; the mechanisms 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;
 - (19) to have overall responsibility for all Medical Staff accreditation policies and procedures. Specific functions of this responsibility may be delegated to appropriate Medical Staff Members and committees; and
 - (20) to perform such other functions as may from time to time be delegated by the Medical Staff or Governing Body.
- (d) **Meetings.** The Executive Committee shall meet prior to each Medical Staff meeting and otherwise as deemed necessary by the Hospital or Medical Staff President, and shall maintain a permanent record of its proceedings and actions.

11.2 Staff Functions

Provision shall be made in these Bylaws, or by resolution of the Executive Committee approved by the Governing Body through assignment to the clinical Services to Service Chiefs or other Medical Staff Members expressly selected to carry out a specified function, to staff committees, to the staff as a whole or to multidisciplinary Hospital committees, for the effective discharge of the staff functions specified in this Section 11.2 and described in Section 11.3, of all other staff functions required by these Bylaws, and of such other staff functions as the Executive Committee or the Governing Body shall reasonably require:

- (a) Conduct, coordinate and review patient care audit and monitoring activities, including tissue, blood usage and drug usage reviews and analysis of autopsy reports.
- (b) Conduct, coordinate and review, or oversee the conduct of, utilization review activities.
- (c) Conduct, coordinate and review credentials investigations and recommendations regarding staff Membership and grants of Clinical Privileges and specified services.
- (d) Monitor and evaluate care provided in and develop clinical policy for: special care areas, such as intensive or coronary care units; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, home care, and other ambulatory care services.
- (e) Provide continuing education opportunities responsive to quality activity findings, new state-of-the-art developments and other perceived needs, and supervise the Hospital's professional library services.

- (f) Review the completeness, timeliness and clinical pertinence of patient medical and related records.
- (g) Develop and maintain surveillance over drug utilization policies and practices.
- (h) Prevent, investigate and control hospital-acquired infections and monitor the Hospital's infection control program.
- (i) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community.
- (j) Supervise and train medical students and graduate trainees.
- (k) Direct staff organizational activities, including Medical Staff Bylaws review and revision, officer and committee nominations, liaison with the Governing Body and Hospital Administration, and review and maintenance of Hospital accreditation.
- (l) Coordinate the care provided by Practitioners with the care provided by the nursing Service and with the activities of other Hospital patient care and administrative services.
- (m) Recommend to the Governing Body all matters relating to appointments, reappointments, staff category, Service assignments, Clinical Privileges and corrective action.

11.3 Description of Functions

- (a) **Quality Assessment and Improvement Functions.** Any committee involved in quality assessment and improvement activities is organized and operated as a part of the Hospital's overall program 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 committee records and proceedings are intended to apply to all activities of the committee relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans. The duties involved in conducting, coordinating and reviewing patient care audit and monitoring programs are to:
 - (1) adopt, subject to the approval of the Governing Body, specific programs and procedures for reviewing, evaluating and maintaining the quality and efficiency of patient care within the Hospital, including at least mechanisms for: (1) establishing objective criteria; (2) measuring actual practice against the criteria; (3) analyzing practice variations from criteria by peers; (4) taking appropriate action to correct identified problems and to improve the quality of patient care; (5) following up on action taken; and (6) reporting the findings and results of the audit activity to the Medical Staff, the Hospital President and the Governing Body;

- (2) review and act upon, on a regular basis, factors affecting the quality and efficiency of patient care provided in the Hospital, including tissue, mortality, drug usage and blood usage studies;
- (3) coordinate the findings and results of: Service, committee and staff audit procedures; Hospital utilization review activities; continuing education activities; review of medical record completeness, timeliness, and clinical pertinence; and other staff activities designed to monitor patient care practices; and
- (4) submit monthly reports to the Executive Committee on the overall quality and efficiency of medical care provided in the Hospital and on the Service, committee and staff patient care audit, utilization review, and other quality review, evaluation and monitoring activities.

