BYLAWS

OF THE MEDICAL STAFF

OF

AURORA MEDICAL CENTER – BAY AREA

VOLUME I

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TABLE OF CONTENTS

PREAMBLE ........................................................................................................................................ 1

DEFINITIONS......................................................................................................................................... 1

ARTICLE I : NAME/SUCCESSOR IN INTEREST .................................................................................... 2
Section 1. Name.................................................................................................................................... 2
Section 2. Successor in Interest ........................................................................................................... 3

ARTICLE II : PURPOSES AND RESPONSIBILITIES .......................................................................... 3
Section 1. Purposes .............................................................................................................................. 3
Section 2. Medical Staff Responsibilities ............................................................................................ 3
Section 3. Medical Staff Member Responsibilities ............................................................................. 4

ARTICLE III : MEDICAL STAFF MEMBERSHIP .............................................................................. 4
Section 1. Nature of Medical Staff Membership ................................................................................. 4
Section 2. Term of Office .................................................................................................................... 4
Section 3. Governing Body Appointment Considerations ................................................................. 5
Section 4. Candidate Qualifications for Membership ......................................................................... 5
Section 5. Conditions of Appointment .............................................................................................. 6
Section 6. Dues and Fees .................................................................................................................... 8

ARTICLE IV : CATEGORIES OF THE MEDICAL STAFF ..................................................................... 8
Section 1. The Medical Staff ............................................................................................................. 8
Section 2. The Provisional Medical Staff .......................................................................................... 8
Section 3. The Active Medical Staff ................................................................................................ 9
Section 4. The Affiliate Medical Staff ............................................................................................... 9
Section 5. The Honorary Medical Staff ........................................................................................... 9
Section 6. Dental and Podiatric Staff ............................................................................................... 9
Section 7. Advanced Practice Professionals .....................................................................................10
Section 8. Locum Tenens ...................................................................................................................10

ARTICLE V : PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT ...................................... 10
Section 1. Applications for Appointment and Reappointment ..........................................................10
Section 2. Leave of Absence .............................................................................................................12
Section 3. Modification of Membership Status or Privileges .............................................................12
Section 4. Reapplicant after Adverse Action ...................................................................................13
Section 5. Time Periods for Processing ............................................................................................13

ARTICLE VI : CLINICAL PRIVILEGES .............................................................................................14
Section 1. Requests for Clinical Privileges ......................................................................................14
Section 2. Temporary Privileges ......................................................................................................14
Section 3. Disaster Privileges ..........................................................................................................14
Section 4. Emergency Privileges ....................................................................................................15
Section 5. Telemedicine Privileges ..................................................................................................15
Section 6. Orders from Individuals without Clinical Privileges or Medical Staff Membership .......15

ARTICLE VII : CORRECTIVE ACTION AND HEARING RIGHTS ......................................................15
Section 1. Hearing Rights ................................................................................................................15
Section 2. Corrective Action ............................................................................................................16
Section 3. Exceptions .......................................................................................................................16
Section 4. Removal of Contract Practitioner ....................................................................................16
Section 5. Procedure and Process ....................................................................................................16

ARTICLE VIII : IMMUNITY FROM LIABILITY ...............................................................................16

ARTICLE IX : OFFICERS ....................................................................................................................17
Section 1. Officers of the Medical Staff ............................................................................................17
Section 2. Qualifications of Officers ...............................................................................................17
Section 3. Election of Officers .........................................................................................................18
Section 4. Term of Office ................................................................................................................18
Section 5. Vacancies in Office ..........................................................................................................18
Section 6. Removal of Officers .......................................................................................................18
PREAMBLE

A. Aurora Medical Center – Bay Area (the “Hospital”) is a non-profit corporation, organized under the laws of the State of Wisconsin.

B. The Hospital’s purpose is to serve as a general hospital providing patient care, education, and research.

C. It is recognized that the Hospital’s Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital’s governing board.

D. The cooperative efforts of the Medical Staff, the Hospital’s Chief Executive Officer, and the Hospital’s governing board are necessary to fulfill the Hospital’s obligations to its patients.

Therefore, the physicians practicing in the Hospital hereby organize themselves into a Medical Staff, in conformity with these Medical Staff Bylaws.

DEFINITIONS:

1. “Admit” or “admission” means registration of an individual as a patient of the Hospital for the purpose of treatment on either an outpatient or an inpatient basis, but excludes registration solely for outpatient laboratory tests or diagnostic imaging not requiring the presence or supervision of the ordering professional.

2. “Advanced Practice Professional” means members of allied health fields affiliated with the Medical Staff as determined by the Medical Staff, and including nurse anesthetists, physician assistants, and other advanced practice fields. Members of the allied health fields shall be affiliated with and subject to monitoring by the Medical Staff, but such Advanced Practice Professional shall not be considered members of the Medical Staff.

3. “Chief Executive Officer” means the individual approved by the Governing Body to act in its behalf in the overall management of the Hospital.

4. “Chief Medical Officer” means the individual contracted with by the Hospital to be a liaison with the Medical Staff and to advise and assist the Hospital with issues affecting patient care and relationships with practitioners and other health care professionals.

5. “Completed application” means a fully-filled out application for Medical Staff membership, completed in the manner required by the Medical Staff Bylaws and Policies, and accompanied by primary source verification of the applicant’s licensure, education, training, practice history, professional liability coverage and claims history, applicable board certifications, Background Information Disclosure form, Data Bank information, professional references and such other elements as may be specified by Policy.

6. “Ex-officio” means service as a member of a body by virtue of office or position held, which service shall be “with vote” unless expressly stated otherwise in the Medical Staff Bylaws.

7. “Good Standing” means that the member has privileges under the bylaws that are in full force and effect.

8. “Governing Body” means the Board of Directors of the Hospital.

9. “Health Status” means the emotional, physical, and mental health status of an individual.

10. “Investigation” means a process specifically initiated by the MEC to determine the validity, if any, of a concern or complaint raised against a medical staff member or individual holding clinical privileges.
11. “Interactive Telemedicine” means responsibility (either total or shared) for care, treatment and services (as evidenced by having the authority to write orders and direct care, treatment and services) through a telemedicine link.

12. “Interpretive Telemedicine” means providing official readings of images, tracings, or specimens through a telemedicine link, but not engaging in Interactive Telemedicine.

13. “MEC” means the executive committee of the Medical Staff.

14. “Medical Staff” means the Hospital’s organized component of physicians, podiatrists, and dentists who are appointed by the Governing Body.

15. “Member” or “membership” means the prerogative of Medical Staff participation and does not necessarily include any clinical privilege whatsoever.

16. “No activity” means no documentation on any patient’s chart reflecting the provision of clinical care, no admissions, no procedures and no tests or orders except those allowed pursuant to Section 6 of Article VI, and the practitioner is not regularly admitting his patients requiring inpatient care through a member of the Active Medical Staff.

17. “Oral surgeon” means an appropriately licensed dentist who has successfully completed a postgraduate program in oral surgery accredited by the American Association of Oral Maxillofacial Surgeons and is board eligible or board certified.

18. “Peer” means individuals from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications.


20. “Policy” and “Policies” means a policy of the Medical Staff, as adopted and approved by the MEC and communicated to the active medical staff at a meeting of the medical staff or via distribution (unless specific reference is made to Hospital policy or policies) or a policy of a Medical Staff department as adopted by that department and approved by the MEC.

21. “Practitioner” means an appropriately licensed physician, dentist, or podiatrist.

22. “Prerogative” means a participatory right granted, by virtue of Medical Staff category or otherwise, to a Medical Staff member and exercisable subject to the conditions imposed in the Medical Staff Bylaws, Policies and Rules, and other Hospital policies.

23. “Privileges” or “clinical privileges” mean the permission granted to a practitioner or a member of an allied health field to render specific diagnostic, therapeutic, medical, dental, or surgical services, which may or may not include permission to admit patients.

24. “Rules” means the Rules and Regulations of the Medical Staff, as adopted and approved pursuant to Article XIV.

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

ARTICLE I: NAME/SUCCESSOR IN INTEREST

Section 1. Name

The name of this organization shall be the Aurora Medical Center - Bay Area Medical Staff.
Section 2. Successor in Interest

As a condition of merger, sale, assignment, or affiliation of any sort, any successor in interest must agree to accept and be bound by these Bylaws.

ARTICLE II: PURPOSES AND RESPONSIBILITIES

Section 1. Purposes

The purposes of the Medical Staff are:

a. To assist in the regulation of the facilities, departments, and services of the Hospital so that patients admitted or treated may receive quality medical care;

b. To regulate a high level of professional performance of all practitioners and allied health professionals authorized to practice in the Hospital;

c. To further quality health care through the appropriate delineation of the clinical privileges that each Practitioner and Advanced Practice Professional may exercise in the Hospital and ongoing review and evaluation of each practitioner’s performance in the Hospital;

d. To provide an appropriate educational setting that will maintain scientific standards and lead to continuous advancement in professional knowledge and skill;

e. To initiate and recommend to the Governing Body Medical Staff Bylaws and Rules for the administration of the Medical Staff;

f. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and the Chief Executive Officer and through which the Medical Staff may participate in the Hospital’s policy making and planning process;

g. 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;

h. To serve as the primary means for providing assurances as to the appropriateness of the professional performance and ethical conduct of its members and Advanced Practice Professionals;

i. To strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available; and

j. To carry out such other purposes and responsibilities as may be delegated to the Medical Staff by the Governing Body.

Section 2. Medical Staff Responsibilities

The responsibilities of the Medical Staff are:

a. To ensure an appropriate level of professional performance for all members of the Medical Staff, and other practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each individual may exercise in the Hospital and 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 patient care audit and other quality assessment and improvement programs;
c. To provide a utilization review program to allocate inpatient medical and health services based upon determinations of inpatients’ and observation patients’ medical, social, and emotional needs, consistent with sound health care resources utilization management;

d. To provide an organizational structure that allows continuous monitoring and improvement of patient care practices;

e. To conduct reviews and evaluation of the quality of patient care through quality assessment, risk management, and improvement activities;

f. To recommend to the Governing Body action with respect to appointments, reappointments, Medical 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 Medical Staff members, when warranted;

j. To develop, administer, and seek compliance with the Medical Staff Bylaws, Policies, and Rules and other patient care related Hospital policies and procedures;

k. To assist in identifying community health needs, setting appropriate institutional goals, and implementing programs to meet those needs;

l. To conduct all of its affairs involving the Medical Staff, the Advanced Practice Professional, patients, and employees in a willing manner and in an atmosphere of civility, dignity, and respect, free of unlawful discrimination because of age, sex, creed, national origin, race, handicap, disability, color, ancestry, religion, sexual orientation, mental status, newborn status, source of payment, or any other unlawful basis; and

m. To carry out such other responsibilities as may be delegated to the Medical Staff by the Governing Body.

