

Loyola University Medical Center

MEDICAL STAFF BYLAWS

Amended June 7, 2013

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Loyola University Medical Center

MEDICAL STAFF BYLAWS

Part I: Governance

Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this medical staff is to organize the activities of physicians and other clinical practitioners who practice at Loyola University Medical Center in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the Loyola University Medical Center Board of Directors.

1.2 Authority

Subject to the authority and approval of the Board of Directors the medical staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of Loyola University Medical Center. Henceforth, whenever the term “the hospital” is used, it shall mean Loyola University Medical Center; and whenever the term “the Board” is used, it shall mean the hospital Board of Directors.

Section 2. Medical Staff Membership

2.1 Nature of Medical Staff Membership

Membership on the medical staff of the hospital is a privilege that shall be extended only to professionally competent physicians (MD or DO), dentists, oral and maxillofacial surgeons, podiatrists, psychologists, optometrists, and doctorate level medical directors who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated policies of the medical staff and the hospital.

2.2 Qualifications for Membership

The qualifications for medical staff membership are delineated in Part III (Credentials Procedures Manual) of these bylaws.

2.3 Nondiscrimination

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, ethnicity, race, color, age, gender, religion, sexual orientation, marital status, veteran status, disability unrelated to the provision of patient care or required medical staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the medical staff. The Board shall act on appointment and reappointment only after the medical staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC). Appointment and reappointment to the medical staff shall be for no more than twenty-four (24) calendar months.

2.5 Medical Staff Membership and Clinical Privileges

Requests for medical staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Membership and/or privileges will be granted and administered as delineated in Part III (Credentials Procedures Manual) of these bylaws.

2.6 Medical Staff Members Responsibilities

- 2.6.1 Each staff member must, consistent with his/her granted clinical privileges, provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals.
- 2.6.2 Each staff member must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions as may be required.
- 2.6.3 Each staff member, consistent with his/her granted clinical privileges, must participate in the on call coverage of the emergency department or in other hospital coverage programs as determined by the appropriate clinical department, to assist in meeting the patient care needs of the community.
- 2.6.4 Each staff member must submit to any pertinent type of health evaluation as requested by the officers of the medical staff; President, Loyola University Medical Center; and/or committee or department chair when it appears necessary to protect the well-being of patients and/or staff or to determine fitness for duty, or when requested by the MEC or Medical Staff Credentials Committee as part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any medical staff and hospital policies addressing physician health or impairment.
- 2.6.5 Each staff member must abide by these bylaws and any other rules, regulations, policies, procedures, and standards of the medical staff and hospital.
- 2.6.6 Each staff member must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession.
- 2.6.7 Each staff member agrees to release absolutely from any liability, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care provided by the medical staff member and his/her credentials.
- 2.6.8 Each staff member shall prepare and complete in timely fashion, according to medical staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments.

- a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.
- b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.
- c. In the case of readmission within 30 days for the same or related condition, at least an interval admission note that includes all additions to the history and subsequent changes in physical findings must be recorded.
- d. At a minimum, a history and physical examination must include the following: medical history, surgical history, medications, history of present illness, vital signs, lung examination, heart examination and abdominal examination.

2.6.9 Each staff member will use confidential information only as necessary for treatment, payment or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform medical staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer review information, and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure.

2.6.10 Each staff member must participate in any type of competency evaluation when determined necessary by the officers of the medical staff, department chairs, the MEC and/or Board in order to properly delineate that member's clinical privileges.

2.6.11 Each staff member shall disclose to the medical staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the medical staff or hospital. Medical staff membership will deal with conflict of interest issues per the *Conflicts of Interest and Disclosure Policy*.

2.6.12 Each staff member must comply with *The Ethical and Religious Directives for Catholic Health Care Services*, as promulgated and revised from time to time by the United States Conference of Catholic Bishops.

2.7 Medical Staff Member Rights

2.7.1 Each staff member in the active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her department chair or other appropriate medical staff leader(s),

that practitioner may, upon written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

- 2.7.2 Each staff member in the active category may initiate a call for a general staff meeting to discuss a matter relevant to the medical staff. Upon presentation of a petition signed by twenty-five percent (25%) of the members in the active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.
- 2.7.3 Each staff member in the active category may challenge any rule or policy established by the MEC. In the event that a rule, regulation or policy is thought to be inappropriate, any medical staff member may submit a petition signed by twenty-five percent (25%) of the members of the active category. Upon presentation of such a petition, the adoption procedure outlined in Part I, Section 9.3 will be followed.
- 2.7.4 Each staff member in the active category may call for a department meeting by presenting a petition signed by twenty-five percent (25%) of the members of the department. Upon presentation of such a petition the department chair will schedule a department meeting.
- 2.7.5 The above Part I, Sections 2.7.1 to 2.7.4 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II (Investigations, Corrective Action, Hearing and Appeal Plan) of these bylaws provides recourse in these matters.
- 2.7.6 Any staff member has a right to a hearing/appeal pursuant to the conditions and procedures described in the medical staff's hearing and appeal procedure (Part II of these bylaws).

2.8 Staff Dues

Annual medical staff dues, if any, shall be determined by the MEC. Failure of a medical staff member to pay dues shall be considered a voluntary resignation from the medical staff. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified positions.

2.9 Indemnification

- 2.9.1 Members of the medical staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and medical staff.
- 2.9.2 Subject to applicable law, the hospital shall indemnify against actual and necessary expenses, costs, and liabilities incurred by a medical staff member in connection with the defense of any pending or threatened action, suit or proceeding to which he/she is made a party by reason of his/her having acted in an official capacity in good faith on behalf of the hospital or medical staff. However, no medical staff member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications

The active staff shall consist of physicians, each of whom:

- a. Meet the basic qualifications set forth in Part I, Section 2.6 of these bylaws;
- b. Are involved in the care of patients at the hospital and/or its ambulatory facilities; and
- c. Agree to the participation of their patients in the educational programs of the hospital.

3.1.2 Prerogatives

Active members may:

- a. Admit patients to the hospital in accordance with these bylaws, rules and regulations and medical staff and/or hospital policies and procedures;
- b. Exercise clinical privileges granted pursuant to Part III of these bylaws; and
- c. Be eligible for all hospital committees as voting members.

3.1.3 Responsibilities

Each member of the active staff who is granted privileges shall:

- a. Be required to discharge the basic responsibilities specified in Part I, Section 2.6;
- b. Care for a sufficient number of patients to provide an adequate assessment of competence and skill;
- c. Retain responsibility within the specified area of professional competence for the daily care and supervision of each patient in the hospital for whom services are provided by such active staff member or arrange a suitable alternative for such care and supervision; and
- d. Participate actively in performance improvement activities required of the staff, and in discharging such other staff functions as may from time to time be required.

3.2 The Medical Director Category (doctorate level, nonphysician)

3.2.1 Qualifications

This category is reserved for medical directors who are not physicians but are at the doctorate level of training.

3.2.2 Prerogatives

Members of this category do not admit patients to the hospital. They may participate in medical staff meetings as full voting members.

3.2.3 Responsibilities

Members of this category must follow these bylaws, rules and regulations, and medical staff and/or hospital policies and procedures. They shall actively participate in performance improvement activities required of the staff.

3.3 The Community Category

3.3.1 Qualifications

The community category is reserved for members who maintain a clinical practice in the hospital service area and wish to be able to follow the course of their patients when admitted to the hospital.

3.3.2 Prerogatives

Members of this category may:

- a. Order non-invasive outpatient diagnostic tests and services, visit patients in the hospital, review medical records and attend medical staff, department, division, and committee meetings, CME functions and social events; and
- b. Not be eligible for clinical privileges, not manage patient care in the hospital and not vote on medical staff affairs or hold office.

3.3.3 Responsibilities

Members of this category shall:

- a. Fulfill or comply with these bylaws, rules and regulations, and medical staff and/or hospital policies and procedures.

3.4 The Allied Staff

3.4.1 Qualifications

The allied category is reserved for members who are dentists, oral and maxillofacial surgeons, optometrists, psychologists, and podiatrists who fulfill the basic qualifications of staff membership and have completed training in their various professional disciplines.

3.4.2 Prerogatives

Members of this category may:

- a. Exercise clinical privileges granted pursuant to Part III of these bylaws; and
- b. Be eligible for all hospital committees as voting members.

3.4.3 Responsibilities

Each member of this category who is granted privileges shall:

- a. Be required to discharge the basic responsibilities specified in Part I, Section 2.6;
- b. Care for a sufficient number of patients to provide an adequate assessment of competence and skill;
- c. Retain responsibility within the specified area of professional competence for the daily care and supervision of each patient in the hospital for whom services are provided by such allied staff member or arrange a suitable alternative for such care and supervision;
- d. Follow these bylaws, rules and regulations, and medical staff and/or hospital policies and procedures; and
- e. Participate actively in performance improvement activities required of the staff, and in discharging such other staff functions as may from time to time be required.

Section 4. Officers of the Medical Staff

4.1 Officers of the Medical Staff

4.1.1 Chief of Staff

4.1.2 Senior Vice President for Clinical Affairs/Chief Medical Officer

4.2 Qualifications of Officers

4.2.1 Officers must be members in good standing in the active category and be actively involved in patient care in the hospital, have previously served in a significant leadership position on a medical staff (e.g. department or division chair, committee chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges, have participated in medical staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the hospital, and have excellent administrative and communication skills. Qualifications for the positions of Senior Vice President for Clinical Affairs/Chief Medical Officer and Chief of Staff also include the degree of MD, DO, DDS, or DMD.

4.2.2 Officers may not simultaneously hold a leadership position on another hospital's medical staff or in a facility that is directly competing with the hospital. Noncompliance with this requirement will result in the officer being automatically removed from office unless the Board determines that allowing the officer to maintain his/her position is in the best interest of the hospital. The Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

4.3 Appointment of Officers

- 4.3.1 Officers shall be appointed by the President, Loyola University Medical Center, and shall hold office upon appointment until their successors are appointed.
- 4.3.2 The Senior Vice President for Clinical Affairs/Chief Medical Officer must be a physician with demonstrated qualifications on the basis of experience and ability to direct the medical, administrative and strategic aspects of hospital activities. He/she must be a member of the full-time medical staff at the time of appointment and must remain a member in good standing during the term of office.
- 4.3.3 The Chief of Staff must be a physician with demonstrated qualifications on the basis of experience and ability to direct the medical and administrative aspects of medical center activities. He/she must be a member of the full-time medical staff at the time of appointment and must remain a member in good standing during the term of office.

4.4 Term of Office

All officers serve at the discretion of the President, Loyola University Medical Center, until their successor is named.

4.5 Vacancies of Office

The President, Loyola University Medical Center, shall fill vacancies of office.

4.6 Duties of Officers

4.6.1 Chief of Staff

- 4.6.1.1 The Chief of Staff shall represent the interests of the medical staff to the MEC and the Board. The Chief of Staff will fulfill the duties specified in Part IV (Organization and Functions Manual) of these bylaws.
- 4.6.1.2 The Chief of Staff shall provide direction to and oversee medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the medical staff bylaws, rules and regulations and policies. The Chief of Staff shall communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital administration, the MEC and the Board. The Chief of Staff shall be involved, in conjunction with the department chair, in the evaluation and administration of practitioner impairment issues. The Chief of Staff shall exercise such authority commensurate with the office as set forth in the medical staff bylaws.

4.6.2 Senior Vice President for Clinical Affairs/Chief Medical Officer

- 4.6.2.1 The Senior Vice President for Clinical Affairs/Chief Medical Officer shall be responsible for providing leadership in the conceptualization, development,

implementation and measurement of the hospital's approach to quality, patient safety, adverse event reduction and clinical effectiveness. The Chief of Staff shall report to the Senior Vice President for Clinical Affairs/Chief Medical Officer. In the absence of the Chief of Staff, the Senior Vice President for Clinical Affairs/Chief Medical Officer or his/her designee shall assume all the duties and have the authority of the Chief of Staff.

4.6.2.2 The Senior Vice President for Clinical Affairs/Chief Medical Officer shall be the primary officer of the medical staff and the medical staff's advocate and representative in its relationships to the Board and the administration of the hospital. The Senior Vice President for Clinical Affairs/Chief Medical Officer, in collaboration with the medical staff, shall be responsible developing and implementing systems which foster innovation, ensure the effective and safe delivery of medical care, and facilitate improvement in patient outcomes and satisfactions. The Senior Vice President for Clinical Affairs/Chief Medical Officer, in collaboration with the Chief of Staff, shall be responsible for the appointment of medical staff committee chairs.

4.6.3 The Chief of Staff and/or the Senior Vice President for Clinical Affairs/Chief Medical Officer may independently request a Focused Professional Practice Evaluation of an active medical staff member and/or practitioner in the event concerns related to quality and/or patient safety arise.

4.7 Removal and Resignation from Office

4.7.1 The President, Loyola University Medical Center, may remove any officer.

Automatic removal shall be for failure to meet those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, for conduct or statements that damage the hospital, its goals, or programs, or an automatic or precautionary suspension of clinical privileges that lasts more than thirty days. The Board will determine if the member has failed in his/her duties after consulting with the Joint Conference Committee.

4.7.2 Resignation: Any officer may resign at any time by giving written notice to the President, Loyola University Medical Center. Such resignation takes effect on the date of receipt, when a successor is appointed, or any later time specified therein.

Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

The medical staff shall be organized into departments. The medical staff may create clinical divisions within a department in order to facilitate medical staff activities. A list of departments organized by the medical staff and formally recognized by the MEC is listed in Part IV (Organization and Functions Manual) of these bylaws based on the clinical departments of the Loyola University of Chicago, Stritch School of Medicine.

5.2 Department Chairs

- 5.2.1 Each academic department of the Stritch School of Medicine shall have a corresponding clinical department at the hospital, and each academic department chair of the Stritch School of Medicine shall serve as the clinical department chair for the corresponding clinical department at the hospital.

