

BYLAWS OF THE MEDICAL STAFF
OF
RUSH UNIVERSITY
MEDICAL CENTER

EFFECTIVE
December 4, 2017

**Medical Staff Bylaws
Rush University Medical Center**

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PREAMBLE

Rush University Medical Center provides patient care, educational services and research in ever broadening horizons of the medical field. The Medical Staff, under the leadership of physicians has overall responsibility for the quality of professional services provided by individuals with Clinical Privileges and for the establishment of an organizational framework for Medical Staff activities and accountability to the Board of Trustees of the Medical Center, and the Medical Staff must assume this responsibility subject to the ultimate authority of the Board of Trustees of the Medical Center. Because the best interests of Medical Center patients and of patient care are protected by concerted effort, the physicians, dentists, and podiatrists who have direct responsibility for services supporting the care of patients do hereby organize themselves as a Medical Staff in conformity with these Bylaws.

These Bylaws provide details of Medical Staff relationships, rights, and responsibilities. The major goal of these Bylaws is to foster continuing improvement in patient care through excellence in patient care and in education and research. Excellent care requires excellent professionals, and an environment which values and encourages excellence. The environment must allow each member of the Medical Staff the opportunity to make maximal use of his or her talents and skills. Members of the Medical Staff shall have equal rights to the benefits and privileges provided by the Medical Center to Staff members with comparable professional qualifications. Similarly, Medical Staff members shall have the responsibility and opportunity to contribute to the patient care, teaching and research functions of the Medical Center.

The Medical Staff, as the principal health care provider, must participate in the planning process that defines the institution's goals, and must pursue these goals in a spirit of collegiality and cooperation. Because the Medical Staff has major responsibility for providing resources, it must participate in the decisions regarding their use, including decisions which may affect the institution's reputation. The institution, its leadership, and the Medical Staff must be guided by a philosophy of fairness.

The Medical Staff Bylaws and Rules and Regulations shall, at all times and in all respects, be subject to the laws of the United States and the State of Illinois and all valid rules and regulations prescribed by governmental and/or other regulatory and administrative agencies. The Bylaws and Rules and Regulations shall be interpreted and applied so that no person, Staff member, APP, applicant for membership or APP privileges, patient or any other person to whom reference is made directly or indirectly shall, on the basis of sex, race, color, national origin, age, handicap, religion, marital status or sexual orientation be excluded from participating in, be denied the benefits of, or be subject to discrimination under, any program or activity of the Medical Staff.

ARTICLE I: Name

The organized Medical Staff members shall be referred to as the Medical Staff of Rush University Medical Center.

ARTICLE II: Definitions

2.1 “Advanced Practice Provider” means those non-physicians, non-dentists, and non-podiatrists who participate in a certain level of patient care in the Medical Center and who may or may not be employees of the Medical Center, but who have been granted privileges to practice as APPs at the Medical Center. They shall include but not be limited to, advanced practice nurses, and physician assistants as defined in Illinois law.

2.2 “Applicant for Advanced Practice Provider Privileges” is an individual who has fulfilled all requirements as outlined in these Bylaws to be credentialed as an APP. Prior to completion of these requirements it is considered that this individual has only made an inquiry for privileges.

2.3 “Applicant to the Medical Staff” is an individual who has fulfilled all requirements as outlined in Section 6.1 of these Bylaws. Prior to completion of these requirements it is considered that this individual has only made an inquiry for staff privileges.

2.4 “Appropriate”, when used with the title of a Staff or Medical Center Officer, may mean the officer having jurisdiction over the subject contained or referred to in the provision of these Bylaws in which the term appears.

2.5 “Board” means the Board of Trustees of the Medical Center or a committee of the Board of Trustees empowered to act.

2.6 “Board Certification” means that an Applicant to the Medical Staff or Member is certified as a specialist by a specialty board organization recognized by the American Board of Medical Specialties or American Osteopathic Association for physicians, the American Board of Podiatric Medicine for podiatrists, or the applicable board certification for dentists.

2.7 “Board Qualified” means that an Applicant to the Medical Staff or Member has completed the number of years of medical, dental or podiatric specialty residency or education in a program approved by the Accreditation Council for Graduated Medical Education sufficient to satisfy the specialty board requirements for eligibility to become certified (which requirements are in effect when the program was completed) and Applicant to the Medical Staff or Member becomes board certified within three years from the date of first eligibility to take the final exam culminating in board certification.

2.8 “Chief Executive Officer of the Medical Center” means the highest ranking officer of the Medical Center.

2.9 “Chief Operating Officer, Dean, Office of the Dean, Chief Administrator of the Medical Center” are defined in the Medical Staff Rules and Regulations. These definitions

may change from time to time but the general authority granted to the title/individual herein cannot be changed by the rules and regulations.

2.10 “Clinical Privileges or Privileges”, includes both the specific privileges to refer and follow and/or provide hospital inpatient and outpatient care at the Hospital and access to Hospital resources to exercise such privileges. It also means the privilege to practice medicine, dentistry or podiatry at the Hospital via those Privileges granted to the extent and in the manner granted by the Medical Staff and Medical Center.

2.11 “Conflict Management Process” means that specific procedure described in Article XXIII of these Bylaws to manage conflict between the organized Medical Staff and the Medical Executive Committee on issues, including but not limited to, proposals to adopt Rules & Regulations, a policy, a Bylaw or an amendment to any of the foregoing.

2.12 “Economic Factor” means any information or reasons for decisions unrelated to quality of care or professional ethics or competency.

2.13 “Executive Committee” means the Executive Committee of the Medical Staff and is comprised of the Medical Staff Officers and the voting members.

2.14 “Ex-Officio” means any persons appointed to a group or committee of the Staff by virtue of their position, with responsibilities to attend and function at meetings except in executive session (unless invited) but without vote unless otherwise specified in these Bylaws.

2.15 “Hospital” means the areas of the Medical Center where inpatient and hospital outpatient diagnostic and therapeutic services or rehabilitation services are provided to patients.

2.16 “House Officer” means all physicians and dentists who are appointed within departments for graduate medical education, who will ordinarily carry a title of intern, resident or fellow. House Officer may also include licensed clinical psychologists who are in training.

2.17 “House Staff” means the group consisting of all House Officers.

2.18 “Medical Center” shall refer to Rush University Medical Center, an Illinois not-for-profit corporation, including all of its patient care, educational, and research components.

2.19 “Medical Staff” and/or “Staff” may be used interchangeably and, unless otherwise modified, means the Medical Staff of Rush University Medical Center, and shall include all those physicians, dentists, and podiatrists, who are granted membership and who practice, work or teach at Rush University Medical Center and/or the Johnston R. Bowman Health Center for the Elderly.

2.20 “Medical Staff Year” means the period from July 1 to June 30.

2.21 “Member” or “Membership” refers to membership on the Medical Staff, and consistent with Illinois law is reserved for physicians, dentists and/or podiatrists. An individual may be a Member of the Medical Staff but not have been granted Clinical Privileges.

2.22 “Practitioner”, unless otherwise modified, means any physician, dentist, podiatrist, Advanced Nurse Practitioner, Physician Assistant and/or licensed clinical psychologist who has Clinical Privileges, and any other category of independent licensed practitioner that is required to be credentialed per these Bylaws.

2.23 “President” means the President of the Medical Staff.

2.24 “Telemedicine” means the exchange of medical information from one site to another via electronic communication for the purpose of providing patient care, treatment and services. The granting of telemedicine privileges and the manner of telemedicine interaction will be outlined in the Medical Staff’s Telemedicine policy.

ARTICLE III: Purposes

These Bylaws are designed to promote the following purposes of the Medical Staff:

- 3.1 quality care for patients admitted to or treated in any of the facilities, Departments, or services of the Medical Center;
- 3.2 a high level of professional performance among all Medical Staff members and Advanced Practice Provider
- 3.3 a framework for Medical Staff activities and accountability to the Board through Staff Bylaws, Rules and Regulations;
- 3.4 cooperative arrangements with the Medical Staffs of other health care, research and educational institutions;
- 3.5 engaging in basic and clinical research;
- 3.6 provision of an exemplary medical and scientific educational program;
- 3.7 a means for discussion between the Medical Staff, Medical Center management and the Board concerning issues of mutual importance; and
- 3.8 such other activities and perform such other services as may be appropriate.

ARTICLE V: Medical Staff Membership

4.1 Nature of Medical Staff Membership.

Membership on the Medical Staff is a privilege which shall be extended only to physicians, dentists, and podiatrists, who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

4.2 Qualifications for Initial and Continued Membership.

4.2-1 To qualify as a member and to remain a member of the Medical Staff, other than an Honorary Member, an individual must:

- a. be a physician, dentist, or podiatrist who holds a valid, current, unrestricted license to practice medicine and surgery, dentistry or podiatry in the State of Illinois;
- b. be able to document and/or support his or her background, experience, training, physical and mental health and demonstrated competence as pertains to privileges requested, his or her adherence to the ethics of his or her profession, current health status as pertains to privileges requested, good reputation and his or her ability to work with others, with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by him or her in the Hospital will be given high quality medical care and/or he or she will be a good steward of resources on behalf of the Medical Staff and Medical Center;
- c. be eligible for a faculty appointment in Rush Medical College and receive such appointment;
- d. as pertains to Clinical Privileges requested, be designated by his or her Department Chairperson as having the appropriate skill and ability to fulfill a specific patient care need of the Medical Center;
- e. as pertains to Clinical Privileges requested, provide evidence of professional competence and treatment of patients;
- f. maintain eligibility as a provider in the Medicare and Illinois Medicaid programs; and
- g. as applicable to his or her practice, maintain a valid DEA license for the prescribing of medications.

4.2-2 An additional criterion or qualification for Staff membership is the ability of the Hospital to provide adequate facilities and support services for the applicant and his or her patients.

4.2-3 Individuals who seek Clinical Privileges as members of the Medical Staff or who are members of the Medical Staff with Clinical Privileges must maintain professional liability insurance coverage, with insured limits of no less than one million dollars (\$1,000,000) per individual/person and three million dollars (\$3,000,000) in the aggregate. The member must submit, on an annual basis, proof of professional liability insurance coverage including information regarding the limits afforded under such coverage, to the Medical Staff Office.

4.2-4 Information regarding previously successful or currently pending challenges to any licensure or registration (local, state or federal drug enforcement administration) or the voluntary relinquishment of such licensure or registration or information regarding voluntary and the involuntary termination of membership or voluntary or involuntary limitation, reduction or loss of Clinical Privileges, a pending suspension or other disciplinary proceeding at another healthcare facility, Medicare or Medicaid sanctions or exclusion from practice or any lapse or reduction in professional liability insurance required under these Bylaws or conviction of a misdemeanor or (other than minor traffic violations) felony must be reported to the Department Chairperson and the Medical Staff Office within five (5) business days of the occurrence. Limitations or termination in any professional medical society or organization must also be reported to the Department Chairperson and the Medical Staff Office within five (5) business days of the occurrence.

4.2-5 Medical Staff members shall be governed by the codes of ethics of their respective professions.

4.3 Conditions and Duration of Medical Staff Membership.

4.3-1 Board action. Initial appointments and reappointments to the Medical Staff shall be made by the Board in accordance with its Bylaws and its decision shall be conveyed by the Secretary of the Board to the President, the Chief Executive Officer of the Medical Center, and the Dean. Thereafter, the President shall inform, in writing, the Chairperson of the Department concerned and the applicant or member of the decision. The Board shall act on appointments, reappointments, or revocation of appointments only after there has been a recommendation from the Executive Committee in accordance with these Bylaws.

4.3-2 Duration of appointments. Initial appointments and the first reappointment to all categories of the Staff shall be no more than two years. The first reappointment following the initial appointment of each Staff member shall be for a period extending to the then current Medical Staff Year. All subsequent reappointments shall be for a period of not more than two Medical Staff years.

4.3-3 Privileges. Appointment to the Medical Staff shall confer on the member only such Clinical Privileges as have been granted by the Board. However, an individual may be a member of the Medical Staff without Clinical Privileges.

4.3-4 Compliance with Bylaws, Rules & Regulations. Every person accepting appointment to the Medical Staff does thereby promise and agree to abide by the terms and conditions of these Bylaws and Medical Staff Rules & Regulations, as may be amended from time to time. Nothing contained herein, however, shall be deemed to constitute either (1) an agreement for the benefit of any person other than the Medical Center or a member of the Medical Staff or the Board, or (2) the creation of a partnership, association or joint venture.

4.3-5 Service to Medical Center. It shall be a requisite for continuing membership on the Medical_Staff that a member devotes a portion of his or her time to performing non-remunerative service to the Medical Center, which may be teaching, research, administrative work, service on committees, or patient care.

4.3-6 Consultations. Each member of the Active Staff, as defined in Section 5.4, shall, upon request by any other member of the Active Staff, be available for consultation at any reasonable time.

4.3-7 Board Certification. Board Certification alone is not the sole criterion for Membership and/or Clinical Privileges. However, it is a requirement that all Members be Board Certified or Board Qualified. For individuals who have completed a program of study and are Board Qualified, they must become Board Certified within three years from the date of first eligibility to take the final exam culminating in board certification. If a Member's Board Certification lapses, (either by expiration or termination), he shall have a two (2) year grace period to re-instate it, starting from the date of expiration or termination. Members of the Medical Staff who are not Board Certified as of the date this provision is effective shall have a five (5) year grace period from its effective date to obtain Board Certification. Those Board Qualified individuals who do not become Board Certified within the applicable time limit (three (3) years after becoming Board Qualified or within time limit established by the respective board) or individual Members who do not reinstate Board Certification or become Board Certified within the two (2) and five (5) year grace periods referenced herein, as applicable, shall be deemed to have voluntarily surrendered Medical Staff Membership. Board Certification must be in the field of specialty that allows practice of the requested privileges. If an individual is a Member or seeks Membership without requesting privileges to practice medicine at the Hospital, the Board Certification requirement may be waived by the Departmental Chair of the Department the Member would be or is in. In addition, the Departmental Chair may request a general waiver of the Board Certification requirement. The waiver may, based on the recommendation of the Department Chair, be perpetual or for a limited amount of time. Such request will be reviewed by the Credentials Committee and the Medical Executive Committee and the recommendations of these Committees will be forwarded to the Board for final consideration. Any request to waive the Board Certification requirement for a Departmental Chair must be made by the Dean. Such request will be reviewed by the Credentials Committee and the Medical Staff Executive Committee and the recommendations of these Committees will be forwarded to the Board for final consideration.

4.4 Leave of Absence.

4.4-1 Members may request a leave of absence from the Medical Staff in writing.

4.4-2 Employed Staff members shall be eligible for Leaves of Absence consistent with the requirements of federal and state law.

4.4-3 For those leaves covered by federal or state law, a member of the Medical Staff shall comply with the documentation and procedures outlined in the Medical Center's Human Resources Policies and Procedures Manual and shall be eligible for a leave and reinstatement from a leave of absence consistent with those laws. For all other leaves, the Member shall submit a written request to his/her Department Chairperson. Thereafter, the written request, together with the recommendation of the Department Chairperson, shall be submitted to the Dean, who shall review the request and submit his or her recommendation and the recommendation of the Chairperson to the Executive Committee for consideration and final decision.

4.4-4 As appropriate, consideration will be given to coordinating leaves of absence, hereunder, with leaves of absence under the faculty Rules for Governance of Rush University.

4.4-5 While on leave of absence, a member of the Medical Staff shall not be eligible to vote, hold office or admit patients. He or she shall have no regularly assigned duties and shall pay no additional dues. Dues already paid shall not be refunded.

4.4-6 With the exception of military leave, when leaves are granted, they shall not exceed one year. If a Staff member on a leave of absence does not return to the Staff within one (1) year he or she shall be considered to have voluntarily resigned from the Medical Staff. However, such voluntary resignation alone shall be deemed to be administrative only for purposes of mandatory reporting by hospitals of adverse credentialing actions. A request for Staff membership subsequently received from a Staff member who so resigns shall be submitted and processed in the manner specified for applications for initial appointments.

4.4-7 With the exception of leaves of absence covered by federal or state law, which shall be handled by the Medical Center's Department of Human Resources, a member on leave of absence may request to be returned to the Medical Staff at any time through his or her Department Chairperson. The written request, along with the recommendation of the Department Chairperson, shall be submitted to the Dean who shall review and comment upon the request prior to consideration by the Executive Committee.

