

BYLAWS OF THE MEDICAL STAFF OF WESTFIELDS HOSPITAL

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BYLAWS OF THE MEDICAL STAFF OF WESTFIELDS HOSPITAL

Article 1 PURPOSE AND AUTHORITY OF THE MEDICAL STAFF

Section 1.1 Purpose. The purpose of the Medical Staff of Westfields Hospital is to oversee, evaluate, and improve the quality of professional services provided by members of the Medical Staff and others at the Hospital and to carry out the functions delegated to the Medical Staff by the Westfields Hospital Board.

Section 1.2 Authority. These Bylaws and other Governing Documents, and Operational Documents set forth the means by which the Medical Staff organizes itself to carry out its duties. As provided in Article 8, Governing Documents are effective when approved by the Board. Operational Documents are effective when approved by the Medical Executive Committee (MEC). Governing and Operational Documents are binding on every member of the Medical Staff and all Practitioners.

Section 1.3 Governing provisions; definitions. Capitalized terms and acronyms in the Bylaws and other Governing Documents are defined in Article 9. All provisions of the Bylaws and other Governing Documents must be interpreted as provided in Article 9.

Article 2 MEMBERSHIP OF THE MEDICAL STAFF

Section 2.1 Minimum eligibility criteria. In order to apply for appointment to the Medical Staff, an applicant must meet each of the following criteria:

- 1.1.1 **Licensure.** Be a Physician who possesses a license that permits the Physician to practice in Wisconsin;
- 1.1.2 **Completion of residency.** Have successfully completed a residency training program approved by the American College of Graduate Medical Education, American Osteopathic Association, or similar organization. (This criterion does not apply to a Physician who is a Dentist.)
- 1.1.3 **Board certification.** If applying for clinical privileges, be board certified, in the process of obtaining board certification, or participating in ongoing maintenance of certification measures with the intent of maintaining board certification in at least one specialty in which the applicant is seeking clinical privileges. (This criterion does not apply to a Physician who is a Dentist.)
- 1.1.4 **DEA registration.** Be registered with the U.S. Drug Enforcement Agency in Wisconsin, if the applicant prescribes or intends to prescribe medication to Hospital patients;
- 1.1.5 **Not excluded from federal programs.** Not be excluded or otherwise ineligible from participation in Federal Health Care Programs, including Medicare and Medicaid;

1.1.6 **Malpractice insurance.** Carry professional liability insurance of at least \$1 million per incident and \$3 million aggregate, or as otherwise specified by the Board, if the applicant requests clinical privileges;

1.1.7 **Cross-coverage.** Have adequate and appropriate arrangements to provide care for the applicant's patients in the Hospital when the applicant is unavailable; and

1.1.8 **Criminal history.**

(a) Has not been convicted of a felony within 10 years immediately prior to an initial application for appointment and

(b) Is not at the time the application is submitted on probation, parole, or any other form of supervision by the criminal justice system.

Section 2.2 Appointment. Every member of the Medical Staff must be appointed by the Board in accord with Article 4 and the Bylaws of the Hospital to one of the categories of membership provided in these Bylaws. An applicant must indicate which category of membership the applicant seeks and the MEC must recommend a category of membership to the Board, but the final decision regarding the category to which an appointee is assigned is reserved to the Board.

Section 2.3 Categories of membership. There are two categories of membership on the Medical Staff: Active and Associate.

2.3.1 **Active Staff.** The Active Staff consists of Physicians who have and regularly exercise clinical privileges at the Hospital (as defined in section 2.3.4), who accept the responsibilities of a member of the Active Staff, and who the Board has appointed to the Active Staff. The Board, upon the recommendation of the MEC, may appoint a Physician who has had fewer than the minimum number of Patient Contacts to the Active Staff.

(a) **Appointment.** A member of the Active Staff must be appointed by the Board, after considering the recommendation of the MEC, to a definite term of no longer than two years.

(b) **Prerogatives.** A member of the Active Staff is eligible to:

(1) Attend Medical Staff meetings;

(2) Vote for Medical Staff officers and on other Medical Staff matters;

(3) Serve as an officer of the Medical Staff; and

(4) Serve as a member of and chair any Medical Staff committee, subject to any other criteria set forth elsewhere in the Governing Documents.

(c) **Responsibilities.** A member of the Active Staff must

(1) Practice regularly at the Hospital;

- (2) Participate in activities and functions of the Medical Staff, including quality, performance improvement and peer review activities; credentialing; risk and utilization management; medical records completion; timely coding and documentation; and the discharge of other staff functions as required; and
- (3) Fulfill and comply with Medical Staff Governing Documents and Hospital policies and procedures, including policies concerning on-call coverage.

2.3.2 **Associate Staff.** The Associate Staff consists of Physicians to whom the Board has granted clinical privileges to practice at the Hospital and who are otherwise eligible to be appointed to the Active Staff except that they do not regularly practice at the Hospital (as defined in section 2.3.4). A member of the Associate Staff is not eligible to vote on Medical Staff matters and or to serve as an officer of the Medical Staff.