5.3 Qualifications, Appointment, and Removal of Department Chairs

- 5.3.1 The Dean, Stritch School of Medicine and the President of Loyola University Medical Center shall mutually agree on all academic department chairpersons of the Stritch School of Medicine and clinical department chairpersons of hospital, after consultation with the Senior Vice President and Provost for Health Sciences of Loyola University of Chicago, the Board and the full-time faculty of the department.
- 5.3.2 Loyola University of Chicago's appointment of academic department chairs shall be in accordance with its policies and procedures for doing so, and Loyola University Medical Center's appointment of clinical department chairs shall be in accordance with its own policies and procedures for doing so. The academic department chairs shall report, for purposes of their academic appointments and duties at the Loyola University of Chicago, Stritch School of Medicine, to the Dean of the Stritch School of Medicine, who shall be responsible for the performance of the academic department chairs with respect to their academic appointments and responsibilities.
- 5.3.3 Loyola University of Chicago may terminate the academic appointment of any academic department chair in accordance with its policies and procedures for doing so and Loyola University Medical Center may terminate its employment of any clinical department chair in accordance with its own policies and procedures for doing so. Prior to any action by Loyola University of Chicago to terminate the academic appointment of an academic department chair, and prior to any action by the hospital to terminate the employment of any clinical department chair, each party shall consult with and seek the advice and input of the other.
- 5.3.4 All clinical department chairs must be members of the active medical staff, have relevant clinical privileges and be certified by an appropriate specialty board, or have affirmatively established comparable competence through the credentialing process. They will be nationally recognized for both clinical and academic excellence.
- 5.3.5 The clinical department chairs shall report, for purposes of their clinical appointments, responsibilities and duties at the hospital, to the President of Loyola University Medical Center, and/or Senior Vice President for Clinical Affairs/Chief Medical Officer, who shall be responsible for the performance of the clinical department chairs with respect to their clinical appointments and responsibilities.
- 5.3.6 Management of both the Stritch School of Medicine and Loyola University Medical Center shall regularly assess the academic and clinical performance of the academic department chairs and clinical department chairs, and shall consult with and seek recommendations from each other in order to evaluate the performance of the academic department chairs and the clinical department chairs.

5.3.7 Department chairs may be removed from office automatically by the President of Loyola University Medical Center if any of the following occur:

- a. The chair suffers an involuntary loss or significant limitation of practice privileges; or
- b. The chair ceases to be a member in good standing of the medical staff.

5.3.8 Department chairs shall carry out the responsibilities assigned in Part IV (Organization and Function Manual) of these bylaws.

5.4 Assignment to Department

The MEC will, after consideration of the recommendations of the chair of the appropriate department, recommend department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary department. Clinical privileges are independent of department assignment.

Section 6. Committees

6.1 Designation and Substitution

There shall be a MEC and such other standing and *ad hoc* committees as established by the MEC and enumerated in Part IV (Organization and Functions Manual) of the bylaws. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the medical staff, may be discharged by medical staff representation on such hospital committees as are established to perform such functions. The Chief of Staff may appoint *ad hoc* committees as necessary to address time-limited or specialized tasks.

6.2 MEC

- a. **Committee Membership: Composition:** The MEC shall be a standing committee consisting of the following voting members: Clinical Leadership Council; two (2) *ad hoc* physicians or allied staff appointed by the Chief of Staff in collaboration with the Senior Vice President for Clinical Affairs/Chief Medical Officer; the President, Loyola University Medical Center or designee; the Senior Vice President for Clinical Affairs/Chief Medical Officer; the Vice President/Chief Nurse Executive; the Chief Operating Officer and the Senior Vice President, Clinical Programs and Practice Development. The chair will be the Chief of Staff. The Dean, Stritch School of Medicine will be a non-voting member of the MEC.
- b. **Removal from MEC:** Any Clinical Leadership Council member will automatically lose his/her membership on the MEC if he/she loses his/her position on the Clinical Leadership Council and will be replaced by his/her replacement on the Clinical Leadership Council.

6.2.1 Duties: The duties of the MEC, as delegated by the medical staff, shall be to:

- a. Serve as the final decision-making body of the medical staff in accordance with these bylaws and provide oversight for all medical staff functions;
- b. Coordinate the implementation of policies adopted by the Board;
- c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, department assignments, clinical privileges, including expedited credentialing, and corrective action;
- d. Report to the Board and to the medical staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities;
- e. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of medical staff members including collegial and educational efforts and investigations, when warranted;
- f. Make recommendations to the Board on medical administrative and hospital management matters;
- g. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;
- h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
- i. Review and act on reports from medical staff committees, departments, and other assigned activity groups;
- j. Formulate and recommend to the Board medical staff rules and regulations, policies, and procedures;
- k. Request and evaluate any Professional Practice Evaluation pursuant to Part III, Section 4 of these bylaws, of practitioners privileged through the medical staff process when there is question about an applicant or member's ability to perform privileges requested or currently granted;
- l. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;
- m. Consult with administration on the quality, timeliness, and appropriateness of clinical contracts for services provided to the hospital by entities outside the hospital;
- n. Oversee that portion of the organizational integrity plan that pertains to the medical staff;
- o. Hold medical staff leaders, committees, and departments accountable for fulfilling their duties and responsibilities;
- p. Make recommendations to the medical staff for changes or amendments to these bylaws; and
- q. Act for the organized medical staff between meetings of the organized medical staff.

- 6.2.2 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

- 7.1.1 General meetings, if any, of the medical staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all medical staff members via appropriate media and posted conspicuously.
- 7.1.2 Except for bylaws amendments or as otherwise specified in these bylaws, the actions of a majority of the members present and voting at a meeting of the medical staff is the action of the group. Action may be taken without a meeting of the medical staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.
- 7.1.3 Special Meetings of the Medical Staff
- a. The Chief of Staff may call a special meeting of the medical staff at any time. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.
 - b. Written or electronic notice stating the time, place, and purposes of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

- 7.2 Committees and departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.3 Special Meetings of Committees and Departments

A special meeting of any committee or department may be called by the chair thereof or by the Chief of Staff.

7.4 Quorum

- 7.4.1 Medical Staff Meetings: Those present and eligible medical staff members voting on an issue will constitute a quorum.
- 7.4.2 MEC: A quorum will exist when fifty percent (50%) of the members are present. When dealing with requests from those eligible for expedited credentialing for

routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least three members.

7.4.3 Medical Staff Credentials Committee: A quorum will exist when fifty percent (50%) of the voting members are present.

7.4.4 Department meetings or medical staff committees other than those listed in Part I, Section 7.4.2 above: Those present and eligible medical staff members voting on an issue will constitute a quorum.

7.5 Attendance Requirements

7.5.1 Members of the medical staff are encouraged to attend meetings of the medical staff.

- a. MEC and Medical Staff Credentials Committee meetings: Members of these committees are expected to attend at least seventy-five percent (75%) of the meetings held. Failure to meet the attendance requirement of at least 75% of regular and special meetings may lead to consideration of removal from the committee.
- b. Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with medical staff or hospital policies or has deviated from standard clinical or professional practice, the Chief of Staff or the applicable department or committee chair may require the practitioner to confer with him/her or with a standing or *ad hoc* committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic termination of the practitioner's membership and privileges. Such termination would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.
- c. Nothing in the foregoing paragraph shall preclude the initiation of restriction or suspension of clinical privileges as outlined in Part II (Investigations, Corrective Action, Hearing and Appeal Plan) of these bylaws.

7.6 Participation by the President, Loyola University Medical Center

The President, Loyola University Medical Center or his/her designee may attend any general, committee or department meetings of the medical staff as an *ex officio* member without vote.

7.7 Robert's Rules of Order

Medical staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest edition of Robert's Rules of Order shall determine procedure.

7.8 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the department or committee not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee or Department

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or department.

7.10 Rights of *Ex officio* Members

Except as otherwise provided in these bylaws, persons serving as *ex officio* members of a committee shall have all rights and privileges of regular members. *Ex officio* members shall not vote or be counted in determining the existence of a quorum.

7.11 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 chair shall authenticate the minutes and copies thereof shall be submitted to the MEC or other designated committee. A permanent file of the minutes of each meeting shall be maintained.

Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, involving issues of patient care or safety, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the officers of the medical staff and an equal number of members of the Board for review and recommendation to the full the Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2 The chair of the Board or the Chief of Staff may call for a joint conference as described above at any time and for any reason in order to seek direct input from the medical staff leaders, clarify any issue, or relay information directly to medical staff leaders.

8.1.3 Any conflict between the medical staff and the MEC will be resolved using the mechanisms noted in Part I, Sections 2.7.1 through 2.7.4 of these bylaws.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

- 9.1.1 The medical staff shall have the responsibility to formulate, review and revise as necessary, and recommend to the Board for approval any medical staff bylaws, rules and regulations, and amendments. Amendments to the bylaws and rules and regulations shall be effective when approved by the Board. The medical staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.
- 9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various divisions of these bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

- 9.2.1 Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by twenty-five percent (25%) of the members of the active category.

Each active member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All active members of the medical staff shall receive at least fourteen (14) days advance notice of the proposed changes. The amendment shall be considered approved by the medical staff unless 33% of those members eligible to vote returns a ballot marked “no”.

Amendments so adopted by the medical staff shall be effective when approved by the Board.

9.3 Methods of Adoption and Amendments to any Medical Staff Rules and Regulations

- 9.3.1 The medical staff may adopt additional rules and/or regulations as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules and Regulations Manual may be used to organize these additional documents.
- 9.3.2 Proposed amendments to the Rules and Regulations Manual may be originated by the MEC.
- 9.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and/or regulations may be adopted, amended or repealed, in whole or in part, and such changes shall be effective when approved by the Board.
- 9.3.4 In addition to the process described in Part I, Section 9.3.3 above, the organized medical staff itself may recommend directly to the Board an amendment(s) to any rule and/or regulation by submitting a petition signed by twenty-five percent (25%)

of the members of the active category. Upon presentation of such petition, the adoption process outlined in Part I, Section 9.2.1 above will be followed.

- 9.4 Methods of Adoption and Amendments to any Medical Staff Policies and Procedures
 - 9.4.1 The medical staff may adopt additional policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Policy and Procedure Manual may be used to organize these additional documents.
 - 9.4.2 Proposed amendments to the Policy and Procedure Manual may be originated by the MEC.
 - 9.4.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Policies and procedures and amendments thereto do not require Board approval and will become effective upon approval of the MEC.
 - 9.4.4 The organized medical staff itself may recommend to the MEC an amendment (s) to any policy or procedure by submitting a petition signed by twenty-five percent (25%) of the members in the active category. Upon presentation of such petition, the adoption process outlined in Part I, Section 9.4.3 above will be followed.
- 9.5 When a new rule and/or regulation, or policy and/or procedure is proposed, the proposing party (either the MEC or the organized medical staff) will communicate the proposal to the other party prior to vote.
- 9.6 The MEC may adopt such amendments to these bylaws, rules and regulations that are, in the committee's judgment, technical or legal modifications or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the President, Loyola University Medical Center. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.
- 9.7 In the event the medical staff disagrees with proposed amendments to these bylaws, rules, and regulations or proposed new rules and regulations and policies, the process outlined in Part I, Section 2.7 above will be followed.

Section 10. Physician Wellness

- 10.1 The medical staff has an obligation to provide a safe environment, to ensure patient safety, and to protect the health and welfare of members of the medical staff as well as students, residents, staff and employees.
- 10.2 All medical staff members are expected to report to the hospital and/or its ambulatory facilities fit for duty, which means they are able to perform their clinical duties in a safe, appropriate and effective manner. The hospital encourages medical staff members to seek assistance voluntarily before clinical and professional performance is affected.

10.3 All medical staff members are entitled to diagnosis, treatment and rehabilitation of any physical, psychiatric or emotional illness, including drug and alcohol dependence that impairs his/her ability to provide safe, appropriate and effective care in an environment that is free of any disciplinary action or judgment.

10.4 Referral

10.4.1 Self Referral

Any medical staff member who feels that his/her ability to practice medicine in a safe, appropriate and effective manner is impaired because of physical, psychiatric or emotional illness, including drug or alcohol dependence, may refer himself/herself for a fitness for duty consultation to the Chief of Staff or Senior Vice President for Clinical Affairs/Chief Medical Officer. This request shall be in writing or in person.

10.4.2 Third Party Referral

Any individual may report to the Chief of Staff or Senior Vice President for Clinical Affairs/Chief Medical Officer any medical staff member behavior or conduct that may interfere with the safe, appropriate and effective practice of medicine due to physical, psychiatric or emotional illness, including drug or alcohol dependence. The report should ordinarily be in writing and should be factual and shall include a description of the incident(s), behavior(s) or conduct that led to the belief that a staff member is not fit for duty.

- a. In the event of a third party referral, the name of the individual making the referral and the specifics of the incident(s), behavior(s) or conduct reported shall remain as confidential as reasonably possible.
- b. The contents of the report and the staff member's name shall remain confidential except as limited by law, ethical obligation or when the safety of a patient is threatened.

10.5 Investigation of a Third Party Referral

10.5.1 The Chief of Staff or Senior Vice President for Clinical Affairs/Chief Medical Officer shall investigate all third party complaints. If investigation reveals that there is no merit to the report, the report shall be destroyed. If investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall remain in the medical staff member's file and the medical staff member's activity and practice shall be monitored until it can be established whether there is a fitness for duty issue. When there is credible evidence that a medical staff member is not fit for duty, he/she shall be referred for consultation.

10.5.2 If there appears to be imminent danger to patients, students, residents, staff or employees, the medical staff member shall be promptly removed from the clinical setting.

10.6 Fitness for Duty Consultation

10.6.1 Fitness for duty consultation will include testing for chemical (e.g. alcohol and drug)

levels, followed by an assessment with referral for psychiatric evaluation or any other evaluation or follow-up deemed necessary. Fitness for duty consultation is limited to the testing for alcohol and drugs. No other medical assessments will be completed and no medical inquiries will be made that are not compliant with applicable federal and state law.

10.6.2 All self and third party referrals involving fitness for duty shall be referred for consultation. The drug and alcohol screening portion of the fitness for duty consultation shall be conducted by the hospital's Employee Health Services. The remainder of the fitness for duty consultation, as described above in Part I, Section 10.6.1, may be conducted by the hospital's Employee Assistance Program staff, a member of the medical staff or by a physician or allied health professional from another institution. The consultant should be mutually agreeable to the referred medical staff member and the hospital.

10.6.3 The referred medical staff member is required to cooperate fully with the Chief of Staff or Senior Vice President for Clinical Affairs/Chief Medical Officer. The referred medical staff member must sign consent forms for both the fitness for duty consultation and communication of its results. Refusal on the part of the referred medical staff member to cooperate with the fitness for duty consultation will result in summary suspension.