(b) **Utilization Review Function.** The duties involved in conducting or overseeing the utilization review function are developed to help improve the quality of health care in the Hospital and such 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 and proceedings are intended to apply to all activities of the committee relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans. These duties include:

- (1) develop a utilization review plan that is appropriate to the Hospital and that meets the requirements of law. Such a plan must include provision for at least: (1) review of admissions and of continued Hospital stay; (2) review of cost and stay duration outlier cases; (3) discharge planning; and (4) data collection and reporting;
- (2) require that the utilization review plan is in effect, known to the staff Members and functioning at all times; and
- (3) conduct such studies, take such actions, submit such reports and make such recommendations as are required by the utilization review plan.

(c) **Credentials Function.** The duties involved in conducting, coordinating and reviewing credentials are developed to help improve the quality of health care in the Hospital and such 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 and proceedings are intended to apply to all activities of the committee relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in

carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans. These duties include:

- (1) review and evaluate the qualifications of each applicant for initial appointment, reappointment, and modification of appointment and for Clinical Privileges, and in connection therewith to obtain and consider the recommendations of the appropriate Services, and to obtain and consider relevant patient care audit information. Investigate the credentials of all applicants for Membership, as well as any who assist or provide services to patients and to make recommendations in compliance with Article 5 of these Bylaws;
 - (2) submit reports, in accordance with Article 5 and Article 6, on the qualifications of each applicant for staff Membership or particular Clinical Privileges. Such reports shall include recommendations with respect to appointment, staff category, clinical Service affiliation, Clinical Privileges or specified services, and special conditions attached thereto;
 - (3) investigate, review and report on matters, including the clinical or ethical conduct of any Practitioner or AHP, assigned or referred by: (1) the President of the Medical Staff; (2) the Executive Committee, (3) the Governing Body, or (4) those responsible, respectively, for the functions described in Sections (a) and (b); and
 - (4) submit reports monthly to the Executive Committee on the status of pending applications, including the specific reasons for any inordinate delay in processing an application or request.
- (d) **Continuing Education and Library Function.** The duties involved in organizing continuing education programs and supervising the Hospital's professional library services are to:
- (1) develop and plan, or participate in, programs of continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to audit findings;
 - (2) evaluate, through the patient care audit function, the effectiveness of the educational programs developed and implemented;
 - (3) analyze, on a continuing basis, the Hospital's and staff's needs for professional library services;
 - (4) act upon continuing education recommendations from the Executive Committee, the Services, the staff, or committees responsible for patient care audit and other quality review, evaluation and monitoring functions; and

- (5) maintain a record of education activities and submit periodic reports to the Executive Committee concerning these activities, specifically including their relationship to the findings of the patient care audit and other quality review, evaluation and monitoring functions;
- (e) **Medical Records Function.** The duties involved in reviewing the completeness, timeliness and clinical pertinence of patient medical records are developed to help improve the quality of health care in the Hospital and such 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 and proceedings are intended to apply to all activities of the committee relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans. These duties include:
- (1) review and evaluate medical records to determine that they: (1) properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken; and (2) are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Hospital;
 - (2) review staff and Hospital policies, rules and regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage, security, destruction and availability and recommend methods of enforcement thereof and changes therein;
 - (3) act upon recommendations concerning medical records from the Executive Committee, the Services, and other committees responsible for patient care audit and other quality review, evaluation and monitoring functions;
 - (4) provide liaison with Hospital Administration and the medical records professionals in the employ of the Hospital on matters relating to medical records practices; and
 - (5) maintain a record of all actions taken and submit periodic reports and recommendations to the Executive Committee concerning medical records practices in the Hospital.
- (f) **Pharmacy and Therapeutics Function.** The Medical Staff shall appropriately participate in the maintenance and improvement of high professional standards through the Hospital by participating on committees which address pharmacy and therapeutics functions. These functions relate to the safety of and the quality of care rendered to patients, as 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 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 and proceedings, are intended to apply to all activities of the committee and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including but not limited to participating in monitoring plans. The duties involved in developing and maintaining surveillance over drug utilization policies and practices are delegated to the Ministry Pharmacy and Therapeutics Committee.