4.4-8 If a member wishes to return prior to the specified expiration date of his or her leave, the Staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the department Chairperson with a copy to the Medical Staff President for transmittal to the Medical Staff Executive Committee with the department Chairperson's recommendation. The Staff member shall submit a written summary of his/her relevant activities during the leave, if the department Chairperson or Medical Executive Committee so requests. If the leave was for medical reasons, appropriate medical clearance may be required. If the leave is governed by federal or state law, and early return from said leave must be compliant with same, and with any

relevant policies and procedures of the Medical Center Department of Human Resources.

4.5 Illness Reporting.

Medical Staff members returning to practice following a major illness, whether returning from a formal leave of absence or not, may be asked to provide information to their Department Chairperson regarding the nature and treatment of that illness. If necessary, the Department Chairperson or Executive Committee may request a fitness for duty examination and/or report prior to reinstatement. This will ensure that the returning Staff member is able to provide care consistent with the standards of medical practice at the Medical Center. The information sought and obtained for medical leaves covered by federal or state laws will be consistent with the requirements of those laws.

4.6 Re-Appointment.

If a Staff member is on a leave of absence and his or her time for re-appointment is to have been considered, he or she shall complete the re-appointment process prior to returning to the active Staff.

ARTICLE V: Categories of the Medical Staff

5.1 The Medical Staff.

The Medical Staff shall be divided into active, honorary, and visiting categories. In addition Medical Staff membership may include those individuals with a designation of Affiliated Scientist.

5.2 The Honorary Medical Staff.

5.2-1 The Honorary Medical Staff shall consist of physicians, dentists, and podiatrists, in the categories of (1) Emeritus members, and (2) Distinguished members, as follows:

- a. Emeritus members. Active Staff members who retire from active practice may be nominated for advancement to Emeritus membership by their department Chairperson(s).
- b. Distinguished members. Physicians, dentists, and podiatrists of outstanding achievement or reputation, regardless of residence in the community, whom the Staff wishes to honor, may be appointed to this category.

5.2-2 Honorary Staff members are not eligible to vote, hold office, or have Clinical Privileges. They shall have no regularly assigned duties and shall pay no dues, but shall be encouraged to participate in all other Staff activities and are eligible to serve on Medical Staff standing committees as ex-officio members.

5.2-3 Honorary members shall demonstrate a level of character, adhere to the ethics of their profession in which they are licensed, loyalty to the Medical Center and ability to work with others sufficient to warrant the designation as an Honorary member.

5.3 The Active Medical Staff. The Active Medical Staff shall consist of physicians, dentists, and podiatrists who are eligible to refer and follow and/or admit and attend patients in the Hospital subject to the scope of privileges granted, vote and hold office, and have regularly assigned duties and responsibilities relating to same. Active Medical Staff members with Clinical Privileges must regularly refer and/or admit patients or be involved in patient care subject to the scope of privileges granted. It is expected that Active Medical Staff Members will attend Medical Staff, Department and Committee meetings and otherwise actively be involved in the Medical Center and Medical Staff.

5.4 Visiting Appointment to the Medical Staff. Visiting Staff must meet all of the basic conditions for Medical Staff membership under section IV hereof, except for the faculty appointment to Rush University. Candidates shall be recommended by the Department Chairperson, the Credentials Committee and the Executive Committee for appointment by the Board. Visiting Staff members are not eligible to hold office or, except as specified in these Bylaws, to vote. They may hold refer and follow privileges, but shall not admit patients, and shall have no regularly assigned duties. Visiting Staff shall pay dues in association with their staff membership and shall be encouraged to participate in all other Staff activities. Visiting Staff may have access to appropriate clinical information on their own patients being cared for at the Hospital and shall demonstrate they have made arrangements with an Active Medical Staff member with admitting privileges to admit their patients to the Hospital. They may visit patients they have referred to the Hospital and may have “read only” access to the patients’ paper and electronic medical record but may not write orders or entries of any kind in the medical record.

5.5 Affiliated Scientists

5.5-1 There are two categories of Affiliated Scientists:

- a. The status of Affiliated Scientist may be conferred upon distinguished, as defined below, faculty members of Rush Medical College who are not practicing physicians or professionals who do not have a license to practice medicine, but who hold the degrees of letter Ph.D., M.D., D.O., D.P.M. or D.D.S. and whose activities, interest and contributions are related and essential to the Medical Center. The word “Distinguished” as it relates to Affiliated Scientist is interpreted to mean an individual (a) who occupies a position of leadership at the Medical Center or University and has gained a general recognition within his or her own profession specialty; (b) who has made substantial contributions to the Medical Staff and its programs; and (c) whose contributions have had a national rather than local influence. Individuals must be recommended for the

designation of Affiliated Scientist through distinction by three active members of the Medical Staff who should send letters of recommendation to the Membership committee, outlining the contributions made to the Medical Center by that individual. The chief sponsor must also send a copy of the applicant's curriculum vitae. The application will be voted upon by the Medical Staff Executive Committee.

- b. The status of Affiliated Scientist may also be conferred upon clinical psychologists. Clinical psychologists are licensed independent practitioners who provide psychological care to patients, in accordance with state licensure laws, without supervision by a physician. They are affiliated members of the Medical staff and are granted recognition as such under the terms of these Bylaws.
 - (1) Clinical psychologists must continuously meet the requirements, qualifications, and responsibilities set forth in the Bylaws for Clinical Privileges. Clinical psychologists may evaluate and treat patients within the scope of their license and training qualifications. They may not admit patients to the Hospital, nor prescribe medication. Psychologists are also exempt from DEA certification requirements as they are not permitted to prescribe any medications.
 - (2) Clinical psychologists are required to hold a doctoral degree (Ph.D. or PsyD) in clinical, counseling, or school psychology and must have completed two years of full-time supervised clinical training, at least one year of which was post-doctoral. They are required to have completed an American Psychological Association accredited pre-doctoral internship or its equivalent.

5.5-2 Affiliated Scientists do not have the right to vote and may not hold any office in the governance of the Medical Staff except on an ex-officio basis.

5.5-3 The President of the Medical Staff will appoint at least one individual with the status of Affiliated Scientist to the Medical Staff Executive Committee as a non-voting member.

ARTICLE VI: Procedure for Appointment and Reappointment

6.1 Application for Appointment

6.1-1 All requests for application to the Medical Staff should be in writing to the Department Chairperson over which the applicant seeks

appointment, who shall promptly provide a copy of all such requests to the Dean. An application will be provided to any faculty member who requests one or anyone who is eligible for faculty appointment and applies for same at the same time as requesting an application for membership in the Medical Staff, on a timely basis, absent information available to the Medical Center or Medical Staff that the applicant cannot meet the minimum qualifications set forth in this section. A complete application shall include the following components submitted on a form approved by the Executive Committee and the Board:

- a. signature of the applicant;
- b. signature of the Chairperson of the Department in which the applicant is applying;
- c. signature of the Chairperson in the Department from which the applicant has his or her primary training as a resident and/or fellow (if different from 6.1-1 b.);
- d. written attestation that the Department Chairperson has verified identification of each new applicant. Use of government issued I.D. (e.g. driver's license or current passport) is recommended although other methods may be applicable;
- e. detailed information concerning the applicant's qualifications, including evidence of current licensure;
- f. drug Enforcement Administration (DEA) and Illinois Controlled Substance licensure.
- g. if seeking Clinical Privileges, current professional liability insurance coverage with insured limits of no less than one million dollars (\$1,000,000) per individual/person and three million dollars (\$3,000,000) in the aggregate including information regarding the limits afforded under such coverage, relevant training and experience, current competence, and current health status relevant to the privileges requested;
- h. letters of recommendation from three persons who are members of the applicant's specialty and who have had experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's training, experience, professional competence and ethical character;
- i. information as to whether the applicant's membership status and/or Clinical Privileges have ever been revoked, suspended, voluntarily or involuntarily reduced or not renewed at any other institution, and as to whether his or her membership in local, state or national professional societies, or his or her license to practice any profession

in any jurisdiction or narcotics registration (state or federal), has ever been voluntarily or involuntarily suspended or terminated or been subject to previously successful or currently pending challenges;

- j. a statement that the applicant has reviewed the Bylaws and Rules and Regulations of the Medical Staff and that he or she agrees to be bound by the terms thereof if he or she is granted membership and Clinical Privileges-to be bound by the terms thereof in all matters relating to consideration of his or her application, whether or not he or she is granted membership and/or Privileges;
- k. a statement that the applicant acknowledges his or her obligation to provide continuous care and supervision to his or her patients, and provide services pursuant to Department regulation;
- l. evidence of professional competence and treatment of patients. To determine fulfillment of this requirement, the Department Chairperson should consider any and all payments made on behalf of the applicant/member in settlement or in satisfaction of judgment in medical malpractice claims or lawsuits, and may consider the existence of unresolved lawsuits pending against the applicant/member. The Department Chairperson may consider any other relevant information;
- m. such other information as the Staff considers necessary for a thorough evaluation of the applicant's qualifications for membership and if applicable request for Clinical Privileges.

An application will be considered complete only when it fulfills all of the requirements in this Section 6.1-1, and until such time it shall be considered an inquiry for application, and shall not be processed per Section 6.2 for consideration. The Department Chairperson shall advise the Medical Staff Office to collect the applicant's references and any other materials and follow-up on any issues presented by the application. When the Chairperson determines the application contains the information set forth above he shall initiate the Appointment Process.

6.1-2 The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. The applicant acknowledges he or she may be requested to undergo a physical and/or behavioral health (neuro-psych) examination as part of the initial appointment process and in submitting an application, consents to doing so if requested and consents to release of the results of same.

6.1-3 By applying for appointment to the Medical Staff, each applicant thereby (1) signifies his or her willingness to appear for interviews in regard to his or her application, (2) authorizes the Medical Center to consult with members of Medical Staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his or her competence, character and ethical qualifications, (3) consents to the Medical Center's inspection of all records and documents that may be material to an evaluation of his or her professional qualifications and competence to carry out the Clinical Privileges he or she requests as well as of his or her ethical qualifications for Staff membership, (4) releases the Medical Center, its agents, officers, employees, and Medical Staff from any liability for their acts performed in good faith in connection with the application process and (5) releases from any liability all individuals and organizations who provide information to the Medical Center in good faith concerning the applicant's competence, ethics, character and other qualifications for Staff appointment and Clinical Privileges, including otherwise privileged or confidential information.

6.2 Appointment Process.

6.2-1 The Medical Staff Office will determine when the application is complete and ready to send to the Department Chairperson, who shall review the application and related materials and shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in the application, references given by the applicant, and from other sources available to the Committee, whether the applicant has established and meets all of the necessary qualifications for the category of Staff membership and the Clinical Privileges he or she has requested. Within no more than thirty days after the application being deemed complete, the Department Chairperson shall make a recommendation to the Credentials Committee that the applicant be either appointed to the Staff or rejected for Medical Staff membership or that the application be deferred for no longer than thirty calendar days for further consideration. All recommendations to reject shall include the reasons for such recommendations. All recommendations to appoint shall also specifically recommend the Clinical Privileges to be granted, if applicable.

6.2-2 The Credentials Committee shall review the application and the recommendations submitted by the Department Chairperson within thirty days review and shall recommend to the Executive Committee (1) that the applicant be appointed to the Staff, (2) that his or her application be rejected, or (3) that his or her application be deferred for no longer than thirty calendar days for further consideration. The recommendation shall include the application and all associated previous documentation. All recommendations to reject shall include the reasons for such recommendations. All recommendations to appoint made by the Credentials Committee shall specifically recommend the Clinical Privileges to be granted, if applicable.

6.2-3 The Credentials Committee shall forward the recommendations along with the application and all associated previous documentation to the President who shall place the application on the agenda of the next regularly scheduled meeting of the Executive Committee. All recommendations to reject shall include the reasons for such recommendations. All recommendations to appoint made by the Credentials Committee shall specifically recommend the Clinical Privileges to be granted, if applicable.

6.2-4 If any of the time limits outlined herein are exceeded without a reasonable explanation or basis the Dean and/or the Chief Executive Officer of the Medical Center after thirty days shall intercede and move the application to the next step in the process.

6.2-5 At its next regular meeting after receipt of the application(s) at issue and associated recommendations, the Executive Committee shall act on the matter and make its recommendations to the Board of Trustees. The Executive Committee shall forward its recommendations to the Board of Trustees, to be considered in accordance with its Bylaws. The Board shall promptly consider the application(s) and recommendation(s) before it, and shall give deference to the Staff regarding clinical decisions relating to privileges granted. If the Executive Committee fails to provide its recommendation in a timely manner, the Dean shall notify the Executive Committee that if they fail to act within 30 days the Dean shall intercede and make a recommendation to the Board of Trustees.

6.2-6 In accordance with its Bylaws, the Board's final decision shall be conveyed by the Secretary of the Board to the President, the Chief Executive Officer of the Medical Center and the Dean. Thereafter, the President shall inform, in writing, the Chairperson of the Department concerned and the applicant of the decision. If the recommendation is adverse to the applicant in respect to appointment, the President shall promptly notify the Dean and the applicant in writing the reasons of such adverse decision including any economic factors. The applicant may request a hearing procedure as outlined in Article XV of these Bylaws.

6.2-7 All initial appointments to the Medical Staff shall be in the Department representing the primary professional-academic discipline of the Staff member. In the event of a question as to the appointee's primary professional-academic discipline, that decision will be resolved by the Dean subject to the approval of the Executive Committee of the Medical Staff.

6.2-8 Conjoint appointments must be made through joint decision of the involved Departmental Chairpersons and the Medical Staff member involved and with the approval of the Office of the Dean for mutually agreed upon functions and proportions of time. A Staff member shall be responsible to the Chairpersons of the Departments in which the conjoint appointments are held for those functions and proportions of time.

6.3 Reappointment Process.

6.3-1 Members shall be subject to the reappointment process every two years. In order to provide for a staggered reappointment process to address the number of members, some Members may be subject to the re-appointment process on an annual basis, but thereafter will be reappointed every two years. All recommendations to reappoint made by the Department Chairperson shall also specifically recommend the Clinical Privileges to be granted including whether or not the individual is to have admitting privileges as well as attending privileges, providing that the Executive Committee and the Dean have approved admitting privileges for the Department.

- a. In a timely manner, the Medical Staff Office shall provide reappointment applications to the relevant Department. The Department Chairperson of each Department shall review the applications for information described in Section 6.3-2 below concerning the practitioner scheduled for re-appointment, and shall transmit his or her recommendations, in writing, to the Credentials Committee. Each subsequent level of review shall recommend for each Staff member requesting re-appointment that he or she (1) be reappointed without change in the requested Clinical Privileges, (2) be reappointed with different Clinical Privileges than those requested (3) not be reappointed or (4) deferred for further consideration. Where non-reappointment or reappointment with different privileges than those requested is recommended, the reason for such recommendation shall be stated and documented. All recommendations to reject, to grant more limited privileges than requested, or to defer for further consideration shall include reasons for such recommendations.
- b. The Credentials Committee shall forward its recommendation to the President who shall place such recommendation on the agenda of the Executive Committee meeting for Executive Committee action. The recommendation of the Executive Committee shall be referred to the Board of Trustees for consideration in accord with its Bylaws. If the recommendation of the Board is that the Staff member not be re-appointed or that his or her Clinical privileges be reduced or restricted, a copy of the written decision and reasons, including any economic factors, shall be given to the staff member, and to the Dean, who as the designee of the Board shall certify the recommendations as an adverse decision of the Board, pending the opportunity for hearing and appeal and final action by the Board. Notwithstanding the foregoing, if the reason for a reduction in or restriction of Clinical Privileges is due to an action or omission by the member that is designated within these Bylaws to constitute a voluntary relinquishment of Privileges, the decision shall not be considered adverse and the member shall not be entitled to a hearing.