10.6.4 Any medical staff member referred for a fitness for duty consultation is relieved from clinical duty pending the outcome of the consultation.

10.6.5 If the consultant determines that the referred medical staff member is fit for duty, he/she will resume clinical duties after meeting with the department chairperson and Chief of Staff or Senior Vice President for Clinical Affairs/Chief Medical Officer.

10.7 Action

10.7.1 Based on the consultant's determination, the following restrictions may be imposed:

- a. The medical staff member should undertake a therapeutic or rehabilitation program as a condition of continued medical staff appointment and clinical privileges;
- b. Appropriate restrictions on the medical staff member's clinical practice; and/or
- c. Immediate suspension of the medical staff member's privileges until rehabilitation has been accomplished if he/she does not agree to discontinue clinical practice voluntarily.

10.8 If the referred medical staff member's privileges were restricted, upon completion of the required treatment program, he/she may request restoration of full medical staff appointment and clinical privileges. The referred medical staff member will be required to provide a letter from the treatment provider attesting to the medical staff member's ability to practice medicine in a safe, appropriate and effective manner. Such letter shall include any requirements for after care or periodic follow-up reports that may be required.

10.9 In cases of drug or alcohol dependence, the referred medical staff member must agree to submit to random alcohol or drug screenings for an unspecified period of time at the request of the Chief of Staff or Senior Vice President for Clinical Affairs/Chief Medical Officer.

10.10 Hospital shall comply with all local, state and federal requirements for reporting impaired practitioners.

10.11 The hospital shall ensure that the medical staff is educated about illness and fitness for duty by written materials, audio visual aids and from time to time other educational endeavors.

Loyola University Medical Center

MEDICAL STAFF BYLAWS

Part II: Corrective Action, Fair Hearing and Appellate Review

Section 1. Definitions

The following definitions apply to the provisions of this Part II.

Appellate Review Body means the group designated under this Part II to hear a request for appellate review properly filed and pursued by a medical staff member.

Day means regular calendar day, including Saturdays, Sundays and official hospital holidays. If the day on which a notice, request or report under this Part II must be received or sent falls on a Saturday, Sunday or official hospital holiday, the deadline shall be the next regular working day thereafter.

Hearing Committee means a committee appointed under this Part II to hold an evidentiary hearing properly filed and pursued by a medical staff member.

Parties mean the medical staff member who requested the hearing or appellate review and the body or bodies upon whose adverse action a hearing or appellate review request is predicated.

Special Notice means written notice that is (a) delivered personally, (b) sent by registered or certified mail, return receipt requested, or (c) sent by overnight delivery service to the person to whom the notice is directed.

Section 2. Corrective Action

2.1 Routine Corrective Action

2.1.1 Criteria for Initiation

Whenever the clinical activity or professional conduct of a medical staff member is detrimental to patient safety, the delivery of quality patient care or disruptive to hospital operations, corrective action may be initiated. Such action may be initiated by the Chief of Staff, Senior Vice President for Clinical Affairs/Chief Medical Officer, chairperson of the respective department, Medical Director of Primary Care or any MEC member.

2.1.2 Requests and Notices

All requests for corrective action shall be in writing to the Chief of Staff. The request shall describe the specific activities or conduct which constitute grounds for the request.

2.1.3 Investigation

All requests will be investigated by the Patient Safety Evaluation Committee as soon as practicable. The Patient Safety Evaluation Committee shall forward a written report to the MEC and the Chief of Staff upon completion of its investigation. As part of the investigative process, the Patient Safety Evaluation Committee may

request a Professional Practice Evaluation pursuant to Part III, Section 4 of these bylaws, for any active medical staff member in the event a quality and/or patient safety concern arises.

2.1.4 Interviews

When the MEC is considering initiating an adverse recommendation concerning a medical staff member, the MEC may afford him/her an interview. The interview shall not be conducted according to the procedural rules provided with respect to hearings. The medical staff member shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of such interview shall be made.

2.1.5 MEC Action

The MEC shall take action at its next meeting following receipt of the investigation report. Such action may include:

Rejecting the request for corrective action;

Issuing a warning, letter of admonition or letter of reprimand;

Recommending terms of probation or requirements of consultation;

Recommending reduction, suspension or revocation of clinical privileges;

Recommending limitation of any staff prerogatives directly related to patient care;

Recommending suspension or revocation of staff membership;

Remanding for further investigation; or

Such other action as determined appropriate by the MEC.

The MEC shall transmit notice of such action to the Board and to the medical staff member, with Special Notice of any adverse recommendation provided as described herein.

2.1.6 Right of Hearing and Appeal

Any adverse recommendation by the MEC shall entitle the medical staff member to the right of hearing and appeal as described in this Part II.

2.2 Summary Suspension

2.2.1 Criteria and Initiation

Whenever the continuation of practice by a medical staff member constitutes an immediate danger to the public, including patients, visitors and hospital employees and staff, any two of the following individuals shall have the authority to summarily suspend the medical staff membership of, or all or any portion of, the clinical

privileges of the member; the respective department chairperson, Senior Vice President for Clinical Affairs/Chief Medical Officer, Chief of Staff, or member of the MEC. Such summary suspension shall be effective immediately upon imposition. Concurrently, the individuals imposing the suspension shall notify the Chief of Staff. Thereafter, the Chief of Staff shall issue written confirmation of the suspension to the medical staff member by Special Notice, including a statement that the medical staff member has three (3) days from the date of the suspension to request a hearing, as provided below.

A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists. This documentation or information must be available at the time the summary suspension decision is made, when that decision is investigated by the Patient Safety Evaluation Committee, and reviewed by the MEC.

2.2.2 Investigation

Summary suspensions should be investigated by the Patient Safety Evaluation Committee as soon as practicable. The Patient Safety Evaluation Committee shall forward a written report to the MEC and the Chief of Staff upon completion of its investigation.

2.2.3 MEC Action

The MEC shall take action as soon as is reasonably practical following receipt of the report of investigation, and may recommend affirming, lifting, expunging or modifying the summary suspension if the medical staff member requests such a review. If the MEC recommends that the summary suspension should be lifted, expunged or modified, this recommendation must be reviewed and considered by the Board, or its designated committee, on an expedited basis.

2.2.4 Right of Hearing and Appeal

Any adverse recommendation by the MEC shall entitle the medical staff member to the right of hearing and appeal consistent with this Part II. The summary suspension shall remain in effect pending a final decision. The medical staff member shall have three (3) days from the date of the suspension to file a written request for a hearing. The request for a hearing shall be addressed to the Chief of Staff by Special Notice. Any requested hearing must be commenced within fifteen (15) days after the summary suspension is imposed and completed without delay, unless otherwise agreed to be the parties, and shall be consistent with the procedures otherwise described herein, but for the fifteen (15) day period. For these hearings and as needed, the MEC may modify the other timelines required and procedural processes.

Section 3. Administrative Suspension

3.1.1 Generally

In the circumstances described in this Part II, Section 3, a medical staff member's

privileges and/or membership will be administratively suspended, with a limited right to hearing upon request. The medical staff member shall have three (3) days from the date of the administrative suspension to file a written request for a hearing. The request for a hearing shall be addressed to the Chief of Staff by Special Notice. Any hearing so requested must be commenced within fifteen (15) days of the administrative action being taken, and must be completed without delay.

While the hearing will be conducted in a manner consistent with this Part II, the scope of any hearing related to administrative suspension of privileges and/or membership is limited to whether or not there was a factual basis to take the administrative action. The Chief of Staff, with the approval of the President, Loyola University Medical Center or the Senior Vice President for Clinical Affairs/Chief Medical Officer, may reinstate the medical staff member's privileges and/or membership after determining that the circumstances that led to the administrative suspension have been rectified or are no longer present.

Unless otherwise provided, if these triggering circumstances have not been resolved within sixty (60) days, the medical staff member's membership and clinical privileges terminate. If the medical staff member desires reinstatement of membership and/or clinical privileges after termination, he/she must reapply. In addition, further corrective action may be recommended in accordance with this Part II whenever any of the following actions occur.

3.1.2 Administrative Actions

3.1.2.1 Loss of Licensure

Whenever a medical staff member's license or other legal credential authorizing practice in this state is revoked, suspended, expired or voluntarily relinquished, membership and clinical privileges shall automatically terminate as of the date such action becomes effective, without right to a hearing or appellate review.

3.1.2.2 Licensure-Restriction

Whenever a medical staff member's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that he/she has been granted at the hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner as of the date such action becomes effective.

3.1.2.3 Licensure-Probation

Whenever a medical staff member is placed on probation by the applicable licensing or certifying authority, his/her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective.

3.1.2.4 Medicare, Medicaid, Tricare or Other Federal Programs

Whenever a medical staff member is sanctioned or barred from Medicare, Medicaid, Tricare or other federal programs, his/her membership and clinical privileges shall automatically terminate as of the date such action becomes effective. The membership and clinical privileges of any medical staff member listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will automatically terminate as of the date of listing.

3.1.2.5 Controlled Substances

- a. Whenever a medical staff member's United States Drug Enforcement Agency (DEA) registration or Illinois Controlled Substance License is revoked, limited or suspended, he/she will automatically and correspondingly lose the right at the hospital to prescribe medications covered by the registration or license as of the date such action becomes effective.
- b. Whenever a medical staff member's DEA registration or Illinois Controlled Substance License is placed on probation, his/her right to prescribe such medications at the hospital shall automatically become subject to the same terms of the probation as of the date such action becomes effective.

3.1.2.6 Medical Record Completion Requirements

A medical staff member's clinical privileges shall be administratively suspended if he/she fails to complete medical records within time frames established by the MEC. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

3.1.2.7 Professional Liability Insurance

Failure of a medical staff member to maintain professional liability insurance in the required amount(s) and sufficient to cover the clinical privileges granted shall result in immediate administrative suspension of his/her clinical privileges. If within sixty (60) calendar days of the suspension the medical staff member does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained) his/her membership and clinical privileges shall terminate and he/she shall not be considered for reinstatement, subject to the discretion of the MEC to accept a reapplication. The medical staff member must notify the Chief of Staff's office immediately of any change in professional liability insurance carrier or coverage.

3.1.2.8 Medical Staff Dues/Special Assessments

A medical staff member's clinical privileges shall be administratively suspended if he/she fails to promptly pay medical staff dues, if any, or any special assessment. If within sixty (60) calendar days after written warning of the delinquency the medical staff member does not remit such payment,

he/she shall be considered to have voluntarily resigned membership on the medical staff.

3.1.2.9 Policy/Misdemeanor Conviction

A medical staff member who has been convicted of or pled “guilty” or “no contest” or its equivalent to a felony related to violence, sexual abuse or healthcare fraud or abuse, and such crimes pursuant to the Illinois Health Care Worker Background Check Act and related regulations, shall have his/her membership and/or clinical privileges administratively suspended. Such suspension shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.

3.1.2.10 Failure to Satisfy the Special Appearance Requirement

A medical staff member who fails without good cause to appear at a meeting where his/her special appearance is required shall have his/her membership and/or clinical privileges administratively suspended. These privileges will be restored when the medical staff member complies with the special appearance requirement. Failure to comply with this requirement within sixty (60) calendar days will be considered a voluntary resignation.

3.1.2.11 Failure to Participate in an Evaluation

A medical staff member who fails to participate in an evaluation of his/her qualifications for membership and/or privileges as required (whether an evaluation of physical or mental health or of clinical management skills) shall have his/her membership and/or clinical privileges administratively suspended. These privileges will be restored when the medical staff member complies with the requirement for an evaluation. Failure to comply with this requirement within thirty (30) calendar days will be considered a voluntary resignation.

3.1.2.12 Failure to Execute Consent for Release of Information and/or Provide Documents

A medical staff member who fails to execute a general or specific consent for the release of information and/or provide documents when requested by the Chief of Staff or Senior Vice President for Clinical Affairs/Chief Medical Officer to evaluate the competency and credentialing/privileging qualifications of the medical staff member shall have his/her membership and/or clinical privileges administratively suspended. If the consent is executed and/or documents provided within thirty (30) calendar days of notice of the automatic suspension, the medical staff member may be reinstated. Thereafter, the medical staff member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.1.2.13 Loss of Faculty Appointment

The membership and clinical privileges of a medical staff member terminate effective as of the date of the medical staff member's loss of faculty appointment.

3.2 Exclusive Contracts

If the hospital enters into an exclusive contract, and that contract results in the total or partial termination or reduction of membership or clinical privileges of a current medical staff member, the Chief of Staff shall provide the affected member with sixty (60) days prior notice of effect on the medical staff member's membership and/or clinical privileges. If the medical staff member requests a hearing pursuant to this Part II, he/she must request such a hearing within fourteen (14) days of receiving the notice described herein. The requested hearing must be commenced and completed within thirty (30) days of the request. Nothing in this Part II shall prohibit a medical staff member from waiving his/her right to a hearing pursuant to an exclusive agreement.

3.3 Economic Decisions

3.3.1 Notice

When an adverse action taken against a medical staff member is based substantially on economic factors, including actions under Part II, Section 3.3 above, notice shall be given to the medical staff member fifteen (15) days before implementation of the action, and shall occur after the medical staff member has exhausted the procedures outlined in Part II, Section 3.3 above.

3.3.2 Reporting

All adverse actions based substantially on economic factors shall be reported to the Hospital Licensing Board, before the action is effective, in accordance with Illinois law.

Section 4. Initiation of Hearing

- 4.1 In addition to the circumstances described above, any medical staff member eligible for appointment and/or clinical privileges shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical activity or professional conduct has been made by the MEC or the Board, including the following:

Denial of reappointment;

Suspension of staff membership;

Revocation of staff membership;

- Denial or restriction of requested clinical privileges;
 - Suspension of clinical privileges;
 - Involuntary reduction, restriction, or revocation of clinical privileges.
- 4.2 There is no right to a hearing for any of the following actions:
- Issuance of a letter of guidance, warning or reprimand;
 - Imposition of a requirement for proctoring (i.e., observation of the medical staff member's performance by another medical staff member in order to provide information to a quality review committee) with no restriction on privileges;
 - Decision to not process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
 - Conducting an investigation into any matter or the appointment of an *ad hoc* investigation committee;
 - Voluntary relinquishment or resignation of appointment or privileges;
 - Denial of a request for leave of absence, or for an extension of a leave;
 - Determination that an application is incomplete or untimely;
 - Determination that an application will not be processed due to misstatement or omission;
 - Decision not to expedite an application;
 - Termination or limitation of temporary privileges; imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;
 - Proctoring, monitoring and any other performance monitoring requirements imposed in order to fulfill Joint Commission standards for ongoing or focused professional practice evaluation;
 - Any recommendation voluntarily accepted by the medical staff member;
 - Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
 - Change in assigned staff category, when not based on the medical staff member's clinical competence or professional conduct;
 - Any requirement to complete an educational assessment;
 - Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;
 - Grant of conditional appointment or appointment for a limited duration; or

Appointment or reappointment for duration of less than twenty-four (24) months.