Ministry Pharmacy and Therapeutics Committee:

- (1) Membership shall be appointed under the direction of the Medical Executive Committee and consist of Medical Staff representing different specialties of practice, and one or more Ministry hospitals or Ministry Medical Group (MMG). Membership will include representatives of pharmacy, nursing service, and administration. A Hospital pharmacist shall act as secretary for the committee. Appointed physicians are voting members on the committee.
- (2) The Ministry Pharmacy and Therapeutics Committee shall:
 - (a) Be responsible for the development and maintenance of a formulary and policies and procedures regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety and all other matters relating to drugs in the Hospital in order to assure optimum clinical results and a minimum potential for hazard.
 - (b) Perform regular review of adverse drug reactions reported to have occurred to hospitalized patients, which includes ongoing monitoring and process improvement activities, to reduce medication errors and adverse medication events.
 - (c) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;
 - (d) Perform such other duties as assigned by the president of the Medical Staff or the Executive Committee; and
 - (e) Meet at least bimonthly and maintain a record of all activities relating to the pharmacy and therapeutics function and submit periodic reports and recommendations to the Executive Committee concerning drug utilization policies and practices in the Hospital.
- (g) **Infection Control Function.** The Medical Staff shall appropriately participate in the maintenance and improvement of high professional standards through the Hospital by participating on committees which address infection control functions and that include representatives from nursing, laboratory and administration. These functions relate to the safety of and the quality of care rendered to patients,

as 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 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 and proceedings, are intended to apply to all activities of the committee and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans. The duties involved in preventing, investigating, and controlling hospital-acquired infections are to:

- (6) maintain surveillance over the Hospital infection control program;
 - (7) develop a system for reporting, identifying and analyzing the incidence and cause of all infections;
 - (8) develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;
 - (9) develop, evaluate, review and revise preventive, surveillance and control policies and procedures relating to all phases of the Hospital's activities, including: operating room, delivery rooms, special care units; central service, housekeeping, and laundry; sterilization and disinfection procedures by heat, chemicals, or otherwise; isolation procedures; prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious material; food sanitation and waste management; and other situations as requested;
 - (10) coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics;
 - (11) act upon recommendations related to infection control received from the President of the Medical Staff, the Executive Committee, the Services and other staff and Hospital committees;
 - (12) maintain a record of all activities relating to infection control and submit periodic reports thereon to the Executive Committee and to the Hospital President; and.
 - (13) annually review infection control policies, procedures, systems and techniques.
- (f) **Disaster Planning Function.** The duties involved in planning to provide appropriate response to and the protection and care of Hospital patients and others at the time of internal and external disasters are to:

- (1) develop and periodically review, in cooperation with the Hospital Administration, a written plan designed to safeguard patients at the time of an internal disaster and require that all key personnel rehearse fire and other internal types of disaster drills at least four times a year for each shift; and
 - (2) develop and periodically review, in cooperation with Hospital Administration, a written plan for the care, reception and evacuation of mass casualties, and assure that such plan is coordinated with the inpatient and outpatient services of the Hospital, that it adequately relates to other available resources in the community and coordinates the Hospital's role with other agencies in the event of disasters in the Hospital and nearby communities, and that the plan is rehearsed by all personnel involved at least twice yearly.
- (g) **Bylaws Review and Revision Function.** The duties involved in maintaining appropriate Bylaws and other organizational documents pertaining to the Medical Staff are to:
- (1) periodically review the Bylaws and the rules, regulations, procedures, and forms promulgated in connection therewith; and
 - (2) submit recommendations to the Executive Committee and to the Governing Body for changes in these documents consistent with the process described herein.
- (h) **Tissue and Transfusion Function.** The Medical Staff shall appropriately participate in the maintenance and improvement of high professional standards through the Hospital by participating on committees which address tissue and transfusion functions. These functions relate to the safety of and the quality of care rendered to patients, as 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 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 and proceedings, are intended to apply to all activities of the committee and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans. The duties involved in the tissue and transfusion function are to:
- (1) review all tissue resulting from surgical procedures and all transfusions performed and to determine whether the procedures were justified and the transfusions required;
 - (2) make recommendations to the various Members of the Medical Staff concerning the findings with regards to appropriate or inappropriate tissues and appropriate or inappropriate transfusions; and submit to the Medical Staff, a report of the findings of the tissue and transfusion review.