- (a) **Appointment.** A member of the Associate Staff must be appointed by the Board, after considering the recommendation of the MEC, to a definite term of no longer than two years.
- (b) **Prerogatives.** A member of the Associate Staff may
 - (1) Attend meetings of the Medical Staff; and
 - (2) Serve as a member of any Medical Staff committee, subject to any other criteria set forth elsewhere in the Governing Documents;
- (c) **Responsibilities.** A member of the Associate Staff must
 - (1) Participate in activities and functions of the Medical Staff, including quality, performance improvement and peer review activities; credentialing; risk and utilization management; medical records completion; timely coding and documentation; and the discharge of other staff functions as requested; and
 - (2) Fulfill and comply with Medical Staff Governing Documents and Hospital policies and procedures, including policies concerning on-call coverage that apply to Associate Staff.

2.3.3 **Honorary Status.** A Physician who does not have clinical privileges at the Hospital but wishes to maintain a professional affiliation with the Hospital may ask to be granted Honorary Status. A physician with Honorary Status is not a member of the Medical Staff, may not vote on Medical Staff matters, serve as an officer of the Medical Staff, or hold clinical privileges at the Hospital.

- (a) **Appointment.** A Physician with Honorary Status must be granted that status by the Board, after considering the recommendation of the Medical Executive Committee. The Board may grant a Physician Honorary Status for a determinate or indeterminate period of time and may rescind Honorary Status at any time

- (b) **Prerogatives. A Physician with** Honorary Status may attend Medical Staff meetings and meetings of committees with the consent of the chair of the meeting.
- 2.3.4 **Definition of “regularly practice.”** For purposes of determining the category of Medical Membership, a Physician “regularly practices” at the Hospital if the Physician has had an average of 50 or more Patient Contacts per year during the course of the Physician’s current appointment or, in the case of an initial applicant for appointment, reasonably expects to have 50 or more Patient Contacts per year during the course of the Physician’s initial appointment.
- 2.3.5 **Definition of “Patient Contact”.** A “Patient Contact” is an inpatient admission, a consultation on an inpatient or outpatient of the Hospital, or performance of an inpatient or outpatient surgical procedure. Notwithstanding this definition, a Physician whose only clinical privileges at the Hospital are to practice Telemedicine is not considered to “regularly practice” at the Hospital.

Article 3 ORGANIZATION OF THE MEDICAL STAFF

Section 3.1 Officers. The Medical Staff has the following officers:

- (a) Chief of Staff (COS),
- (b) Chief of Staff-Elect (COS-E), and
- (c) The immediately preceding Chief of Staff (Chief of Staff-Past, “COS-P”).

3.1.1 **Eligibility.** Only a member of the Active Staff may serve as an officer and must have been a member of the Active Staff for at least two consecutive years immediately prior to taking office.

3.1.2 **Election and term of office.** An officer serves a one year term, or until a successor is qualified. The COS-E serves for one year, then succeeds to the office of COS for a one-year term, followed by a one-year term as COS-P...

3.1.3 **Nomination of candidates**

- (a) **Nominating Committee.** Every year prior to the expiration of the officers’ terms the COS must convene a Nominating Committee of at least three members of the Active Staff, including the COS-P who serves as chair of the committee. The Nominating Committee must determine and announce a slate of one or more candidates for the office of COS-E at least 30 days before the scheduled date of the election. The Nominating Committee must not nominate a candidate who is ineligible or unwilling to be nominated and serve in the office if elected.
- (b) **Nomination by petition.** After the Nominating Committee announces its slate of candidates, any three members of the Active Staff may nominate one or more additional candidates who are eligible to serve by signing a nominating petition and

submitting it to the COS at least 14 days before the election. A written statement signed by the nominee that the nominee would accept service in the office if elected must accompany the petition.

3.1.4 **Election.** The Medical Staff must elect a Chief of Staff-Elect every year at a time and in a manner as determined by Medical Staff policy. The COS must announce a ballot containing the names of all nominated candidates to all Active Members at least seven days before the election. A candidate must receive a majority of votes cast to be elected. If more than two candidates are nominated for the same office and none receives a majority of votes cast, a run-off election must be promptly held between the two candidates who receive the most votes.

3.1.5 **Voting procedures.** The MEC may adopt an elections policy that sets forth the specific procedures for ensuring fair and accurate elections and voting. The policy may provide that eligible voters may vote in person, written ballot, electronic means, or by other means as determined by the MEC.

Section 3.2 Duties of officers.