Section 3. Medical Staff Member Responsibilities

The basic responsibilities of each Medical Staff member are:

a. To provide patients with care at a generally recognized professional level of quality and efficiency;

b. To abide by the Medical Staff Bylaws, Policies, Rules, and all other applicable standards, policies, rules and regulations of the Hospital; and

c. To willingly and in a collegial manner discharge the Medical Staff, committee, department, and Hospital functions for which the member is responsible by membership category, appointment, election, or otherwise.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege that shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws, Policies, and Rules.

Section 2. Term of Appointment
a. All initial appointments to the Medical Staff shall be made by the Governing Body upon the recommendation of the MEC shall be for a period of not more than two (2) years. Unless otherwise specified, appointment terms run through the fourteenth day of the practitioner’s birth month.

b. Reappointment/renewal dates are defined as the practitioner’s month of birth on the odd or even year of birth. Reappointment, if granted, shall be for a period of not more than two (2) years, with reappointment scheduled according to the month of the practitioner's birth.

c. If a credentials verification organization (CVO) or a telemedicine service organization (TSO) will participate in the credentials verification process, the application/reapplication or a portion of the application/reapplication may be sent by the CVO or TSO.

d. The Governing Body shall not act on an application for appointment, reappointment or cancel an appointment previously made without prior conference and consultation with the MEC. However, in the event of unwarranted delay, the Governing Body may act on the basis of the applicant’s professional and ethical qualifications obtained from reliable sources.

e. Appointments to the Medical Staff shall confer on appointees only such privileges and prerogatives as are specified in the notice of appointment, in conformity with the Medical Staff Bylaws, Policies, and Rules and the Hospital’s rules and regulations.

Section 3. Governing Body Appointment Considerations

a. The Governing Body shall solely determine whether to approve or reject any applicant based on the limitations of the Hospital’s facilities, services, equipment, Medical Staff, support capabilities, or any combination of these.

b. The Governing Body may decide not to appoint or grant privileges to a practitioner or affiliated health professional in accord with the criteria of a Medical Staff development plan. In addition, the Governing Body may decide not to appoint or reappoint a practitioner due to the existence of pre-existing contracts for provision of clinical services, whether exclusive or not, or for other reasons, when consistent with the Hospital’s purposes, needs, and capabilities, or to fulfill a community need.

c. The Governing Body shall, upon the recommendation of the Medical Staff, determine whether to:
   1. execute an exclusive contract in a previously open medical department or medical service;
   2. renew or modify an exclusive contract in a particular medical department or medical service; or
   3. terminate an exclusive contract in a particular medical department or medical service.

Should the Governing Body’s determination vary from the Medical Staff recommendations, the Governing Body shall set forth its decision in writing.

Section 4. Candidate Qualifications for Membership

a. Candidates for Medical Staff membership or clinical privileges must fulfill the following prerequisites before they are eligible to receive an application:
   1. Hold a valid, active Wisconsin license or have an application for a Wisconsin license pending before the Wisconsin Medical Examining Board.
   2. Not be excluded from participating in federal health care programs.
   3. Not be listed in the General Service Administration Excluded Parties Listing System.
4. Not be listed in any Wisconsin caregiver misconduct registry or have committed a serious crime as defined under Wisconsin’s caregiver background check laws.

5. Carry current professional liability insurance covering the full scope of privileges desired in the amounts required for participation in Wisconsin’s Injured Patients and Families Compensation Fund and if eligible to do so, participate in that Fund.

6. Not be seeking clinical privileges that are subject to an exclusive arrangement authorized by the Governing Body (whether by contract or direct employment).

7. Identify specific call coverage arrangements, in accordance with the hospital’s call/continuing care policies, to cover expected and unexpected absences from practice.

8. Either be board certified or be actively applying for certification as required by Article III, Section 4.c.

b. In addition to the prerequisites set forth in Section 4.a above necessary to obtain an application, applicants must also document with sufficient adequacy to assure the Medical Staff and the Governing Body that they can provide care at a generally recognized level of quality in an economically efficient manner (based on patient need, available hospital facilities and utilization standards at the Hospital), by providing evidence of:

1. Their background, experience, training, and demonstrated current competence;

2. Adherence to the ethics of their profession;

3. Good reputation and satisfactory Health Status; and

4. Ability to work with others.

c. In addition, practitioners who were not members of the active or provisional active Medical Staff in Good Standing as of January 1, 2006, must either:

1. Be certified by a certifying board in the practitioner’s primary specialty as specified in the applicable Medical Staff policy regarding board certifications; or

2. Have completed all of the residency or other specialized training required for admission to the examination of such a certifying board and have an active application for certification, including meeting any “minimum years in practice” requirements followed by certification within five years of the date of completion of residency or specialized training.

d. The Governing Body may waive the requirement set forth in Section 4.a.8 or Section 4.c upon the recommendation of the MEC, for a particular practitioner when the practitioner has extensive experience, qualifications, and training, or for a particular specialty based on a review of the board certification requirements of the certifying board in that specialty.

Section 5. Conditions of Appointment

a. As conditions of appointment or reappointment to the Medical Staff or the exercise of any clinical privileges, all individuals granted clinical privileges shall:

1. Participate in and be subject to the quality assessment and improvement activities of the Hospital and Medical Staff;

2. Submit and maintain on file evidence of continued licensure, DEA registration (if applicable) and insurance;

3. Comply with federal and state laws and regulations applicable to the practice of his or her profession;
4. Comply with the Rules and Policies including, but not limited to, the Medical Staff’s Code of Conduct and Conflict of Interest Policies and the Hospital’s Compliance and Ethics Code of Conduct Policy and other applicable Hospital policies;

5. Abide by the Hospital’s mission statement and its bylaws, the Medical Staff Bylaws, and the Code of Ethics of the American Medical, Dental, Osteopathic, or Podiatry Association, or other applicable Code of Ethics;

6. Not receive from or pay to another physician, directly or indirectly, any part of a fee received for professional services;

7. Provide continuous care for their patients, and refrain from delegating the responsibility for diagnosis or care of patients to an individual who is not qualified to undertake the responsibility or adequately supervised;

8. Provide such call coverage as is established by each individual Department, pursuant to the hospital’s call/continuing care policies;

9. Acknowledge participation in the Hospital’s organized health care arrangement (the BAMC OHCA), which is comprised of all clinically integrated settings in which patients receive services such that all individuals with clinical privileges shall follow the privacy practices of the BAMC OHCA, as set forth in its notice of privacy practices, with respect to protected health information received through the BAMC OHCA;

10. Comply with health requirements established by the MEC or the Governing Body;

11. For applicants for Medical Staff membership, undertake willingly a fair share of responsibility for the discharge of Medical Staff responsibilities; and

12. At all times, treat other practitioners as colleagues, treat all individuals with respect and dignity and maintain the confidentiality of information obtained through the discharge of these responsibilities, in accordance with Policy. Disputes arising among any of Medical Staff members, Hospital employees, Advanced Practice Professionals or other privilege holders relating to professional conduct or the delivery of patient care shall be addressed in accordance with a Medical Staff Policy and these bylaws, as applicable.

b. For applicants granted clinical privileges that include performing physical examinations and medical histories, complete and document those physical examinations and medical histories no more than 30 days before or 24 hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia, in sufficient time for completion of transcription within the 24-hour period post-admission or registration. When the medical history and physical are completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient’s condition must be completed and documented in the medical record within 24 hours after admission, but prior to surgery or a procedure requiring anesthesia services.

c. As a condition of appointment or reappointment to the Medical Staff or Advanced Practice Professional or the exercise of any clinical privileges, appointees and privilege holders must promptly, but in no case more than 15 days after the triggering action, notify the Chief Executive Officer of, and provide such additional information as may be requested regarding, each of the following:

1. The revocation, limitation or suspension of his or her professional license or DEA registration;

2. Any reprimand or other disciplinary action taken by any state or federal government agency relating to his or her professional license or the practice of his or her profession;

3. The imposition of terms of probation or limitation by any licensing board;
4. Loss of Medical Staff membership or privileges at any hospital or other health care facility, whether temporary or permanent, including all suspensions;

5. Cancellation or change of professional liability insurance coverage;

6. Receipt of a quality inquiry letter, an initial sanction notice or a notice of proposed sanction; the commencement of a formal investigation; or the filing of charges regarding health care matters by a Medicare quality improvement organization, the Department of Health and Human Services, the Office of the Inspector General, or any law enforcement agency or health regulatory agency of the United States or State of Wisconsin;

7. Any criminal conviction pending criminal charge, or finding by a governmental agency that the individual has abused or neglected a child or patient, or misappropriated a patient’s property;

8. Any proposed or actual exclusion from any federally-funded health care program, including any notice, actual exclusion, or pending investigation;

9. Receipt of notice of the filing of any suit or request for mediation alleging the individual’s professional liability in connection with the treatment of any patient in or at the Hospital; and

10. Settlement of any claim by payment from an insurance company, the individual or any other party or any other agreement that results in a release being given by a patient to the individual relating to the treatment of any patient in or at the Hospital.

d. Conflicts of interest must be disclosed and addressed as specified in the Policy on conflict of interest.

Section 6. Dues and Fees

The Medical Staff will assess dues annually and application processing fees at the time of applications for Medical Staff appointment, Advanced Practice Professional appointment, and requests for clinical privileges. The amounts of such dues and application processing fees shall be determined by the MEC in accordance with the Initial Appointment and Reappointment Policies. The use of such dues and fees will be designated by the MEC, consistent with the purposes and responsibilities of the Medical Staff and subject to the approval of the Governing Body.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into the following categories: provisional, active, affiliate and honorary staff.