11.4 Participation on Multidisciplinary Hospital Committees

The Medical Staff shall appropriately participate in the maintenance and improvement of professional standards throughout the Hospital by maintaining physician, podiatric and dental representation on all multidisciplinary committees which relate to the safety of and the quality of care rendered to patients, as part of the Hospital's program organized and operated to help improve the quality of health care. 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 and proceedings, are intended to apply to all activities of the committee and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans. Appointment of Medical Staff Members to any Hospital committees shall be made and such committees shall operate in accordance with the Hospital corporate bylaws and the written policies of the Hospital and of the Medical Staff.

11.5 Performance of Functions

The Executive Committee shall perform those functions and responsibilities delegated to the Medical Staff that are not assigned by the Executive Committee to a particular standing or special committee, to the clinical Services or to a designated Medical Staff Member and those functions and responsibilities assigned to a named Medical Staff committee where no such committee exists. The Medical Staff shall appropriately participate in the maintenance and improvement of high professional standards throughout the Hospital by participation on the committee of the whole, as part of the Hospital's program organized and operated to help improve the quality of health care. 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 and proceedings, are intended to apply to all activities of the committee and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans.

11.6 Standing Committees of the Medical Staff

- (a) **Composition and Appointment.** A staff committee established to perform one or more of the staff functions required by these Bylaws shall be composed of Members of the active, associate and provisional staffs and may include where appropriate, Allied Health Professionals and representation from Hospital Administration, nursing Service, medical records Service, pharmaceutical Service, social Service, Hospital Governing Body and such other Hospital departments as are appropriate to the function(s) to be discharged. Standing committees which are part 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 and proceedings are intended to apply to all activities of the committee relating to improving the quality of health care and include activities of the individual members of the committee as well as other individuals designated by the committee to assist in carrying out the duties and responsibilities of the committee including, but not limited to, participating in monitoring plans. Unless otherwise specifically provided, the Medical Staff Members shall be appointed by the President of the Medical Staff, and the administrative staff members shall be appointed by the Hospital President. Each committee, shall, with the approval of the Executive Committee select its chairman and secretary where the same are not provided for in these Bylaws. The President of the Medical Staff and the Hospital President, or their respective designees, shall serve as Ex-Officio members without vote on all committees, unless otherwise expressly provided.

- (b) **Term and Prior Removal.** Unless otherwise specifically provided, a Medical Staff committee member shall continue as such until the end of the Medical Staff Year and until his successor is elected or appointed, unless he shall sooner resign or be removed from the committee. A Medical Staff committee member, other than one serving Ex-Officio, may be removed by a majority vote of the Executive Committee. An administrative staff committee member shall serve for a term equivalent to that of a Medical Staff committee member and until his successor is elected or appointed, unless he shall sooner resign or be removed from the committee. An administrative staff committee member may be removed by action of the Hospital President.
- (c) **Vacancies.** Unless otherwise specifically provided, vacancies on any staff committee shall be filled in the same manner in which the original appointment to such committee is made.
- (d) **Meetings.** A staff committee established by resolution to perform one or more of the staff functions required by these Bylaws shall meet as often as directed in the resolution.

11.7 Physicians' Health Committee

- (a) **Composition.** The Physicians' Health Committee shall consist of no fewer than three Members of the Medical Executive Committee representing, where practicable, various specialties. Long term service on the Committee is encouraged so as to provide continuity and development of expertise. Appointments are made by the President of the Medical Staff in consultation with the Hospital President and the Executive Committee.
- (b) **Purpose.** The Committee will provide identification and management of individual Practitioner health issues, separate from the Medical Staff disciplinary function, and to assist in the recognition and evaluation of issues of health and well-being or impairment of Members of the Medical Staff.

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

- (c) **Meetings.** The Committee will meet twice per year and as necessary to fulfill its functions, at the call of its chair.
- (d) **Responsibilities.** The Committee's responsibilities and procedures are covered in further detail in the Medical Staff policy on the Physicians' Health Committee.

11.8 Special Committees

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 Staffs' responsibility for assuring optimum patient care in the Hospital, and may provide for Medical Staff representation thereon. The President of the Medical Staff or Executive Committee may also assign new functions to one or more selected Medical Staff Members, to existing committees, or make certain functions the responsibility of the Medical Staff as a whole. The President of the Medical Staff shall appoint Members of the Medical Staff to special committees established by the Executive Committee.