3.2.1 **Chief of Staff (COS).** The Chief of Staff has the following duties:

- (a) Provide executive leadership to and be responsible for the organization and conduct of the Medical Staff;
- (b) Promote communication between the Medical Staff, the CEO, and the Board;
- (c) Chair the MEC and report the MEC's activities and reports to the Board;
- (d) Suspend clinical privileges of any Practitioner when necessary to prevent imminent harm to another person.
- (e) In conjunction with the VPMA, mediate grievances and conflicts between members of the Medical Staff, and between members of the Medical Staff and the MEC;
- (f) Exercise the responsibilities as a Responsible Person under the Fair Hearing Policy;
- (g) Serve as an *ex-officio*, member of all Medical Staff committees, non-voting unless otherwise provided in a Governing Document or the committee's charter;
- (h) Call and preside at all Medical Staff meetings;
- (i) Convey the opinions and concerns of the Medical Staff to the Board;
- (j) In all medical and administrative matters, act in coordination and cooperation with the CEO in giving effect to the policies adopted by the Board
- (k) Perform other duties and accountabilities as stated in the Governing Documents or Operational Documents; and
- (l) Participate in other activities as requested by the Hospital.

- 3.2.2 **Chief of Staff Elect (COS-E).** The Chief of Staff Elect has the following duties:
- (a) Assume the duties of the COS when the COS is unavailable and upon removal of the COS from office;
 - (b) Serve as a member of the MEC;
 - (c) Participate on other committees as provided in other Governing or Operational Documents; and
 - (d) Carry out other responsibilities as requested by the COS, VPMA, or CEO.

- 3.2.3 **Chief of Staff-Past.** The COS-P has the following duties:
- (a) Serve as a member of the MEC;
 - (b) Serve as chair of the Nominating Committee; and
 - (c) Participate on other committees and perform other tasks as requested by the COS, VPMA, or CEO.

Section 3.3 Vacancies.

- 3.3.1 **COS.** If a vacancy occurs in the office of COS, the COS-E assumes the COS's duties for the remainder of the vacancy and subsequently serves his or her own term as COS. In such a case, the term of the COS-P continues for one additional year.
- 3.3.2 **COS-E.** If a vacancy occurs in the office of COS-E, the MEC must appoint a member of the Active Staff to serve as interim COS-E until the Medical Staff elects a new COS-E in a special election following as appropriate the process described in sections 3.1.3 and 3.1.4. A COS-E elected to fill a vacancy continues as COS-E for the remainder of the term, and succeeds to the office of COS in the same manner as if no vacancy had occurred.

Section 3.4 Removal from office. An officer may be removed from office as follows:

- 3.4.1 **Immediate and automatic removal from office.** An officer's term ends immediately and automatically without any additional action by the MEC when the officer ceases to be a member of the Active Staff.
- 3.4.2 **Removal by vote.** The Active Staff may remove an officer from office as provided in this subsection.
- (a) **Petition.** A vote to remove an officer from office must be held if five or more members of the Active Staff file a petition with the CEO asking for a vote to remove the officer.
 - (b) **Notice.** Upon receiving a petition the CEO must promptly arrange for a vote and give the officer at least five days written notice prior to holding the vote. The notice must give the officer a reasonable opportunity to address the Medical Staff prior to the vote being held. This opportunity need not take place in a meeting of the Medical Staff and may be in writing or other means, at the discretion of the CEO.

- (c) **Majority required to remove.** An officer is removed if a majority of all eligible voters on the Active Staff (including the officer subject to removal who is entitled to vote) vote to remove the officer. If, the officer is removed, the vacancy must be filled as provided in section 3.3.

Section 3.5 Departments. The Medical Executive Committee may create departments or other subordinate organizations to assist the Medical Staff in carrying out its functions by adopting an Operational Document setting forth the composition and duties of the department or organization.

Section 3.6 Medical Executive Committee.

3.6.1 **The Medical Executive Committee** (“MEC”) is a standing committee of the Medical Staff. The MEC consists of the officers as voting members and the following as *ex officio*, non-voting members:

- (a) The CEO;
- (b) The VPMA;
- (c) The Director of Quality (or an equivalent position, as determined by the CEO); and
- (d) The nurse executive of the Hospital.

3.6.2 **Duties.** In addition to duties given to the MEC elsewhere in the Governing and Operational Documents, the MEC must:

- (a) Oversee and coordinate the Medical Staff’s quality and performance improvement program;
- (b) Oversee and coordinate the Medical Staff’s regulatory compliance functions;
- (c) Develop, oversee and enforce standards of professional conduct of members of the Medical Staff.
- (d) Act on behalf of the Medical Staff between Medical Staff meetings;
- (e) Submit recommendations to the Board on all matters relating to the appointment, reappointment, clinical privileges, and corrective action that requires Board approval;
- (f) Review and act on reports from Medical Staff committees and other assigned activity groups;
- (g) Request an evaluation or initiate an investigation of a Practitioner when there is question about the Practitioner’s ability to perform clinical privileges requested or currently granted;
- (h) Make recommendations to the Board concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or clinical privileges may be suspended, revoked, or limited, and the fair hearing procedures used to review such actions;