6.3-2 Except for Honorary Staff, each recommendation concerning the reappointment of a Medical Staff member and the Clinical Privileges to be granted upon reappointment shall be based upon evidence of such member's current licensure; current health status relevant to the privileges requested, professional liability insurance coverage (if Clinical Privileges are requested); professional competence and clinical judgment in the treatment of patients as provided for in 4.2-1(e) (if Clinical Privileges are requested); sufficient level of activity at Hospital subject to privileges granted allowing the FPPE and OPPE as required by the Joint Commission; attestation of continuing education activities consistent with the requirements of the State of Illinois; completion of all required Rush University Medical Center mandatory training courses by end of the academic year (June 30th); ethics and conduct; attendance at Medical Staff meetings and participation in Staff affairs; compliance with the Medical Center Bylaws and the Medical Staff Bylaws and Regulations; cooperation with Medical Center personnel in regard to patient care and/or otherwise; appropriate use of the Medical Center's facilities for his or her patients; relations with other practitioners and general attitude toward Medical Center personnel and patients; information regarding previously successful or currently pending challenges to any licensure or registration (state or federal) or the voluntary or involuntary relinquishment of licensure or registrations, and voluntary or involuntary limitation, reduction or loss of Clinical Privileges or membership status at another Medical Center. Departments may consider sources of reappointment information from other Rush entities, on an individual basis, as part of the process providing this information is presented and reviewed by the Departmental Advisory Committee in the same manner as for other Medical Staff members.

6.4 Resignation from the Medical Staff or Relinquishment of Privileges.

6.4-1 Any member of the Medical Staff may resign at any time. Resignation should be in writing to the Medical Staff Office and the Chairperson of each Department in which the member holds an appointment. A voluntary resignation will occur when the member no longer meets eligibility criteria as referenced in Section 4.2 of these Bylaws, goes on leave but has not been granted a Leave of Absence from the Medical Staff or fails to complete his/her application for reappointment within required time frames.

6.4-2 A member of the Medical Staff is expected to have completed all clinical and/or research record keeping responsibilities at the time of resignation. A physician, dentist, or podiatrist who resigns from the Medical Staff without having completed and signed medical records and fulfilled other clinical and/or research related responsibilities has resigned, but not in good standing.

6.4-3 A member may relinquish his or her privileges, but remain a member upon circumstances recommended by the member's Department Chairperson and accepted by the Executive Committee, or as referenced within these Bylaws.

ARTICLE VII: Clinical Privileges for Members of the Medical Staff and Advanced Practice Providers and Clinical Psychologists

7.1 Clinical Privileges.

7.1-1 Every member of the Staff practicing medicine, podiatry or dentistry at the Hospital and any APP or clinical psychologist granted Clinical Privileges by the Medical Center shall be entitled to exercise only those Clinical Privileges specifically granted to him or her by the Board pursuant to a recommendation by the Executive Committee of the Medical Staff and all other requirements of the Medical Staff Bylaws, except as provided in Section 7.2 and 7.3 of this Article.

7.1-2 Every initial application for Staff appointment except as allowed by Section 7.2-4, must contain a request for the specified Clinical Privileges desired by the applicant, or a statement that the applicant is not requesting Clinical Privileges. The evaluation of such requests shall be made in accordance with these Bylaws. The evaluation shall be based upon the applicant's education, judgment, current health status relevant to the privileges requested, peer recommendations, and other relevant information, including the following: an appraisal by the clinical department or departments in which such privileges are sought; the patient care needs for additional Staff members with the applicant's skill and training; and, the ability of the Medical Center to provide adequate facilities and support services for the applicant and his or her patients. The applicant shall have the burden of establishing his or her qualifications and competency in the Clinical Privileges requested.

7.1-3 Re-evaluation of Clinical Privileges shall occur at the time of reappointment. The renewal, increase, or curtailment of Clinical Privileges shall be based upon the direct observation of care provided, review of the records of patients treated in the Hospital, and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical care, and shall be determined by the criteria described in Section 7.1-2. The member shall have the burden of establishing his or her qualifications and competency in the Clinical Privileges to be renewed.

7.1-4 Privileges granted to dentists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be exercised in and under the overall supervision of the Department of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

7.1-5 Privileges granted to podiatrists shall be based on their training, experience, and demonstrated competence and judgment. If a podiatrist is granted privileges to perform surgical procedures, they must be exercised in and performed under the overall supervision of the Department of Orthopedic Surgery. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during the hospitalization.

7.2 Temporary Privileges.

7.2-1 Upon receipt of a complete application for Medical Staff membership from an appropriately licensed physician, dentist or podiatrist, the Chief Executive Officer of the Medical Center or the Dean or his or her designee as delegated by the Chief Executive Officer of the Medical Center, with the subsequent approval of the Board of Trustees may, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the appropriate Department Chairperson and of the President of the Medical Staff, grant temporary admitting and Clinical Privileges, provided that there shall first be obtained such individual's signed acknowledgment that he or she has been oriented to and agrees to be bound by Medical Staff Bylaws and Regulations in all matters relating to such temporary Clinical Privileges and to his or her practice in the Hospital. In exercising such privileges, the applicant shall act under the supervision of the Chairperson of the Department to which he or she is assigned. Temporary privileges will be granted for a period of up to 120 days and may be renewed under special circumstances if approved by the Chief Executive Officer of the Medical Center or the Dean or his or her designee.

7.2-2 Special requirements of supervision and reporting may be imposed by the appropriate Department Chairperson on any practitioner granted temporary privileges. Temporary privileges may be terminated immediately by the President or the Chief Executive Officer of the Medical Center or his or her designee upon notice of any failure by the practitioner to comply with these special conditions.

7.2-3 Temporary privileges may be summarily suspended consistent with Section 8.3 of these Bylaws. The appropriate Department Chairperson, or in his or her absence, the Chief Medical Officer, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patients until they are discharged from the Hospital. The wishes of the patients shall be considered, where feasible, in selection of the substitute practitioner.

7.2-4 Emergency Clinical Privileges for the care of specific patients may also be granted by the Chief Executive Officer of the Medical Center or his or her designee, and the President of the Medical Staff or his or her designee to a physician, dentist or podiatrist who is not an applicant for membership, in the same manner and upon the same conditions as set forth herein. Such emergency privileges shall be restricted to the treatment of the patients identified in the

original request. If such practitioner requests to treat more than the authorized number of patients, such practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

7.2-5 Temporary Privileges for Specific Patients: Physicians requesting temporary privileges for the care of specific patients for a limited number of procedures or a specific time frame (*e.g.*, one day) must fulfill the requirements as listed in the Medical Staff & Faculty Appointment Policies & Procedures. The following items are mandatory requirements for temporary privileges for specific patients:

- Cover memo from Department Chairperson describing the basis for the need for Temporary Privileges and the specific patient(s), treatment(s), and/or the procedure(s) to be performed including the specific time frame for patient care
- Current state license or valid visiting physician license
- Current Professional Liability Coverage
- Documentation that Professional Liability Coverage is without geographical limitation

7.3 Disaster Privileges

7.3-1 When there is an activation of an emergency disaster plan and the institution is unable to handle the immediate patient needs, the Chief Medical Officer or his or her designee has the option to grant disaster privileges.

7.3-2 The Chief Medical Officer is designated as the Chief Medical Officer of the RUMC Emergency Management Plan. For the purpose of this particular section of the Bylaws, the Dean has designated the President of the Medical Staff to serve in the capacity of Chief Medical Officer.

7.3-3 The Chief Medical Officer has the authority to grant or not to grant privileges based on the information presented. Privileges will be granted within the requestor's discipline and shall be time limited.

7.3-4 Once the Chief Medical Officer has granted disaster privileges to a physician, the Command center (Hospital Volunteer Office) will provide a temporary identification badge to the physician (which is yellow in color) to clearly identify the physician. The Chief Medical Officer or his or her designee will determine the duration of the privileges granted.

7.3-5 All physicians requesting temporary disaster privileges are to be referred to the Medical Staff Office. If the Medical Staff Office is not open, the physician shall be referred to the Chief Medical Officer.

7.3-6 The granting of disaster privileges is to be determined at the discretion of the Chief Medical Officer or his or her designee. Before a volunteer practitioner is considered for Clinical Privileges, the Medical Staff Office will obtain his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:

- a. A current hospital PICTURE ID card from a health care organization that clearly identifies professional designation
- b. A current license to practice (wallet card ok)
- c. Member of Disaster Medical Assistance Team (DMAT)
- d. Federal authority identification
- e. Presentation and confirmation by a credentialed Medical Staff member who personally knows individual
- f. Primary source verification of licensure

7.3-7 The Medical Staff Office will start verification of credentials utilizing the same mechanism as for temporary privileges after the disaster is under control. The name of the practitioner's primary hospital affiliation shall also be ascertained. Primary source verification of licensure begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed within 72 hours (e.g., no means of communication or lack of resources) verification will be done as soon as possible. In this extraordinary circumstance, the following will be documented: why primary source verification could not be performed in the required timeframe; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. In the event that the volunteer practitioner does not provide care, treatment or services under the disaster privileges, primary source verification of license is not required. As soon as possible, the Medical Staff Office will also query the National Practitioner Data Bank, State licensing agency *IDFPR*, *OIG*, and hospital where current privileges are held by the volunteer. Records of these queries will be retained by the Medical Staff Office.

7.3-8 Any information gathered that is not consistent with that provided by the physician must be referred to the Senior Medical Officer immediately who will determine any additional necessary action including but not limited to revocation of disaster privileges.

7.3-9 Once disaster privileges are granted, a record of the practitioner's actions shall be maintained. The record shall indicate that the practitioner exercising the disaster privileges does so at the request of an attending physician currently on the Medical Center Medical Staff. To the extent feasible, these

practitioners shall be paired with current Medical Staff members of the same specialty and should act under direct observation.

7.3-10 The Medical Center and any of its employees or others involved in granting privileges who, in good faith, grant disaster privileges to respond to an emergency shall not, as a result of their acts or omissions, be liable for civil damages for granting or denying disaster privileges except in the event of willful and wanton misconduct.

7.4 Emergency Care.

In emergency situations, all Medical Staff members, regardless of status with respect to Staff membership, but with regard to the limitations of their license to practice, shall be permitted and expected to do everything possible to save the lives of patients. Every facility of the Medical Center may be used including the call for appropriate assistance. For the purpose of this paragraph, an “emergency” is defined as a condition which might result in permanent and/or serious harm to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

7.5 Advanced Practice Provider.

7.5-1 Eligibility. Advanced Practice Providers (“APPs”) shall consist of those non-Medical Staff professionals who provide a certain level of patient care at the Medical Center and who may or may not be employees of the Medical Center. Only those categories of APP for whose skills the Board of Trustees, after consultation with the Executive Committee, has determined a demonstrated need shall be eligible to provide patient care services. Persons granted APP status are not members of the Medical Staff.

7.5-2 Granting of Privileges. Patient care privileges may be granted to only those APPs holding a license, certificate or other legal credentials as required by state law who:

(i) Document their experience, background, training, demonstrated ability, physical health status, completion of continuing medical education as required by applicable licensure or certification and, upon request of the Executive Committee or the Board of Trustees (or appropriate committee thereof), mental health status with sufficient adequacy to demonstrate to the Medical Staff and to the Board that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency and that they are qualified to provide a needed service within the Medical Center; and are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions and to work cooperatively with others. Where appropriate, the Executive Committee may establish particular qualifications required for a specific category of APP, provided that such qualifications are not arbitrary or contrary to applicable law. The application and credentialing process

for granting privileges shall generally be consistent with the process for Medical Staff Members.

7.5.3 APP's Prerogatives include the following:

(i) Exercising independent judgment in their areas of competence, provided that a member of the Medical Staff shall have the ultimate responsibility for patient care.

(ii) Participating directly in the management and care of patients under the general supervision or direction of a member of the Medical Staff.

(iii) Recording reports and writing notes on patient records in accordance with Hospital policy and writing orders for treatment or prescribing medications to the extent established in the Rules and Regulations of the Medical Staff, and provided that such orders are within the scope of licensure, certification or other legal credential, and identifies the APP as such in accord with his or her specialty.

(iv) Maintaining professional liability insurance as required by the Medical Center. Certification of coverage must be provided prior to the granting of privileges, and coverage must be maintained throughout the APP's tenure at the Hospital.

Applications for patient care privileges as an APP shall be reviewed as any application for privileges and the re-appointment process shall be generally the same as that reflected in Article VI of these Bylaws, subject to Section 7.5.4 below.

APPs must be assigned to a clinical Department appropriate to their professional training. If asked, they may serve on appropriate committees of the Medical Staff and exercise voting privileges on such committees if such privileges are granted by the terms of their committee appointment. APPs may be invited to attend certain Medical Staff meetings and may, as a condition of continued privileges, be required to attend meetings involving the clinical and peer review of patient care in which they participated.

The quality of patient care services provided by APPs shall be reviewed as part of the quality assurance program of the Medical Staff and Hospital.

7.5-4 Removal Procedures and Status for APPs. The Medical Center retains the right to suspend or terminate any or all of the privileges or functions of any category of APP, without recourse on the part of such person or others to the review and hearing process of these Bylaws, except as provided below.

APPs whose privileges are terminated or curtailed shall be told the reasons for such action and, if they so request, shall be entitled to have a meeting with the Executive Committee or a committee duly appointed by the Executive Committee

to present their position on the matter. At any such meeting, the individual shall be present and allowed to participate.

If the Executive Committee appoints a committee to hear the APP's objections, that committee shall report to the Executive Committee. The Medical Executive Committee shall make a recommendation to Medical Center administration based on the information gathered. The affected APP may appeal the Executive Committee's recommendation to the Chief Executive Officer or his or her designee, who shall meet with the parties to consider the recommendation and appeal but shall have final decision making authority.

Final actions regarding APPs will be reported to the National Practitioner Data Bank or Illinois Department of Financial and Professional Regulation only if reporting is required by law.

ARTICLE VIII: Corrective Action

8.1 Routine Corrective Action.

8.1-1 Criteria for initiation of investigation. Whenever the activities or professional conduct of any practitioner with Clinical Privileges are deemed to be, or are deemed to be reasonably likely to be, detrimental to patient safety or to the delivery of good patient care or are, or are reasonably likely to be disruptive to Medical Center operations, or otherwise fail to comply with these Bylaws, routine corrective action against such practitioner may be initiated by any officer of the Medical Staff, Department Chairperson, the Chief Executive Officer of the Medical Center, the Chief Medical Officer, Senior Vice President, from a recommendation of the Physician Conduct Panel (*See Medical Staff Rules and Regulations, "Disruptive Conduct Policy for Medical Staff Members"*), or by the Board. All requests for routine corrective action shall be in writing, submitted to the Executive Committee and supported by reference to the activities or conduct which constitute the grounds for the request. Actions against a Department Chairperson or the Dean shall be investigated by the Executive Committee.

8.1-2 Investigation by Department. Unless the Executive Committee believes there is no possible reason to initiate action on the routine corrective action investigation request, it shall promptly forward the request for corrective action to the Chairperson of the Department in which the questioned activities or conduct occurred. The Chairperson of such Department shall immediately convene an Ad Hoc Committee to investigate the matter. The Ad Hoc Committee shall consist of not fewer than three or more than five individuals and shall be comprised of members of the Department when the issues raised are clinical in nature. The composition of the Ad Hoc Committee shall be reviewed and approved by the President. The Committee shall in a timely manner forward a written report of the investigation to the Executive Committee and the Department Chairperson. The investigation process for routine corrective action may include consultation with the practitioner involved and appropriate others along with a

review of relevant records. The process however, will not be conducted according to the formal hearing procedures outlined in Article XV of these Bylaws.

8.1-3 Executive Committee action. As soon as it's practicable after receipt of the Ad Hoc Committee and/or Physician Conduct Panel report, the Executive Committee shall take action upon the request. Such action may include without limitation:

- a. A determination that there is no basis for corrective action;
- b. Issuance of a warning, a letter of admonition, or a letter of reprimand;
- c. Recommending terms of individual requirements of consultation;
- d. Recommending probation, reduction, change, suspension or revocation of Clinical Privileges;
- e. Recommending reduction of Staff category or limitation of any Staff prerogatives directly related to patient care; and/or
- f. Recommending suspension or revocation of Staff membership.