4.3 Notice of Proposed Adverse Action

The Chief of Staff shall, within seven (7) days of receiving written notice of a proposed adverse action as set forth under Part II, Section 4.1, give the medical staff member Special Notice thereof. The notice shall:

Advise the medical staff member of the nature of the proposed adverse action and of his/her right to a hearing upon timely and proper request pursuant to Part II, Section 4.5;

Contain a concise statement of the medical staff member's alleged acts or omissions, a list by number of the specific or representative patient records in question, any other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing, including reasons based on the quality of care or any other basis, including economic factors;

Unless the result of a summary suspension or administrative suspension as provided for herein, specify that the medical staff member has thirty (30) days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of Part II, Section 4.5;

State that failure to request a hearing within the required time period and in the proper manner constitutes a waiver of rights to a hearing and to an appellate review of the matter that is the subject of the notice as stated in Part II, Section 4.6;

State that as soon as practical after receipt of his/her hearing request, the medical staff member will be notified of the date, time and place of the hearing.

The notice shall also contain a copy of this Part II.

4.4 Reports of External Review

In the event external peer review is used as part of the peer review process that led to the proposed adverse action against the medical staff member, a copy of any adverse report(s) prepared by an external reviewer during the peer review process will be provided to the medical staff member along with the notice of the proposed adverse action. If the medical staff member or the relevant committee prepares a written response to the report(s) within thirty (30) days of receipt of the report(s), the response will be considered by the Board prior to the implementation of any final decision by the Board that adversely affects the medical staff member's membership and/or clinical privileges.

4.5 Request for Hearing

A medical staff member shall have thirty (30) days following the receipt of notice of adverse action to file a written request for a hearing. The request for a hearing shall be addressed to the Chief of Staff by Special Notice.

4.6 Waiver by Failure to Request a Hearing

A medical staff member who fails to request a hearing in writing within thirty (30) days waives any right to a hearing or any appellate review to which he/she might otherwise have been entitled.

Section 5. Hearing Prerequisites

5.1 Notice of Date, Time and Place for Hearing

Upon receipt of a timely and proper request for a hearing, the Chief of Staff shall schedule and arrange for a hearing which shall be not less than thirty (30) days from receipt of the request for hearing. The Chief of Staff shall give the medical staff member Special Notice of the time, place and date of the hearing at least thirty (30) days prior to the hearing. A hearing for a medical staff member under administrative or summary suspension shall be held in accordance with the timelines specific to the particular action described herein.

5.2 Notice of Hearing

The Special Notice of hearing shall contain a concise statement of the subject matter forming the basis for the adverse action which is the subject of the hearing. The Special Notice shall also include the names of the individuals who, as far as is then reasonably known, will give testimony or evidence in support of the party whose action gave rise to the hearing rights.

5.3 Appointment of Hearing Committee

A hearing shall be conducted by a Hearing Committee comprised of three (3) members of the Medical-Dental Staff, two (2) of whom shall be appointed by the Chief of Staff and one of whom shall be appointed by the Senior Vice President for Clinical Affairs/Chief Medical Officer. One of the members so appointed shall be designated by the Chief of Staff as Chair.

5.4 Qualifications for Hearing Committee Membership

To be qualified to serve on a Hearing committee, a member shall:

Be an active full-time or part-time member of the medical staff;

Not have actively participated in initiating or investigating the underlying matter which resulted in the adverse action which gave rise to the request for hearing;

Not be a member of the same department as the medical staff member;

Not be a member of any committee, panel or other group when such committee, panel or other group conducted interviews, heard testimony, considered evidence or undertook any action, recommended action, or review with respect to the adverse action which gave rise to the request for hearing; and

Not be in direct economic competition with the medical staff member involved or otherwise have a direct, personal interest in the outcome of the hearing such that, in the opinion of the Chief of Staff, his/her impartiality is in doubt.

Not be disqualified from serving on a Hearing Committee merely because he/she has heard of the matter or has knowledge of the facts involved or what he/she supposes the facts to be.

5.5 List of Witnesses

At least ten (10) days prior to the scheduled date for commencement of the hearing, the medical staff member who requested the hearing shall give to the Chief of Staff, by Special Notice, a list of the names of the individuals who, as far as is then reasonably known, will give testimony or evidence in support of the medical staff member at the hearing. At the same time and by Special Notice, the Chief of Staff shall update the list of names provided to the medical staff member in the Special Notice of hearing under Part II, Section 5.2. Each list shall be amended as soon as possible when additional witnesses are identified. The Hearing Committee may permit a witness who has not been listed in accordance with the Part II, Section 5.5 to testify if it finds that the failure to list such witness(es) was justified, that such failure did not prejudice the party entitled to receive such list, or that the testimony of such witness(es) will materially assist the Hearing Committee in making its report and recommendation under Part II, Section 7.

Section 6. Hearing Procedure

6.1 Personal Presence

After the date, time and place of the hearing has been communicated to the requesting medical staff member, the hearing shall proceed on schedule.

The medical staff member who requested the hearing shall be present at the hearing.

A medical staff member who fails to appear, without good cause, shall be deemed to have waived his/her rights to a hearing and appellate review and with the same consequence as provided in Part II, Section 4.6.

6.2 Chair

The Chair of the Hearing Committee shall oversee the conduct of the hearing.

The Chair of the Hearing Committee shall ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant evidence.

The Chair of the Hearing Committee shall determine all procedural aspects of the hearing and make all ruling on the admissibility of evidence presented.

6.3 Representation

The medical staff member requesting the hearing is entitled to be accompanied and represented at the hearing by another member of the medical staff in good standing or by a member of his/her local professional society. The medical staff member is entitled to representation by an attorney at the medical staff member's sole expense. The medical staff member or accompanying non-attorney representative shall be required to actively present witnesses and information and generally conduct the presentation. The medical staff member shall respond personally to any questions directed to him/her by the Hearing Committee. The medical staff member's attorney shall not be permitted to accompany the medical staff member into the hearing room, but the Chair of the Hearing Committee shall ensure that space is provided for the attorney to be available and nearby to consult with the medical staff member. The medical staff member is permitted to request a recess at any time during the hearing for the purpose of leaving the hearing room to consult his/her attorney. If the medical staff member will be represented by an attorney, he/she shall provide the Chief of Staff with the name of the attorney representative at least ten (10) days prior to the hearing. The medical staff shall also have the right to representation by an attorney, who shall not be permitted to be present in the hearing room during the hearing. The Chair of the Hearing Committee or any member is permitted to request a recess at any time during the hearing for the purpose of consulting the attorney.

6.4 Rights of Parties

All of the rights set forth in this Part II, Section 6.4 shall be exercised in a manner so as to permit the hearing to proceed efficiently and expeditiously. During the hearing, each party shall have the following rights:

Call and examine witnesses;

Introduce exhibits, and other relevant information, regardless of the information's admissibility in a court of law;

Cross-examine any witness on any matter relevant to the issues;

Impeach any witness; and

Rebut any information presented.

If the medical staff member does not testify on his/her own behalf, he/she may be called and examined as if under cross-examination. In addition, the medical staff member has the right to inspect all pertinent information in the hospital's possession with respect to the action.

6.5 Procedure

The hearing shall be conducted according to such procedures as are adopted by the Hearing Committee and need not be conducted strictly according to rules of law relating to the examination of witnesses or the presentation of evidence. The Hearing Committee shall consider any and all material which it believes to be important and/or relevant in resolving the issue before it.

6.6 Record of Hearing

The Chair of the Hearing committee shall assure that a verbatim transcript of the hearing is prepared that is of sufficient accuracy to permit an informed recommendation or decision to be made by the Senior Vice President for Clinical Affairs/Chief Medical Officer or the Board on review or appeal. The medical staff member has the right to obtain a copy of the transcript upon payment of any reasonable charges associated with the preparation.

6.6.1 Postponement, Recesses and Adjournment

6.6.2 Postponement

Requests for postponement of the hearing shall be granted at the discretion of the Chair of the Hearing Committee only upon the showing of good cause.

6.6.3 Recess

The Chair of the Hearing Committee may recess the hearing at any point and reconvene without additional notice for the convenience of the participants or if he/she believes such a recess is necessary.

6.6.4 Adjournment

Upon conclusion of the presentation of evidence, the Hearing Committee shall complete its deliberations within fourteen (14) days.

6.7 Written Statement

The medical staff member and the medical staff shall have the right to submit a written statement at the close of the hearing. Such a statement must be submitted to the Chair of the Hearing Committee within three (3) days after the day on which the hearing concludes.

Section 7. Hearing Committee Report and Action

- 7.1 The Hearing Committee shall have fourteen (14) days after the conclusion of the hearing within which to make a written report of its findings and recommendations.
- 7.2 The report of the Hearing Committee's findings and recommendations shall be sent to the Senior Vice President for Clinical Affairs/Chief Medical Officer. The medical staff member shall also receive a copy of the Hearing Committee's findings and the basis for the Committee's recommendations via Special Notice.
- 7.3 The Senior Vice President for Clinical Affairs/Chief Medical Officer shall consider the findings and recommendations and arrive at a decision within thirty (30) days of receipt of the report. The Senior Vice President for Clinical Affairs/Chief Medical Officer shall then notify the medical staff member, the Chief of Staff, and the Board of his/her decision, and the basis for the decision, by Special Notice.

- 7.4 If the decision is adverse to the practitioner, he/she shall be notified by Special Notice by the Senior Vice President for Clinical Affairs/Chief Medical Officer that he/she has a right to appellate review by the Board.

Section 8. Initiation and Prerequisites of Appellate Review

8.1 Request for Appellate Review

A medical staff member shall have ten (10) days after receiving Special Notice of an adverse decision by the Senior Vice President for Clinical Affairs/Chief Medical Officer to file a written request for an appellate review. The request must be delivered to the Senior Vice President for Clinical Affairs/Chief Medical Officer by Special Notice. The Senior Vice President for Clinical Affairs/Chief Medical Officer shall promptly transmit the request for appellate review to the Board.

8.2 Waiver by Failure to Request Appellate Review

A medical staff member who fails to request an appellate review within ten (10) days waives any right to such review. The waiver has the same force and effect as provided in Part II, Section 4.6.

8.3 Notice of Time and Place for Appellate Review

8.3.1 Within ten (10) days after a timely request for appellate review, the Board shall schedule and arrange for an appellate review which shall be not less than thirty (30) days and not more than ninety (90) days from the date of receipt of the appellate review request. If the medical staff member is under suspension, the review shall be held as expeditiously as possible.

8.3.2 At least ten (10) days prior to the appellate review, the Senior Vice President for Clinical Affairs/Chief Medical Officer shall send the medical staff member Special Notice of the time, place and date of the review.

8.4 Appellate Review Body

8.4.1 The Board shall determine whether the appellate review shall be conducted by the full Board or by a special appellate review subcommittee of the Board appointed by the Chair of the Board. If a subcommittee is appointed, one of its members shall be designated Chair of the Appellate Review Body.

8.4.2 No person who has had active involvement in the case, has actively participated in formulating the adverse recommendation or action that occasioned the hearing, or has had an active part in initiating or investigating the underlying matter at issue at any earlier stage of the proceedings, shall serve on the Appellate Review Body.

8.5 Scope of Review

The issues considered on appeal shall be limited to the following: (1) whether there was a material failure to comply with the bylaws, this Part II or other applicable policies prior to the hearing as to deny the medical staff member a fair hearing; and/or (2) whether the recommendations of the MEC were not supported by credible information.

Section 9. Appellate Review Procedure

9.1 Nature of Proceedings

The Chair of the Appellate Review Body shall be appointed by the Chair of the Board. The Chair of the Appellate Review Body shall determine the order of the procedure during the appellate review and make all required rulings.

9.1.2 The Proceedings

The Appellate Review Body shall consider the record of the hearing before the Hearing Committee, the Hearing Committee's report, the Senior Vice President for Clinical Affairs/Chief Medical Officer's decision, and all subsequent results and actions.

9.1.3 Written Statements

The medical staff member shall submit a written statement detailing the basis of his/her request for appellate review. This written statement may cover any matters raised at any step in the hearing, recommendation or decision process. The statement shall be submitted to the Appellate Review Body through the Senior Vice President for Clinical Affairs/Chief Medical Officer at least ten (10) days prior to the scheduled date for the appellate review.

9.1.4 Oral Statement

The Appellate Review Body, in its sole discretion, may allow the medical staff member, the Senior Vice President for Clinical Affairs/Chief Medical Officer, or any other individual it deems appropriate to appear before the committee and make oral statements, not to exceed fifteen (15) minutes, in support of their positions. Any party appearing shall be required to answer questions posed by any member of the Appellate Review Body.

9.1.5 Consideration of New or Additional Matters

The Appellate Review Body, in its sole discretion, shall determine whether new or additional matters or information not raised or presented during the original hearing or in the hearing report, or not otherwise reflected in the record, shall be considered.

9.1.6 Recesses and Adjournment

The Appellate Review Body may recess and review the proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of

obtaining new or additional information or consultation.

9.2 Appellate Review Body Action

Within ninety (90) days after the conclusion of the appellate review, the Appellate Review Body shall render its final decision in the matter in writing, which shall include a statement regarding the basis of the decision, and shall give Special Notice thereof to the medical staff member, the Chief of Staff and the Senior Vice President for Clinical Affairs/Chief Medical Officer.

Section 10. General Provisions

10.1 Number of Hearings and Reviews

Notwithstanding any other provision of these bylaws or of this Part II, no medical staff member shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to the subject matter that is the basis of the adverse action giving rise to the exercise of the rights under this Part II.