- (i) Recommend changes or amendments to the Governing Documents to the Medical Staff and Board; and
 - (j) Adopt and amend Operational Documents.
- 3.6.3 **Chair; voting.** The COS is the chair of the MEC, presides at its meetings, and may vote on any matter except for matters that directly and individually affect the chair.
- 3.6.4 **Meetings.**
- (a) **Regular and called meetings.** The MEC must meet on a regular basis as frequently as it determines is necessary. The MEC may also meet in special meetings at the call of the COS, the CEO, VPMA, or a majority of the officers. The person calling a special meeting must announce the time and place of the meeting and its purpose to all members of the MEC at least 24 hours in advance of the meeting. The 24-hour notice may be waived if all voting members of the MEC attend the meeting or every voting member of the MEC waives notice in a writing signed either before or after the special meeting.
 - (b) **Telephonic meetings.** The MEC may meet in person or by telephonic or other method that permits attendees to participate in the meeting substantially simultaneously.
 - (c) **Electronic voting.** The MEC may take any action it could take in a meeting by electronic means (e.g., email) if every member of the MEC is notified of the action being proposed, is given a reasonable time to vote, no member objects to voting by electronic means, and a majority of the MEC votes electronically in the affirmative.
 - (d) **Minutes.** The MEC must keep accurate written minutes of the proceedings of and actions taken at its meetings. The MEC may arrange with administrative personnel of the Hospital to keep minutes on the MEC's behalf. Minutes must be available for review by any member of the Active Staff, except that minutes containing review organization information or is otherwise confidential must be redacted or withheld.
- 3.6.5 **Attendance at meetings; executive session.**
- (a) Voting members of the MEC may attend any meeting of the MEC, except that no member of the MEC may attend a meeting or portion of a meeting where the MEC is considering a matter specifically concerning that member.
 - (b) The CEO or the CEO's designee must attend every MEC meeting. However, the failure of the CEO or the CEO's designee to attend a MEC meeting does not invalidate any otherwise valid action taken at the meeting.
 - (c) The MEC may allow others (including Hospital employees who provide support to the MEC) to attending any MEC meeting or portion of a meeting if allowing them to attend will assist the MEC in performing its duties.
 - (d) If a majority of voting members of the MEC cannot attend a meeting or cannot participate in a matter under consideration, the COS or, in the COS's absence, the

VPMA, may temporarily appoint one or more members of the Active staff to serve as an acting member of the MEC solely for the purpose of considering the matter or making a decision.

Section 3.7 Meetings of the Medical Staff.

3.7.1 **Regular meetings.** The Medical Staff must hold at least one meeting a year and may meet more often on a schedule determined by the Medical Staff or MEC.

3.7.2 **Special meetings.** A special meeting of the Medical Staff may be called by

- (a) the COS,
- (b) the MEC, or
- (c) a petition signed by five or more members of the Active Staff.

3.7.3 **Notice of meetings.** The COS must provide notice to the Medical Staff of a regular meeting, and the person or body calling for a special meeting must provide notice of a special meeting at least five days prior to the meeting.

- (a) **Means of notice.** The MEC may determine the appropriate means of notice. Notice may be by publication, mail, posting, electronic means, or other method or methods that the MEC customarily uses to convey important information to the Active Staff. It is not required that each Active Staff member be notified individually.
- (b) **Content of notice.** Notice of a regular or special meeting must include the time and place of the meeting, whether the meeting is regular or special, and the proposed agenda. Notice of a special meeting must also include a statement that no business other than that included in the notice will be considered at the special meeting.

3.7.4 **Attendance.** A member of the Active Staff must be counted as having attended a meeting if the member

- (a) Physically attends the meeting; or
- (b) Signs a proxy, in a form approved by the MEC, before the meeting authorizing another member in physical attendance at the meeting to cast a vote for the physically absent member; or
- (c) Casts a vote outside of the meeting in a manner authorized by the MEC.

3.7.5 **Quorum.** The attendance of 25% percent of the Active Staff constitutes a quorum to conduct business at a regular or special meeting of the Medical Staff.

Section 3.8 Committees. The Medical Staff may establish standing or ad hoc committees as appropriate to help it carry out its duties.

3.8.1 **Composition; duties; term.** Except for the MEC whose members and terms of office are governed by these Bylaws, the Medical Staff must provide for the committee's duties and its composition, in a Governing or Operating Document or by resolution.

- 3.8.2 **Accountability.** All committees are accountable to the Medical Staff through the MEC. All committee reports must be directed to the MEC unless otherwise provided by the MEC.

Section 3.9 Accountability of MEC to the Medical Staff; Communication with the Board; conflict resolution.

- 3.9.1 **Accountability of MEC to the Medical Staff.** In addition to other provision of these Bylaws under which members of the Medical Staff may hold the MEC accountable, any member of the Active or Associate Staff may communicate with the MEC about a concern the member has with any action or decision made by the MEC, including any failure to act or decide, by submitting a written statement of the concern to the MEC. If requested, the member must be given a reasonable amount of time, as determined by the MEC, to personally address the MEC concerning the subject matter of the request. This paragraph does not apply to a member's concern about an action or decision concerning the credentialing of any individual.
- 3.9.2 **Communication with the Board.** Nothing in these bylaws is intended to prevent a member of the Active or Associate Staff from communicating with the Board concerning a Governing or Operational Document adopted by the Medical Staff or the MEC. The Board must determine the method by which the communication may be made.