The President shall promptly notify the Department Chairperson, the Dean, the Chief Executive Officer of the Medical Center and the Staff member against whom the corrective action was considered of the Executive Committee's recommendation. If the recommendation imposes any or a combination of items C-F on the Member, he or she shall be advised of his right to a hearing pursuant to Article XV of the Bylaws and the basis for the recommendation. The notice shall advise the affected member that if he or she does not timely request a hearing he or she shall waive his or her rights to same.

8.1-4 As an alternate or precursor to routine corrective action, in the event the activities or professional conduct of a practitioner might give rise to the need for corrective action, but might be resolved through collegial intervention, the latter may be initiated by the same individuals listed in Section 8.1-1. Collegial intervention might be in the form of a meeting, suggested education or training and/or a series of possible reporting or meetings by the practitioner at issue. The success of collegial intervention relies on the willingness of the practitioner to voluntarily participate in same. The process and mode of intervention shall be documented and considered to be part of the performance review and improvement process. As the participation in collegial intervention is voluntary, the process is collaborative and does not entail an adverse action and a request of a practitioner to participate in same shall not give rise to any hearing or due process rights. If a practitioner refuses to participate in collegial intervention or objects to it, he may be subject to corrective action as described above.

8.2 Summary Suspension.

8.2-1 Criteria for initiation. Whenever conduct on the part of any individual holding Medical Staff privileges requires that immediate action be taken to protect the life of any patient or if the continuation of clinical practice of a Medical Staff member constitutes an immediate danger to the public, including patients, visitors, other Medical Staff members and/or Medical Center personnel, at least two of the following individuals: the President, the Chairperson of a Department, the Chief Executive Officer of the Medical Center, the Dean, the Chief Medical Officer, or other officer of the Executive Committee, shall have the authority to suspend summarily the Medical Staff membership or all or any portion of the Clinical Privileges of such Staff member based upon actual documentation or other reliable information of the immediate danger existing at the time of the summary suspension. Such summary suspension shall become effective immediately upon imposition, and the Dean or Chief Executive Officer of the Medical Center shall promptly notify the individual of imposition of the basis therefore and his or her hearing and procedural rights. In the event of any such suspension, the individual's patients then in the Hospital whose treatment by such individual is terminated by the summary suspension shall be assigned to another individual by the appropriate Department Chairperson. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

8.2-2 Executive Committee action: procedural rights. Within five (5) days of such summary suspension, a meeting of the Executive Committee shall be convened to review and consider the action taken. The Executive Committee may recommend (a) suspension or (b) continued suspension pending final Board action on revocation or restriction of Membership and/or privileges, (c) termination of the terms of the summary suspension and reinstatement of the individual with no further action. Upon recommendation by the Executive Committee that the summary suspension should be lifted, expunged, or modified, this recommendation shall be reviewed by the Board, consistent with its Bylaws, on an expedited basis. Unless the Executive Committee recommends immediate termination of the suspension which has been reviewed and approved by the Board in accord with its Bylaws, the practitioner shall be entitled, upon his or her request, to the hearing and review rights as provided in Article XV. Termination of the suspension shall not preclude the Medical Center and/or Executive Committee from investigating the concerns raised in the suspension to determine if other corrective action is warranted.

8.3 Automatic Suspension.

8.3-1 License. A Staff member whose license, certificate or other legal credential authorizing him or her to practice in Illinois is revoked or suspended shall immediately and automatically be suspended from practicing in the Medical Center, including but not limited to the Hospital and any physician offices located in space owned by the Medical Center but not functioning as hospital outpatient

services departments. The suspension shall continue until the licensure action ends or the Board terminates Medical Staff membership and privileges, whichever first occurs. Any Staff member whose license or other legal credential is revoked or suspended shall notify the President immediately of such revocation or suspension. A Staff member whose privileges are suspended or revoked as a result of his or her having their license suspended or revoked is not entitled to a hearing pursuant to Article XV of the Bylaws.

8.3-2 Drug Enforcement Administration (DEA) License and Illinois Controlled Substance License. A Staff member whose DEA or Illinois Controlled Substance License is revoked or suspended shall immediately and automatically be divested at least of his or her right to prescribe controlled substances. The suspension shall continue until the DEA action ends or the Board terminates Staff membership or the relevant privileges, whichever first occurs. Any Staff member whose DEA license or Illinois Controlled Substance license is revoked shall notify the President immediately of such revocation or suspension. As soon as practicable after such automatic suspension of the practitioner's right to prescribe medications covered by the DEA license or Illinois Controlled Substance license the Executive Committee shall convene to review and consider the facts under which the DEA license or Illinois Controlled Substance was revoked or suspended. The Executive Committee may then recommend such further routine corrective action as is appropriate to the facts disclosed in its investigation.

8.3-3 Faculty Appointment. A Staff member whose faculty appointment in Rush University is suspended shall immediately and automatically be suspended from practicing in the Medical Center subject to the applicable appeals process in the Rush University Rules for Governance. The suspension shall continue until the faculty appointment suspension ends or the Board terminates Staff membership, whichever first occurs. The Medical Staff membership of a Staff member whose faculty appointment in Rush University is terminated shall immediately and automatically be terminated subject to the applicable appeals process in the Rush University Rules for Governance. If entitled to an appeal under the University Rules for Governance, his or her Medical Staff appointment will be suspended until final resolution of the appeal under those Rules.

For such faculty appeals that involve revocation of Medical Staff membership, the faculty member may ask the Executive Committee of the Medical Staff to investigate the matter and make a recommendation to the Grievance Committee of Rush Medical College to be considered by them as part of their deliberations. The Grievance Committee of Rush Medical College shall be advised in advance by the President of the Medical Staff that the Executive Committee will be making a recommendation to them on such cases.

If a Medical Staff member is terminated as a result of loss of faculty appointment he or she shall not be entitled to a hearing as set forth in Article XV hereof.

8.3-4 Medical Records. Admitting and visiting privileges may be temporarily withheld, in accordance with the Medical Staff Regulations, for failure to complete medical records in a timely manner.

8.3-5 Medicare or Medicaid. A Staff Member whose participation as a provider of services in Medicare, Medicaid, or other federally funded health care programs is involuntarily suspended or revoked is subject to suspension or termination of his or her privileges or membership. If a Medical Staff member is terminated as a result of such involuntary suspension, revocation, or exclusion, he or she shall not be entitled to a hearing as set forth in Article XV hereof.

8.3-6 Malpractice Insurance. Admitting and visiting privileges will be temporarily withheld or suspended for failure to obtain or maintain requisite malpractice insurance.

8.3-7 Administrative Suspension. As soon as practicable after an administrative suspension is imposed and where the Medical Staff member contests the basis for the suspension, the Executive Committee shall convene to review and consider the underlying facts, including, where a bona fide dispute exists regarding the facts and whether the action causing the automatic suspension has occurred. The scope of review by the Executive Committee shall be limited to whether the allegation is factually correct. The Executive Committee may then lift the suspension if the facts do not warrant it, and/or recommend such further corrective action as is appropriate to the facts disclosed in its investigation. If the suspension is not lifted, or if further corrective action is recommended by the Executive Committee, the hearing and review rights specified in Article XV shall be available to the practitioner. However, at hearing, the only subject matter for review is the factual basis for the administrative suspension.

ARTICLE IX: Departments, Clinical Sections and Divisions

9.1 Organization of Departments and Clinical Sections and Divisions.

Each Department shall be organized as a separate part of the Medical Staff and shall have a Chairperson who shall be selected and have the authority, duties and responsibilities as set forth in Article X. The Departments currently recognized by the Medical Staff and Medical Center are listed on Appendix A hereto.

Each clinical Section and Division shall be organized as a specialty subdivision within a Department, shall be directly responsible to the Department within which it functions, and shall have a Section director who shall be selected and have the authority, duties and responsibilities as set forth in Article X.

Only those Departments, Sections and Divisions which have been approved in accordance with Section 9.2 of these Bylaws, shall be recognized within the Medical Center.

9.2 Changes to Departments, Divisions and Sections.

Departments may be established or abolished, when approved by the Dean, the Executive Committee, the Chief Executive Officer of the Medical Center, and the Board.

Sections and Divisions may be established or abolished by the Executive Committee, upon recommendation of the appropriate Department Chairperson and approval of the Dean. A proposal to establish a new Section shall be circulated to the Executive Committee, Departmental Chairpersons and division or section directors at least 14 days prior to presentation to the Executive Committee for consideration of approval or disapproval.

Amendments to Appendix A to reflect changes to the Departments may be made from time to time pursuant to the process outlined herein and without the process outlined in Article XVI. A list of Sections and Divisions shall be maintained at the Departmental level, with copies provided to the Office of the Dean, Rush Medical College.

9.3 Assignment to Departments and Clinical Sections.

Each member of the Staff shall be assigned membership in at least one Department, but may be granted membership or Clinical Privileges or both in one or more of the other Departments in accordance with Article VI of these Bylaws. The exercise of privileges and specified services within each department and section shall be subject to these Bylaws, to the Medical Staff Regulations, to the regulations of such Department and section and to the authority of the Department Chairperson.

9.4 Functions of Departments.

Each Department shall implement and conduct review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the Department. To carry out this responsibility, each Department shall:

9.4-1 Conduct patient care evaluations for the purpose of analyzing, reviewing and evaluating the quality of care and service within the Department and improve that care. All clinical work performed under the jurisdiction of a Department is subject to review by that Department, whether or not the practitioners performing such work are members of that Department. Practitioners shall be subject to review by each Department in which they exercise Clinical Privileges. Departments shall establish a minimum level of clinical activity for members with privileges in the department for the purpose of conducting meaningful FPPE and OPPE. The level of activity shall take into account whether the member has admitting privileges.

9.4-2 Establish guidelines for the granting of Clinical Privileges and the performance of specified services within the Department and submit the recommendations required under Articles VI and VII of these Bylaws regarding the specific privileges each Staff member or applicant may exercise.

9.4-3 Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and to findings in review, evaluation and monitoring activities.

9.4-4 Conduct periodic reviews of the department's overall operation in conjunction with departmental reviews which may from time to time be performed in accordance with the Rules for Governance of Rush University.

9.4-5 Monitor, on a continuing and concurrent basis, adherence to: (1) Staff and Medical Center policies and procedures; (2) requirements for alternate coverage and for consultations; (3) such other matters as may be requested from time to time by the Executive Committee.

9.4-6 Coordinate the patient care and other services provided by the Department's members with nursing and ancillary patient care services and with administrative support services.

9.4-7 Submit written reports to the Executive Committee through the Medical Staff Quality Committee on a regularly scheduled basis concerning: (1) findings of the Department's review, evaluation and monitoring activities, actions taken thereon, and the results of such action; (2) recommendations for maintaining and improving the quality of care and services provided in the department and the Medical Center and (3) such other matters as may be requested from time to time by the Executive Committee.

9.4-8 Meet at least eleven times per year for the purpose of receiving, reviewing, and considering patient care and other Departmental and Staff matters. Each member of the Active Staff shall be required to attend regular departmental meetings as outlined by the Department, unless excused from attendance by the Chairperson. Unless excused for good cause, failure to meet the attendance requirements may be grounds for any of the corrective actions specified in 8.1-3 of these Bylaws.

9.4-9 Establish such committees or other mechanisms as necessary and desirable to properly perform its assigned functions.

9.5 Functions of Clinical Divisions and Sections.

Each division and section shall, upon the approval of the Executive Committee and the Board, perform the functions assigned to it by the Department Chairperson. Such functions may include, without limitation, retrospective, concurrent or prospective patient care monitoring activities, the operation and supervision of special procedure functions, the continuous monitoring of patient care practices, credentials review and privileges delineation and continuing education program. The division and/or section shall report regularly to the Department Chairperson on the conduct of its assigned functions.

9.6 Departmental Advisory Committees.

9.6-1 Membership. Each department shall have an Advisory Committee consisting of no fewer than three members, appointed by the Department Chairperson, including an appropriate number of elected members from all ranks. A department consisting of three members or less shall have an Advisory Committee consisting of the entire membership of the department.

9.6-2 Duties. The duties of each Advisory Committee shall be:

- a. To assist its Department Chairperson in the formulation and execution of policies and regulations pertinent to the functions of the department; and
- b. To perform the activities set forth in these Bylaws relating to Medical Staff appointments and Clinical Privileges.

9.6-3 Meetings. Department Advisory Committees shall have regularly scheduled meetings, but shall meet at least once each quarter, and copies of their minutes shall be forwarded to the President for review and filed in the Medical Staff Office.

9.6-4 Quorum. A majority of the members of the Department Advisory Committee shall constitute a quorum at any meeting of the Committee. Decision shall be by majority vote of the members present at a meeting at which a quorum is present.

ARTICLE X: Officers

10.1 Medical Staff Officers.

10.1-1 Officers of the Medical Staff. The Officers of the Staff shall be a President, President-Elect, Secretary and Treasurer.

10.1-2 Other Medical Staff Officials. Other officials of the Staff may include Department Chairpersons, section and program directors and such other officials as may be selected pursuant to these Bylaws.

10.1-3 Qualifications. Officers and other officials of the Staff must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their terms of offices. Failure to maintain such status shall immediately create a vacancy in the office involved. The President and President-Elect must be practitioners holding the M.D. or D.O. degree.

10.1-4 Nominations.

- a. Nominating Committee. The Nominating Committee shall select its candidates for officers of the Staff and shall notify via regular or electronic mail or posting in the Medical Staff office each member

of the Staff of these selections at least six weeks prior to the annual meeting in April or May. The report of the Nominating Committee shall be read at the annual meeting.

- b. By Petition. Additional nominations may be made upon written petition signed by at least twenty voting members of the Staff, such petition to be delivered to the Secretary at least three weeks prior to the annual meeting. The Secretary shall advise each member of the Staff, by regular or electronic mail, of such additional candidates at least one week prior to the annual meeting.

This Section shall not apply to the office of President. The President-Elect shall, upon the completion of his or her term of office in that position, immediately succeed to the office of President. The outgoing President is eligible to be a candidate for President-elect. However, the office of President and President-elect cannot be occupied by the same person simultaneously.

10.1-5 Election. Officers shall be elected at the annual meeting of the Staff. Only such candidates as have been selected by the Nominating Committee, or nominated by petition as provided in Section 10.1-4, may be voted upon. If more than one candidate is nominated for any office, the voting for each such office shall be conducted by secret written ballot. Only Staff members accorded the prerogative to vote for Staff officers shall be eligible to vote. Voting by proxy shall not be permitted. Ballots may be cast on the site of the annual meeting from one hour before the annual meeting until 30 minutes after the start of the meeting. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes at the annual meeting.

10.1-6 Term of Office. The President and the President-Elect shall serve two-year terms elected on odd years, and the Secretary and the Treasurer shall be elected on even years and each shall serve two-year terms, each term to begin on the first day of July of the year in which the officer is elected or succeeds to office. Each officer shall serve until the end of his or her term and until a successor is elected, unless he or she shall sooner resign or be removed from office. Newly elected officers shall be invited to attend and participate, without vote, in all meetings of the Executive Committee, following their election and prior to the commencement of their terms of office.

10.1-7 Removal of Elected Officers. Except as otherwise provided, removal of a Staff officer may be initiated by:

- a. petition signed by at least 10% of the voting members of the Staff;
or
- b. recommendation of the Executive Committee;

Such petition or recommendation must receive an affirmative vote of at least 50% of the Staff eligible to vote for Staff officers at any special meeting of the Staff call within which a quorum is present for this purpose. The meeting will be initiated by the President within thirty days of receipt of the petition of recommendation. Any Medical Staff Officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, serious acts of moral turpitude, failure to carry out or perform the duties of his or her office, or to perform the duties of, the position held as described in these Bylaws.

10.1-8 Vacancies in Elected Offices. Vacancies in offices, other than those of President and President-Elect, shall be filled by the Executive Committee. If there is a vacancy in the office of President, the President-Elect shall serve out the remaining term. A vacancy in the office of President-Elect shall be filled by a special election conducted as reasonably soon after the vacancy occurs following the general mechanism outlined in Sections 10.1-4 and 10.1-5.