10.2 Time Periods

Exceptions to any of the time frames provided in this Part II may be made by mutual agreement of the parties.

10.3 Burden of Proof

The medical staff member shall have the burden of proving, by clear and convincing evidence, that he/she is competent to perform any requested privileges and/or hold any requested memberships, that any adverse action(s) taken lack(s) any factual basis, or that the conclusions drawn from the facts are arbitrary, unreasonable or capricious.

10.4 Immunity

All medical staff members and/or practitioners and all those participating in or providing information to any department, committee, Hearing Committee or medical staff officer shall, to the fullest extent permitted by law, not be liable for any actions taken or information provided in connection with the review, granting or denial of membership or clinical privileges, or any other action taken pursuant to the bylaws or this Part II.

10.5 Discovery

Except as specifically provided in this Part II, there shall be no right to conduct discovery in connection with any hearing and no medical staff member shall be permitted access to any peer review records, medical records, minutes or other documents relating to any other medical staff member or any action taken or not taken with regard to any other medical staff member.

Section 11. Fair Hearing and Appeal Process for Allied Health Practitioners

- 11.1 Allied health practitioners are not entitled to the hearing and appeals procedures set forth above in Part II, Section 2 through Section 10. In the event an allied health practitioner receives notice of recommendation by the MEC that will adversely affect his/her exercise of clinical privileges, the allied health practitioner and his/her supervising physician shall have the right to meet with two (2) physicians and a peer assigned by the Vice President/Chief Nurse Executive and the Chief of Staff to discuss the recommendation. The allied health practitioner and the supervising physician must request such a meeting in writing to the Vice President/Chief Nurse Executive within ten (10) days from the date of receipt of such notice. At the meeting, the allied health practitioner and the supervising physician must be present to discuss, explain, or refute the recommendation. Such meeting shall not constitute a hearing and none of the procedural rules set forth in this Part II with respect to hearings shall apply. Within thirty (30) days of the conclusion of the meeting, the review body will issue a written decision. The written decision will be sent to the allied health practitioner, the Vice President/Chief Nurse Executive, the MEC, and the Board. If the written decision is adverse to the allied health practitioner, the written decision will include a notice that the allied health practitioner has the right to appeal the decision of the Board.
- 11.2 The allied health practitioner and the supervising physician must request an appeal in writing to the President, Loyola University Medical Center, within ten (10) days of receipt of the review body's written decision. Two (2) Board members, assigned by the Chair of the Board, will hear the appeal of the allied health practitioner and the supervising physician. Either the Vice President/Chief Nurse Executive or the Chief of Staff may be present. The report of the appeal body's findings and recommendation will be forwarded to the Board for final decision within fifteen (15) days of the conclusion of the appeal. The Board shall consider the findings and recommendations of the appeal body and arrive at a final written decision within fifteen (15) days of receipt of the report. A copy of the final written decision will be forwarded to the allied health practitioner, supervising physician, Vice President/Chief Nurse Executive and Chief of Staff within ten (10) days of the final decision of the Board.

Loyola University Medical Center

MEDICAL STAFF BYLAWS

Part III: Credentials Procedures Manual

Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the Medical Staff Credentials Committee shall consist of at least seven (7) members of the active medical staff who represent the major areas of the medical staff, the Senior Vice President for Clinical Affairs/Chief Medical Officer, or designee, will appoint the chair and other members. Any member may be relieved of his/her committee membership by a two-thirds (2/3) vote of the MEC. The committee shall include the Senior Vice President for Clinical Affairs/Chief Medical Officer and Chief of Staff as member, the Vice President/Chief Nursing Executive will be a voting member of the committee for consideration of application of advanced practice professionals. The committee may also invite members such as representatives from hospital administration and the Board. The Dean, Stritch School of Medicine is a non-voting member of the Medical Staff Credentials Committee.

1.2 Meetings

The Medical Staff Credentials Committee shall meet on call of the chair.

1.3 Responsibilities

- 1.3.1 To review and recommend action on all applications and reapplications for membership on the medical staff not eligible for expedited review and includes assignments of medical staff category;
- 1.3.2 To review and recommend action on all requests regarding privileges from eligible applications;
- 1.3.3 To recommend eligibility criteria for the granting of medical staff membership and privileges;
- 1.3.4 To develop, recommend, and consistently implement policies and procedures for all credentialing and privileging activities;
- 1.3.5 To review, and where appropriate take action on, reports that are referred to it from other medical staff committees, medical staff or hospital leaders;
- 1.3.6 To perform oversight over the peer review processes in the medical staff; and
- 1.3.7 To perform such other functions as requested by the MEC.
- 1.3.8 To review and recommend all applications and reapplications for membership on the medical staff eligible for expedited review is completed by the MEC and not the Medical Staff Credentials Committee unless the Medical Staff Credentials Committee is specifically requested to do so by the Chief of Staff.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

1.4.1 The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the President, Loyola University Medical Center or designee.

1.4.2 Individual medical staff members and/or practitioners may review their credentials file under the following circumstances:

Only upon written request approved by the Chief of Staff; President, Loyola University Medical Center; Medical Staff Credentials Committee chair or Senior Vice President for Clinical Affairs/Chief Medical Officer. Review of such files will be conducted in the presence of the medical staff service professional, medical staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by medical staff members and/or practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a medical staff member and/or practitioner. Nothing may be permanently removed from the file. Copies of materials can be made except for peer references and the National Practitioner Data Bank (NPDB) report. The medical staff member and/or practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership and/or Privileges

2.1 No applicant shall be entitled to membership on the medical staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

2.2 The following qualifications must be met by all applicants for medical staff appointment, reappointment or clinical privileges:

2.2.1 Appointment and retention as faculty of Loyola University of Chicago, Stritch School of Medicine or be granted faculty emeritus status by Loyola University of Chicago, Stritch School of Medicine. This excludes affiliated and courtesy faculty appointments.

2.2.2 Demonstration that he/she has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, optometry or

applicable recognized course of training in a clinical profession eligible to hold privileges.

- 2.2.3 A current unrestricted state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Illinois.
- 2.2.4 A record that is free from current Medicare/Medicaid sanctions and any inclusion on the OIG List of Excluded Individuals/Entities or EPLS (Excluded Parties List System).
- 2.2.5 A record that is free of felony convictions related to violence, sexual abuse or healthcare fraud or abuse pursuant to the Illinois Healthcare Worker Background Check Act.
- 2.2.6 A physician (MD or DO), must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or any foreign board recognized by the State of Illinois and must be currently board certified or become board certified within two (2) board cycles after initial eligibility as defined by the appropriate specialty board of the American Board of Medical Specialties or the AOA. Once obtained, board certification must be maintained. If board certification lapses, the applicant must become recertified within two (2) years.
- 2.2.7 A dentist must have graduated from an American Dental Association (ADA) approved school of dentistry accredited by the Commission of Dental Accreditation.
- 2.2.8 An oral, and maxillofacial surgeon must have graduated from an ADA approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an ADA approved residency program or any foreign board recognized by the State of Illinois and must be board certified or become board certified with two (2) board cycles after initial eligibility as defined by the American Board of Oral and Maxillofacial Surgery or any foreign board recognized by the State of Illinois. Once obtained, board certification must be maintained. If board certification lapses, the applicant must become recertified with two (2) years.
- 2.2.9 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and must be board certified or become board certified within two (2) board cycles after initial eligibility as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine or any foreign board recognized by the State of Illinois. Once obtained, board certification must be maintained. If board certification lapses, the applicant must become recertified within two (2) years.
- 2.2.10 A psychologist must have earned a doctorate degree, (Ph.D., Ed.D. or Psy.D. in psychology) from an educational institution accredited by the American Psychological Association (APA) and must have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and must have completed an internship endorsed as appropriate to the area of clinical practice.

- 2.2.11 A doctorate level, non-physician medical director must have earned a Ph.D. in a field appropriate to the privileges requested.
- 2.2.12 If applicable, must possess a current, valid, unrestricted Drug Enforcement Administration (DEA) number with an Illinois address or a current, valid Illinois State Controlled Dangerous Substance (CDS) certificate or a letter detailing coverage arrangements until a valid DEA number with an Illinois address or a valid Illinois State CDS is available.
- 2.2.13 Appropriate written and verbal communication skills.
- 2.2.14 Appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum;
 - a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and
 - b. A history of consistently acting in a professional, appropriate and collegial manner with others in previous clinical and professional settings.
- 2.3 The following qualifications must also be met by all applicants requesting clinical privileges:
 - 2.3.1 Demonstration of his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;
 - 2.3.2 Evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of medical staff membership and the specific privileges requested by and granted to the applicant;
 - 2.3.3 If granted privileges to admit an inpatient, the capability to provide continuous and timely care to the satisfaction of the MEC and Board must be demonstrated;
 - 2.3.4 Recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;
 - 2.3.5 The requested privileges are for a service the Board has determined appropriate for performance at the hospital. There must also be a need for this service under any Board approved medical staff development plan; and
 - 2.3.6 Evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC.
- 2.4 Exceptions
 - 2.4.1 All practitioners who are current medical staff members and/or were granted privileges on or before January 1, 1990 and who met prior qualifications for membership and/or privileges and were never board certified shall be exempt from

board certification requirements.

- 2.4.2 All practitioners who are current medical staff members and/or were granted privileges as of the date these bylaws were approved and who met prior qualifications for membership and/or privileges, but were deemed never eligible to sit for board certification shall be exempt from board certification requirements.
- 2.4.3 All practitioners who are current medical staff members and/or were granted privileges and allowed their board certification to lapse must become recertified within two (2) years from the date these bylaws were approved.
- 2.4.4 Only the Board may create additional exceptions to the above Part III, Section, 2.2 after consultation with the MEC.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 Applications are requested by department chairs for individuals in their department to complete. Upon receipt of the request, the medical staff office will provide the applicant an application package, which will include a complete set or overview of these medical staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for medical staff membership and/or privileges and a list of expectations of performance for individuals granted medical staff membership or privileges (if such expectations have been adopted by the medical staff).

A completed application includes, at a minimum:

- a. A completed, signed, dated application form;
- b. A completed privilege delineation form if requesting privileges;
- c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;
- d. All applicable fees;
- e. A current picture (a Picture ID card issued by a state or federal agency (e.g. driver's license or passport) or current picture hospital ID card to be verified prior to the applicant seeing patients);
- f. Receipt of all references: References shall come from peers knowledgeable about the applicant's experience, ability and current competence to perform the privileges being requested;
- g. Documentation of training, experience and current competence for all privileges requested including specific outcome data for privileges designated as requiring

evidence of added training, experience and current competence;

- h. If applicable, a current, valid, unrestricted Drug Enforcement Administration (DEA) number with an Illinois address or a current, valid Illinois State Controlled Dangerous Substance (CDS) certificate or a letter detailing coverage arrangements until a valid DEA number with an Illinois address or a valid Illinois State CDS is available;
- i. Relevant practitioner-specific data as compared to aggregate data, when available; and
- j. Morbidity and mortality data, when available.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. If at any time during the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action will be taken and the applicant will not be entitled to a fair hearing or appeal.

- 3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the medical staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a communication requesting such information will be sent to the applicant. If the requested information is not returned to the medical staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn and the applicant will not be entitled to a fair hearing or appeal.
- 3.1.3 Upon receipt of a completed application the President, Loyola University Medical Center, Senior Vice President for Clinical Affairs/Chief Medical Officer, or Chief of Staff in collaboration with the medical staff office will determine if the requirements of Part III, Sections 2.2 and 2.3 are met. In the event the requirements of Part III, Sections 2.2 and 2.3 are not met, the potential applicant will be notified that he/she is ineligible to apply for membership or privileges on the medical staff, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of Part III, Sections 2.2 and 2.3 are met, the application will be accepted for further processing.
- 3.1.4 Applicants seeking appointment shall have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.
- 3.1.5 Upon receipt of a completed application, the medical staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable

secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the medical staff office will collect relevant additional information which may include:

- a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements and judgments, (if any) during the past ten (10) years;
- b. A current curriculum vitae documenting the applicant's past five (5) years of clinical work experience. In the event there are gaps in education or work experience of six (6) months or greater, the applicant will provide a written statement explaining the gaps;
- c. Licensure status in all current or past states of licensure at the time of initial granting of membership of privileges. In addition, the medical staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;
- d. Information from the AMA or AOA Physician Profile, Federation of State Medical Board, OIG list of excluded Individuals/Entities, and EPLS;
- e. Information from professional training programs including residency and fellowship programs;
- f. Information from the NPDB. In addition the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;
- g. Other information about adverse credentialing and privileging decisions;
- h. One or more peer recommendations, as selected by the Medical Staff Credentials Committee, chosen from health care providers who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges;
- i. Information from any other sources relevant to the qualifications of the applicant to serve on the medical staff and/or hold privileges;
- j. Morbidity and mortality data and relevant applicant-specific data as compared to aggregate data, when available; and
- k. If available and not legally protected, the results of any drug testing and/or other health testing required by a health care institution or licensing board.

Note: In the event there is undue delay in obtaining required information, the medical staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of any applicant to adequately respond to a request for assistance after forty-five (45) calendar days will be deemed a withdrawal of the application and the applicant will not be entitled to a fair hearing or appeal.

- 3.1.6 Applicant will consent to drug and alcohol testing on initial application.
- 3.1.7 When the items identified in Part III, Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, Authorization and Acknowledgement

The applicant must complete and sign the application form. By signing this application the applicant:

- 3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agrees that any substantive inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may lapse effective immediately upon notification of the individual without the right to a fair hearing or appeal.
- 3.2.2 Applicant will consent to appear for interviews in regard to his/her application, if requested.
- 3.2.3 Authorizes the hospital and medical staff representatives to consult with prior and current associates and others who may have information bearing on his/her professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.
- 3.2.4 Consents to hospital and medical staff representatives' inspection of all records and documents that may be material to an evaluation of:
 - a. Professional qualifications and competence to carry out the clinical privileges requested;
 - b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;
 - c. Professional and ethical qualifications;
 - d. Professional liability actions including currently pending claims involving the applicant; and
 - e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.
- 3.2.5 Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to the hospital representatives concerning his/her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges;

emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

- 3.2.6 Authorizes the hospital medical staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits or challenges against any medical staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.
- 3.2.7 Acknowledges that the applicant has had access to these medical staff bylaws, including all rules, regulations, policies and procedures of the medical staff and agrees to abide by their provisions.
- 3.2.8 Notwithstanding Part III, Section 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, he/she shall reimburse the hospital and any member of the medical staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.
- 3.2.9 Agrees to provide accurate answers to all inquiries, and agrees to immediately notify the hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's medical staff membership or privileges. If the applicant answers any questions on the State of Illinois application affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.