Article 4 CREDENTIALING AND CLINICAL PRIVILEGES

Section 4.1 Appointment and privileges granted by Board; no entitlement to membership or privileges. No one may be appointed to the Medical Staff or be granted clinical privileges except as provided in this Article. No one is entitled to appointment to the Medical Staff or clinical privileges solely by virtue of licensure, membership in any professional organization, or privileges held at any other health care organization. No member of the Medical Staff is entitled to clinical privileges solely by virtue of having been appointed to the Medical Staff.

Section 4.2 Credentials Committee; Credentialing Verification Organization. References to the "Credentials Committee" means a committee established by the MEC for the purpose of carrying out the Medical Staff's responsibility to review and evaluate the credentials and professional competence of Practitioners and to make recommendations to the Board regarding appointment to the Medical Staff and the granting of clinical privileges.

- 4.2.1 The MEC may appoint itself to act as the Credentials Committee and to perform the duties of the Credentials Committee and the MEC described in this Article simultaneously.
- 4.2.2 If the MEC appoints a separate Credentials Committee, the Committee must consist of at least three members of the Active Staff, the VPMA and the CEO.
- 4.2.3 The Credentials Committee may engage the services of Hospital staff and a Credentialing Verification Organization ("CVO") to administer the application process, verify the accuracy of information contained in an application, classify applications, and perform

any other duty delegated to it by the Credentials Committee. The CVO is accountable to the Credentials Committee which must periodically evaluate the performance of the CVO.

Section 4.3 Minimum qualifications. The Credentials Committee or CVO must not accept an application for appointment to the Medical Staff unless the applicant meets the minimum eligibility criteria listed in Section 2.1.

Section 4.4 Application. Except for a Practitioner seeking telemedicine-only privileges, a Practitioner seeking membership on the Medical Staff or clinical privileges must apply using standard application forms approved by the Credentials Committee. The Minnesota Uniform Credentialing Application, as amended, is deemed to comply with the requirements listed in section 4.4.1.

4.4.1 Contents of application. The standard application form must ask information establishing that the applicant meets each of the minimum eligibility criteria for appointment set forth in section 2.1. In addition, the application must ask at least the following:

- (a) **Adverse Licensing Action.** Information regarding any Adverse Licensing Action (as defined in Article 9) taken against the applicant.
- (b) **License investigation status.** Whether the applicant's professional license or registration is being or has ever been investigated, the result and status of any such investigation, and information describing any such investigation.
- (c) **DEA certification.** Whether the Drug Enforcement Administration (DEA) has ever
 - (1) revoked, suspended, limited, or conditioned the applicant's DEA certification in any way,
 - (2) whether the applicant has ever voluntarily relinquished his or her DEA registration, and
 - (3) whether the DEA is currently considering taking such action.
- (d) **Disciplinary Action.** Whether the applicant has been subject to Disciplinary Action by a Health Care Organization (as those terms are defined in Article 9) and whether any Health Care Organization is currently considering any such action.
- (e) **Voluntary relinquishment.** Whether the applicant has voluntarily relinquished membership, participation, clinical privileges, or a request for privileges, employment a professional license or registration
 - (1) In lieu of Disciplinary Action or investigation, or
 - (2) During an investigation into the applicant's professional conduct or competency.

- (f) **Involuntary relinquishment.** Whether the applicant has ever involuntarily relinquished membership, participation, clinical privileges or a request for privileges, employment, professional license or registration.
- (g) **Membership in professional organization.** Whether the applicant's membership or fellowship in a professional organization or specialty board certification has ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended, or revoked.
- (h) **Other discipline.** Whether the applicant has ever been reprimanded, censured, or otherwise disciplined by, or been subject to a corrective action agreement or plan, with a licensing board or Health Care Organization.
- (i) **Participation in government programs.** Whether the applicant's certificate or participation in any private, federal (e.g., Medicare, Medicaid, Tricare, etc.) or state health insurance program (e.g., Medicaid, Badger Care, MinnesotaCare) has ever been revoked or otherwise limited or restricted or is currently under investigation or subject to a proceeding with respect to an investigation.
- (j) **Criminal history.** Whether the applicant is currently or ever has been charged with a felony, gross misdemeanor (other than a minor traffic violation) and a description of all such charges, their disposition, and current status.
- (k) **Sexual misconduct.** Whether the applicant has ever been found guilty, liable, or responsible for sexual impropriety, sexual misconduct, or sexual harassment, and a description of all such occurrences.
- (l) **Malpractice history.** A list and description of every professional liability claim or lawsuit in which the applicant was a named defendant, including
 - (1) Any claim or lawsuit pending on the date the application is submitted; and
 - (2) Any claim or lawsuit that has been dropped, dismissed, settled, or resulted in judgment, whether in favor of or adverse to the applicant.
- (m) **Denial of malpractice insurance.** Whether the applicant has ever had professional liability insurance refused, cancelled, or been excluded from coverage for exercising privileges within the applicant's specialty.
- (n) **Practice while not covered by insurance.** Whether the applicant has ever practiced while not covered by professional liability insurance.
- (o) **Physical and mental ability.** Whether the applicant has a physical or mental condition that would affect the applicant's ability, with or without reasonable accommodation, to exercise the clinical privileges held or sought without posing a health or safety risk to the Practitioner's patients, and whether, if accommodation is necessary, what accommodations would help the Practitioner to safely and competently exercise the clinical privileges sought.