10.2 Duties of Officers.

10.2-1 President. The President shall be the presiding and chief executive officer of the Staff and, in such capacity shall perform the following:

- a. aid in coordinating the activities and concerns of the Medical Center administration and of the nursing and other patient care services with those of the Medical Staff;
- b. act as a liaison between the Medical Staff and the Chief Executive Officer of the Medical Center, the Executive Committee of the Board, the Liaison Committee of the Board, and other officials of the Staff;
- c. serve as an annual member of the Board of Trustees;
- d. serve as a member of the Executive Committee of the Board of Trustees which is established by the Board of Trustees. The President shall report to the Medical Staff on the meeting proceedings;
- e. notify the Executive Committee of the Board of Trustees when a faculty appointment has been rescinded.
- f. be responsible for the enforcement of Medical Staff Bylaws and Regulations;
- g. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

- h. serve as Chairperson of the Executive Committee and as an ex officio member (without vote, unless otherwise specified in these Bylaws) of all Staff committees except the Nominating Committee;
- i. appoint, with the approval of the Executive Committee, a replacement for any member of the Nominating Committee or the Medical Staff Liaison Committee who shall not be able to serve;
- j. appoint the members of the standing committees of the Staff and of all special committees created by the Staff, and, unless otherwise specified in the Bylaws, shall designate the Chairperson of such committees; and
- k. perform such other functions as may from time to time be assigned by the Executive Committee or the Board.

10.2-2 President-Elect. The President-Elect shall assist the President and shall assume the duties and authority of the President in the event of the latter's inability or failure to serve. The President-Elect shall assume the office of President upon expiration of the term of the President, shall be an ex officio member without vote on all Staff committees with the exception of the Nominating Committee of which he or she is not a member and shall perform such additional duties as may be assigned by the President, the Executive Committee or the Board.

10.2-3 Immediate Past-President. The Immediate Past President of the Medical Staff position shall be filled by the most immediate Past President able to serve. The duties shall include membership in the Executive Committee of the Medical Staff, the Agenda Planning Subcommittee of the Executive Committee, the Nominating Committee, and the Quality Care Committee of the Board of Trustees.

10.2-4 Secretary. The Secretary is responsible for:

- a. preparing, preserving and making available accurate and complete minutes and attendance records of all Staff meetings;
- b. forwarding a copy of the adopted minutes of the Executive Committee of the Medical Staff and other pertinent information to the Chief Executive Officer of the Medical Center and the Chairperson of the Board of Trustees;
- c. calling meetings on the order of the President;
- d. attending to correspondence;
- e. verifying and authenticating petitions;

- f. contacting and verifying the willingness and availability of candidates to serve on the Executive Committee;
- g. producing ballots;
- h. overseeing and authenticating elections;
- i. presiding at officially called meetings in the absence of both the President and President-Elect, and
- j. performing such other duties that ordinarily pertain to the office of Secretary.

10.2-5 Treasurer. The Treasurer shall be responsible for the collection, accounting, and disbursement of Staff funds. At the annual meeting the Treasurer shall report on the status of the funds in the treasury. An audit of these funds shall have previously been made by two Staff members appointed by the President. The Treasurer shall perform such other duties as ordinarily pertain to the office of Treasurer.

10.3 Other Officials of the Staff

10.3-1 Department Chairperson.

- a. Qualifications. Chairpersons shall be a member of the Active Staff; shall have demonstrated ability in at least one of the clinical areas covered by the Department (if it is a medical department); shall be board certified (unless a waiver of the Board Certification requirement is granted pursuant to Section 4.3-7) in the clinical area covered by the department. If it is a Medical department, shall have demonstrated ability in at least one of the areas covered by the department, (if a scientific department); and shall be willing and able to discharge faithfully the functions of the office. No Department Chairperson may serve as Chairperson or head of a Department outside of the Medical Center, or as a member of the governing body of another Medical Center except under exceptional circumstances and with the approval of the Executive Committee.
- b. Selection and Appointment. Nominations for appointments of Department Chairpersons shall originate in a Search Committee representing the Medical Staff and the Faculty of Rush University. This Search Committee shall be appointed and shall function in accordance with the Rules for Governance of Rush University.
- c. Term of Office. The term of office for a Chairperson will be determined in accordance with the Rules for Governance of Rush University.

- d. Vacancies. In the event of a vacancy in the Chairpersonship of a Department, an acting Chairperson shall be appointed as soon as possible in accordance with the procedures set forth in the Rules for Governance. Acting Department Chairpersons shall not replace vacancies left by Chairpersons on the Medical Executive Committee. Such vacancies shall be filled by the Executive Committee.
- e. Duties. Each Chairperson shall:
- (1) be accountable to the Executive Committee and to Medical Center management for all professional and administrative activities within the department and particularly for the quality of patient care and other services rendered by members of the department and for the effective conduct of patient care evaluations and other quality review and evaluation functions delegated to the department;
 - (2) develop and implement in cooperation with Medical Center management and consistent with the provisions of Section 9.4 and Article XI of these Bylaws, Departmental programs for evaluating the quality and appropriateness of patient care, monitoring of practice, credentials review and privileges delineation, continuing medical education, and utilization review;
 - (3) provide guidance on the overall medical policies of the Medical Center; and make specific recommendations and suggestions regarding the Department;
 - (4) assure the participation of Department members in department continuing education programs and required meetings;
 - (5) maintain continuing review of the professional performance of all department members with Clinical Privileges and of all Advanced Practice Provider with specified services in the Department and report regularly thereon to the Executive Committee;
 - (6) transmit to the appropriate authorities, as required by Articles VI through VIII, the Department's recommendations concerning appointment classification, reappointment, delineation of Clinical Privileges or specified services, and corrective action with respect to the Department's Staff members;

- (7) appoint such committees as are necessary to conduct the functions of the department specified in Section 9.4 and designate a Chairperson and secretary for each;
- (8) enforce the Medical Center and Medical Staff Bylaws, and the Departmental Regulations and policies;
- (9) implement within the Department actions taken by the Executive Committee, the Medical Center Management and the Board;
- (10) participate in every phase of administration of the department through cooperation with the nursing service and Medical Center administration in matters affecting patient care;
- (11) be responsible for the assignment and control of medical students and house officers in the Department (the Department Chairperson shall be responsible for the maintenance of standards of high quality for student clerkships, for the high quality of programs in graduate medical education, for the maintenance of standards for its specialty board(s) certification, and such other programs in continuing medical education as will serve to maintain and increase professional skills);
- (12) take such action as may be necessary to establish, maintain and strengthen the Rush network of health care institutions, consistent with the purpose of the Medical Staff as set forth in Article III of these Bylaws;
- (13) take such action as may be necessary to increase the number of patients treated by members of the Department in a manner consistent with the Medical Center's patient care capabilities;
- (14) participate in Department budgetary planning and the preparation of required Department reports;
- (15) hold monthly meetings of the Department and forward the minutes and attendance records of such meetings to the President after review by the Dean; and
- (16) perform such other duties commensurate with the office of Chairperson as may from time to time be reasonably requested by the President of the Medical Staff, the Chief Executive Officer of the Medical Center, the Senior Vice President, the Dean, the Executive Committee, or the Board.

10.3-2 Division or Section Director.

- a. Qualifications. Each director of a section or division which has patient care responsibilities shall be a member of the Active Staff and a member of the section concerned; shall be qualified by training, experience, interest and demonstrated current ability in the clinical or service area covered by the section; and shall be willing and able to discharge the administrative responsibilities of the office of section director.
- b. Selection and Appointment. A section or division director shall be appointed by the Department Chairperson of whose department the section is a part and with the approval of the Dean. The Department Chairperson will notify the Executive Committee of each such appointment.
- c. Term of Office. A division or section director shall be appointed and shall serve solely at the discretion of the Department Chairperson. Notwithstanding retirement or removal from the directorship, the former section director may continue as a Medical Staff member provided he or she meets the qualifications and conditions for Staff membership set forth in these Bylaws.
- d. Duties. Each division or section director shall:
 - (1) account to the appropriate Department Chairperson and to the Executive Committee for the effective operation of the division or section and for the division's/section's discharge of all tasks delegated to it under Section 9.5.;
 - (2) develop and implement, in cooperation with the Department Chairperson, programs to carry out the quality review, evaluation and monitoring functions assigned to the division/section;
 - (3) exercise general supervision over all clinical work performed within the division/section;
 - (4) conduct investigations and submit reports and recommendations to the Department Chairperson regarding the Clinical Privileges to be exercised within the division/section by members of or applicants to the Medical Staff;
 - (5) act as presiding officer at all division/section meetings; and
 - (6) perform such other duties commensurate with the office of section director as may from time to time be reasonably

requested of him by the Department Chairperson, the Executive Committee, the Dean, the Medical Center Management, the Chief Executive Officer of the Medical Center or the Board.

ARTICLE XI: The Executive Committee and the Committees of the Staff

11.1 The Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff shall have charge of the affairs of the Staff between regular meetings of the Staff, with the authority to take necessary and appropriate action on any business occurring between such meetings.

- a. Membership. The Executive Committee shall consist of nineteen voting members as follows: The President, President-Elect, Secretary and Treasurer of the Staff; the most recent past-President of the Staff able to serve; and, fourteen members to be elected in accordance with Section 11.1-2. The Dean, Rush Medical College shall serve as an Ex-officio member of the Executive Committee, without vote.
- b. There shall be an Agenda and Planning Subcommittee consisting of the President, the President-Elect, the most recent Past President, the Secretary and the Treasurer of the Medical Staff. The Subcommittee will be chaired by the President of the Medical Staff.

11.1-2 Election of Members. The fourteen members of the Executive Committee referred to in Section 11.1 -1 .a shall be elected to the Executive Committee for two years on the basis of a secret ballot as follows;

- a. Department Chairpersons shall be elected on even numbered years. Three Department Chairpersons from the Medical Sciences and Services will be elected by the Department Chairperson of Medical Sciences and Services from a list of Departmental Chairpersons who are eligible and willing to serve as representatives to the Executive Committee of the Medical Staff. Three Chairpersons from the Surgical Sciences and Services will be elected by the Department Chairperson of Surgical Sciences and Services from a list of Departmental Chairpersons who are eligible and willing to serve as representatives to the Executive Committee of the Medical Staff. The Secretary of the Medical Staff will contact each Departmental Chairperson and ask if they wish to be considered as a candidate for election. Any Chairperson who has been elected to the Executive Committee and is dropped for failure to attend will not be a candidate for two years.

All of the voting will be by secret ballots which will be mailed either by regular or electronic mail by the Secretary of the Medical Staff

to be returned to the Secretary of the Medical Staff within ten days in the first two weeks of May in even numbered years for positions on the Executive Committee to begin in July of that year. Each Chairperson may vote for three candidates. In the event of a tie vote, a second runoff by secret ballot will be conducted.

- b. Eight members at large of the Medical Staff shall (excluding Department Chairpersons) be elected by secret ballot at the annual meeting of the Medical Staff in odd number years for a two year term beginning the July following their election. The ballot process shall be the same as that used for the election of officers in Section 10.1-5. The Secretary of the Medical Staff will post a notice in March and send an email to active Medical Staff members asking for nominations including self-nominations and contact each department and ask them to make nominations for a representative to the Executive Committee. The Secretary will then confirm that these nominees are willing and able to serve if elected. The Secretary shall notify each member of the Staff of these nominations at least six weeks prior to the annual meeting. All ex-officio members of the Medical Staff who are serving on the Executive Committee are ineligible to be elected as candidates. Members who have been dropped from the Executive Committee for failure to comply with attendance requirements, will be ineligible to be candidates for four years. Each staff member entitled to vote may only vote for one candidate. The eight members with the highest vote totals will be elected with no more than three members from any department elected, based on primary appointment. In the event of a tie between Medical Staff members, a second runoff election by secret ballot will be conducted at that meeting.
- c. The Secretary of the Medical Staff shall keep on file the runner-ups in the elections. Should any member elected to the Executive Committee be unable to serve the Secretary shall appoint from this list the next closest runner-up to fill the vacancy from the same category (Medical Sciences and Services/Surgical Sciences and Services) represented by the vacating member. Any elected member of the Executive Committee who does not attend at least two-thirds of the meetings in a twelve month period of the Executive Committee shall be considered unable to serve and at the next meeting of the Executive Committee if unable to obtain a vote of a simple majority for retention will be dropped from the Executive Committee and replaced by the next available runner-up candidate by the Secretary of the Medical Staff. This individual will be ineligible for re-election for two years. The President will appoint at least one distinguished scientist of the Affiliated Scientist category pursuant to Article V, Section 5.4, to serve as an ex-officio member of the Executive Committee.

- d. During the first election in which these Bylaws are effective, both Chairperson and at-large members will be elected. Those officers elected in their non-election year will serve one year terms.

11.1-3 Meetings.

- a. Full meetings: There shall be a meeting of the Executive Committee at least once per month. These meetings shall have an agenda which shall be circulated at least five (5) days in advance of the meeting. Any member of the Medical Staff may attend these meetings as an observer. A record of attendance will be kept by the Secretary.
- b. Executive Session: All matters regarding denial of appointments or disputes of Clinical Privileges, appointments, or professional conduct shall be in executive session. At any other time the President may decide to meet in executive session. Executive Sessions of the Executive Committee shall consist only of the elected officers, elected voting members, the Dean and those designated by the President of the Medical Staff.
- c. All meetings of the Executive Committee are to be the main forum for issues of the Medical Staff, which may hold hearings to discuss, explore or investigate matters of interest of the Medical Staff. Time will be allotted to permit discussion by the members of the Executive Committee.

11.1-4 Duties. The duties of the Executive Committee shall be to:

- a. To maintain, oversee and enforce the Bylaws and Rules and Regulations of the Medical Staff.
- b. Receive and act upon reports and recommendations from the departments, committees and officers of the Staff concerning (1) the quality and appropriateness of patient care evaluation and monitoring functions and (2) the discharge of their delegated administrative responsibilities;
- c. Recommend to the Board, through the President of the Medical Staff, specific programs and systems to implement these functions;
- d. Coordinate the activities of and policies adopted by the Staff, Departments and committees;
- e. Approve all new appointments, re-appointments and other Staff changes in accordance with the requirements established under Articles V and VI of these Bylaws and recommend to the Board all matters relating to appointments, re-appointments, staff category, department assignments, Clinical Privileges and corrective action;

- f. Account to the Board and to the Staff for the overall quality and efficiency of patient care, and on the status of the Medical Staff in the Medical Center;
- g. Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of the Staff members, including initiating investigations and initiating and pursuing corrective action, when warranted;
- h. Inform the Medical Staff of the accreditation program and the accreditation status of the Medical Center;
- i. Represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws.
- j. Administer the Medical Staff Grievance Procedure in accordance with Section XV of these Bylaws.
- k. Comment on quality of care for given departments as a part of the Departmental Review process using information obtained from the Medical Staff Quality Committee and other sources as appropriate.
- l. Receive, review and act upon items from the Agenda and Planning Subcommittee.
- m. Approve individual department clinical privilege forms at least every two years and any requested privilege additions/changes in the interim subject to previous comment and advice by the Department Chairpersons and the Dean, Rush Medical College.
- n. Review, develop and adopt Medical Staff Rules and Regulations and policies, consistent with these Bylaws.

11.1.5 Duties and Purpose of the Agenda and Planning Subcommittee: The duties and goals of the Agenda and Planning Subcommittee shall be to:

- c. Meet once a month with the Chief Executive Officer of the Medical Center;
- d. attend meetings convened at the discretion of the President of the Medical Staff for the purpose of meeting with other members of medical center management;
- e. promote communication between the leadership of the Medical Staff, the Chief Executive Officer of the Medical Center and other members of Medical Center management;

- f. identify issues to be included within the agenda at Executive Committee meetings which shall be circulated to members of the Executive Committee and other individuals, as appropriate, prior to meetings of the Executive Committee;
- g. participate and contribute to the Medical Center's policy making and planning process. These policy and planning processes may include, but are not limited to, the establishment of institutional policy, planning, utilization of resources, and the Medical Center's acquisition of or affiliation with new entities, or any other issues that affect the Medical Staff.

11.1.6 Presiding Officers. The President shall be Chairperson, and the presiding officer of the Executive Committee. In the President's absence, the President-elect or the past President will preside, in accordance with Section 10.2 of these Bylaws.

11.1.7 Meeting. Meetings of the Executive Committee will ordinarily be held every month at a time designated by the President. Special meetings may be called upon notification to the Committee membership by the President, or upon petition by the majority of the Committee.