3.3 Application Evaluation

Expedited Credentialing: An expedited review and approval process may be used for initial appointment and reappointment provided the application for membership/privileges does not include areas of potential concern. Areas of potential concern include, but are not limited to:

- a. The application is deemed to be incomplete;
- b. The final recommendation of the MEC is adverse or with limitation;
- c. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
- d. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

- e. Applicant has had an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;
- f. Material discrepancy is found between information received from the applicant and references or verified information;
- g. Applicant has an adverse NPDB report related to behavioral issues;
- h. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;
- i. Applicant has potentially relevant physical, mental and/or emotional health problems;
- j. Other reasons as determined by a medical staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism or appropriateness of the applicant for membership or privileges.

Applicants whose files are free from these concerns may be granted medical staff membership and/or privileges after review and action by the following: department chair, Senior Vice President for Clinical Affairs/Chief Medical Officer, Chief of Staff acting on behalf of the Medical Staff Credentials Committee, the MEC and a Board committee consisting of at least two (2) individuals.

If one or more of the above outlined criteria are identified in the course of reviewing a completed and verified application, the application must be reviewed and acted on by the department chair, Medical Staff Credentials Committee, MEC, and the Board. The Medical Staff Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that he/she meets the criteria for membership on the medical staff and for the granting of requested privileges.

3.3.1 Applicant Interview

- a. All applicants for appointment to the medical staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the department chair, Medical Staff Credentials Committee, MEC or Board. The interview may take place in person or by telephone at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate medical staff performance expectations.
- b. Procedure: The applicant will be notified if an interview is required. Failure of the applicant to participate in a scheduled interview will be deemed a withdrawal of the application.

3.3.2 Chief of Staff Action

- a. All completed applications are reviewed by the Chief of Staff to ensure that it fulfills the established standards for membership and/or clinical privileges.
- b. The Chief of Staff may obtain input if necessary from an appropriate subject matter expert. The Chief of Staff will make a recommendation to the applicant's respective department chair to either move forward with the expedited credentialing process (if the application meets the eligibility criteria for expedited credentialing) or to have the application reviewed by the Medical Staff Credentialing Committee.
- c. The Chief of Staff then forwards the application to the MEC or the Medical Staff Credentials Committee with the following:

A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;

A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and

Comments supporting the recommendations in Part III, Section 3.3.2 b above.

3.3.3 Medical Staff Credentials Committee Action

If the application is eligible for expedited credentialing, it is presented to Chief of Staff or designee for review and recommendation. The Chief of Staff or designee reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. If the file is eligible for the expedited process, the Chief of Staff shall act on behalf of the Medical Staff Credentials Committee and forward the application with recommendations to the MEC for review.

Recommendations shall include:

- a. Approval of the applicant's request for membership and/or privileges; approval of membership but modification of the requested privileges; or denial of membership and/or privileges;
- b. Definition of those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and
- c. Comments supporting the recommendations in Part III, Section 3.3.2 b above.

If the file is not eligible for the expedited process or the Chief of Staff deems the application not eligible for the expedited credentialing process, the Medical Staff Credentials Committee shall review the application and forward the following to the MEC:

- a. A recommendation to approve the applicant's request for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges; and
- b. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
Comments supporting the recommendations in Part III, Section 3.3.2 b above.

3.3.4 MEC Action

If the application is eligible for the expedited process it is presented to the MEC which may meet in accordance with quorum requirements established for expedited credentialing. If the application is not eligible for the expedited credentialing process, it shall be presented to the MEC at its next regular meeting.

The MEC shall review each application to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

- a. A recommendation as to whether the application is eligible for expedited credentialing or not;
- b. A recommendation to approve the applicant's request for membership and/or privileges or deny membership and/or privileges;
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and
- d. Comments supporting the recommendations in Part III, Section 3.3.5 b above.

Whenever the MEC makes an adverse recommendation to the Board, a Special Notice, stating the reason, will be sent to the applicant who shall then be entitled to the hearing and appeal rights provided in Part II or these bylaws as appropriate.

3.3.5 Board Action:

- a. If the application is designated by the MEC as eligible for expedited credentialing it is presented to the Board or the Credentialing Committee of the Board, which consists of at least two (2) Board members, where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or the Credentialing Committee of the Board agrees with the recommendation of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to exceed twenty-four (24) months. If the Credentialing Committee of the Board takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or the Credentialing Committee of the Board disagrees with the recommendation, then the procedure for processing applications not eligible for expedited credentialing will be followed.
- b. If the application is designated as not eligible for the expedited credentialing

process, the Board reviews the application and votes for one of the following actions:

Adopt or reject in whole or in part a recommendation of the MEC or to refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges, it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months.

If the Board's action is adverse to the applicant, a Special Notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws as appropriate; or

The Board shall take final action in the matter as provided in Part II of these bylaws.

- 3.3.6 Notice of final decision: Notice of the Board's final decision shall be given, through the President, Loyola University Medical Center, or designee, to the MEC and to the chair of each department concerned. The applicant shall receive written notice or appointment and special notice of any adverse final decision within sixty (60) days. A decision and notice of appointment includes the staff category to which the applicant is appointed, the department to which he/she is assigned, the clinical privileges he/she may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.
- 3.3.7 Time periods for processing: All individual and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Professional Practice Evaluation

- 4.1 All initially requested privileges shall be subject to a period of focused professional practice evaluation (FPPE). The MEC, after receiving a recommendation from the department chair, will define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his/her initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: direct observation, chart review, the tracking of performance monitor/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The MEC will also establish the duration for such FPPE and triggers that indicate the need for

performance monitoring. The MEC, the Patient Safety Evaluation Committee, the Clinical Practice Peer Review Committee, the Chief of Staff, Senior Vice President for Clinical Affairs/Chief Medical Officer and department chair may independently request a FPPE of an active medical staff member and/or practitioner in the event concerns related to quality and/or patient safety arise.

- 4.2 The medical staff will also engage in ongoing professional practice evaluation (OPPE) to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the medical staff's evaluation, measurement, and improvement of medical staff member and/or practitioner's current clinical competency. In addition, each medical staff member and/or practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process, the peer review process, or are identified through reports involving quality or patient safety. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

Section 5. Reappointment

5.1 Criteria for Reappointment

- 5.1.1 It is the policy of the hospital to approve for reappointment and/or renewal of privileges only those medical staff members and/or practitioners who meet the criteria for initial appointment as identified in Part III, Section 2. The MEC must also determine that the medical staff member and/or practitioner provide effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. The medical staff member and/or practitioner must provide the information enumerated in Part III, Section 5.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new or expanded clinical privileges to existing medical staff members and/or practitioners will follow the steps described in Part III, Section 3 above concerning the initial granting of new clinical privileges in Part III, Section 4 above concerning focused professional practice evaluation. A suitable peer shall substitute for the department chair in the evaluation of current competency of the department chair, and recommend appropriate action to the credentials committee.

5.2 Information Collection and Verification

- 5.2.1 From appointee: On or before four (4) months prior to the date of expiration of a medical staff appointment or grant of privileges, a representative from the medical staff office notifies the medical staff member and/or practitioner of the date of expiration and supplies him/her with an application for reappointment for membership and/or privileges. At least ninety (90) calendar days prior to this date

the medical staff member and/or practitioner must return the following to the medical staff office:

- a. A completed reapplication form, which includes complete information to update his/her file on items listed in his/her original application, any required new, additional, or clarifying information, and any required fees or dues;
- b. Information concerning continuing training and education internal and external to the hospital during the preceding period; and
- c. By signing the reapplication form, agreement to the same terms as identified in Part III, Section 3.2 above.

5.2.2 From internal and/or external sources: The medical staff office collects and verifies information regarding each medical staff member and/or practitioner's professional and collegial activities.

5.2.3 The following information is also required:

- a. A summary of clinical activity at this hospital for each appointee due for reappointment;
- b. Performance and conduct in this hospital and other healthcare organizations in which the medical staff member and/or practitioner has provided substantial clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;
- c. Documentation of any required hours of continuing medical education activity per state licensure requirements;
- d. Timely and accurate completion of medical records in compliance with the rules and regulations;
- e. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff;
- f. Any significant gaps in employment or practice since the previous appointment or reappointment;
- g. Verification of current licensure;
- h. NPDB query, OIG query for excluded individuals/entities, and query of the EPLS;
- i. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the Medical Staff Credentials Committee, chosen from medical staff member(s) and/or practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and

professionalism as well as the physical, mental and emotional ability to perform requested privileges; and

- j. Malpractice history for the past four (4) years, which is primary source verified by the medical staff office with the applicant's malpractice carrier(s).

5.2.4 Failure, without good cause, to provide any requested information, at least sixty (60) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the medical staff office verifies this additional information and notifies the applicant of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

5.3 Evaluation of Application for Reappointment of Membership and/or Privileges

5.3.1 Expedited review of reappointment applications will be categorized as described in Part III, Section 3.3.1 above.

5.3.2 The reappointment application will be reviewed and acted upon as described in Part III, Sections 3.3.3 through 3.3.8 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in Part III, Section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to the procedural rights provided in Part II of these bylaws as appropriate.

5.3.3 The terms "applicant" and "appointment" as used in this Part III shall be read respectively, as "staff appointee" and "reappointment" as appropriate.

Section 6. Clinical Privileges

6.1 Exercise of privileges

A medical staff member and/or practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the medical staff. Such individuals may be Advanced Practice Nurses (APN), Certified Registered Nurse Anesthetist (CRNA), Physician Assistants (PA), physicians serving short locum tenens positions, telemedicine physicians, or residents or fellows in training such as residents moonlighting in the hospital, or others deemed appropriate by the MEC and Board.

6.2 Requests

When applicable, each application for appointment or reappointment to the medical staff must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

6.3 Basis for Privileges Determination

- 6.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.
- 6.3.2 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determinations to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privileges determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.
- 6.3.3 The procedure by which requests for clinical privileges are processed are as outlined in Part III, Section 3 above.

6.4 Special Conditions for Dental Privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral and maxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the medical staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence.

6.5 Special conditions for allied health practitioners (AHP) eligible for clinical privileges without membership

- 6.5.1 Practitioners permitted by law and the hospital to provide patient care services independently and/or under the supervision or direction of a physician and who are not medical staff members must have delineated clinical privileges. These individuals shall include, but shall not necessarily be limited to: advanced practice nurses (APN); physician assistants (PA); and certified registered nurse anesthetists (CRNA), if they are delegated prescriptive authority, they are providing anesthesia services in a physician, dental or podiatric office setting, and/or they are providing anesthesia services independent of any anesthesia plan of care approved by an anesthesiologist.
- 6.5.2 Requests for privileges from such practitioners are processed in the same manner as requests for clinical privileges by providers eligible for medical staff membership, with the exception that such practitioners are not eligible for membership on the medical staff and do not have the rights and privileges of such membership, AHPs

shall not have the same fair hearing and appeal process as members of the medical staff. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges. Allied health practitioners in this category may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care. The privileges of an AHP shall terminate immediately, without the AHP hearing and appeal rights in Part II, in the event that the employment of the AHP with the hospital is terminated for any reason or if the employment contract or sponsorship of the AHP with a physician member of the medical staff organization is terminated for any reason.

- 6.5.3 Each APN who applies for clinical privileges must have a collaborative practice agreement signed by the practitioner's supervising physician. An APN may only enter into a collaborative practice agreement with one supervision/collaborating physician. CRNAs are not required to enter into a collaborative practice agreement unless (a) they are delegated prescriptive authority; (b) they are providing anesthesia services in a physician, dental or podiatric office setting; or (c) they are providing anesthesia services independent of any anesthesia plan of care approved by an anesthesiologist.
- 6.5.4 A PA may provide medical/surgical services delegated by the supervising physician when such services are within his/her skills and within the current scope of practice of the supervising physician. The physician/PA team shall establish written practice guidelines, including guidelines regarding prescriptive authority where applicable, that are individual to the PA in the practice setting and keep those guidelines current and available in the supervising physician's office or location where the PA is practicing. PAs shall not perform any medical procedure or other task delegated by a supervising physician until written notice of the employment and the assumption of supervisory control of the PA by the supervising physician is received and acknowledged by the Illinois Department of Professional and Financial Regulation. PAs shall not perform medical procedures independently or without the supervision of a supervising physician.
- 6.5.5 A collaborating or supervising physician may delegate limited prescriptive authority or drugs and controlled substances categorized as Schedule III, IV or V controlled substances to an APN, CRNA or PA. In order to prescribe Schedule III, IV or V controlled substance, the APN, CRNA or PA must obtain a mid-level practitioner controlled substances license, a copy of which must be provided. Before the APN, CRNA or PA may exercise delegated prescriptive authority, the collaborating or supervising physician must file the required notice of delegation of prescriptive authority with the Illinois Department of Professional and Financial Regulation. The collaborating or supervising physician must also notify the Illinois Department of Professional and Financial Regulation in the event that an APN, CRNA or PA's delegated prescriptive authority is revoked.
- 6.5.6 An adverse recommendation at any stage in the processing of an initial application for clinical privileges or a renewal of clinical privileges shall not be grounds for hearing and appeal under Part II.

6.6 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. Podiatrists may do history and physical examinations on their own patients and may independently admit patients without significant medical co-morbidities upon submission of documentation of completion of an accredited postgraduate residency in podiatric medicine and surgery and demonstrated current competence. If a patient has significant medical co-morbidities, the podiatrist must co-admit the patient with another member of the active medical staff.

6.7 Special Conditions for Residents or Fellows in Training

6.7.1 Residents or fellows in training in the hospital shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the supervision policies developed by the residency training program directors in conjunction with the Graduate Medical Education Committee. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which residency training program directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital leaders.

6.7.2 The Graduate Medical Education Committee must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervision activities.