- (p) **Alcohol and drug use.** Whether the applicant believes, or has been told by another, that the applicant's use of alcohol or drugs affects the applicant's ability to exercise the clinical privileges held or sought without posing a health risk to patients, and what, if any, accommodation would help the applicant to safely and competently exercise the clinical privileges sought.
- (q) **Illegal drug use.** Whether the applicant is currently using illegal drugs, including unlawful use of a prescription controlled substance not being taken under the supervision of another licensed health care professional.
- (r) **Professional and employment history.** A complete chronology of the applicant's professional and educational appointments, employment or positions, including the names and complete addresses of all hospitals or other institutions at which the applicant has worked or trained and an explanation of any chronological gap in the applicant's practice history.
- (s) **Other training or experience.** Information concerning any additional experience or training that relate to the applicant's clinical competence.
- (t) **Membership in an exclusive contracted group.** If the applicant is seeking clinical privileges in a specialty for which the Hospital has an exclusive contract with a medical group, evidence that the applicant is a member of the group or will be by the time the appointment is made.

4.4.2 **Agreements required of Applicants.** As a condition of consideration for appointment or reappointment or for clinical privileges, every applicant and appointee must specifically agree in writing, by signing the application and other forms provided for this purpose, to:

- (a) **Bylaws and Governing Documents.** Have read the Medical Staff Bylaws and Governing Documents and is familiar with the principles, standards and ethics of the national, state and local associations that apply to and govern the Practitioner's specialty and profession.
- (b) **Follow Hospital policies.** To be bound by the principles, standards and ethics of the Hospital, and to agree to abide by all current and future hospital policies, and the Medical Staff Governing and Operational Documents.
- (c) **Notice of Adverse Licensing Action.** To promptly provide the Hospital with any and all information concerning any Adverse Licensing Action or proposed action and to acknowledge that failure to meet this requirement may result in an automatic administrative suspension of privileges.
- (d) **Notice of malpractice claims.** To provide the Hospital with prompt notice of any professional liability claim naming or proposing to name the applicant as a defendant, regardless of whether the claim involved care provided in the Hospital and or whether the applicant notified a professional liability carrier of the claim.

- (e) **Authorization to disclose information; release of liability.** To authorize the Hospital and its Medical Staff (including their representatives) to disclose information requested by any other Health Care Organization, licensing board, medical malpractice insurance carrier, or other organization concerned with provider performance regarding the applicant's professional status, including information about Disciplinary Action, and to not hold the Hospital, its Medical Staff, or their officers, directors, or representatives liable if the information was provided in good faith and without malice.
- (f) **Authorization to consult with others.** To authorize representatives of the Hospital and its Medical Staff to consult with and receive information – including documents and medical records – from any other Health Care Organization with which the applicant has been associated (including any present and past professional liability carrier) about the applicant's professional competence, health, character, and ethical qualifications.
- (g) **Release of liability for credentialing activities.** To not hold the Hospital, its officers, directors, Medical Staff or representatives liable for actions taken in good faith and without malice in connection with evaluating the applicant's application, credentials, and qualifications, and to not hold any other individual or organization liable for providing information to the Hospital, its Medical Staff or their representatives concerning the applicant's professional competence, physical and mental health, ethics, character and other qualifications.
- (h) **Acceptance of burden to produce.** To accept the burden of producing all information needed to properly evaluate the applicant's professional competence, health, character, and ethics, and, to resolve any doubts about such qualifications, to appear for interviews regarding the application, and to submit to a health examination, if requested.
- (i) **Unethical conduct.** To not participate in any form of the following:
 - (1) Fee-splitting;
 - (2) Seeking unwarranted publicity;
 - (3) Dishonest means of making money or commercialism; or
 - (4) Conduct that does not comply with HealthPartners' Code of Conduct or the Medical Staff's Standards of Professional Conduct.
- (j) **Respect of patient rights.** To respect the rights of and provide continuous care and supervision for the Practitioner's patients.
- (k) **Respectful treatment.** To treat every patient, staff member, hospital employee, and visitor with respect and courtesy at all times, including during times of stress and disagreement.