Section 2. The Provisional Medical Staff

a. All initial appointments to the provisional and active categories of the Medical Staff except Honorary Medical Staff shall be provisional for a 12-month period. At the end of a provisional period the MEC, upon the written recommendation of both the chair of the department to which the appointee is assigned and the Credentials Committee, may continue the provisional status of the practitioner’s appointment to the Medical Staff for an additional period not to exceed two full Medical Staff years, at which time the failure to advance an appointee from Provisional to Regular Medical Staff status shall be deemed a termination of his or her Medical Staff appointment. A provisional appointee whose membership is so terminated for reasons other than no activity shall have the right accorded by these Bylaws to a member of the Medical Staff who has been denied reappointment.

b. Provisional Medical Staff members shall be subject to monitoring per monitoring protocols established under Policy and overseen by the chair of the department to which the appointee is assigned.
c. Members of the Provisional Medical Staff shall not be eligible to vote at general Medical Staff meetings nor to hold office but shall be required to attend Medical Staff and department meetings in accord with the same requirements and subject to such other restrictions as are set forth in the Medical Staff Bylaws and Policies for the category of the Medical Staff to which the member is seeking regular appointment. Provisional Medical Staff members may not serve on the MEC or the Credentials Committee and may serve only as non-voting members on other committees.

Section 3. The Active Medical Staff

a. The Active Medical Staff shall consist of practitioners who regularly attend patients in the Hospital or are physicians with an active outpatient practice in the community who regularly refer their patients with inpatient needs to a member of the Active Medical Staff for admission to the Hospital; who are located closely enough to the Hospital to provide continuous care to their patients; and who assume all the functions and responsibilities of membership on the Active Medical Staff. Members of the Active Medical Staff shall be appointed to a specific department; are eligible to vote, to hold office, and to serve on Medical Staff committees; and shall be required to attend Medical Staff and department meetings. Eligibility for Active Medical Staff membership requires at least one year of Provisional Medical Staff membership.

b. Members of the Active Medical Staff shall promote the quality of medical care in the Hospital, offer sound counsel to the Chief Executive Officer and the Governing Body, and manage and participate in the internal governance of the Medical Staff according to these Bylaws. The members of the Active Staff shall, within the scope of their privileges, provide emergency care and attend to patients as outlined in Policies per the MEC.

Section 4. The Affiliate Medical Staff

a. The Affiliate Medical Staff shall consist of those practitioners eligible for Medical Staff membership who do not admit inpatients to the Hospital but who are given privileges to consult on a limited number of hospitalized inpatients. The Affiliate Medical Staff may include practitioners who have a significant level of patient-related activity and interaction, such as performing test reads. Members of the Affiliate Medical Staff must have been members of the Provisional Medical Staff for a period of at least one year. Affiliate Medical Staff members may neither vote nor hold office, but may be appointed to committees. They shall not be required to attend Medical Staff or department meetings, but are encouraged to do so.

b. A physician member of the Affiliate Medical Staff must be a member of the Active or Affiliate Medical Staff of another hospital where he or she actively participates in a patient care audit program and other quality maintenance activities similar to those required of the Active Medical Staff of the Hospital.

Section 5. The Honorary Medical Staff

The Honorary Medical Staff shall consist of physicians who are not active in the Hospital or who are honored by emeritus positions. These may be physicians who have retired from active Hospital practice who are of outstanding reputation, not necessarily residing in the community. Honorary Medical Staff members shall not be eligible to admit or treat patients, or to vote, hold office or to serve on standing committees of the Medical Staff. Honorary Medical Staff members are designated as such by the Governing Body and are not subject to the appointment or reappointment process.

Section 6. Dental and Podiatric Staff

a. Dentists and podiatrists granted membership on the Medical Staff in accordance with the procedures set forth in Article V shall be members of the Active Medical Staff. The dental and podiatric Medical Staff shall consist of duly licensed dentist, oral surgeons, and podiatrists who are qualified legally, professionally, physically, mentally, and ethically to attend patients in the Hospital as determined by the Credentials Committee and the MEC and approved by the Governing Body. The procedure for appointment and reappointment to the dental and podiatric Medical Staff shall be assigned to the clinical service of dental surgery within the department of surgery and anesthesiology and shall be subject to the terms of these Bylaws and the Rules. Members of the
dental and podiatric Medical Staff are eligible to vote, to hold office, and to serve on Medical Staff committees and shall be required to attend Medical Staff and department meetings.

b. Patients admitted to the Hospital for dental or podiatric care shall be given the same medical appraisal as those admitted for other services, except that oral surgeons granted clinical privileges to do so may admit and perform their own medical appraisals on patients without medical problems. Admission of a dental or podiatric patient shall be the dual responsibility of the dentist or podiatrist and a physician member of the Medical Staff. The physician shall be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization of the dental or podiatric patient.

Section 7. Advanced Practice Professionals

Staff affiliates, such as nurse anesthetists, physician assistants, clinical psychologists and other advanced practice fields may apply to become Advanced Practice Professionals subject to qualifications, conditions, rights, responsibilities and procedures outlined in Medical Staff policy. Advanced Practice Professionals are not members of the Medical Staff and have none of the prerogatives of Medical Staff membership, such as rights under the Plan or rights to attend Medical Staff meetings or to vote.

Section 8. Locum Tenens

a. Practitioners who intend to serve as a locum tenens but who do not seek membership on the Active Medical Staff must complete an application as if applying for Medical Staff membership and will be subject to the procedures for grant of temporary privileges to new applicants under these Bylaws. The duration of the locum tenens privileges shall be determined by the Chief Executive Officer upon the recommendation of the appropriate Department Chair or the Medical Staff President but in no event may such privileges extend beyond 180 consecutive days.

b. The privileges of a locum tenens may, at any time upon the recommendation of the appropriate Department Chair or the Medical Staff President, be terminated immediately by the Chief Executive Officer where there is reason to believe that it would be in the best interest of the Hospital or patient care. The Department Chair or the Medical Staff President shall assign a member of the Active Staff to assume responsibility for the care of such patient.

c. In the absence of separate application for Active Medical Staff membership, locum tenens practitioners are not members of the Medical Staff and have none of the prerogatives of Medical Staff membership, such as rights under the Plan or rights to attend Medical Staff meetings or to vote. Locum tenens practitioners are required to reapply as initial applicants when granted privilege terms expire.

ARTICLE V: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

Section 1. Applications for Appointment and Reappointment.

a. All applications for appointment to the Medical Staff shall be submitted electronically with electronic signature and shall contain detailed information concerning the applicant’s professional qualifications, background and practice history, as specified in more detail in the appointment and reappointment Policy.

b. The applicant shall specify the names of at least two persons who have had extensive recent experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant’s current professional competence and ethical character. One of those references must be from a peer.

c. The completed application shall be submitted to the Chief Executive Officer or designee, who shall oversee the collection of information on the applicant before forwarding the application for evaluation by the Credentials Committee and appropriate department chair.
d. Certain categories of applicants may be eligible for expedited processing, in which the Credentials Committee chair may act in lieu of the full Credentials Committee, and a subcommittee of the Governing Body may finalize the appointment, subject to subsequent ratification by the Governing Body.

e. The MEC shall adopt one or more Policies outlining the details of the application process for initial appointments, for reappointments and for clinical privileges, including, at a minimum, timeframes for submission and processing, expedited processing options, categories of applicants eligible for expedited processing, and the content of application forms for appointment, reappointment and clinical privileges. The process shall require the collection, verification, and assessment of information relating to the applicant’s qualifications for medical staff membership and for clinical privileges, including, at a minimum: current licensure; education and relevant training; experience, ability and current competence to perform any requested clinical privileges; Health Status; and, for reappointments, review of the applicant’s performance at the Hospital, including adherence to Medical Staff Bylaws, rules, regulations and policies, and Hospital policies applicable to Medical Staff members or clinical privilege holders.

f. Medical Staff members who have had no activity during their current term of appointment will only be sent an application for reappointment upon their express request. If they continue to have no activity during the next term of appointment, they will be ineligible to apply for reappointment unless they provide evidence of a change in circumstances that will result in future activity at the Hospital. Medical Staff members with activity during their current term of appointment will automatically be sent an application for reappointment within the timeframe specified in the Reappointment Policy.

g. Medical Staff members who have not obtained board certification within the required time as required under Article III, Section 4.c, or who fail to maintain board certification will be ineligible for reappointment and will not receive an application for reappointment unless they have obtained a waiver of this requirement from the Governing Body pursuant to Article III, Section 4.d. Practitioners who fail to obtain board certification within the required time shall have no right to hearing or appeal of the decision to not allow them to apply for reappointment, but may submit additional information to refute any error in determining whether they satisfied the prerequisite. Practitioners who were board certified but fail to maintain board certification during their current term of appointment and are denied a waiver of this requirement from the Governing Body shall have a right to request a hearing the scope of which shall be limited to an appeal of the denial of the waiver.

h. By applying for appointment to the Medical Staff, each applicant signifies a willingness to appear for interviews in regard to the application, authorizes the Hospital to consult with others who have been associated with the applicant and/or who may have information that may be material to an evaluation of the applicant’s professional qualifications - including current technical competence, Health Status and ethical qualifications to carry out the clinical privileges requested; consents to the Hospital’s inspection of all records and documents, including the query to the National Practitioner Data Bank, that may be material to the Hospital’s evaluation of the applicant request for clinical privileges or Medical Staff membership or both; releases from any liability all representatives of the Hospital and its Medical Staff for their acts performed in connection with evaluating the applicant; releases from any liability all individuals and organizations who provide information to the Hospital concerning the applicant’s competence, professional ethics, character, Health Status and other qualifications for Medical Staff appointment and clinical privileges including otherwise privileged or confidential information; and authorizes and consents to the Hospital’s 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 the applicant, and releases the Hospital and its representatives from liability for doing so.

i. Medical Staff forms shall include a statement that the applicant has received, read, and will abide by the Medical Staff Bylaws, Policies and Rules, and the applicant’s membership category, if any.

j. The applicant shall sign and submit along with the completed application such other consents, authorizations, and releases as may be required under the Medical Staff Bylaws for the proper evaluation of the applicant’s qualifications for membership or privileges.
k. The Medical Staff Office, with the approval of the Credentials Committee chair, may reject an application for appointment or reappointment to the Medical Staff or for clinical privileges without further review or processing, if it determines that the applicant:

1. does not hold a valid Wisconsin license and no application is pending;
2. does not have adequate professional liability insurance;
3. is barred from receiving payment from the Medicare or Medical Assistance program, is currently excluded from any health care program funded in whole or in part by the federal government or is listed in the General Service Administration Excluded Parties Listing System;
4. is barred from providing services under Chapter DHS 12 of the Wisconsin Administrative Code;
5. has requested clinical privileges that have been exclusively granted to another Medical Staff member pursuant to a written contract currently in effect without notice of intent to terminate by either party, which contract covers all the privileges requested by the applicant;
6. fails to supply all information requested by the Credentials Committee or to otherwise see that the Medical Staff Office secures all required verifications and other information the Credentials Committee deems necessary to process the application; or
7. has not submitted a specific call coverage or continuity of care plan consistent with the hospital’s call/continuing care policies.

l. Applicants who are rejected under subsection k do not have a right to a fair hearing under the Plan, but may submit additional information to refute the basis for the rejection.