6.8 Telemedicine Privileges

6.8.1 Requests for telemedicine privileges at the hospital that includes patient care, treatment, and services will be processed through one of the following mechanisms:

- a. The hospital fully privileges and credentials the practitioner; or
- b. The hospital privileges practitioners using credentialing information from the distant site if the distant site is a Medicare-participating hospital.

6.9 Temporary Privileges

The President, Loyola University Medical Center, or designee, acting on behalf of the Board and based on the recommendation of the Chief of Staff or designee, may grant temporary privileges provided the medical staff office is able to verify the applicant's current licensure and competence. Temporary privileges may be granted only to fulfill an important patient care, treatment or service need.

6.9.1 Care of specific patients: An appropriately licensed individual with required professional liability insurance who is not an applicant for membership may be

granted temporary privileges for the care of specific patients at the written request of the appropriate department chair.

- 6.9.2 Fulfillment of Patient Care Commitments: In the unusual circumstance where clinical commitments of the hospital cannot be met by the medical staff, temporary privileges may be granted to an appropriate individual to ensure fulfillment of said commitments. Granting of temporary privileges to fulfill patient care commitments requires:
- a. Written documentation of need by the appropriate department chair and request for temporary privileges;
 - b. An applicant must have training and experience that would ordinarily qualify them for a faculty and staff appointment;
 - c. Formal application to the medical staff must be made in the usual manner;
 - d. The application will be processed according to these medical staff bylaws including all primary source verification, verification of malpractice history and letters of recommendation by the Chief of Staff's office;
 - e. The temporary privileges shall be time limited. The initial granting of privileges shall be for no longer than one hundred-twenty (120) days; and
 - f. The temporary privileges will not confer any rights or expectation of a faculty appointment or a regular staff appointment in the future.
- 6.9.3 Important Patient Care, Treatment of Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed one hundred-twenty (120) calendar days, while the full credentials information is verified and approved.
- 6.9.4 Clean Application Awaiting Approval: Temporary privileges will not be granted for applicants with clean applications awaiting approval. These applications will be processed through the expedited credentialing process.
- 6.9.5 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the individual has agreed in writing to abide by the bylaws, rules, and regulations and policies of the medical staff and hospital in all matters relating to his/her temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.
- 6.9.6 Termination of temporary privileges: The President, Loyola University Medical Center, acting on behalf of the Board and after consultation with the Chief of Staff, may terminate any or all of the individual's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about an individual's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose precautionary suspension under these medical staff

bylaws may affect the termination. In the event of any such termination, the individual's patients then will be assigned to another medical staff member and/or practitioner by the President, Loyola University Medical Center or his/her designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute health care provider.

- 6.9.7 Rights of the individual with temporary privileges: An individual is not entitled to the procedural rights afforded in Part II of these bylaws because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.
- 6.9.8 Emergency Privileges: In the case of a medical emergency, any individual is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the individual's license, regardless of department affiliation, staff category, or level of privileges. An individual exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.
- 6.9.9 Disaster Privileges:
- a. If the institution's disaster plan has been activated and the organization is unable to meet immediate patient needs, the President, Loyola University Medical Center and other individuals as identified in the institution's disaster plan with similar authority, may on a case by case basis, consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected AHPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
 - A current picture hospital ID card that clearly identifies professional designation;
 - A current license to practice;
 - Primary source verification of the license;
 - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
 - Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
 - Identification by a current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

- b. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within seventy-two (72) hours whether disaster recovery privileges should be continued.
- c. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer practitioner presents to the organization.
- d. Once the immediate situation has passed and such determination has been made consistent with the institution's disaster plan, the practitioner's disaster privileges will terminate immediately.
- e. Any individual identified in the institution's disaster plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to the procedural rights afforded in Part II of these bylaws.

Section 7. Reapplication after Modifications of Membership Status or Privileges and Exhaustion of Remedies

7.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a medical staff member and/or practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the medical staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any application received within five (5) years from the dates of the notice of the final adverse decision or the effective date of the resignation or application withdrawal is ineligible to be processed and the applicant will not be entitled to exercise the procedural rights contained in Part II of these bylaws.

7.2 Request for modification of appointment status or privileges

A department chair, either in connection with reappointment or at any other time, may request a modification of staff category, department assignment, or clinical privileges of a medical staff member by submitting a written request to the chairman of the Medical Staff Credentials Committee. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A medical staff member and/or practitioner who determines that he/she no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that he/she has been granted shall send written notice to the department chair who shall forward the request to the chairman of the Medical Staff Credentials

Committee, and MEC. A copy of this notice shall be included in the medical staff member and/or practitioner's credentials file.

7.3 Resignation of staff appointment or privileges

A medical staff member and/or practitioner who wishes to resign his/her staff appointment and/or clinical privileges must provide written notice to the appropriate department chair and Chief of Staff. The resignation shall specify the effective date. A medical staff member and/or practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the medical staff member and/or practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of administrative remedies

Every medical staff member and/or practitioner agrees that he/she will exhaust all the administrative remedies afforded in the various sections of these medical staff bylaws, including the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan sections before initiating legal action against the hospital or its agents.

7.5 Reporting requirements

The President, Loyola University Medical Center or his/her designee shall be responsible for assuring that the hospital satisfies its obligation under the Health Care Quality Improvement Act of 1986 and its successor statutes and any state reporting requirements, if applicable. Actions that must be reported include any negative professional review action against a physician related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 8. Leave of Absence

- 8.1 Requests for leave of absence will be processed through the faculty employment mechanism.
- 8.2 A medical staff member and/or practitioner who returns from a leave of absence of one year or longer, must reapply for membership on the medical staff and clinical privileges pursuant to Part III of these bylaws.

Section 9. Practitioners Providing Contracted Services

- 9.1 Requests for telemedicine privileges at the hospital that includes patient care, treatment, and services will be processed through one of the following mechanisms:

- a. The hospital fully privileges and credentials the practitioner; or
- b. The hospital privileges practitioners using credentialing information from the distant site if the distant site is a Medicare-participating hospital.

9.2 Qualifications

An individual who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee.

- ## 9.3
- The terms of the medical staff bylaws will govern disciplinary action taken by or recommended by the MEC.

9.4 Effect of contract or employment expiration or termination

The effect of expiration or other termination of a contract upon a medical staff member and/or practitioner's staff appointment and clinical privileges will be governed solely by the terms of the medical staff member and/or practitioner's contract with the hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the medical staff member and/or practitioner's staff appointment status or clinical privileges.

Loyola University Medical Center

MEDICAL STAFF BYLAWS

Part IV: Organization and Functions Manual

Section 1. Organization and Functions of the Staff

1.1 Organization of the Medical Staff

The medical staff shall be organized as a departmentalized staff including departments that correspond to the academic departments of Loyola University of Chicago, Stritch School of Medicine as may be changed from time to time. Currently those departments include anesthesiology, preventive medicine and epidemiology, emergency medicine, family medicine, medicine, neurological surgery, neurology, obstetrics and gynecology, ophthalmology, orthopaedic surgery and rehabilitation, otolaryngology, pathology, pediatrics, psychiatry and behavioral neurosciences, radiology, radiation oncology, surgery, thoracic and cardiovascular surgery, and urology. The academic department chair shall head each clinical department with overall responsibility for the supervision and satisfactory discharge of assigned functions by direction of the MEC.

1.2 Responsibilities for Medical Staff Functions

The organized medical staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Part IV, Section 1.3 with the ultimate responsibility lying with MEC. The MEC may create committees to perform certain prescribed functions. This process may include periodic reports as appropriate to the appropriate department, division, or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory accreditation compliance and appropriate standards of medical care.

1.2.1 Description of Medical Staff Functions

The medical staff, acting as a whole or through committee, is responsible for the following activities:

1.2.2 The development, refinement, measurement, assessment, and improvement of hospital and practitioner activities that include, but are not limited to the following:

- a. Strategic planning;
- b. Medical Staff Bylaws and Rules and Regulations review and revisions;
- c. Practitioner Wellness Medical assessment and treatment of patients;
- d. Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process;
- e. Use and management of medications;
- f. Use of blood and blood components;
- g. Operative and other procedures;
- h. Infection control;

- i. Education of patients and families;
- j. Health information Management;
- k. Quality of medical histories and physical examinations Appropriateness of clinical practice patterns;
- l. Use of developed criteria for autopsies;
- m. Sentinel events;
- n. Emergency preparedness;
- o. Patient safety;
- p. Patient satisfaction;
- q. Clinical contracts.

1.2.3 The Credentials Process

Qualifications and outcomes of practitioners including members of the medical staff, and advanced practice practitioners.

1.2.4 Supervision and graded responsibilities of graduate medical and dental education trainees.

1.3 Responsibilities of Department Chairs or designees

- a. To oversee all clinically-related activities of the department;
- b. To oversee all administratively-related activities of the department, unless otherwise provided by the hospital;
- c. To provide ongoing surveillance of the performance of all individuals in the medical staff department who have been granted clinical privileges;
- d. To recommend to the Medical Staff Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff department;
- e. To recommend clinical privileges for each member of the department and other licensed independent practitioners practicing with privileges within the scope of the department;
- f. To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the medical staff department or the hospital;
- g. To integrate the department into the primary functions of the hospital;

- h. To coordinate and integrate interdepartmental and intradepartmental services and communications;
- i. To develop and implement medical staff and hospital policies and procedures that guide and support the provision of patient care services;
- j. To recommend to the hospital administrator sufficient numbers of qualified and competent persons to provide patient care and service;
- k. To provide input to the hospital administrator regarding the qualifications and competence of department or service personnel who are not AHPs but provide patient care, treatment, and services;
- l. To continually assess and improve the quality of care, treatment, and services;
- m. To maintain quality control programs as appropriate;
- n. To orient and continuously educate all persons in the department or service;
- o. To make recommendations to the MEC and hospital administration for space and other resources needed by the medical staff department to provide patient care services; and
- p. Oversight of the OPPE and FPPE process for their department members.

1.4 Responsibilities of the Senior Vice President for Clinical Affairs/Chief Medical Officer

- 1.4.1 The Senior Vice President for Clinical Affairs/Chief Medical Officer is the primary officer of the medical staff and is the medical staff's advocate and representative in its relationships to the Board and the administration of the hospital. The Senior Vice President for Clinical Affairs/Chief Medical Officer, in collaboration with the medical staff, is responsible for developing and implementing systems which foster innovation, ensure the effective and safe delivery of medical care, and facilitate improvement in patient outcomes and satisfactions. The Senior Vice President for Clinical Affairs/Chief Medical Officer, in collaboration with the Chief of Staff, is responsible for the appointment of medical staff committee chairs.
- 1.4.2 The Senior Vice President for Clinical Affairs/Chief Medical Officer is responsible for providing leadership in the conceptualization, development, implementation and measurement of the hospital's approach to quality, patient safety, adverse event reduction and clinical effectiveness. The Chief of Staff reports to the Senior Vice President for Clinical Affairs/Chief Medical Officer. In the absence of the Chief of Staff, Senior Vice President for Clinical Affairs/Chief Medical Officer or designee shall assume all duties and have the authority of the Chief of Staff.
- 1.4.3 The Senior Vice President for Clinical Affairs/Chief Medical Officer may independently request a FPPE of an active medical staff member and/or practitioner in the event concerns related to quality and/or patient safety arise.

1.5 Responsibilities of the Chief of Staff

- 1.5.1 The Chief of Staff provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the medical staff bylaws, rules and regulations and policies. The Chief of Staff communicates and represents the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital administration, the MEC and the Board. The Chief of Staff shall be involved, in conjunction with the department chair, in the evaluation and administration of practitioner impairment issues. The Chief of Staff shall exercise such authority commensurate with the office as set forth in the medical staff bylaws.
- 1.5.2 The Chief of Staff shall represent the interests of the medical staff to the MEC and the Board.
- 1.5.3 The Chief of Staff may independently request a FPPE of an active medical staff member and/or practitioner in the event concerns related to quality and/or patient safety arise.

1.6 Responsibilities of the Chair of the MEC

Call and preside at all Medical Executive Committee meetings of the medical staff.

Section 2. Medical Staff Committees

2.1 Joint Conference Committee

- 2.1.1 **Composition:** The Joint Conference Committee shall consist of the Chief of Staff, the Senior Vice President for Clinical Affairs/Chief Medical Officer and an equal number of Board members.
- 2.1.2 **Responsibilities:** The Joint Conference Committee shall be the conflict resolution mechanism where there are differences of opinion between the MEC and the Board. The Joint Conference Committee may also be called by the Chair of the MEC, the Chair of the Board, or the President of Loyola University Medical Center to discuss issues pertinent to all parties.

2.2 General language governing committees

The following shall be the standing committees of the medical staff: Medical Executive Committee, Medical Staff Credentials Committee, Bylaws Committee, Graduate Medical Education Committee, ICU/Critical Care Committee, Informatics Committee, Quality and Patient Safety Council, Perioperative Executive Committee, Pharmacy and Therapeutics Committee, Blood Usage Committee, Clinical Practice Peer Review Committee, Patient Safety Evaluation Committee and Utilization Review Committee. These committees shall meet as often as necessary to fulfill their responsibilities. They shall maintain a permanent

record of their proceedings and actions and shall report their activities, findings and recommendations to the MEC. The Chief of Staff may appoint additional *ad hoc* committees for specific purposes. *Ad hoc* committees will cease to meet when they have accomplished their appointed purpose or on a date set by the Chief of Staff when establishing the committee. The Chief of Staff, the Senior Vice President for Clinical Affairs/Chief Medical Officer, and the President, Loyola University Medical Center, or their designees, are *ex officio* members of all standing and *ad hoc* committees unless otherwise specified in the committee description below.

Committee members may be removed from the committee by the Chief of Staff or by action of the MEC for failure to remain a member of the medical staff in good standing or for failure to adequately participate in the activities of the committee. Any vacancy in any committee shall be filled for the remaining portion of the term in the same manner in which the original appointment was made. The chair of any medical staff committee other than MEC, shall be appointed by the Senior Vice President for Clinical Affairs/Chief Medical Officer.

Description of the MEC is in Part I: Governance, Section 6.2.

2.3 Credentials Committee

Description of the Credentials Committee is Part III: Credentials Procedures Manual, Section 1.

2.4 Bylaws Committee

2.4.1 Composition: The Bylaws Committee shall consist of at least five (5) members of the medical staff. The Chief of Staff shall appoint the hospital representatives to the committee.