11.1.8 Quorum. Fifty percent of the Executive Committee members entitled to vote shall constitute a quorum at any regular or special meeting. Decision shall be by majority vote of the members present. In the absence of a quorum, the voting members present may move to adjourn the meeting to a future time, or may move that those present shall constitute a quorum in regard only to those items on the current agenda.

11.1.9 Minutes. Other than with respect to minutes from the Executive Session, the Secretary shall make them available after adoption and they shall be filed in the Medical Staff Office together with the minutes of meetings of the Staff.

11.1.10 Function Review. The voting members of the Executive Committee, the Dean and those designated by the President of the Medical Staff will meet independently as a group twice a year for the purpose of assessing the progress made by the Executive Committee, the effectiveness of the communications between the Executive Committee and Medical Center Management, and other related items. When meeting in this capacity, the voting members of the Executive Committee will take no specific action on new items but will make recommendations based on their assessment of the performance of the Executive Committee in meeting the needs of the Medical Staff and the role of the Medical Staff outlined in the Bylaws.

11.2 Additional Committees of the Staff.

The Committees of the Medical Staff shall be standing and special. Staff support for these committees will be provided by the Medical Staff Office.

11.2-1 Standing Committees and Sub-Committees

- a. Other than the Executive Committee, the standing committees of the Staff shall be the: (1) Nominating Committee, (2) Quality Committee, (3) Professional Advocacy Committee, (4) the Bylaws Review Committee, (5) Credentials Committee, and such other ad hoc committees as may be approved by the Executive Committee from time to time.
- b. The Chairperson and members of each standing committee are to be appointed annually by the President. Each committee shall have a Chairperson appointed by the President. At his or her discretion, the President may appoint additional members to Standing Committees in addition to those specified in the Bylaws. The Chairperson shall be appointed annually and members are appointed for two years, except where otherwise stated herein. The annual term of each standing committee will begin on July 1st of each year. House Staff members, when applicable, shall be designated by the house staff organization with approval by the President. The Dean, the Chief Medical Officer, the Director for Medical Staff Operations, and the Director of Quality Improvement shall be ex-officio members of all standing committees except the Nominating Committee and the Professional Advocacy Committee.
- c. Meetings of each committee shall be called by the Chairperson as specified by these Bylaws, as indicated by need, or at the request of the President.
- d. Reports or minutes of each meeting, from all committees with the exception of the Nominating Committee, shall be submitted in writing to the Executive Committee through the President. These reports are usually to be submitted at least ten days prior to the regularly scheduled meeting of the Executive. Such reports will, if no other action is required, be received for information. If action is required, either recommendations will be made or specific action will be taken by the Executive Committee. The original copies of all reports shall be kept on file in the Medical Staff Office.
- e. Medical Staff Standing Committees and sub-committees may at times use cumulative data on individual physician performance for patient safety and quality improvement. To protect the rights of physician confidentiality and prevent the inappropriate dissemination of such information, the Medical Staff Standing Committees must maintain strict confidentiality of this material and the Medical Staff Office shall maintain separate and secure files of such information. Such data may be used in the credentialing process if the following process is performed prior to data

collection: 1) the Medical Staff Standing Committee has developed specific review criteria which is reviewed by the Medical Staff Quality Committee for relevancy of the data and appropriateness of the criteria and which recommends it to the Executive Committee; 2) the Executive Committee further reviews the appropriateness of the data for credentialing after specific Departmental comments on the review criteria and approves of forwarding this data to the Department Chairperson for use in the credentialing and reappointment process; 3) the individual physician has had the opportunity to review and comment on the review criteria, the cumulative data and his or her individual performance prior to its use in the credentialing and reappointment process. Access to cumulative data on individual physician performance is limited to the Medical Staff Standing Committee which generates these data unless approved for use in the credentialing process in which case access is limited to the individual physician, the physician's Department Chairperson, the Credentials Committee and the Medical Staff Office, limited by its responsibility to secure and when appropriate distribute such data.

- f. It shall be the responsibility of each standing committee and sub-committee to maintain a document defining its goals, procedures and policies.
- g. It shall be the responsibility of each standing committee and sub-committee to perform its functions at all sites of the Medical Center.

11.2-2 Subcommittees. The following standing subcommittees are subcommittees of the Medical Staff Quality Committee: (1) Medical Records Subcommittee, (2) Utilization Management Subcommittee, (3) Pharmacy and Therapeutics Subcommittee, (4) Transfusion/Blood Usage Subcommittee, and (5) Operative and Invasive Procedure Review Subcommittee. They shall report results of activity on a regular basis to the Medical Staff Quality Committee. The membership meetings, activities and duties shall be as set forth in the Rules and Regulations of the Medical Staff.

11.2-3 Term of Committee Membership and Prior Removal. Unless otherwise specifically provided, a Medical Staff committee member shall continue as such for two years and until a successor is elected or appointed, unless he or she shall sooner resign or be removed from the committee. A Medical Staff committee member, other than one serving ex officio, may be removed by a majority vote of the Executive Committee. An administrative staff committee member shall serve for a term equivalent to that of a Medical Staff committee member and until a successor is elected or appointed, unless he or she shall sooner resign or be removed from the committee. An administrative staff committee member may be removed by action of the Chief Executive Officer of the Medical Center.

11.2-4 Vacancies. Unless otherwise specifically provided, vacancies on any Staff committee shall be filled in the same manner in which original appointment to such committee was made.

11.2-5 Meetings. Unless otherwise specifically provided, a Staff committee established to perform one or more of the Staff functions required by the Bylaws shall meet as often as is necessary to discharge its assigned duties, but no less often than quarterly.

11.2-6 Quorum. Unless otherwise provided, a majority of the voting members of a Staff committee shall constitute a quorum of that committee, and the committee may act upon the vote of a majority of its members at a meeting at which a quorum is present.

11.3 Membership and Duties of Standing Committees.

The membership and duties of each of the standing committees of the Staff shall be as follows:

11.3-1 Nominating Committee.

a. Membership:

- (1) The Nominating Committee shall be composed of seven members of the staff, three appointed by the President to serve a term of three years, one to be appointed each year; and four members to be elected biannually on the even years at the fall Medical Staff meeting by the Staff, with seconded nominations submitted in writing, 10 days prior to that meeting. Nominations from the floor at the semi-annual meeting will be allowed.
- (2) Only Staff members privileged to vote shall be eligible for appointment or nomination to this Committee.
- (3) The Chairperson shall be the presidentially-designated member with the longest tenure on the Committee.
- (4) In the event of a vacancy, the President shall appoint a replacement to fill the remainder of the vacated term.

- b. Duties: It shall be the duty of the Committee to nominate candidates for the offices of the Medical Staff to be filled at the annual Medical Staff meeting in the spring. Candidates for the office of President-Elect will include voting members of the Medical Staff who have previously been elected to serve on the Executive Committee.

- c. Meetings: The Nominating Committee shall initiate its deliberations by the second Tuesday in February or as close to this date as possible. All members of the Nominating Committee should be available either in person or by telephone for the meeting of the Nominating Committee. The meeting of the Nominating Committee will be chaired by the Chairperson of the Nominating Committee. A majority of the Nominating Committee must agree on the candidates for the officers of the Medical Staff. Although the Nominating Committee must nominate at least one candidate for each office, the Committee can nominate more than one candidate for any office. Members of the Nominating Committee wishing to be considered nominees for office must resign their position on the Committee at least three weeks prior to the final selection of candidates by the Nominating Committee.
- d. Reports: The Nominating Committee shall notify each voting member of the Medical Staff of its selections at least six weeks prior to the annual meeting of the Medical Staff in the spring. The report of the Nominating Committee shall be presented at the annual meeting of the Medical Staff. No vote on the Nominating Committee's report should be taken.

11.3-2 Medical Staff Quality Committee.

- a. Membership. The Committee shall consist of the following members: The Chairperson of the Committee; one (1) Medical Staff representative from each clinical department Quality Improvement Committee; one (1) Medical Staff representative each from Surgical Intensive Care, Medical Intensive Care, Pediatric/Neonatal Intensive Care, Emergency Department, Rush Medical Laboratories, the Chairpersons of the Performance Improvement Oversight Committee, Nursing Quality Improvement Committee. The Chairpersons of the following Committees or their designees shall be ex-officio members of the Committee: Executive Committee, Utilization Management Sub-Committee, Operative and Invasive Procedure Review Sub-Committee, Transfusion Sub-Committee, Pharmacy and Therapeutics Sub-Committee, Medical Records Sub-Committee. One (1) House Staff physician representing the surgical Departments and one (1) House Staff physician representing the medical Departments of the Staff as designated by the House Staff Organization shall be ex-officio members. The Director, Medical Staff Operations, The Director of Advanced Practice Providers, the Director, Quality Improvement, the Director of Medical Records, and the Director of Utilization Management shall also be ex-officio members. The Chairperson of the Committee may appoint additional ex-officio members,

including allied health practitioners, as may be required to evaluate the quality and appropriateness of patient care.

- b. Chairperson. The Chairperson of the Committee shall be a physician who is not also the Chairperson of another Medical Staff Standing Committee.
- c. Duties. The Committee is responsible for coordinating and reviewing the quality improvement activities of the Medical Staff and, to that end, shall:
 - (1) develop policies and procedures concerning the manner in which quality improvement activities are performed by the Departments of the Staff or interdisciplinary activities in which the Departments participate and by hospital-wide Medical Staff quality committees in keeping with external requirements and institutional goals;
 - (2) adopt, subject to the approval of the Executive Committee, specific programs and procedures for reviewing, evaluating and continuously improving the quality and efficiency of patient care within the Medical Center including at least mechanisms for (i) establishing objective measures and criteria; (ii) measuring actual practice against the criteria; (iii) analyzing aggregate data for opportunities to improve patient care based on patterns, trends or variation and review of specific cases by peers; (iv) taking appropriate action to correct identified problems or improve systems of care; (v) following up on action taken to ensure continuous improvement; and (vi) reporting the findings and results to the Medical Staff, and the Institution. (See Peer Review Policy, MS, Rules and Regulations)
 - (3) review and advise Departments on medical care studies and indicators in which the Departments participate and monitor the progress of such evaluations;
 - (4) advise the Executive Committee on factors affecting the quality and efficiency of patient care provided in the Medical Center;
 - (5) coordinate the following: the findings and results of Department, hospital-wide committee and Staff quality improvement activities; the Medical Staff role in interdisciplinary quality improvement efforts; and continuing education activities related to quality

improvement; and other Staff activities designed to monitor and improve patient care practices.

- d. Meetings. The Committee shall meet at least ten times a year.
- e. Reports. The Committee shall report its findings to the appropriate committees, Departments, Executive Committee, President and the Board through the Executive Committee. The Department representatives shall report the findings of Departmental quality assurance activities and of the Committee to their respective Department members. The Committee shall maintain written reports of their findings, actions taken and the results of such actions.
- f. Quorum. Fifty percent of the Committee members shall constitute a quorum at any regular or special meeting. Decision shall be by majority vote of the members present. In the absence of a quorum, the voting members present may move to adjourn the meeting to a future time, or may move that those present shall constitute a quorum in regard only to those items on the current agenda.

11.3-3 Professional Advocacy Committee

- a. Membership. The Committee shall consist of five (5) members appointed by the President of the Medical Staff. No member serving shall at the same time be an active member of the Executive Committee, the Medical Staff Quality Committee or any other committee having review authority over members of the Medical Staff. Members shall serve for a term of four (4) years. The President, after consultation with the Chief Executive Officer of the Medical Center and the Dean, shall appoint one of the members to serve as Chairperson. Non-Medical Staff members may be appointed to the Committee in an Advisory capacity. Minutes shall be forwarded to the President and shall relate to actions taken by the Committee. The Committee is established for the purpose of improving internal quality control, reducing morbidity or mortality and improving patient care.
- b. Duties. The Professional Advocacy Committee may assist Staff in providing the following:
 - (1) encouraging all cases of suspected impairment to be reported confidentially as soon as the suspicion of impairment arises and investigating such cases;
 - (2) encouraging an impaired Medical Staff member to voluntarily accept treatment;
 - (3) monitoring the Medical Staff member during treatment;

- (4) helping to restore the impaired Medical Staff member to optimal functioning after treatment;
- (5) educating the Medical Staff concerning impairment.

For purposes of this section, “impairment” shall mean inability to exercise privileges with reasonable skill and safety due to 1) mental illness, 2) disability, 3) physical illness, including deterioration through the aging process or loss of motor skills, or 4) abuse of drugs or alcohol, or disruptive or inappropriate behavior that result in an individual’s inability to practice his or her profession with reasonable judgment, skill, or safety. Under no circumstances shall the Professional Advocacy Committee function in any disciplinary manner; its function is rehabilitative. Any rules for the operation and function of this Committee shall be submitted by the Committee pursuant to the provisions of these Bylaws.

- c. Access. The Committee shall evaluate any concerns it receives through its Chairperson. The Chairperson shall be responsible for receiving and transmitting any concerns to the Committee. Any Medical Staff member in need of assistance may seek the assistance of the Committee voluntarily.
- d. Feedback. The Committee shall assist the Medical Staff member by securing appropriate professional resources for diagnostic, therapeutic, and rehabilitative purposes. The Committee shall also monitor the status of the physician in order to determine the success of such assistance programs.

In the event the information received by the Professional Advocacy Committee demonstrates probable cause to believe that the health or known impairment of a Medical Staff member poses an unreasonable risk of harm to patients and/or Medical or Medical Center staff, that information may be referred for corrective action as outlined in Article VIII of these Bylaws and shall also be reported in accordance with the Committee rules.

- e. Confidentiality. All records kept are intended to be used in the course of internal quality control for the purpose of reducing morbidity or mortality and for improving patient care and are intended to be protected under the Illinois Medical Studies Act and the Illinois Medical Practice Act to the fullest extent provided. The Committee shall act with sensitivity and discretion. The Committee shall keep minutes, however, any reference to a Staff member shall be by an identification number assigned by the Committee and not by name. Materials generated from the Committee concerning an individual Medical Staff member shall be maintained in a file

separate from the individual Medical Staff member's staff file in order to ensure confidentiality.

11.3-4 Bylaws Review Committee.

- a. Membership. The Committee shall consist of at least six members to be appointed by the Medical Staff President: including three members from the Medical Sciences and Services and three members from the Surgical Sciences. The Chairperson shall be the President-Elect of the Medical Staff. A representative from Legal Affairs shall be an ex-officio member.
- b. Duties. The duties of the Bylaws Review Committee shall include the following:
 - (1) recommend to the Executive Committee and the Medical Staff for approval Bylaw amendments as specified in Article XVI;
 - (2) draft amendments to the Bylaws as requested by the Executive Committee;
 - (3) advise the Medical Staff Executive Committee on interpretations of the Bylaws relative to Medical Staff issues as requested;
 - (4) review the compliance of the Bylaws to changes in government regulations or external review agency standards annually; and
 - (5) work with the Medical Center to draft Bylaw amendments necessary to maintain compliance with government regulations or external review agency standards.
- c. Meetings. The Committee shall meet at least once every six months for purposes of overall review and as necessary for drafting recommendations.

11.3-5 Credentials Committee:

- a. Membership.

The Credentials Committee shall be composed of at least four members from Departments of the Surgical Sciences and Services including representation from General Surgery, Ob/Gyn, Surgical Sub-Specialties, Diagnostic Radiology and at least four members from Departments of the Medical Sciences and Services including representation from the Department of Pediatrics, Internal Medicine

and Medical Subspecialties performing invasive procedures, including invasive pediatrics and invasive cardiology. The committee shall also include the Director(s) of Advanced Practice Providers or approved designee. The Chairperson shall be the President-Elect of the Medical Staff. The Director of Medical Staff Operations, the Chief Medical Officer and the Chair of the Quality of Care Committee or a member of the Committee designated by the Chair shall be ex-officio members of the committee. The Chairperson of the Committee may appoint additional Department members as may be required to assist with the credentialing and privileging process.