Section 2. Leave of Absence

Medical Staff members and Advanced Practice Professionals may apply for a leave of absence in accordance with the Leave of Absence Policy. A Medical Staff member or Advanced Practice Professional who leaves practice for more than 90 consecutive days without requesting a leave or who otherwise cannot be located after reasonable attempts to do so will be deemed to have resigned his or her Medical Staff membership or Advanced Practice Professional classification and shall be required to reapply before returning.

Section 3. 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 Medical Staff category, service assignment, or clinical privileges by submitting a written application to the Chief Executive Officer or designee, subject to the limitations of Section 4. Such application shall be processed in the same manner as provided in Section 1 of Article V for reappointment.

b. Because it is inevitable that from time to time, the Health Status of some practitioners may limit their ability to exercise their clinical privileges, 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 department chair, or the Chief Executive Officer, such limitations to be reported to the Practitioner Wellness Committee pursuant to the Policy concerning Impaired Medical Staff and Advanced Practice Professionals. The Practitioner Wellness Committee shall review any such practitioner’s Health Status and report to the MEC, which may require evidence of current Health Status, determined by a physician acceptable to the MEC.

c. If, as a result of the Medical Staff member’s self-reporting of a disability, the MEC 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 Medical Staff member chooses to exercise any right to hearing available under the Plan, and the notice shall so state. If the Medical Staff recommends modification of membership status or privileges due to a
Medical Staff member’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 Plan. This Section is subject to and shall be administered in accordance with all applicable laws, including the Americans with Disabilities Act, and is not intended to violate such laws.

Section 4. Reapplication after Adverse Action

a. Unless subsection d applies, an applicant who has received a final adverse action regarding appointment, clinical privileges, or both, and does not exercise any of the hearing rights provided in the Plan may reapply for the membership or privileges that were the subject of the adverse action after six months from the date of final adverse action if there has been a documented change in the applicant’s education, training, experience or call coverage arrangement related to the privileges being requested. Without such a documented change, the applicant shall not be eligible to reapply for membership or the clinical privileges that were the subject of the adverse action until the later of: (i) a period of one year from the date of final adverse action; or (ii) a documented change in the applicant’s education, training, experience, call coverage arrangement, or other basis for earlier denial.

b. Unless subsection d applies, an applicant who has received a final adverse action regarding appointment, clinical privileges, or both, and who exercises some or all of the hearing rights provided in the Plan shall not be eligible to reapply for the membership status or privileges that were the subject of the adverse action until the later of: (i) a period of two years from the date of final adverse action; or (ii) a documented change in the applicant’s education, training, experience, call coverage arrangement or other basis for earlier denial.

c. Any reapplication under Section 4.a or Section 4.b shall be processed as an initial application, but the applicant shall submit such additional information as the Medical Staff, MEC, or Governing Body may require in demonstration that the basis for the earlier adverse action no longer exists. If the recommendation of the MEC or the action proposed by the Governing Body upon reapplication under Section 4 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.

d. Notwithstanding any other provision of this Section 4, an applicant who was rejected or a practitioner who lost Medical Staff membership due to any of the following reasons shall not be eligible to reapply, regardless of any lapse of time:

1. Providing false or misleading information in connection with an application for membership or clinical privileges;
2. Falsifying patient records;
3. Engaging in patient abuse; or
4. Engaging in sexual assault.

The provisions of this section also apply to an applicant who withdraws an application for medical staff membership or privileges after being recommended for denial by the MEC but before final action is taken by the governing body.

Section 5. Time Periods for Processing

Applications for appointment or reappointment shall be considered in a timely and good faith manner by all individuals and groups who are required by the Medical Staff Bylaws to act on such applications and, except for good cause, shall be processed within the time periods specified in the applicable Policies, but in no event longer than 120 days after receipt of the fully-completed application, all supporting materials, and all required verifications. However, the time periods specified are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the practitioner to have his or her application processed within those periods nor to create a right for a Medical Staff member to be automatically reappointed for the coming term.
ARTICLE VI: CLINICAL PRIVILEGES

Section 1. Requests for Clinical Privileges

a. Requests for clinical privileges, including requests for telemedicine, temporary or disaster privileges, shall be processed pursuant to procedures detailed in Policy, to include development and approval of a procedures list and elements of core privileges; collection of information relating to training, experience, ability and current competence; peer recommendations; review and evaluation of that information by the department chair or designee, the Credentials Committee, and the MEC, with the MEC forwarding a recommendation to the Governing Body for final action; and communication of the results to the applicant, other relevant personnel, and, as required by law external entities.

b. Every practitioner and Advanced Practice Professional practicing at the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body, based on their training, experience, demonstrated competence and judgment, references or direct observation of care and any other relevant information. The applicant has the burden of establishing his or her qualifications for the clinical privileges requested.

c. Clinical privileges must be reapplied for with the same frequency as applications for reappointment to the Medical Staff. Applications for additional or new clinical privileges will be processed in the same manner as the initial request for clinical privileges. All individuals granted clinical privileges will be subject to ongoing monitoring of the exercise of those privileges and for quality of care issues.

d. Applicants for clinical privileges will be informed of the decision on their application within 30 days of the final decision by the Governing Body.

Section 2. Temporary Privileges

a. Temporary privileges may be granted to fulfill an important patient care need, for a period not to exceed 120 days. Before granting temporary privileges to fulfill an important patient care need, current licensure and current competence must be verified. Requests for temporary privileges to fulfill an important patient care need will be processed according to procedures detailed in Policy.

b. Temporary privileges for Medical Staff applicants may be granted for up to 120 days while awaiting review and approval of their applications for Medical Staff membership and clinical privileges upon receipt of a completed application and all required supporting materials and verification of current licensure, relevant training or experience, current competence, ability to perform the privileges requested, receipt of NPDB query results, provided the applicant has no current or previously successful challenge to licensure or registration and has not been subject to involuntary termination of medical staff membership elsewhere or to involuntary limitation, reduction, denial, or loss of clinical privileges, or such other disqualifying factors as may be set forth in Policy.

c. The temporary privileges allowed under this section may be granted or extended by the CEO or authorized designee upon the recommendation of the President of the Medical Staff or authorized designee.

d. Denials and revocations of temporary privileges do not give rise to any right to hearing or appeal under the Plan.

e. Other terms and conditions applicable to the grant of temporary privileges may be set forth in Policy.

Section 3. Disaster Privileges

During any disaster in which the Hospital’s emergency management plan has been activated, the Chief Executive Officer or the President of the Medical Staff, or their designees, may grant disaster privileges in accord with the disaster privileges Policy.
Section 4. Emergency Privileges

In the case of emergency, any practitioner, to the degree permitted by his or her license and regardless of service or Medical Staff status or lack of it, may 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 to continue to treat the patient. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or not requested, the patient shall be assigned to an appropriate member of the Medical Staff. For the purpose of this Section 4, an “emergency” is a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Section 5. Telemedicine Privileges

a. Applicants based at distant sites whose practice at the Hospital will be limited to Interpretive or Interactive Telemedicine may apply for telemedicine privileges in accordance with the Telemedicine Privileges Policy.

b. In processing requests for telemedicine privileges, the Hospital may rely upon credentialing information obtained and verified in accord with applicable accreditation standards by an accredited facility where the applicant currently holds medical staff membership clinical privileges being requested in accordance with the Telemedicine Privileges Policy.

c. Applicants granted telemedicine privileges may be granted membership on the Affiliate Medical Staff if they apply for Medical Staff membership in addition to requesting telemedicine privileges, or they may be granted telemedicine privileges independent of any category of the Medical Staff.

Section 6. Orders from Individuals without Clinical Privileges or Medical Staff Membership

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

a. The order is within the scope of practice, as established by state law, of the ordering professional;

b. The ordering professional is currently licensed, certified or registered in any state in a field of practice recognized by Wisconsin law and, upon the Hospital’s request, provides evidence satisfactory to the Hospital of such current licensure, certification or registration;

c. The order can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering professional;

d. The ordering professional is not excluded from any federally-funded health program (such as Medicare or Medicaid); and

e. The ordering professional does not hold him or herself out to be associated or affiliated with the Hospital or the Medical Staff.

ARTICLE VII: CORRECTIVE ACTION AND HEARING RIGHTS

Section 1. Hearing Rights

A practitioner shall have the opportunity for a hearing in the manner and according to the limits set forth in the Plan, Volume II of these Bylaws, for those actions identified in the Plan involving:

a. Denial, suspension, reduction or termination of clinical privileges;
b. Denial, suspension or revocation of Medical Staff membership;

c. Consultation requirements that limit clinical privileges; or

d. Imposition of terms of probation/preceptorship that limits clinical privileges.

Section 2. Corrective Action

All Medical Staff members are subject to corrective action. Since Advanced Practice Professionals are not Medical Staff members, Advanced Practice Professionals are not subject to Article VII and have no rights hereunder. The Plan sets forth 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 hearing.

Section 3. Exceptions

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor any other action except those specified in the Plan, shall give rise to any right to a hearing or appellate review, including certain suspensions, denials or terminations (such as automatic suspensions) that are not subject to hearing rights under the Plan.

Section 4. Removal of Contract Practitioner

Removal of a contract practitioner may be accomplished in accordance with the terms of such individual’s contractual agreement. If such individual has Medical Staff membership and privileges, removal shall not terminate such privileges and Medical Staff membership unless a provision to the contrary is set forth in the individual’s contract with the Hospital.

Section 5. Procedure and Process

All hearings and appellate reviews shall be conducted in accordance with the Plan.