2.4.2 Responsibilities: The committee shall be responsible for conducting periodic review and revision of the medical staff bylaws, rules, regulations and policies. The committee shall also be responsible for submitting written recommendations to the MEC and to the Board for amendments to the medical staff bylaws, rules, regulations and policies.

2.5 ICU/Critical Care Committee

2.5.1 Composition: The ICU/Critical Care Committee shall consist of at least three (3) members of the medical staff. The Chief of Staff shall appoint the hospital representatives to the committee.

2.5.2 Responsibilities: The committee has the responsibility for overseeing the care provided in the Coronary Care, Intensive Care, and Post Critical Care Units. The committee will review the treatment of individual cases, and may suggest that attending physicians seek consultations when appropriate. The committee will establish an in-service teaching program for hospital personnel and medical staff associated with these special care units.

2.6 Graduate Medical Education Committee

2.6.1 Composition: The Graduate Medical Education Committee shall consist of the Chief

of Staff, the Designated Institutional Official (DIO), representative program directors, residents nominated by their peers and administrators as determined appropriate to the function of the committee. Other members may be appointed as appropriate. The DIO shall serve as the chair of the committee.

- 2.6.2 Responsibilities: The committee is responsible for insuring ACGME standards in collaboration with the DIO, and meeting or exceeding expectations with respect to resident education and training.
 - 2.6.3 The Graduate Medical Education Committee shall communicate with the medical staff and the Board about the safety and quality of patient care, treatment, and services provided by, and related educational and supervisory needs of, the participants in professional graduate medical educational programs.
- 2.7 Informatics Committee
- 2.7.1 Composition: The Informatics Committee shall consist of at least one (1) representative from the medical staff. The President, Loyola University Medical Center shall appoint the hospital representatives to the committee.
 - 2.7.2 Responsibilities: The committee shall be responsible for conducting a monthly review of currently maintained medical records to assure that they properly describe the condition and progress of the patient, the quality of medical histories and clinical examinations, the therapy provided, the results thereof, and the identification of responsibility for all actions taken; and that they are sufficiently complete at all times in the event of transfer of physician responsibility for patient care. It shall also conduct a review of records of selected discharged patients to determine the promptness, pertinence, adequacy and completeness thereof. The committee shall report to the MEC assuring that all medical records reflect realistic documentation of medical events. The committee shall develop, review, enforce and maintain surveillance at least quarterly over enforcement of medical staff and hospital policies and rules related to medical records including completion, preparation, forms, format, and recommend methods of enforcement thereof and changes therein. Finally, the committee shall serve as a liaison with hospital administration, nursing services, and medical record professionals in the utilization of the hospital on matters relating to medical record practices and information management planning.
- 2.8 Perioperative Executive Committee
- 2.8.1 Composition: The Perioperative Executive Committee is a multidisciplinary committee that shall consist of the Chief of Staff, the department chair of Surgery, the department chair of Anesthesiology, the medical director of Anesthesia perioperative services, the medical director of Surgery perioperative services, hospital administrators as determined appropriate to the function of the committee. The Chief of Staff shall appoint the hospital representatives to the committee. The President, Loyola University Medical Center, or designee shall also serve as an *ex officio* member.
 - 2.8.2 Responsibilities: The committee is responsible for policy and procedures concerning operating room management and function. It is also responsible for operating room operations and the function of operating room support areas such as surgical

reprocessing, the surgical admitting center and the post anesthesia care unit. The committee also has administrative oversight concerning policies and protocols dealing with patient safety and quality of patient care.

- 2.8.3 The Surgical and Other Invasive Procedures Committee shall be a subcommittee of the Perioperative Executive Committee and shall report its activities to the Perioperative Executive Committee.

2.9 Pharmacy and Therapeutics Committee

- 2.9.1 **Composition:** The Pharmacy and Therapeutics Committee is a multidisciplinary committee that shall consist of at least one (1) member of the medical staff, members of pharmacy administration, and members of hospital administration. The chair shall be appointed by the Senior Vice President for Clinical Affairs/Chief Medical Officer.

- 2.9.2 **Responsibilities:** The committee is responsible for policy and procedures concerning pharmacy management and function. It is also responsible for the hospital's drug formulary. The committee also has administrative oversight concerning policies and protocols dealing with patient safety and quality of patient care.

- 2.9.3 The Medication Use Safety Improvement Committee shall be a subcommittee of the Pharmacy and Therapeutics Committee and shall report its activities to the Pharmacy and Therapeutics Committee.

2.10 Blood Usage Committee

- 2.10.1 **Composition:** The Blood Usage Committee is a multidisciplinary committee that shall consist of at least six (6) medical staff members, hospital administration, a representative from the Center for Clinical Effectiveness, and hospital administrators as determined appropriate to the function of the committee.

- 2.10.2 **Responsibilities:** The committee is responsible for the improvement of all dimensions of performance in blood and blood component usage. The committee is also responsible for policies and procedures concerning blood and blood component usage. The committee also has administrative oversight concerning policies and protocols dealing with patient safety and quality of patient care.

2.11 Utilization Review Committee

- 2.11.1 **Composition:** The Utilization Review Committee is a multidisciplinary committee that shall consist of at least seven (7) medical staff members and hospital administrators as determined appropriate to the function of the committee.

- 2.11.2 **Responsibilities:** The committee is concerned with an overall perspective regarding the use of health care services, addressing under-utilization as well as over-utilization of services. The committee is responsible for reviewing UR statistics, avoidable stay/delay trend reports, transfer reports, case mix data and other applicable information. When warranted, the committee distributes the data to appropriate individuals or departments and requests action, as indicated.

2.12 Clinical Practice Peer Review Committee

2.12.1 Composition: The Clinical Practice Review Committee shall consist of at least four (4) members of the medical staff.

2.12.2 Responsibilities: The committee is responsible for conducting all medical staff peer review activities. The committee may independently request a FPPE of an active medical staff member and/or practitioner in the event concerns related to quality and/or patient safety arise.

2.13 Patient Safety Evaluation Committee

2.13.1 Composition: The Senior Vice President for Clinical Affairs/Chief Medical Officer is the chair of the committee. The Chief of Staff is a member.

2.13.2 Responsibilities: The Patient Safety Evaluation Committee evaluates and investigates events and occurrences associated with or resulting in any adverse clinical outcome or adverse impact on patient satisfaction; identifies all sentinel events; identifies aspects of clinical care or physician performance that requires focused review in order to ensure patient safety; maintains systems for the reporting, tracking, and trending of events and other risk management investigations/activities. The Patient Safety Evaluation Committee may independently request a FPPE of an active medical staff member and/or practitioner in the event concerns related to quality and/or patient safety arise.

2.14 Quality and Patient Safety Council (QPSC)

2.14.1 Composition: This is a medical staff committee whose membership is determined by the Chief Quality Officer or designee in collaboration with the President, Loyola University Medical Center. The committee is chaired by the Chief Quality Officer or designee.

2.14.2 Responsibilities: The committee provides leadership by overseeing, coordinating, and directing organizational quality, performance improvement, and patient safety activities by identifying, prioritizing and re-prioritizing activities. The committee is a peer-protected body with a direct reporting relationship to the MEC and the Quality and Patient Safety Council of Loyola University Medical Center.

2.14.3 The following subcommittees shall report their activities to the QPSC: Infection Control Committee, Pain Management Committee, Environment of Care Committee, CPR Committee, Patient Experience Committee, and Nursing Quality and Safety Council.

2.15 The following committees have medical staff representation, but shall be standing committees of the hospital: Ethics Committee, Cancer Committee, Transplant Committee, and Trauma Committee.

Section 3. Confidentiality, Immunity, Releases, and Conflict of Interest

3.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

- a. Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- b. Evaluations of current clinical competence and qualifications for staff appointment/affiliation and/or clinical privileges or specified services; and
- c. Contributions to teaching or clinical research; or determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

This information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of medical staff appointment/affiliation and/or clinical privileges or specified services.

3.2 Immunity from Liability

No representative of the hospital shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his/her duties as an official representative of the hospital or medical staff. No representative of the hospital shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The absolute immunity protections afforded in these bylaws are in addition to those prescribed by applicable state and federal law.

3.3 Covered Activities

The confidentiality and immunity provided by this article apply to all information or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

- a. Applications for appointment/affiliation, clinical privileges, or specified services;
- b. Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
- c. Corrective or disciplinary actions;

- d. Hearings and appellate reviews;
- e. Quality assessment and performance improvement/peer review activities;
- f. Utilization review and improvement activities;
- g. Claims reviews;
- h. Risk management and liability prevention activities; and
- i. Other hospital, committee, department, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

3.4 Releases

When requested by the Chief of Staff or designee, each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn and not processed further.

3.5 Conflict of Interest

A member of the medical staff requested to perform a board designated medical staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able to render an unbiased opinion. An absolute conflict of interest would result if the physician is the provider under review, his/her spouse, or his/her first degree relative (parent, sibling, or child). Potential conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussion or decisions other than to provide specific information requested.

3.6 Peer Review

“Peer Review” refers to any and all activities and conduct which involve efforts to reduce morbidity and mortality, improve patient care or engage in professional discipline. These activities and conduct include, but are not limited to: the evaluation of medical care, the making of recommendations in credentialing and delineation of privileges for physicians, dentist and podiatrists or allied health professionals seeking or holding such clinical privileges at a medical center facility, addressing the quality of care provided to patients, the evaluation of appointment and reappointment applications and qualifications of physicians, dentists and podiatrists or allied health professionals, the evaluations of complaints, incidents and other similar communications filed against members of the medical staff and others granted clinical privileges. They also include the receipt, review, analysis, acting on and

issuance of incident reports, quality and utilization review functions, and other functions and activities related thereto or referenced or described in any peer review policy, as may be performed by the medical staff or the Board directly or on their behalf and by those assisting the medical staff and Board in its peer review activities and conduct including, without limitation, employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other person or organization who assist in performing peer review functions, conduct or activities.

3.7 Peer Review Committees

“Peer Review Committees” means a committee, section, division, department of the medical staff as well as the medical staff and/or the Board, when participating in any peer review function, conduct or activity as defined in these bylaws. Included are those serving as members of a Peer Review Committee or their employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other person or organization, whether internal or external, who assist the Peer Review Committee in performing its peer review functions, conduct or activities. All reports, studies, analyses, recommendations, and other similar communications which are authorized, requested or reviewed by a Peer Review Committee or persons acting on behalf of a Peer Review Committee shall be treated as strictly confidential and not subject to discovery nor admissible as evidence consistent with those protections afforded under the Illinois Medical Studies Act. If a Peer Review Committee deems appropriate, it may seek assistance from other Peer Review Committees or other committees or individuals inside or outside the hospital. As an example a Peer Review Committee shall include, without limitation: the MEC, all clinical departments and divisions, the Medical Staff Credentials Committee, the Quality and Patient Safety Council, Infection Control Committee, Clinical Practice Peer Review Committee, the Patient Safety Evaluation Committee, the Board and all other committees when performing peer review functions, conduct or activities.

3.8 Patient Safety Evaluation System

Patient Safety Evaluation System (“PSES”) means the collection, management or analysis of information for reporting to or by a patient safety organization for patient safety activities including, but not limited to, efforts to improve patient safety and the quality of patient safety delivery, the collection and analysis of patient safety work product, the development and dissemination of information, maintenance of confidentiality and security measures and all other activities relating to improving patient safety.

3.9 Patient Safety Work Product

Patient safety work product means any data, reports, records, memoranda, analyses, including root cause analysis, or oral or written statements which are assembled or developed by a patient safety organization for the conduct of patient safety activities and which could result in improved patient safety, healthcare quality or healthcare outcomes or which identify the fact of reporting to a patient safety organization.

Loyola University Medical Center

MEDICAL STAFF BYLAWS

Part V: Definitions

Definitions

The following definitions are used throughout these bylaws. Part II (Investigations, Corrective Action, Hearing and Appeal Plan) also contains definitions, which are specific to that Part.

Allied Health Practitioner (AHP): A licensed practitioner other than a dentist, optometrist, oral and maxillofacial surgeon, physician, podiatrist, or psychologists who has been granted clinical privileges at the hospital. AHPs are not members of the medical staff.

Board Certified or Board Certification: Certification as a specialist or subspecialist by a certifying board that is recognized as such by the American Board of Medical Specialties, the American Osteopathic Association, or the American Dental Association's Commission on Dental Accreditation, or certification by the American Board of Podiatric Surgery.

Board Eligible or Board Eligibility: A medical staff member's eligibility to sit for the certification examination offered by a certifying board that is recognized as such by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association's Commission on Dental Accreditation, or the American Board of Podiatric Surgery.

Dentist: An individual licensed in Illinois to practice dentistry.

Ex Officio: Service on a committee by virtue of an office or position held. Unless otherwise expressly provided, *ex officio* members are without vote and are not counted in determining the existence of a quorum.

Focused Professional Practice Evaluation (FPPE): The time-limited evaluation of a medical staff member's or AHP's competence in performing specific clinical privilege(s) and professional behavior.

Medical Staff or Staff: Those dentists, optometrists, oral and maxillofacial surgeons, physicians, podiatrists, psychologists, podiatrists, and doctorate level medical directors admitted to practice at the hospital in accordance with these bylaws.

Medical Staff Member or Staff Member: A member of the medical staff.

Ongoing Professional Practice Evaluation (OPPE): Ongoing collection, verification and evaluation of data relevant to a medical staff member or AHP's clinical competence and professional behavior.

Optometrist: An individual licensed in Illinois to practice optometry.

Oral and Maxillofacial Surgeon: An individual who has successfully completed a residency program in oral and maxillofacial surgery accredited by the American Dental Association's Commission on Dental Accreditation, and who is licensed in Illinois to practice dentistry and oral and maxillofacial surgery.

Physician: An individual who is licensed in Illinois to practice allopathic or osteopathic medicine.

Podiatrist: An individual who is licensed in Illinois to practice podiatric medicine and surgery.

Practitioner: An individual licensed in Illinois in a profession that is eligible for allied health practitioner status.

Psychologist: An individual licensed in Illinois to practice psychology.

Rules: All medical staff policies, the rules and regulations, and hospital policies applicable to medical staff members and practitioners in the hospital, collectively.

Rules and Regulations: The rules and regulations of the medical staff adopted in accordance with these bylaws.