- b. Duties. The duties of the Credentials Committee shall include the following:
- (1) Assist with the credentialing and privileging process by also reviewing Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) data prior to submission to the Medical Staff Executive Committee.
 - (2) Coordinate the development of a policy and applicable criteria whenever a privileging question arises for which there is no policy or privileging criteria.
 - (3) Research any and all disputes concerning the granting of Clinical Privileges for initial appointments, reappointments or new privilege requests and report to the Department Chair, Dean or Medical Executive Committee regarding its findings or recommendations.
 - (4) Participate in reviewing a waiver request from Department Chairs pertaining to the requirement for Board Certification and making a recommendation regarding same.
 - (5) Assist departments in the development of focused professional practice evaluation (FPPE) for new procedures, technology or Clinical Privileges.
 - (6) Review the justification for new privileges.
 - (7) Review Medical Staff Quality Committee (MSQC) performance data, when necessary.
 - (8) Review (as requested by the Executive Committee, Medical Staff Office, or Departments) physician specific data, clinical pertinence review data or other data related to the

clinical performance, and Clinical Privileges exercised by staff physicians.

- (9) Review of Advance Practice Provider credentials and privilege packet with respect to “special” or non-core privileges for initial requests, renewals or new privilege requests, prior to presentation to the Executive Committee. Review Advance Practice Provider focused professional performance evaluation (FPPE) and ongoing professional performance evaluation (OPPE) data related to “special” or non-core Clinical Privileges.
 - (10) Review of Visiting Staff credentials for initial requests and renewals prior to recommendation to the Executive Committee.
 - (11) Assist Department Chairpersons with review of physician specific data, clinical pertinence review data or other data related to the clinical performance and Clinical Privileges exercised by Medical Staff physicians.
- c. **Meetings.** The Committee shall meet once per month or as necessary to review relevant data related to credentialing and/or privileging.
 - d. **Executive Session.** All matters regarding the review of peer review or other physician specific data, disputes of Clinical Privileges or review of FPPE, OPPE related data shall be in executive session. At any other time the Chairperson of the Credentials Committee may decide to meet in executive session. Executive Sessions of the Credentials Committee shall consist only of Active Medical Staff members of the committee and those designated by the Chairperson of the Credentials Committee.
 - e. **Reports.** This Committee shall maintain a record of all activities relating to the Committee’s findings, recommendations, actions taken and their result. The Committee shall submit reports and recommendations to the Executive Committee of the Medical Staff. Confidentiality of peer review activities will be maintained.

ARTICLE XII: Meetings

12.1 Regular Meetings.

12.1-1 Meetings of the entire Staff will be held during November and May, except when otherwise directed by the Executive Committee.

12.1-2 At the November meeting, which shall be the semi-Annual meeting, a Nominating Committee shall be constituted pursuant to Section 11.3-1 of these Bylaws.

12.1-3 At the May meeting, which shall be the Annual Meeting, officers for the ensuing year shall be elected and take office as specified in Section 10.1 of these Bylaws.

12.1-4 At both meetings, the Staff shall consider and vote upon any matters specifically required of it by these Bylaws, upon specific matters submitted by the Executive Committee, and upon such other business as shall be considered appropriate by the President.

12.1-5 A regular meeting may also occur in the third week of February upon notice from the President.

12.2 Special Meetings.

Special meetings of the entire Medical Staff may be called at any time upon reasonable notice by the President or the Acting President; or shall be called upon written petition signed by at least twenty percent (20%) of the voting members of the Staff.

12.3 Quorum and Manner of Action.

For all regular and special meetings of the Medical Staff, one-tenth of the voting members of the Staff shall constitute a quorum. A quorum may be reasonably determined by the President and action taken at any such meeting shall be valid, unless a Member challenges the President's determination and requests a count or roll call for purposes of determining a quorum. Except as otherwise specified, the action of a majority of the members present, and voting at a meeting at which a quorum is present shall be the action of the group.

12.4 Minutes.

Minutes of all meetings shall be prepared by the Secretary and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the Secretary, forwarded to the President and Executive Committee and made available to the Staff. A permanent file of the minutes of each meeting shall be maintained.

12.5 Attendance at Meetings.

Each member of the Active Medical Staff shall be expected to attend all regular and special Staff meetings. Unless an excuse for good cause is provided and accepted by the President, failure to meet the attendance requirements of this section may be grounds for any of the corrective actions specified in Section 8.1-3. If corrective action includes revocation of membership, reinstatement of a Staff member whose membership has been revoked shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

12.6 Parliamentary Procedure. The parliamentary authority for the Medical Staff Bylaws, and Medical Staff, Committee and other meetings referenced herein, shall be the current edition of the Roberts Rules of Order Newly Revised.

ARTICLE XIII: Medical Education

13.1 Education Program. Except as provided for in Section 5.3, residents or fellows in training in the hospital shall not hold membership on the Medical Staff and shall not be granted specific privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the Residency Program.

The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows, including which types of residents may write patient orders, under what circumstances they may do so, and what entries a supervising physician must countersign. The protocols must also describe the mechanism through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care. All protocols must comply with ACGME standards relative to the Residency Program.

The postgraduate education program director (if any) or Department Chairperson must communicate periodically with the Medical Executive Committee and the Board of Trustees about the performance of residents and the applicable Residency Program.

13.2 Dedication to Maintain Schools.

The Staff herein affirms its dedication to maintain schools for the purpose of training physicians and other health care personnel. To this end, therefore, each patient admitted to the Medical Center shall be available for the undergraduate and graduate educational programs of the Medical Center, unless the patient expressly refuses to participate in such educational programs. House staff physicians shall be under the supervision, of an Attending physician(s).

13.3 Responsibility for Educational Programs.

Each Department Chairperson shall be responsible for educational programs of the Department as set forth in Section 10.3-1.e of these Bylaws.

13.4 Continuing Education.

Each member of the Medical Staff shall participate in continuing education activities that relate to his or her clinical practice and consistent with the requirements of the State of Illinois as described in Article VI, Section 6.3-3 of these bylaws.

ARTICLE XIV: Rules and Regulations and General Provisions

14.1 Relationship to Bylaws.

Subject to approval by the Board, the Executive Committee shall adopt, amend, or repeal such Rules and Regulations as may be necessary to implement more specifically the general principles found in these Bylaws. These Rules and Regulations shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Medical Center. They shall not be a part of these Bylaws, but shall not be in conflict with these Bylaws. Except as outlined in Article 14.4, the Active Medical Staff must be informed of any proposed Rules and Regulations or amendments thereto at least thirty (30) days before a vote is taken by the Executive Committee. The Rules and Regulations will not become effective until approved by the Board of Trustees.

14.2 Consistency.

All Medical Staff rules, regulations and policies, as well as these Bylaws, must comply with State and Federal law as well as Joint Commission requirements.

14.3 General Medical Staff Rules and Regulations.

The Medical Staff via the Executive Committee and Bylaws Committee shall periodically review and revise the Rules to comply with current Medical Staff practice and/or legal requirements. New Rules or changes to the Rules (proposed Rules) may emanate from the Executive Committee or Bylaws Committee, or by a petition signed by at least 51% of the voting members of the Medical Staff. Additionally, Medical Center administration may develop and recommend proposed Rules to the Bylaws or Medical Executive Committees. The Rules shall become effective immediately following approval of the Board or automatically within 60 days if no action is taken by the Board

14.4 Conflict with Bylaws.

If at any time there is a conflict between the Bylaws and the Rules, the Bylaws shall prevail.

14.5 Medical Staff Policies.

Policies may be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules. New or revised policies (proposed policies) may emanate from any responsible committee, department, Medical Staff officer, or by petition signed by at least 51% of the voting members of the Medical Staff. The policies must be consistent with those Bylaws and the Rules and shall not supersede or materially alter their interest.

14.6 Conflict Resolution Process for Disputes Between the Medical Staff and the Executive Committee.

In the event that thirty three per cent (33%) of the voting members of the organized Medical Staff each signed a petition or otherwise evidence disagreement with any action taken by the Executive Committee or Medical Center including, but not limited to, any

proposed Bylaw, rule, regulation or policy, these members can require that the conflict management process under this Article be followed:

The petition should clearly state the basis of the disagreement and may include any other information by way of additional explanation to Medical Staff members. The petitioner must acknowledge that he/she has read the petition and all attachments, if any, in order for their signature to be considered valid. Once the conflict resolution threshold has been achieved, the petition and any attachments, and a list of petitioners shall be forwarded to the Medical Executive Committee. Within thirty (30) days of the Medical Executive Committee's receipt of the petition, a meeting between representatives of the Medical Executive Committee, the Medical Center as determined by the President of the Medical Staff, and the petitioners shall be scheduled. The parties shall act in good faith and shall take reasonable steps to resolve the conflict in question.

If the parties are able to resolve the conflict, the resolution shall be submitted to the voting members consistent with the provisions of Article 16.1 of the Bylaws. If the voting members approve the proposed resolution, the proposal and all accompanying materials will be forwarded to the Board for its review and consideration. If approved by the Board, the decision shall be final.

Should the parties fail to reach resolution, or if the voting members do not approve any proposed solution agreed to by the parties, the petition and all accompanying materials will be forwarded to the Board for its review and consideration. The decision of the Board shall be final.

Nothing in this Article precludes an individual member from communicating with the Board and/or the Executive Committee on any rule, regulation or policy already adopted by the Medical Staff the Executive Committee.

Such communication shall be forwarded to the Board through the Chief Executive Officer and to the Executive Committee through the President. The Chairperson of the Board shall determine the manner and method of responding to any member communicating to the Board under this Article.

14.7 Joint Conference Committee.

Composition. The joint conference committee is comprised of Medical Staff officers and an equal number of Board of Trustee members who are neither Medical Staff members nor hospital employees. The Chairperson alternates between Board and Medical Staff members annually.

Duties. The committee is the forum in which the Medical Staff and Board resolve any disputes between the Medical Staff and Hospital administration and may accept requests to resolve differences between or among other Medical Staff and/or hospital leaders. The committee may request additional information from throughout the hospital community to assist in the resolution of disputes. Either the Executive Committee or the Board can refer disputes to the joint conference committee. The joint conference committee will attempt

to resolve differences between the Executive Committee and Board in credentialing and privileging matters, and fulfills other responsibilities set forth in these bylaws.

Meetings. This Committee shall meet on the call of the President of the Medical Staff or Chairperson of the Board, and shall maintain a permanent record of its proceedings and actions.

14.8 Members with Contracts.

A member of the Medical Staff having medical administrative responsibility as well as patient care privileges shall not lose his or her admitting or Clinical Privileges on the basis of termination of his administrative responsibilities unless otherwise stated in the contract. A Medical Staff member who has entered into a separate contractual relationship directly or indirectly with the Medical Center or who is an employee of the Medical Center shall enjoy all of the rights and privileges provided for in these Bylaws unless otherwise stated in such contract. The grant of membership and Clinical Privileges must be consistent with the qualifications, standards and requirements for membership and Clinical Privileges for other members of the Medical Staff. Medical Center contracts with contracting members for clinical services are subject to the review process established in these Bylaws.

Members employed by the Medical Center, on a full-time or part-time basis, to provide clinical services to patients or to provide back-up call or other coverage, referred to as “employed members,” must meet all qualifications and otherwise comply with these Bylaws. Employed members are eligible for election to Medical Staff leadership and appointment to committees. Employed members shall be entitled to the same rights provided in these Bylaws to all members, unless otherwise stated in the member’s employment agreement with the Medical Center.

14.9 External Review.

External peer review will take place in the context of an initial membership application, Departmental review, Investigation, or at any other time only under the following circumstances, if and when deemed appropriate by the relevant Department Chairperson and/or Executive Committee or by the Board:

- (a) Ambiguity when dealing with vague or conflicting recommendations from committee or department review(s) where conclusions from this review could directly and adversely affect an individual’s membership or privileges.
- (b) Lack of internal expertise, in that no one on the Medical Staff has adequate expertise in the clinical procedure or area under review.
- (c) When the Medical Staff or Hospital needs an expert and/or impartial witness for a fair hearing, for evaluation of a credential file, to conduct an Investigation or for assistance in developing a benchmark for quality monitoring.
- (d) To promote impartiality in peer review

(e) Upon the reasonable request of a practitioner, when subject to focused review or investigation.

If an external review occurs, a written report will be generated and shared with the member being reviewed by the peer review and/or Executive Committee. If either prepares a written response within thirty (30) days of receipt of the report it shall be shared with the Board and the Board will review same prior to implementing action which may result in an Adverse Decision.

14.10 Director, Medical Staff Operations.

To help fulfill the quality management needs of the Medical Center and to satisfy the regulatory and quality needs of the Medical Staff, there will be a Director of Medical Staff operations employed by the Medical Center. The job duties and representatives will be mutually agreed upon by the Medical Center and Executive Committee.

ARTICLE XV: Corrective Action and Grievance Hearing Procedures

The purpose of this article is to delineate the rights of a Medical Staff member to a hearing procedure and/or grievance process and the procedure the Medical Staff shall follow to afford same. The first section (15.1) outlines the procedure for a hearing when an individual disagrees with decisions made relative to his or her appointment or reappointment, including the granting or limitation of Clinical Privileges (on an involuntary basis) when appointed or re-appointed to the Medical Staff. In addition this first section allows for an appeal to a routine corrective action which has been imposed on a Medical Staff member that limits, restricts, suspends or revokes Clinical Privileges. Since decisions regarding appointments, re-appointments and corrective actions are voted on and/or recommended by the Executive Committee of the Medical Staff, the appeal mechanism is designed to be a review by a hearing committee of peers excluding members of the Executive Committee. The recommendation of the hearing committee is made to the President of the Medical Staff.

The second section (15.2) allows for a grievance procedure when a Medical Staff member believes that his or her medical practice is adversely affected by restriction of access to resources or unreasonable actions as specified in Section 15.2-a, Matters Grievable. This process allows for an initial informal attempt to resolve the grievance followed by a grievance committee selected from members of the Executive Committee of the Medical Staff. The recommendation of this ad hoc committee is forwarded to the Executive Committee of the Medical Staff for further action.

The third section of this article (15.3) outlines the actual hearing process relating to Section 15.1. Unless otherwise waived, it is the purpose of this Section to allow a Medical Staff member an avenue for appeal and due process, but not for multiple appeals and therefore is restricted in its flexibility. Matters affecting Medical Staff appointments/re-appointments/corrective action may only proceed through the hearing procedure of the first section although it is recognized that a change in these privileges will affect an individual's medical practice.

15.1 Appointment/Reappointment/Corrective Action Hearing Committee.

a. Grounds for Hearing

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed an adverse action and constitute grounds for a hearing:

- (1) denial of Medical Staff appointment;
- (2) denial of Medical Staff reappointment;
- (3) suspension of Staff membership other than for certain administrative reasons delineated in these Bylaws;
- (4) revocation of Medical Staff membership;
- (5) denial of requested Clinical Privileges;
- (6) involuntary reduction or denial of current Clinical Privileges;
- (7) suspension of Clinical Privileges of Staff membership other than for certain administrative reasons delineated in these Bylaws;
- (8) termination of Clinical Privileges which are reportable under the FHCQIA;
- (9) involuntary imposition of significant consultation or monitoring requirements or;
- (10) any other recommendation or action which, if taken, would be reportable to state or federal agencies.

b. Notice of Action or Proposed Action.

In all cases of adverse action, the President shall give the affected Staff member or applicant prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the appropriate state and federal agencies, if required; (2) the reasons for the proposed action, including all reasons based on the quality of medical care or any other basis, including economic reasons; (3) a statement of the Medical Staff member's right to request a fair hearing on the adverse decision whose membership is mutually agreed upon by the Medical Staff and the Board as outlined below, and that such hearing must be requested within thirty (30) days; when the adverse action is a

summary suspension the Medical Staff member must request such hearing within seven (7) days of receiving notice; and (4) a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws including the member's right to review all pertinent information in the hospital's possession with respect to the decision, a statement of the member's right to present witnesses and other evidence at the hearing, that the decision of the hearing panel and notice of that decision shall be in writing and that notice of a final adverse decision by the Board pursuant to its rules will be provided in writing. If the recommendation or the final proposed action adversely affects the Clinical Privileges of a physician or dentist for a period longer than 30 days and is based on competence or professional conduct, said written notice shall state that the action, if adopted, will be reported to the National Practitioner Data Bank, and shall state the text of the proposed report.

c. Initiation.