ARTICLE 12

MEETINGS

12.1 General Staff Meetings

- (a) **Regular Meetings.** Regular meetings of the staff shall be held at least quarterly. The regular staff meeting immediately prior to the end of each Medical Staff Year, which shall coincide with the Hospital Fiscal Year (October – September) shall be designated as the annual staff meeting.
- (b) **Order of Business and Agenda.** The order of business at a regular meeting shall be determined by the President of the Medical Staff. The agenda shall include at least:
 - (1) Acceptance of the minutes of the last regular and of all special meetings;
 - (2) Administrative reports from the Hospital President, President of the Medical Staff, and Services and committees;

- (3) The election of officers, when required by these Bylaws;
 - (4) Reports by responsible officers, committees and Services on the overall results of patient care audit and other quality review, evaluation and monitoring activities of the staff and on the fulfillment of other required staff functions;
 - (5) Recommendations for improving patient care within the Hospital; and
 - (6) New business.
- (c) **Special Meetings.** Special meetings of the Medical Staff may be called at any time by the Governing Body, the President of the Medical Staff, the Executive Committee or at the written request of not less than four (4) Members of the active or associate staff and shall be held at the Hospital at the time designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

12.2 Committee and Clinical Service Meetings

- (a) **Regular Meetings.** Committees and Services may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings, if set forth in these Bylaws, shall be as required by these Bylaws.
- (b) **Special Meetings.** A special meeting of any committee or Service may be called by, or at the request of, the chairman or Chief thereof, the Governing Body or the President of the Medical Staff. No business shall be transacted at any special meeting except that stated in the meeting notice.
- (c) **Meetings Called by Service Members.** A special meeting of a Service shall be called by the Service Chief upon receipt of a petition for a special meeting stating the purpose of the meeting and signed by at least one-third of the active Medical Staff Members assigned to that Service.

12.3 Notice of Meetings

- (a) Written notice of the time and place of all meetings, other than those set by resolution for which no additional notice is required, shall be:
 - (1) delivered either personally or by mail to each person entitled to be present; or
 - (2) posted and each person entitled to be present shall be informed of the meeting by telephone not less than forty-eight (48) hours before the date of such meeting.
 - (3) By electronic mail provided that receipt verification can be determined/recorded by the sender.

If mailed, the notice of the meeting shall be deemed delivered seventy-two (72) hours after deposit, postage prepaid, in the United States mail addressed to the person entitled to the notice at his address as it appears on the records of the Hospital.

- (b) Personal attendance at a meeting shall constitute a waiver of notice of meeting.

12.4 Quorum

- (a) **General Staff Meeting.** The presence of 50% of the voting Members of the active and associate Medical Staff at any regular or special meeting shall constitute a quorum for the purpose of transaction of business.
- (b) **Clinical Service and Committee Meetings.** 50% of the voting members of a Service or committee, but not less than three (3) members, one (1) member being a physician, shall constitute a quorum at any meeting of such Service or committee.

12.5 Manner of Action

Except as otherwise specified, the action of a majority of the members eligible to vote who are present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a Service or committee by a writing setting forth the action taken and signed by each member entitled to vote.

12.6 Minutes

Minutes of all meetings shall be prepared by the President of the meeting or his designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the Executive Committee and made available to the staff. A permanent file of the minutes of each meeting shall be maintained.

12.7 Attendance Requirement

- (a) **Regular Attendance.** Attendance records shall be kept of Medical Staff Meetings. Each Member of a staff category required to attend meetings under Article 4 shall be required to attend:
 - (1) at least 50% of all general Medical Staff meetings duly convened pursuant to these Bylaws; and
 - (2) at least 50% of all meetings of each Service and committee of which he is a member.
- (b) **Absence from Meetings.** Any Member who is compelled to be absent from any Medical Staff, Service or committee meeting shall promptly provide the reason for such absence to the regular presiding officer. Unless excused for good cause, failure to meet the attendance requirements of Section (a) may be grounds for corrective action,

including, without limitation, removal from such Service or committee or the Medical Staff. Reinstatement of a staff Member whose Membership has been revoked because of absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for reappointment.