- (l) **Participation in Medical Staff affairs.** To accept committee and consultation assignments made by the Chief of Staff (COS) or Vice President of Medical Affairs (VPMA).
- (m) **Board certification not sufficient for privileges.** To acknowledge that certification by a Board does not necessarily qualify the applicant to exercise clinical privileges
- (n) **Assignment of credentialing functions.** To acknowledge that the Hospital may delegate or assign some or all of its credentialing and quality improvement activities to one or more other organizations and that any such organization (including its officers, directors, Medical Staff, representatives and employees) is considered a representative of the Hospital for purposes of carrying out those activities.
- (o) **Posting information on web site.** To authorize the Hospital to post information about the applicant's affiliation with the Hospital on the Hospital's website which the applicant understands is available to the public.
- (p) **Employed Practitioners.** If the applicant is an employee of or has applied for employment by a Health Care Organization,
 - (1) To authorize the Hospital to disclose credentialing and peer review information to the applicant's employer for the purposes of credentialing, re-credentialing and ongoing peer review and quality improvement activities by the employer; and
 - (2) To authorize representatives of the employer to release credentialing information to any and all third party payors that contract with the Hospital.
- (q) **Notice of change of employment status.** To notify the Medical Staff Services Office prior to or immediately following the termination of employment with any employer that provides professional liability insurance coverage or cross coverage for the Practitioner's patients, and to acknowledge that termination of employment may result in administrative suspension of the Practitioner's privileges unless the Practitioner provides satisfactory evidence that professional liability insurance and that cross coverage will continue without interruption.
- (r) **Quality improvement.** To participate in peer review and quality improvement activities.
- (s) **Execute documents.** To execute documents as requested to demonstrate compliance with the Hospital's policies and Medical Staff's Governing Documents.
- (t) **Affirmation of completeness and accuracy.** To certify that all the information in the application is complete and accurate to the best of the applicant's knowledge and to affirm that the applicant understands that any material misstatement or omission on the application, whenever discovered, is cause for denial or revocation of membership on the Medical Staff and clinical privileges.

- 4.4.3 **Complete application.** The Credentials Committee must not consider an application for membership or privileges until the application is complete. An application is not complete unless the application (a) includes all information asked for in the application, and (b) the CVO has verified information provided in section 4.4.5.
- 4.4.4 **Burden of production on applicant.** The burden of providing the information required for a complete application and for evaluation of the application is solely on the applicant.
- 4.4.5 **Primary source verification.** The Credentials Committee or a CVO must verify the accuracy of at least the following information with a primary source before the Credentials Committee considers the application. This primary source verification must be done upon an initial application for appointment or clinical privileges and at any reappointment or renewal of clinical privileges:
- (a) The applicant's current licensure.
 - (b) The applicant's relevant education and training.
 - (c) The applicant's current competence to perform any clinical privileges being sought.
- 4.4.6 **Responsibility to provide additional information.** If the Credentials Committee, CVO, or any other approval body asks an applicant for additional information to explain or amplify information contained in an otherwise complete application, the application may be deemed incomplete until the applicant provides the information.

Section 4.5 Classification of applications. Upon receiving a completed application and verifying the information in it, the Credentials Committee or CVO must classify the application according to this section.

4.5.1 **Class 1.**

- (a) **Initial appointment.** An initial application for appointment and clinical privileges must be assigned as Class 1 if *all* of the following are true:
- (1) **Primary source verification.** The Credentials Committee or CVO has verified all applicable information provided in the application with a primary source of the information or a reliable secondary source. (Primary source verification of certain information may be waived in individual cases with the consent of the Credentials Committee chair when the original source of the information is unavailable due to extraordinary circumstance [for example, if original records have been destroyed by fire or flood] if there are reasonable grounds to believe that the information is true and there is no reason to suggest that the information on the application is not true.)
 - (2) **Appropriate privileges requested.** The clinical privileges requested by the Practitioner are consistent with the specialty and the criteria established by the Medical Staff.

- (3) **Support of references.** Each reference provided gives unqualified support for the applicant's professional competence.
 - (4) **No pending malpractice litigation.** The applicant is not a defendant in any currently pending professional liability claim or lawsuit.
 - (5) **Physically and mentally able.** The application raises no reasonable doubt that the applicant is currently physically and mentally capable of exercising the privileges being sought.
 - (6) **No malpractice judgment.** No professional liability monetary settlement, judgment, or award has been paid by or on behalf of the applicant.
 - (7) **No Disciplinary or Adverse Licensing Action.** The applicant has not been the subject of any Disciplinary Action or Adverse Licensing Action.
 - (8) **Criminal history.** The applicant has not been charged with, indicted for, convicted of, or pled guilty or no contest to either of the following: (a) a felony or (b) a misdemeanor involving dishonesty, deceit, fraud, violence, or sexual misconduct.
- (b) **Reappointment.** An application for reappointment must be assigned as Class 1 if the applicant meets all of the criteria in paragraphs (1) – (5), and if the facts or events described in paragraphs (6)– (8) are true for the course of the applicant's current period of appointment.

4.5.2 **Class 2.** Any application that does not meet the criteria for Class 1 is classified as Class 2

Section 4.6 Evaluation of the application and recommended action. The Credentials Committee must review and evaluate each complete application and documentation that accompanies the application according to the criteria listed in section 4.7.

4.6.1 The Credentials Committee's evaluation must include a recommendation for action on the application. For applications classified as Class 2, the Credentials Committee must include a brief explanation of the reason for the recommendation.

4.6.2 The Credentials Committee must forward its recommendation regarding an application to the MEC, and the MEC its recommendation to the Board (or to a committee of the Board, as designated by the Board) for its consideration and final action, except that a recommendation that would entitle a Practitioner to request a hearing under Article 7 must not be forwarded to the Board until the Practitioner has been notified of his or her right to request a hearing under Article 7 and has either exercised or waived that right.