A hearing must be requested in writing by the applicant or Medical Staff member within thirty (30) days of receipt of notice of the adverse action. When the adverse action is a summary suspension, the Medical Staff member must request such hearing within seven (7) days of receiving notice and that the hearing must be commenced within fifteen (15) days after the summary suspension (unless the parties agree in writing to extend the time frame) and be completed without delay. The request must be addressed to the President and post-marked no later than the thirtieth (30th) or seventh (7th) day in the case of a summary suspension, following receipt of the notice of adverse action. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

d. Appointment/Reappointment/Corrective Action Hearing Committee.

The President, as the designee of the Medical Staff, and the Chief Executive Officer, as the designee of the Board, shall concur on and thereafter appoint an Appointment/ Reappointment/Corrective Action hearing committee consisting of five (5) members selected from the Medical Staff who are willing and able to serve, none of whom shall be in direct economic competition with the grievant. The members of the Committee shall designate a Chairperson. In the Committee's sole discretion, a hearing officer may be appointed to preside at the hearing. If appointed, the hearing officer shall be experienced in presiding at adjudicatory hearings. In the event that the hearing officer is an attorney, he or she shall not be an individual

who has been utilized or his or her firm has been utilized on a regular basis by the Hospital, the Medical Staff or the affected member or applicant requesting a hearing. The hearing officer shall gain no direct financial benefit from the outcome of the hearing. His or her duties will be limited to presiding over the hearing. In that regard, the hearing officer shall endeavor to assure that all participants to the hearing have an opportunity to be heard and to present relevant oral and documentary evidence. The hearing officer shall determine the order of and/or the procedure for presenting evidence and argument during the hearing and shall rule on questions of law, procedure or the admissibility of evidence. If the hearing officer determines that any party to the hearing is not proceeding in an appropriate manner, the hearing officer may take such action as is warranted. If requested by the hearing committee, the hearing officer may participate in the committee's deliberations as an advisor, but the hearing officer shall not be entitled to vote. In the event that no hearing officer is appointed, the Committee Chairperson shall be responsible for presiding over the hearing in a like manner. The affected member or applicant shall be informed of the members of the committee and its Chairperson. He or she may file an objection(s), for stated reasons, to particular members with the President. If the President finds the objections(s) meritorious, he and the Chief Executive Officer of the Medical Center shall concur on and thereafter appoint a replacement(s) according to the procedure outlined above.

e. Notice of Hearing.

If a hearing is requested in a timely fashion, the affected member shall be provided with notice of the time, date and place of the hearing, which date shall not be less than thirty days after the date of this notice, and with a list of the witnesses (if any) expected to testify at the hearing against the grievant.

f. Hearing.

The Appointment/Reappointment/Corrective Action hearing committee shall hold a hearing within a reasonable time of being named pursuant to Article XV, Section 3 of these Bylaws. In the case of a summary or automatic suspension, the hearing shall be commenced within fifteen days after the suspension, and shall be completed without delay.

g. Forfeiture.

The right to a hearing shall be forfeited if the affected member or applicant fails, without good cause, to appear.

h. Decision.

To reach a decision with respect to the matter before the Appointment/Reappointment/Corrective Action hearing committee, the Committee must be satisfied by a simple majority of its members that the preponderance (i.e., more likely than not) of the evidence establishes that there was or was not adequate cause for the action taken with respect to the individual requesting the hearing. In weighing the evidence, the committee shall examine the record as a whole. Committee members who are not present at the hearing cannot be part of the deliberations nor can they vote on the outcome of the hearing.

The decision of the Appointment/Reappointment/Corrective Action hearing committee shall be in writing and shall include a statement of the basis for the recommendation including any economic factors. If requested by an affected member or applicant or by the Board, the Appointment/ Reappointment/Corrective Action Committee shall make findings concerning the nature of each basis for any adverse decision recommended to the Board. The decision shall be delivered to the Board of Trustees for review in accordance with its Bylaws. The Board's decision shall be conclusive with no further right of appeal and shall be transmitted to the relevant individuals as set forth in these Bylaws.

15.2 Medical Staff Grievance Procedure.

- a. Matters grievable. A member of the Medical Staff may file a grievance alleging (1) unreasonable denial of, or restriction of access to, the available resources of the member's Department, or (2) unreasonable actions or practices by the Department, the Medical Staff, or the Medical Center. A member of the Medical Staff may also file a grievance when he or she believes the Bylaws of the Medical Staff and/or the Rules and Regulations of the Medical Staff are not followed and the Executive Committee has not acted on the matter. The preceding situations are grievable if they affect the member's medical practice and the actions are inconsistent with the clinical and academic mission of the Department, Medical Staff or Medical Center.
- b. Initiation. A member of the Medical Staff may initiate a grievance by filing it in writing with the President of the Medical Staff within thirty (30) days of the event or events upon which the grievance is based. The President shall notify the Dean that a grievance has been received. The grievance shall identify as respondent(s) the person(s) within the Department, the Medical Staff, or the Medical Center against whom it is directed.

A grievance will not serve to postpone the action which is the subject of the grievance unless the grievant initiates a request in writing to stay the action within 30 days of being informed of the action. If the grievant requests this preliminary relief then a decision will be rendered within 14 days by a Committee of the three most recent and available Presidents of the Medical Staff (to include President Elect, President & Past President unless unable to serve). This Committee by majority vote will stay the action if it finds that the grievant will suffer irreparable harm absent a postponement of the action. The grievant shall have the burden of establishing by clear and convincing evidence that he or she will suffer irreparable harm and that he or she will have a likelihood of success in the event that a hearing is conducted on the merits of the grievance. The Respondent(s) to the grievance shall be given the opportunity to oppose the grievant's request for preliminary relief.

- c. Informal resolution. The President may attempt informal methods of resolving the grievance, including, but not limited to, the appointment of a mediator.
- d. Ad hoc grievance committee. If the grievance has not been resolved through informal methods within thirty days after it is filed, the grievant may request the President of the Medical Staff in writing to afford a hearing on the grievance. The President shall then appoint an ad hoc grievance committee consisting of five (5) members selected from the Executive Committee. Two members shall be selected by the member filing the grievance (the grievant) and two members shall be selected by the individual against whom the grievance is filed (the respondent). Those four shall select a fifth member from the Executive Committee to be Chairperson. In the event that they cannot agree, the President shall select the Chairperson from among the Executive Committee members. The grievant or the respondent shall be informed of the members of the committee and the Chairperson, and may object for stated reasons to particular members. If the President deems these objections meritorious, he or she shall replace the member or members in question.
- e. Grievance Hearing. If the grievance committee by majority vote concludes that the grievance does not concern a grievable subject matter, it shall dismiss the grievance. Otherwise, it shall hold a hearing within a reasonable time of being named.
- f. Report and recommendations after hearing. The grievance committee by majority vote shall recommend in writing whether the grievance should be allowed or denied, and if allowed, shall specify recommendations to the Board for appropriate remedial action. The

recommendation shall be forwarded to the Executive Committee through the President, to the grievant, the respondent, the Chief Executive Officer of the Medical Center and the Board of Trustees for review and implementation in accordance with its Bylaws.

15.3 Hearing Procedure.

The following procedure shall apply in hearings filed pursuant to Section 15.1 of the Medical Staff Bylaws:

- a. If the subject matter of the Appointment/Reappointment/Corrective action is being heard either by another body within the Medical Center or by a court or administrative agency, the Appointment/Reappointment/ Corrective action committee in its discretion may hold the proceedings in abeyance or dismiss it.
- b. The Chairperson or the hearing officer shall preside over the hearing, rule on the admissibility of evidence, dispose of procedural requests, and interpret these rules and the Medical Staff Bylaws as needed for purposes of the hearing.
- c. The hearing officer may convene a pre-hearing conference with the parties to define the scheduling of the hearing, to narrow the issues to be heard, to resolve procedural questions, to identify witnesses to be called at the hearing, and to resolve other questions concerning the hearing. The parties will also exchange or be permitted to inspect all pertinent, non-privileged, information prior to the date of the hearing.
- d. A record shall be made of the hearing by a court reporter. The cost of attendance of the shorthand reporter shall be borne by the Medical Center, but the cost of the transcript, if any, shall be borne by the party requesting it.
- e. The parties may be represented by legal counsel or other representative at the pre-hearing conference and hearing, in an advisory capacity only, unless agreed otherwise.
- f. Formal rules of evidence shall not be applicable. The affected member, the respondent, committee members may examine and cross-examine witnesses and present other evidence, subject to the oversight and authority of the hearing officer and/or committee as applicable. Both parties may submit a written statement at the close of the hearing.

ARTICLE XVI: Adoption and Amendment of Bylaws

16.1 Method.

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

16.1-1 Medical Staff.

Following submission by the Bylaws Review Committee and approval by the Executive Committee, the affirmative vote of a majority of the Staff members voting by written mail or electronic ballot or by a majority vote at a meeting of the Staff at which a quorum is present, provided the amendment is discussed at that meeting prior to the vote and provided at least 30 days written notice, accompanied by the proposed Bylaws or amendments, has been given of the intention to take such action by ballot or meeting. Bylaws or amendments thereto may also be originated by a petition signed by thirty three percent (33%) of the voting members of the Medical Staff. If proposed by the Medical Staff, the proposal must be communicated in writing to the Executive Committee. Thereafter, the Medical Staff may submit the proposal for vote according to the procedure outlined above. Notwithstanding the foregoing, changes to these Bylaws may be made by the Medical Center to correct grammar or typographical errors and to update titles and provide for consistency if the changes are submitted to and approved by the Chairman of the Bylaws Committee and President of the Medical Staff.

16.1-2 Board.

Suggested amendments shall be submitted to the Board of Trustees for affirmative action of the Board consistent with its Bylaws.

16.2 Effect of Adoption.

These Bylaws shall become effective when approved by the Board and, thereupon, shall supersede and replace any Bylaws previously adopted and shall be equally binding upon the Medical Staff and the Board.

16.3 Urgent Amendment to Rules, Regulations or Policies

In the event that the Medical Center receives a written notice, demand or other similar communication from a governmental, regulatory or similar entity, or a rule or regulation of the Medical Staff needs to be amended in order to comply with any law or regulation, the Executive Committee shall be delegated with the authority to provisionally adopt and the Board may provisionally approve such amendment as may be required to comply with the law, or regulation without any prior approval of the Medical Staff. In such cases, the voting members of the Medical Staff will be promptly notified of the amendment by the Executive Committee. Copies of any notice or materials requiring the urgent amendment, if not otherwise confidential, will be submitted along with the written notice. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Executive Committee, the provisional amendment will remain in effect. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the Medical Center outlined at Article 14.6 shall be implemented. If

necessary, a revised amendment will be submitted to the Board for its review and consideration.

Where the urgent change only involves a change to a policy of the organized Medical Staff, the approval process referenced above does not apply but a copy of the policy amendment will be sent to all voting members of the organized Medical Staff.

16.4 Effect of Affiliation.

Affiliation with other hospitals, healthcare systems or similar entities shall not in and of itself affect these Medical Staff Bylaws.

16.5 Successor in Interest.

These Bylaws, and privileges of individual members of the Medical Staff accorded under these Bylaws, will be binding upon the Medical Center and Medical Staff of any successor in interest in this Medical Center.

ARTICLE XVII: Immunity

17.1 Authorizations and Conditions.

By applying for, or exercising, Clinical Privileges or providing specified patient care services in the Medical Center, a practitioner:

17.1-1 Authorizes representatives of the Medical Center and the Medical Staff to solicit, provide and act upon information bearing on his or her professional ability and qualifications;

17.1-2 Agrees to be bound by the provisions of this Article and to waive all legal claims against any such representative who acts in accordance with the provisions of this Article; and

17.1-3 Acknowledges that the provisions of this Article are express conditions to his or her application for, or acceptance of, Staff membership and the continuation of such membership, or to his or her exercise of Clinical Privileges or provision of specified patient services at the Medical Center.

17.2 Immunity from Liability.

17.2-1 For Action Taken. The Medical Center, its agents, officers, employees, and Medical Staff shall not be liable to a practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of its or his or her duties, of the Medical Center, its agents, officers, employees, or Staff acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts.

17.2-2 For Providing Information. The Medical Center, including its agents, officers, employees and Medical Staff, and any third party shall not be liable to a practitioner for damages or other relief by reason of providing any information, including otherwise privileges or confidential information, to a representative of the Medical Center or Medical Staffer to any other health care facility or organization of health professionals concerning a practitioner who is or has been an applicant to or member of the Staffer who did or does exercise Clinical Privileges or provides specified services at the Medical Center, provided that such representative or third party acts in good faith and without malice.

17.3 Activities and Information Covered.

17.3-1 Activities. The immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with the activities of the Medical Center or any other health care facility or organization but not limited to:

- a. applications for appointment, Clinical Privileges or specified services;
- b. periodic reappraisals for reappointment, Clinical Privileges or specified services;
- c. corrective action;
- d. hearings and reviews;
- e. utilization reviews; and
- f. any Medical Center, department, committee or Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

17.3-2 Information. The acts, communications, reports, recommendations, disclosures and other information referred to in this Article may related to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

17.4 Cumulative Effect.

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

17.5 Indemnification.

The medical center shall defend (or cover the costs incurred for defense by), and cover settlements, judgments and damages amounts on behalf of any member of the Medical Staff serving on or assisting any medical center or Medical Staff committee, or assisting in peer review or quality management activities involving care provided at the Hospital, involved in claims arising out of such activities, so long as the member of the Medical Staff acted in good faith.

ARTICLE XVIII: History and Physicals

18.1 A medical history and physical examination must be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration. The medical history and physical examination must be completed and documented in hospital records by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual including Advanced Practice Providers with appropriate privileges to do so in accordance with state law and hospital policy.

18.2 An updated examination of any patient, including any changes in the patient's condition, must be completed and documented within the twenty-four (24) hours after admission or registration, prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination was 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 in hospital records by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual including Advanced Practice Providers in accordance with state law and hospital policy.

18.3 The content and details associated with the complete and focused history and physical examination are set forth in the Medical Staff Rules and Regulations.

Adopted by the voting Medical Staff of Rush University Medical Center at its meeting held on May 14, 2015.

President of the Medical Staff

Date

Approved by the Board of Trustees at the meeting of the Trustees held on.

Larry Goodman, MD
CEO, Rush University Medical Center

Date

APPENDIX A: Departments

A. MEDICAL SCIENCES AND SERVICES

- (i) DEPARTMENT OF CELL AND MOLECULAR BIOLOGY
- (ii) (iii) DEPARTMENT OF DERMATOLOGY
- (iv) DEPARTMENT OF EMERGENCY MEDICINE
- (v) DEPARTMENT OF FAMILY MEDICINE
- (vi) DEPARTMENT OF IMMUNITY AND EMERGING PATHOGENS
- (vii) DEPARTMENT OF INTERNAL MEDICINE
- (viii) DEPARTMENT OF NEUROLOGICAL SCIENCES
- (ix) DEPARTMENT OF PEDIATRICS
- (x)
- (xii) DEPARTMENT OF PHYSIOLOGY AND BIOPHYSICS
- (xiii) DEPARTMENT OF PREVENTIVE MEDICINE
- (xiv) DEPARTMENT OF PSYCHIATRY
- (xv) DEPARTMENT OF BEHAVIORAL SCIENCES

B. SURGICAL SCIENCES AND SERVICES

- (i) DEPARTMENT OF ANESTHESIOLOGY
- (ii) DEPARTMENT OF CARDIOVASCULAR-THORACIC SURGERY
- (iii) DEPARTMENT OF DIAGNOSTIC RADIOLOGY & NUCLEAR MEDICINE
- (iv) DEPARTMENT OF SURGERY
- (v) DEPARTMENT OF NEUROLOGICAL SURGERY
- (vi) DEPARTMENT OF OBSTETRICS & GYNECOLOGY
- (vii) DEPARTMENT OF OPHTHALMOLOGY

- (viii) DEPARTMENT OF ORTHOPEDIC SURGERY
- (ix) DEPARTMENT OF OTORHINOLARYNGOLOGY -
HEAD AND NECK SURGERY
- (x) DEPARTMENT OF PATHOLOGY
- (xi)
- (xii) DEPARTMENT OF RADIATION ONCOLOGY
- (xiii)

This Appendix A may be amended from time to time pursuant to Article 9.2 of the Medical Staff Bylaws.

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