- (c) **Special Appearance.** A Practitioner whose patient's clinical course of treatment is scheduled for discussion at a regular committee or staff meeting shall be so notified. The chairman of the meeting shall give the Practitioner at least two (2) days advance written or oral notice of the time and place of the meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, Special Notice shall be given in writing at least seven (7) days in advance of the meeting and shall include a statement of the issue involved and that the Practitioner's appearance is mandatory. Failure of a Practitioner to appear at any meeting with respect to which he was given such Special Notice may, unless excused by the Medical Executive Committee, upon a showing of good cause, result in a suspension of all or such portion of the Practitioner's Clinical Privileges as the Medical Staff may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Executive Committee or of the Governing Body or through corrective action, if necessary. If the Practitioner makes a timely request for postponement supported by an adequate showing of good cause, such appearance may be postponed by the President of the Medical Staff until not later than the next regular staff meeting.

ARTICLE 13

GENERAL PROVISIONS

13.1 Medical Staff Rules and Regulations

The Executive Committee is authorized to adopt and amend such Rules and Regulations and policies as may be necessary for the proper conduct of the Medical Staff's work and to implement more specifically the general principles set forth in these Bylaws, subject to the approval of the Governing Body. These shall relate to the proper conduct of the Medical Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner and Allied Health Professional in the Hospital. Changes to the Rules and Regulations and policies shall become effective when approved by the Governing Body.

Rules and Regulations shall apply to and are to be observed by all Practitioners, Allied Health Professionals and Hospital staff, unless otherwise stated.

13.2 Clinical Service Rules and Regulations

Subject to the approval of the Medical Staff and the Governing Body, each clinical Service, acting through its Service Chief, shall formulate its own Rules and Regulations for the conduct of its affairs and the discharge of its responsibilities. Such Rules and Regulations shall not be inconsistent with these Bylaws, the general Rules and Regulations of the Medical Staff, or other policies of the Hospital.

13.3 Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of Clinical Privileges, corrective action, notices, recommendations, reports, and other matters shall be adopted by the Governing Body after considering the advice of the Medical Staff.

13.4 Construction of Terms and Readings

Words used in these Bylaws shall be read as the singular or plural, as the context requires. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provisions of these Bylaws.

13.5 Transmittal of Reports

Reports and other information which these Bylaws require the Medical Staff to transmit to the Governing Body shall be deemed so transmitted when delivered, unless otherwise specified, to the Hospital President.

13.6 Governing Body Action

Whenever these Bylaws require or authorize action by the Governing Body, such action may be taken by a committee of the Governing Body to which the Governing Body has delegated the responsibility and authority to act for it on the particular subject matter, activity or function involved.

13.7 Substantial Compliance

Technical or insignificant deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

ARTICLE 14

ADOPTION AND AMENDMENT OF BYLAWS

14.1 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.

14.2 Methodology

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

- (a) **Medical Staff.** A proposed amendment of the Bylaws may be introduced at a regular or special meeting of the Medical Staff. The proposed Bylaws will then be acted upon at the following meeting of the Medical Staff provided a quorum is present. A proposed change in Bylaws will be passed if a majority of all Members of the active and associate staff present at the meeting and entitled to vote votes in the affirmative. A written proxy shall be accepted for voting on Bylaws changes; and
- (b) **Governing Body.** The Governing Body shall act no later than 30 days after the vote of the active Medical Staff on the proposed amendment. The affirmative vote of the majority of the Governing Body shall be final.

The Governing Body may not adopt a bylaw amendment by unilateral action.

14.3 Effective Date

These Bylaws, including the Corrective Action and Fair Hearing Plan Addendum shall be adopted at any regular or special meeting of the 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.

14.4 Review and Revision

The Medical Staff Bylaws, along with the Rules and Regulations and policies 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.

14.5 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 Good Samaritan Health Center, Inc., on April 28, 2000; revised June 28, 2001; revised May 25, 2007; revised February 24 2012; revised February 16, 2018.

President of the Medical Staff

Approved by the Board of Directors on February 23, 2018.

Hospital President
Good Samaritan Health Center