ARTICLE VIII: IMMUNITY FROM LIABILITY

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

a. That any act, communication, report, recommendation, or disclosure, with respect to any such individual, performed or made at the request of any authorized representative of this or any other health care facility, for the purpose of achieving, maintaining and furthering quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law;

b. That such privilege shall extend to members of the Hospital’s Medical Staff and of its Governing Body, its other practitioners, its Chief Executive Officer and his or her representatives, and to third parties, who supply information to or receive information from any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article VIII, the term “third parties” means both individuals and organizations from which information has been requested or which have received information from an authorized representative of the Governing Body or the Medical Staff;

c. That 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. That such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution’s activities related, but not limited to:

1. Application for appointment or clinical privileges;
2. Periodic reappraisals for reappointment or clinical privileges;
3. Corrective actions;
4. Hearings and appellate reviews;
5. Medical care evaluations;
6. Utilization review;
7. Profiles and profile analyses;
8. Malpractice loss prevention; and
9. Other Hospital, department, or committee activities related to maintaining quality and efficient patient care and appropriate professional conduct;

e. That the acts, communications, reports, recommendations and disclosures referred to in this Article VIII may relate to an individual’s professional qualifications, clinical competency, character, Health Status, ethics, or any other matter that might directly or indirectly have an effect on patient care;
f. That in the furtherance of the foregoing, each practitioner and Advanced Practice Professional shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article VIII in favor of the individuals and organizations specified in Section b, subject to such requirements, including the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State; and
g. That the consents, authorizations, releases, rights, privileges and immunities provided by Section 1 of Article V of the Medical Staff Bylaws for the protection of the Hospital’s practitioners, other appropriate Hospital officials and personnel, and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article VIII. All provisions in the Medical Staff Bylaws, Policies and Rules, and 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 thereof. Execution of releases required under this Article VIII is not prerequisite to the effectiveness of this Article VIII.

ARTICLE IX: OFFICERS

Section 1. Officers of the Medical Staff

The officers of the Medical Staff shall be:

a. President;
b. President-Elect; and
c. Secretary.

Section 2. Qualifications of Officers

a. Officers must be members of the Active Medical Staff at the time of nomination and election, and must remain members in Good Standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Officers must be physicians with demonstrated competence in their field of practice and demonstrated ability to direct the medical-administrative aspects of Hospital and Medical Staff activities.
b. Only members in Good Standing who have met the attendance requirements in Section 4 of Article XII in the preceding year shall be eligible to hold office.

Section 3. Election of Officers

a. Officers shall be elected at the annual meeting of the Medical Staff and confirmed by the Governing Body. Only members of the Active Medical Staff in Good Standing who have met the attendance requirements shall be eligible to vote for the election of officers.

b. The Nominating Committee shall consist of members of the Active Medical Staff appointed by the President of the Medical Staff. This committee shall offer one or more nominees for each office with the consent of the nominees.

c. Nominations may also be made from the floor at the time of the annual meeting. The individual nominated must meet the qualifications set forth in Section 2 above and affirmatively signify willingness to serve if elected or must have done so in writing prior to the annual meeting.

d. Office holders shall be elected by majority vote, subject to confirmation by the Governing Body. In the event that there are more than two candidates for an office and none receives a majority on the first ballot, there shall be successive balloting such that the name of the candidate receiving the fewest votes is omitted from each successive slate until one candidate obtains a majority vote.

Section 4. Term of Office

Upon confirmation by the Governing Body, the officers will serve two years from installation date or until a successor is elected. Officers shall take office on the first day of the Medical Staff year after their election, being the first day of January.

Section 5. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the presidency, shall be filled by the MEC. If there is a vacancy in the office of the President, the President-Elect shall serve out the remaining term. If the event of a vacancy in the office of President-Elect, the vacancy shall be filled by special election held at the first medical staff meeting of the staff following the vacancy. In the event of a vacancy in both the offices of President and President-Elect, the MEC shall fill the office of President until the vacancies for both offices are filled by special election held at the first medical staff of the staff following the vacancy.

Section 6. Removal of Officers

The Governing Body may remove an officer of the Medical Staff on its own motion passed by three-fourths of its members or upon receipt of a recommendation of a two-thirds majority of all members of the active Medical Staff. Permissible bases for removal include, without limitation, failure to continuously meet the qualifications for office and failure to timely and appropriately perform the duties of the office held. Vacancies shall be filled pursuant to Section 5 of this Article IX.

Section 7. Duties of Officers

a. President – The President shall serve as the chief administrative officer of the Medical Staff and shall:

1. Act in coordination and cooperation with the Chief Executive Officer 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. Serve as chair of the MEC, ex-officio, with vote;
4. Serve on all other Medical Staff committees, ex-officio, without vote;

5. Be responsible for the enforcement of Medical Staff Bylaws and Rules, for implementation of sanctions where these are indicated for noncompliance, for presentation to the MEC in those instances where corrective action may be recommended to the Governing Body, and for compliance with the procedural requirements set forth in the Medical Staff Bylaws and the Plan;

6. Appoint committee members to all standing, special and multi-disciplinary Medical Staff committees except the Credentials Committee and Practitioner Wellness Committee which shall be elected;

7. Be responsible, either in person or through his or her designee, for representing the views, policies, needs, and grievances of the Medical Staff to the Governing Body and to the Chief Executive Officer;

8. Be responsible, either in person or through his or her designee, for receiving and interpreting the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff’s delegated responsibility to provide medical care;

9. Be responsible for the educational activities of the Medical Staff meetings, 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

b. President-Elect – In the absence of the President, the President-Elect shall assume all the duties and have the authority of the President. The President-Elect shall be a member of the MEC and of the Medical Staff/Board of Directors Joint Conference Committee and shall automatically succeed the President when the latter fails to serve for any reason.

c. Secretary – In the absence of the President and the President-Elect, the Secretary shall assume all the duties and have the authority of the President. The Secretary shall be a member of the MEC. The Secretary shall be responsible for taking and keeping accurate and complete minutes of all Medical Staff meetings, calling Medical Staff meetings on order of the President, attending to all correspondence, and performing such other duties as ordinarily pertain to the office. The Secretary shall serve as chair of the Health Information/Case Management Committee and shall report to the MEC.

ARTICLE X: DEPARTMENTS

Section 1. Organization of Departments

a. Each department shall be organized as a separate part of the Medical Staff and shall have a chair that is selected and has the qualifications, authority, duties, and responsibilities as specified elsewhere in the Medical Staff Bylaws. Each department shall consist of a group of physicians practicing at the Hospital, but no less than three, who have interests and privileges within a traditionally-accepted clinical segment of medicine or surgery.

b. The MEC may, by resolution, divide departments into services, create additional departments or services, or eliminate or combine departments or services.

Section 2. Departments

The departments of the Medical Staff as of the effective date of the Medical Staff Bylaws shall be as follows:

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<thead>
<tr>
<th>Emergency Medicine</th>
<th>Pathology</th>
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<tr>
<td>Medicine</td>
<td>Pediatrics</td>
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<tr>
<td>Radiology/Radiation Oncology</td>
<td>Surgery</td>
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<tr>
<td>Obstetrics</td>
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<tr>
<td>Anesthesiology</td>
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</table>
Cardiology

Section 3. Assignment to Departments

a. Each member of the Medical Staff shall be assigned membership in at least one department, but may be granted membership or clinical privileges in one or more of the other departments. The exercise of clinical privileges within each department shall be subject to the Rules and Regulations of that department and to the authority of the department chair. A Medical Staff member with privileges in more than one department shall be required only to vote and attend meetings in the department in which the practitioner holds primary privileges.

b. Advanced Practice Professionals shall be assigned to one department for general direction and supervision of the exercise of clinical privileges and shall be subject to the Rules and Regulations of that department and to the authority of the department chair.

Section 4. Functions of Departments

a. The department chairs are essential elements in the line of authority within the Medical Staff organization, and are accountable to the MEC and the President of the Medical Staff for all professional and Medical Staff administrative activities within their departments. Departments are a major component in the Hospital’s program, organized and operated to help improve the quality of health care in the Hospital. Department activities will be conducted in a manner consistent with the provisions of secs. 146.37 and 146.38 of the Wisconsin Statutes. The peer review protections of these statutes, including the protection of the confidentiality of department records and proceedings, are intended to apply to all activities of the department relating to improving the quality of health care and include activities of the individual members of the department as well as other individuals designated by the department to assist in carrying out the duties and responsibilities of the department including but not limited to participating in monitoring plans. In fulfilling its responsibilities, each department shall:

1. Maintain continuing surveillance of the professional performance of all members of the Medical Staff with privileges in their department, and other individuals with privileges in the department, and report regularly on such performance to the MEC;

2. Assure adherence by all Medical Staff members practicing in the department to the Hospital’s corporate bylaws, and the Medical Staff Bylaws, Policies and Rules;

3. Transmit to the Credentials Committee the department chair’s (or designee’s) recommendations and assessment concerning the classification, the reappointment, and the delineation of clinical privileges for all members and Advanced Practice Professionals in the department;

4. Recommend to the MEC the department’s criteria for the granting of clinical privileges, and for the holding of office in that department;

5. Conduct a primary retrospective review of selected completed records of discharged patients and other pertinent sources of medical data relating to patient care;

6. Develop objective criteria that reflect current knowledge and clinical experience to be used in monitoring and evaluating patient care and, pursuant to these criteria, 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;

7. Meet separately on a regular basis to review and analyze on a peer group basis the clinical work of the department. Such meetings shall not release the Medical Staff members from their obligation to attend the general meetings of the Medical Staff;
8. Coordinate the patient care provided in the department with nursing and other professional patient care services and administrative support services and with the quality assurance and patient safety programs of the Hospital;

9. Formulate policies relating to the functions of the department; and

10. Create, subject to the approval of the MEC, call coverage criteria, which is applicable to all members of the department, which is sufficient to meet the needs of patients and comply with all laws, and meets requirements of the hospital’s call/continuing care policies.

b. The Pathology Department will:

1. Evaluate the appropriateness of all transfusions;
2. Evaluate all confirmed transfusion reactions;
3. Develop or approve policies and procedures relating to the distribution, handling, use and administration of blood and blood components; and
4. Review the adequacy of transfusion services to meet patient needs.

Section 5. Qualifications, Selection and Tenure of Department Chair

a. Each department chair shall be a board certified member of the Active Medical Staff qualified by training, experience, and demonstrated ability for the position. A chair who is not board certified should be a member of the Active Staff in Good Standing for two years who has demonstrated comparable competence as determined by the individual’s department.

b. Each department chair shall be elected by a majority vote of all Active Medical Staff members of the respective department who are in Good Standing. Candidates for the position of department chair shall be nominated and elected by the Active Medical Staff members of the department at a regular meeting of the department held before the close of the year in which the department chair’s current term expires. The consent of the Active Staff members so nominated shall be obtained prior to the election.

c. The department chair shall assume office on January 1 of the election year of the respective department.

d. Each department chair shall serve a two-year term commencing January 1.

e. If no department chair has been elected before the expiration of the current chair’s term or if the elected chair has not agreed to serve, the MEC shall appoint the chair from the Active Medical Staff at its next meeting. The appointed chair is obligated to serve a one-year term.

f. A two-thirds majority vote of all Active Medical Staff members in Good Standing of the respective department may be taken to remove a department chair during the term of office. The vote may be by mail ballot. A signed petition stating the reasons for the requested removal of the chair shall be sent to the President of the Medical Staff who shall forward it to the MEC. The MEC shall hold an interview with the department chair after which it shall make its recommendation to the Governing Body. No removal shall be effective unless and until it has been ratified by the MEC and the Governing Body.

Section 6. Duties of Department Chair

Each department chair shall have the following responsibilities with respect to medical staff members of the department:

a. Be accountable for all clinically related activities of the department to the MEC, and all administratively-related activities of the department to the Chief Executive Officer;
b. Be a member of the MEC, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his or her own department to assure quality patient care;

c. Maintain continuing surveillance and review of the professional performance of all individuals with clinical privileges in the department and report regularly thereon as directed by the MEC;

d. Be accountable for the continuous assessment and improvement of the quality of care, services, and treatment in the department;

e. Determine when consultation is being improperly withheld, inform the attending practitioner of this fact, and inform the MEC of any ongoing problems which exist with members of the department;

f. Be responsible for enforcement of Medical Staff Bylaws, Rules, and Policies and departmental policies within the department;

g. Be responsible for implementation within the department of actions taken by the MEC;

h. Assess and recommend to the MEC concerning the Medical Staff classification, the reappointment, and the delineation of clinical privileges for all practitioners and Advanced Practice Professionals in the department;

i. Establish, together with the Medical Staff and administration, the type and scope of services required to meet the needs of the patients in the department and the Hospital;

j. Develop and implement policies and procedures that guide and support the provision of care, treatment and services in the department;

k. Recommend to the MEC and Credentials Committee the criteria for clinical privileges that are relevant to the care provided in the department;

l. Integrate the department into the primary functions of the Hospital;

m. Coordinate and integrate intradepartmental and interdepartmental services;

n. Recommend a sufficient number of qualified and competent persons to provide care, treatment and services;

o. Determine the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

p. Be responsible for maintaining quality control programs, as appropriate;

q. Be responsible for the orientation and education of all persons in the department;

r. Recommend space and other resources needed by the department;

s. Be responsible for teaching, education, and research in the department;

t. Be responsible for the preparation of periodic and annual reports of the department including budgetary planning as may be required for the MEC, Chief Executive Officer, Chief Medical Officer, Governing Body, and general Medical Staff;

u. Be responsible for recruitment of practitioners for the department;

v. Be responsible for recommending the number of cases for monitoring new clinical privileges granted to practitioners in the department;
w. Assess and recommend to the MEC or Hospital administration off site sources for needed patient care, treatment and services not provided by the department or the Hospital;

x. Resolve disputes and address concerns between Medical Staff members, Advanced Practice Professionals, and Hospital staff in consultation with the applicable Senior Leader;

y. Oversee services provided through any functional unit or clinical service within the department for which a medical director has been appointed and report on such unit or clinical service to the MEC;

z. Designate an alternate to preside at department meetings in the chairman’s absence; and

aa. Perform such other duties commensurate with his or her office as may from time to time be reasonably requested of him or her by the President of the Medical Staff, the MEC, CMO, or the Governing Body.

**ARTICLE XI: COMMITTEES**

**Section 1. General Policies**

a. Any Medical Staff member desiring to attend committee meetings may do so, except when a committee convenes in executive session. However, only members of the Medical Staff who were elected, or were appointed to the committee by the President or are serving ex-officio with vote, may vote. The Credentials Committee and the MEC, as well as other committees that address issues of individual performance, conduct or competence, may go into executive session. Committees shall consist of at least three members.

b. The President of the Medical Staff shall appoint the entire membership of all committees except the Credentials Committee, and the Practitioner Wellness Committee, for which membership is elected, and the MEC.

c. Any Active Medical Staff member may request appointment to a second committee. The President is not required to honor the request.
d. The following reporting relationships enable activities of the professional activities committees and the review committees to be brought before the MEC:

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<th>COMMITTEE</th>
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<th>REPORTS TO</th>
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<tr>
<td>PROFESSIONAL ACTIVITY:</td>
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<tr>
<td>Bylaws</td>
<td>Elected by Committee</td>
<td>MEC</td>
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<td>Credentials</td>
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<td>Health Information/ Case</td>
<td>M/S Secretary</td>
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<td>Critical Care</td>
<td>Elected by Committee</td>
<td>MEC</td>
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The chairs of the respective committees shall report their activities quarterly by sending a report or attending the MEC meeting.

e. Whenever a committee appointment is for more than a two-year term, such term shall be subject to the appointee’s continued membership on the Medical Staff. Should a committee member fail to be reappointed to the Medical Staff and otherwise cease to be a member of the Medical Staff before the expiration of committee appointment, such appointment shall be automatically revoked as of the date the practitioner ceases to be a member of the Medical Staff, and the President of the Medical Staff shall elect a new appointee to serve out the remaining term.

Section 2. MEC

a. Composition: The MEC shall be chaired by the President of the Medical Staff and shall consist of officers of the Medical Staff, the Chief Medical Officer, the chair of each department, the chair of the Credentials Committee, and the immediate past President of the Medical Staff. In addition, the Chief Executive Officer or his or her designee shall be an ex-officio member, without vote, of the MEC. The President of the Medical Staff may at his or her discretion invite other people to attend MEC meetings.

b. Authority: The organized Medical Staff delegates, through these Medical Staff Bylaws, Rules and the Plan, as they may be amended, to the MEC the authority to represent and act on behalf of the organized Medical Staff as a whole in all matters affecting or involving the Medical Staff, subject to such limitations as may be imposed by the Medical Staff Bylaws, including the Rules and the Plan. The Medical Staff as a whole may remove or limit this delegation of authority through amendment of the Medical Staff Bylaws, Rules or Plan (including adoption of the amendment by the Governing Body), or by resolution passed by a vote of two-thirds of the Active Medical Staff present and eligible to vote at a regular meeting or a special meeting called for this purpose.

c. Duties:

1. To represent and to act on behalf of the Medical Staff subject to such limitations as may be imposed by the Medical Staff Bylaws, including the Rules and the Plan;

2. To create, approve, adopt, alter, or terminate any and all Policies of the Medical Staff, provided, however, that any Policy may be overridden by a vote of two-thirds of the Active Medical Staff present and eligible to vote at a regular or special meeting called for such purpose;

3. To coordinate the activities and general policies of the various departments;

4. To receive and act upon committee and department reports;
5. To provide liaison between the Medical Staff, the Chief Executive Officer, and/or CMO, and the Governing Body;

6. To recommend action to the Chief Executive Officer on matters of a medico-administrative nature;

7. To make recommendations on Hospital management matters (for example, long range planning) to the Governing Body;

8. To fulfill the Medical Staff’s accountability to the Governing Body for the medical care rendered to patients in the Hospital; including, but not limited to, monitoring all medical care quality assurance and patient safety activities and be responsible for taking any necessary and appropriate action or delegating the responsibility for such action to the appropriate committee or group;

9. To review the quality assurance and patient safety activities of the respective departments and forward the quality assurance report to the board of directors with appropriate recommendations;

10. To ensure that the Medical Staff is kept abreast of the accreditation status of the Hospital;

11. To review the recommendations of the Credentials Committee regarding all applicants to the Medical Staff and to make recommendations to the Governing Body for Medical Staff membership, assignment to departments, and delineation of specific clinical privileges; recommendations will be reported to the Medical Staff for information;

12. To review periodically all information available regarding the performance and clinical competence of Medical Staff members and other individuals with clinical privileges and, as a result of such reviews, to make recommendations to the Governing Body for reappointment and for renewal of changes in clinical privileges; recommendations will be reported to the Medical Staff for information;

13. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff and affiliates including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

14. To serve as the Equipment Committee, an advisory committee working closely with Hospital administration to determine major equipment needs;

15. To report at each general Medical Staff meeting;

16. To be regularly involved in Medical Staff management, including the enforcement of Medical Staff Rules, and committee and service affairs;

17. To make recommendations to the Governing Body regarding the organization of quality assurance and patient safety activities of the Medical Staff, the mechanisms used to review credentials and to delineate individual clinical privileges, the mechanisms by which membership on the Medical Staff may be terminated, and the mechanisms for fair hearing procedures;

18. To determine and authorize appropriate criteria, screening tools and follow-up processes to be employed in assessing a practitioner’s competence and publish such determination in applicable Policy; and

19. To report to the Governing Body the activities of the Medical Staff, as outlined, on a regular basis. No deliberation affecting the discharge of Medical Staff duties shall occur without Medical Staff representation.

d. The MEC is a major component in the medical center’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.

e. Meetings: The MEC shall meet at least six times a year and maintain a permanent record of its proceedings and actions.

Section 3. Professional Activities Committees

a. Bylaws Committee

1. Composition: The Bylaws Committee shall consist of at least three members of the Active Medical Staff, appointed by the President of the Medical Staff to staggered terms of three years.

2. Duties:
   a) To review the Bylaws and Rules on an as needed basis and
   b) To make recommendations to the Medical Staff for revisions and updating of the Medical Staff Bylaws and Rules.

b. Credentials Committee

1. Composition: The Credentials Committee shall consist of at least three members of the Active Medical Staff, elected by the Medical Staff for four-year staggered terms. This election shall take place at the annual Medical Staff meeting.

2. Duties:
   a) To investigate the credentials of all applicants or re-applicants for membership and clinical privileges or modification of appointment; then
   b) To gather the necessary credentials and recommendations needed to adequately evaluate a candidate; then
   c) To convey the applications to the chair of the appropriate departments for written recommendations; then
   d) To present the application, after review by the department chair has been completed, to the MEC with a recommendation for action. Such recommendations shall include appointment, Medical Staff category, department affiliation, clinical privileges or specified services, and any special conditions;
   e) To present the candidates and their qualifications at the Medical Staff meeting if approved by the MEC;
   f) To determine the scope and acceptability of each allied health field as necessary;
   g) To investigate the credentials of any Advanced Practice Professional applicant or re-applicant and proceed through the application steps a-e above; and
   h) To review reports that are referred by the other committees and by the President of the Medical Staff.
3. The Credentials/Advanced Practice Professionals Committee is a major component in the medical center’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.

4. Meetings: The Credentials/Advanced Practice Professionals Committee shall meet as necessary, and maintain a permanent record of its proceedings and actions and report on them to the MEC.

c. Practitioner Wellness Committee

1. Composition: The Practitioner Wellness Committee shall consist of at least three members of the Active Medical Staff. The members are elected by the Medical Staff for to serve staggered terms, the length of which will be at the discretion of the President of the Medical Staff. This election shall take place at the annual Medical Staff meeting. The committee members elect the chair. The President of the Medical Staff and the chair of Credentials Committee are not eligible to serve on this committee. The Chair of the Practitioner Wellness Committee may at his or her discretion invite other people to attend meetings and prohibit non-members from attending.

2. Duties:
   a) Receive and review reports related to Health Status or well-being of Medical Staff members and Advanced Practice Professionals;
   b) As deemed appropriate, investigate reports related to Health Status or well-being of Medical Staff members and Advanced Practice Professionals;
   c) Meet with Medical Staff members and Advanced Practice Professionals if reports warrant concern;
   d) Provide, on a voluntary basis, advice, counseling, or referrals, but the committee will NOT diagnose or prescribe treatment. Such activities shall be confidential;
   e) The committee’s function is advisory in nature and not a disciplinary body and the committee has no authority to take disciplinary action; however, in the event information received by the committee clearly demonstrates that the Health Status of a Medical Staff member or Advanced Practice Professional poses an unreasonable risk of harm to patients, that information may be referred to the MEC for corrective action; and
   f) The committee shall also consider general matters related to the health and wellbeing of the Medical Staff and Advanced Practice Professionals and, with the approval of the MEC, develop educational programs or related activities.

3. The Practitioner Wellness Committee is a major component in the medical center’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.

4. Meetings: The committee shall meet as often as necessary. It shall maintain only such records of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the MEC. Names
and detailed records of deliberation about an individual shall not be given to the MEC. Identity and information about the situation needs to be known only to the signers of the monitoring agreement, the monitors, and the Medical Staff committee responsible for monitoring.

Section 4. Review Committees

a. All review committees are a major component in the Hospital’s program, organized and operated to help improve the quality of health care in the Hospital and their activities will be conducted in a manner consistent with the provisions of 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 these committees relating to improving the quality of health care and include activities of the individual members of the committees as well as other individuals designated by the committees to assist in carrying out the duties and responsibilities of the committees, including, but not limited to, participating in monitoring plans.

b. Peer Evaluation Committee

1. Composition. The Peer Evaluation Committee shall consist of at least four Active Medical Staff members, including representatives from at least three departments, appointed by the MEC to staggered terms of three years. The Committee members elect the chair, with final approval by the MEC.

2. Duties:

   a) To assure that quality indicators for peer review are reviewed and updated on an annual basis, as indicated;

   b) To undertake quality assessment as a part of the Medical Staff peer review, and coordinating the quality assessment and peer review activities of all Medical Staff departments;

   c) To monitor and evaluate the ongoing professional practice of Practitioners and Advanced Practice Professionals;

   d) Perform Focused Professional Practice Evaluation when potential Practitioner and/or Advanced Practice Professional opportunities are identified;

   e) To assure that the process for peer review is clearly defined, fair, defensible, timely, consistent, and useful;

   f) To provide a forum to discuss quality of care issues;

   g) To make recommendations to the MEC regarding professional practice improvement opportunities, as indicated; and,

   h) To perform such other duties as requested from time to time by the MEC.

3. Meetings: The Peer Evaluation Committee shall meet at least monthly, maintain a permanent record of its proceedings, and report its findings and recommendations to the MEC through its chair.

c. Infection Prevention Committee

1. Composition: The Infection Prevention Committee shall consist of at least three Active Medical Staff members appointed by the President of the Medical Staff to staggered terms of three years. As appropriate, representatives of other professional disciplines and the administration shall participate in infection prevention functions but shall not have voting privileges. The Committee members elect the chair.
2. **Duties:**

   a) To establish an effective system of reporting, identifying and analyzing the incidence and cause of all infections within the Hospital and for notification to public health officials, when appropriate;

   b) To develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation and sanitation technique;

   c) To distinguish as far as possible between Hospital and community-acquired infections;

   d) To develop, evaluate and revise preventive, surveillance and control policies and procedures relating to all phases of the Hospital’s activities, including: operating rooms, delivery rooms, special care units; central service, Hospital owned clinics, 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 materials; food sanitation and waste management; and other situations as requested;

   e) To monitor use of antibiotics, particularly as prophylaxis, and treatment with steroids;

   f) To develop a program for discovering infections developing after discharge from the Hospital;

   g) To establish employee health Policies related to infectious diseases;

   h) To establish employee education programs related to infectious diseases;

   i) To establish regulations for Hospital visitors related to infectious diseases;

   j) To have the authority to institute any appropriate control measure or study to prevent the spread of infections when they are reasonably felt to be a danger to patients or Hospital personnel; and

   k) To act upon recommendations related to infection prevention received from the President of the Medical Staff, the MEC, the departments, and other Medical Staff and Hospital committees.

3. **Meetings:** The Infection Prevention Committee shall meet at least quarterly, maintain a permanent record of its proceedings, and report its findings and recommendations to the MEC through the chair of Infection Control Committee to the Chief Executive Officer and to nursing.

4. **Health Information/Case Management Committee/Information Technology**

   1. **Composition:** The Health Information/Case Management Committee/Information Technology shall consist of at least three Active Medical Staff members, including representatives from at least two departments, appointed by the President of the Medical Staff to staggered terms of three years. The Secretary of the Medical Staff shall serve as the chair of the Health Information/Case Management/Information Technology Committee. Representatives from nursing and administration shall also participate in committee functions, without vote. The Health Information Director and Case Management Supervisor shall be ex-officio members, without vote, of this committee.

   2. **Duties:**

      a) To review the quality of medical records at least quarterly;

      b) To ensure that a representative sample of records reflects the diagnosis, results of diagnostic tests, therapy rendered, condition, and in-Hospital progress of the patient and the condition of the patient at discharge;
c) To review the timely completion of all medical records;

d) To act upon recommendations concerning medical records from the MEC, the departments, and other committees responsible for patient care audit and other quality review, evaluation and monitoring functions;

e) To provide liaison with Hospital administration and the medical records professionals in the employ of the Hospital in the matters relating to medical record practices;

f) To require that a utilization review plan is in effect, known to the Medical Staff members and functioning at all times; and

g) To conduct such studies, take such actions, submit such reports, and make such recommendations as are required by the utilization review plan.

3. **Meetings:** The committee shall meet at least quarterly and maintain a permanent record of its proceedings. It shall report its findings and recommendations to the MEC through the Secretary of the Medical Staff.

4. e. **Trauma Committee**

1. **Composition:** The Trauma Committee shall consist of at least six members of the Active Medical Staff representing, at a minimum, the emergency department and the surgery or anesthesia department. Expanded membership is defined by the committee with consideration of medical specialties including hospitalists, orthopedics, pediatrics, and infectious disease. Members of the committee are appointed by the President of the Medical Staff to staggered terms of three years. The committee members will elect the chair. Representatives from nursing and administration shall also participate in committee functions, without vote.

2. **Duties:**

   a) To develop policies related to trauma consult requirements and timelines for attending physicians’ admission orders, rounding, and response to patients’ crises;

   b) To discuss issues resolution with regard to nursing and other hospital disciplines and the Medical Staff;

   c) To develop evidence based practice protocols and guidelines for trauma care; and

   d) To establish policies and procedures and monitor performance related to evidence-based trauma care practices.

3. **Meetings:** The committee shall meet at least quarterly and shall maintain a permanent record of its proceedings, and report its findings and recommendations to the MEC through its chairperson.

f. **Critical Care Committee**

1. **Composition:** The Critical Care Committee shall consist of at least 3 members of the Active Medical Staff representing, at a minimum, the medicine department, and the surgery/anesthesia department. Expanded membership is defined by the committee with consideration of medical specialties including, cardiology, pediatrics, pulmonology, nephrology, infectious disease and neurology. Members of the committee are appointed by the President of the Medical Staff to staggered terms of three years. The committee members will elect the chair. Representatives from nursing and administration shall also participate in committee functions, without vote.
2. **Duties:**

   a) To establish admission, prioritizing, and discharge criteria for intensive and intermediate level care beds, and to monitor appropriateness of admissions;

   b) To establish criteria for intensive care privileges;

   c) To develop policies related to intensive care consult requirements and timelines for attending physicians’ admission orders, rounding, and response to patients’ crises;

   d) To discuss issues resolution with regard to nursing and other hospital disciplines and the Medical Staff;

   e) To develop evidence-based practice protocols and guidelines for intensive and intermediate care; and

   f) To establish policies and procedures and monitor performance related to evidence-based cardiopulmonary arrest practices.

3. **Meetings:** The committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and report its findings and recommendations to the MEC through its chairperson.

   

   **Section 5. Ad Hoc Committees**

   Special committees may be appointed by the President of the Medical Staff with concurrence of the MEC for such tasks as circumstances warrant. Such special committees shall limit their activities to the accomplishment of the task for which created and appointed and shall have no power to act except as is specifically conferred by action of the MEC. Upon completion of the task for which appointed, such special committees shall stand discharged.

   **Section 6. Standing Committees**

   The standing committees of the Medical Staff described in these Bylaws may be combined or modified, and new standing committees may be created, by written resolution adopted by the MEC and communicated to the Active Medical Staff, setting forth the changes in the composition, duties, and meeting obligations of the committee being affected or created.

   **Section 7. Participation on Multi-Disciplinary Hospital Committees**

   Staff functions and responsibilities relating to liaison with the Governing Body and Hospital administration, facility and services planning and financial management shall be discharged by the appointment of Medical Staff members to such Hospital committees as are established to perform those functions. Appointment of Medical Staff members to any Hospital committee shall be made, and such committees shall operate in accordance with, the Hospital’s corporate bylaws and the written policies of the Hospital and of the Medical Staff.

   **ARTICLE XII: MEDICAL STAFF MEETINGS**

   **Section 1. Regular Meetings**

   a. The Medical Staff shall hold regular Medical Staff meetings at least quarterly.

   b. The annual Medical Staff meeting at which any elections of officers for the ensuing period are conducted shall be the fourth quarter regular meeting.

   c. The MEC shall, by standing resolution, designate the time and place for all regular Medical Staff meetings. Notice of the original resolution and any changes thereto shall be given to each member of the Medical Staff in the same manner as provided in Section 2 of this Article XII for notice of a special meeting.
d. Medical Staff meetings shall be conducted in accordance with Roberts Rules of Order.

Section 2. Special Meetings

a. The President of the Medical Staff, the MEC, or not less than one-fourth of the members of the Active Medical Staff may file, at any time, a written request, including an electronic mail request, with the President that within 14 days of such filing, a special meeting of the Medical Staff be called. The MEC shall designate the time and place of any such special meeting.

b. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail (including electronic mail), to each member of the Active Staff not less than two nor more than seven days before the date of such meeting by or at the direction of the President. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each Medical Staff member at his or her address as it appears on the records of the Hospital. Notice may also be sent to members of other Medical Staff groups who have so requested. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

Section 3. Quorum

For Medical Staff meetings, a quorum shall consist of those present and voting. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action. Medical Staff members may attend meetings remotely via telecommunications when such option is made available.

Section 4. Attendance Requirements

Each member of the Active and Affiliate Medical Staff is encouraged to attend at least 50% of all regular Medical Staff meetings in each year.

Section 5. Minutes

Minutes of each regular and special meeting of the Medical Staff shall be prepared and shall include a record of the attendance of members and the vote taken on each matter; voting may be by telephone or electronic means for those attending remotely. The presiding officer shall sign the minutes and copies thereof shall be promptly submitted to the attendees for approval. After such approval is obtained, the minutes shall be forwarded to the MEC or delegate for retention.

ARTICLE XIII: COMMITTEE AND DEPARTMENT MEETINGS

Section 1. Regular Meetings

Committees may provide, by resolution, the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings at least quarterly as needed per year, conducted either in person or electronically.

Section 2. Special Meetings

A special meeting of any committee or department may be called by or at the request of the chair thereof, by the President of the Medical Staff, or by one-third of the group’s then members, but not less than two members.

Section 3. Notice of Meetings

Written (including via electronic transmission) or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than 24 hours before the time of such meeting, by the person or persons calling the meeting. If
mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, addressed to the member at his or her address as it appears on the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

Section 4. Quorum

a. Department Meetings. For department meetings, a quorum shall consist of those department members present and voting. Department members may attend meetings remotely via telecommunications when such option is made available.

b. Committee Meetings. One-half, but not less than two, of the committee members entitled to vote shall constitute a quorum at any committee meeting. Committee members may attend meetings remotely via telecommunications when such option is made available.

Section 5. Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department; voting may be by telephone or electronic means for those attending remotely. Action may be taken without a meeting by consent in writing (setting forth the action so taken) signed by two-thirds of the members entitled to vote.

Section 6. Rights of Ex-Officio Members

The President of the Medical Staff (except when chairing or attending a meeting of the MEC) and individuals who are not Medical Staff members but who serve as members of a Medical Staff committee or department shall have the rights and privileges of the Medical Staff members appointed or assigned to the committee or department members except they shall not vote unless expressly authorized to do so in these Bylaws or be counted in determining the existence of a quorum.

Section 7. Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding officer shall sign the minutes and copies thereof shall be promptly submitted to the attendees for approval, and after such approval is obtained, forwarded to the MEC. Each committee and department shall maintain a permanent file on the minutes of each meeting.

Section 8. Attendance Requirements

Each Active Staff member shall be expected to attend not less than 50% of all meetings of each primary clinical department and/or committee to which the member is assigned.

ARTICLE XIV: RULES AND REGULATIONS

The Medical Staff shall adopt Rules recommended by the MEC as necessary for the proper conduct of the work of the Medical Staff and to implement more specifically the general principles set forth in the Medical Staff Bylaws. Such Rules shall be a part of these Bylaws. Such Rules may be amended or repealed at any regular or special meeting of the Medical Staff, with the recommendation of the MEC, by a majority vote of a quorum of the Active Medical Staff eligible to vote, provided at least ten days’ notice, accompanied by the proposed Rule and/or alterations, has been given of the intention to take such action. Such changes shall become effective when approved by the Governing Body. The Medical Staff as a whole may adopt Rules without a prior recommendation by the MEC by following the process set forth in Article XVII, Section 2.b, of the Medical Staff Bylaws.

In the event there is a documented need for an urgent amendment to the rules and regulations, or the adoption of a new rule or regulation to comply with a law or regulation, the MEC may provisionally adopt, and the Governing Body may provisionally approve, an urgent amendment to the rules and regulations without prior notification to the
Medical Staff. In such event, the Medical Staff shall be promptly notified of the amendment and members of the Medical Staff may within 30 calendar days submit to the MEC any comments regarding the provisional amendment. Upon petition signed by 20 percent of the Medical Staff members entitled to vote, any adoption or amendment to the rules and regulations, including provisional amendments, may be submitted to the conflict management process set forth in Article XVII, Section 3, of these Bylaws. The results of the conflict management process shall be communicated to the MEC, the voting members of the Medical Staff and the Board. Any repeal or revision of a rule or regulation, including the repeal or revision of a provisional amendment, shall be subject to approval by the Board.

ARTICLE XV: POLICIES

The MEC may from time to time create and/or amend policies that define the manner in which the Medical Staff and its committees, services and departments carry out the duties assigned to each group. Any policy or amendment thereto adopted by the MEC and approved by the Governing Body shall be promptly communicated to the Medical Staff.

Should any member(s) of the Medical Staff subsequently conclude that a policy or amendment thereto improperly infringes on the duties and responsibilities of a practitioner(s), that practitioner(s) may submit his/her/their objections to the policy or amendment to the MEC in writing. The MEC shall then seek to identify an appropriate solution to the concern raised by the practitioner(s). If the MEC is unable to identify a solution acceptable to all parties, the issue shall resolved in accordance with the guidelines for policy development, as referenced under Article XI of these Bylaws.

ARTICLE XVI: FAIR HEARING PLAN

The Medical Staff shall adopt a Fair Hearing Plan recommended by the MEC to delineate the bases and process for corrective actions, hearings and appeals and to implement more specifically the general principles set forth in the Medical Staff Bylaws. This Plan shall be included as Volume II of these Bylaws. The Plan may be amended or repealed at any regular or special meeting of the Medical Staff, with the recommendation of the MEC, by a majority vote of a quorum of the Active Medical Staff eligible to vote, provided at least ten days’ notice, accompanied by the proposed amendment to the Plan and/or alterations, has been given of the intention to take such action. Such changes shall become effective when approved by the Governing Body. The Medical Staff as a whole may adopt changes to the Plan without a prior recommendation by the MEC by following the process set forth in Article XVII, Section 2.b, of the Medical Staff Bylaws.

ARTICLE XVII: FORMULATION AND AMENDMENT OF MEDICAL STAFF BYLAWs

Section 1. Medical Staff Responsibility

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and recommend to the Governing Body, the Medical Staff Bylaws, and amendments to them, each of 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, to have Medical Staff Bylaws of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with the supervising licensing authorities, and to provide a system of on-going, effective professional review.

Section 2. Methodology

The Medical Staff Bylaws, excluding the Rules and the Plan which are governed by Article XIV and Article XVI respectively, may be adopted, amended, or repealed by the following combined action:

a. Medical Staff. Any proposed amendment to the Medical Staff Bylaws must be referred to the Bylaws Committee, which shall review and refer the proposed amendment to the MEC with the Bylaws Committee’s recommendation. If the Bylaws Committee has not formulated a recommendation within 60 days of receipt of a proposed amendment, the party proposing the amendment may submit the amendment directly to the MEC. The MEC shall review the amendment, may recommend modifications, and shall distribute copies of the proposed amendment, along with the MEC’s recommendation, to all Active Staff members. The vote will be
taken at the next full staff meeting or may be mailed to voting members of the Medical Staff for approval by written or secure electronic ballot. To be adopted, an amendment shall require a majority vote of the voting members of the Active Medical Staff. The MEC shall determine whether to submit the proposed amendments for approval by mail or at a meeting of the Medical Staff. Bylaw amendments submitted for approval by mail shall be subject to approval by a majority of the voting members of the Active Staff by submitting written or secure electronic ballots. Written or secure electronic ballots shall be prepared and validated in such manner as the MEC shall determine. An affirmative vote will be counted by returning the ballot marked “yes”.

b. **Inaction by MEC.** If the MEC fails or refuses to distribute the proposed amendment to the Active Staff within 60 days of its receipt of a proposed amendment and at least 10% of the Active Staff members eligible to vote sign a petition supporting the amendment, the party proposing the amendment may distribute copies of the proposed amendment to all Active Staff members, for consideration at the next Medical Staff meeting, regular or special, held at least 14 days after distribution of the proposed amendment to the Active Staff. To be effective, the amendment must be adopted by a majority of the Active Staff present and eligible to vote.

c. **Governing Body.** The Governing Body shall act no later than 30 days after the vote of the Active Staff on the proposed amendment. The affirmative vote of the majority of the Governing Body shall be final. The Governing Body may not adopt an amendment to the Medical Staff Bylaws by unilateral action. Unilateral action for these purposes would be the adoption of a proposed amendment without notice to the MEC and Medical Staff and further without providing a reasonable time for response and recommendation.

**Section 3. Conflict Resolution**

In the event of a conflict between members of the Active Staff and the MEC regarding the adoption of any bylaw, or any amendment thereto, the matters shall be submitted to a vote at the next regular meeting or special meeting called to resolve such conflict. The adoption of any bylaw or any amendment thereto may be overridden at such meeting by a simple majority vote of Active Medical Staff present and eligible to vote. In the event the Medical Staff proposes an amendment that is not approved by the MEC, the same process for resolving conflict between the Medical Staff and the MEC shall be followed.

**Section 4. Technical Modifications**

Modifications that do not materially change any Bylaw provision, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, or correction of statutory, regulatory, or accreditation standard citations contained in a footnote reference, shall not be considered an amendment of the Medical Staff Bylaws and shall not require approval as described above.

**ARTICLE XVIII: ADOPTION**

The Medical Staff Bylaws and Rules shall be adopted at any regular or special meeting of the Active Medical Staff, replace any previous Medical Staff Bylaws and Rules, and become effective when approved by the Governing Body.

The Medical Staff Bylaws and Rules shall be reviewed periodically.
ADOPTED by the Active Medical Staff on October 31, 2007.
Revised/Adopted: November 30, 2010; August 18, 2011; May 18, 2017; February 13, 2020; March 3, 2021

Mohamed El-Jack, MD
President of the Medical Staff

APPROVED by the Governing Body on October 31, 2007.
Revision Approved: December 2, 2010; August 25, 2011; June 29, 2017; February 17, 2020; March 15, 2021

Edward A. Harding, FACHE
President

Dennis Potts
Chair, Advocate Aurora Health Wisconsin Hospital Board