Section 4.7 Clinical privileges. Physicians and the following categories of Practitioners must not exercise clinical privileges in the Hospital unless the Board has granted the practitioner the clinical privileges or as otherwise provided in this Article:

- Physicians assistants (PA)
- Nurse practitioners (NP)

- Certified registered nurse anesthetists (CRNA)
- Certified nurse midwives (CNM)
- Clinical psychologists

4.7.1 **Criteria.** Before making a recommendation to the Board for appointment or granting clinical privileges, the Credentials Committee and MEC must review and assess each applicant's demonstrated competence in each of the following areas:

- Medical and clinical knowledge.** A Practitioner must demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of that knowledge to patient care and the education of others.
- Practice-based learning and improvement.** A Practitioner must use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
- Interpersonal and communication skills.** A Practitioner must demonstrate interpersonal and communication skills that enable the Practitioner to establish and maintain professional relationships with patients, families, and other members of the health care team.
- Professionalism.** A Practitioner must demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity (including diversity of race, culture, gender, religion, ethnic background, sexual orientation, language, mental capacity, and physical disability), and a responsible attitude towards patients, the Practitioner's profession, and society.
- Systems-based practice.** A Practitioner must demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

4.7.2 **Privileges requested simultaneously with an application for appointment or reappointment.** A request for privileges must accompany every application for appointment or reappointment to the Active or Associate Medical Staff and must be reviewed and considered along with and in the same manner as an application for appointment or reappointment.

4.7.3 **Request for expanded privileges.** A Practitioner may ask for additional or expanded privileges by notifying the VPMA or COS.

- A request for expanded privileges must be made on a form provided for that purpose by the Credentials Committee or CVO. The request form must be accompanied by a privilege delineation form relevant to the privileges being sought, the answers to disclosure questions listed in section 4.4.1, the authorization required in section 4.4.2(e), and the release required by 4.4.2(g).
- The Credentials Committee or CVO must verify applicable information provided with primary sources and collect and process all documents and other information related

to the request for additional or expanded privileges. The request for additional or expanded privileges must be evaluated and follow the approval process based on the information provided on the request for expanded privileges.

4.7.4 Obligation to provide EMTALA coverage. Clinical privileges must not be granted unless the Practitioner accepts obligations associated with the privileges, including emergency service and other rotational obligations as necessary to fulfill the hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act (EMTALA) and other applicable laws, requirements, or standards.

4.7.5 Basis for granting privileges. A recommendation or decision concerning clinical privileges must be based on the following:

- (a) The applicant's current licensure or certification status, as appropriate;
- (b) The applicant's specific relevant training;
- (c) The applicant's health and physical ability to perform the requested privilege;
- (d) Data collected from professional practice review by any Health Care Organization with which the applicant currently has privileges, to the extent that the data are available;
- (e) Recommendations from peers or teachers based on the Practitioner's current
 - (1) Medical and clinical knowledge;
 - (2) Technical and clinical skills;
 - (3) Clinical judgment;
 - (4) Interpersonal skills;
 - (5) Communication skills; and
 - (6) Professionalism;
- (f) If the applicant currently exercises privileges in the Hospital, review of the applicant's performance within the Hospital;
- (g) The applicant's history of Adverse Licensing Action and Disciplinary Action;
- (h) The number and pattern of professional liability judgments against the applicant;
- (i) Morbidity and mortality data, to the extent the data are available; and
- (j) The Hospital's resources and personnel necessary for the competent exercise of the privileges being sought.

4.7.6 Privilege requests from non-Physicians. A request for clinical privileges from a non-Physician is processed in the same way as a request from a Physician.

4.7.7 **Clinical privileges after Age 70.** Every Practitioner with clinical privileges must provide evidence of a physical examination by a physician acceptable to the Credentials Committee beginning in the year that the Practitioner turns 70 years old and annually thereafter that addresses whether the Practitioner is physically and mentally able to exercise clinical privileges safely and competently.

Section 4.8 Temporary privileges. A Practitioner may temporarily exercise clinical privileges prior to or in lieu of Board approval only as provided in this section. Being granted temporary privileges does not constitute appointment to the Medical Staff.

4.8.1 **Emergencies.** In an emergency, any Practitioner with clinical privileges at the Hospital is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm, without regard to the Practitioner's Medical Staff status or clinical privileges, as long as the care, treatment, and services provided are within the scope of the Practitioner's license.

4.8.2 **Temporary privileges to meet important patient care need.** Upon the joint recommendation of the VPMA and the COS, the CEO may grant a Practitioner privileges to meet an important patient care need for a period not to exceed 120 days.

(a) **Purposes.** Temporary privileges to meet an important patient care need may be granted for either of the following purposes:

- (1) To treat a particular patient for the duration of the patient's admission at the Hospital, not to exceed 120 days; or
- (2) To assist the Hospital to address an acute staffing need for a limited period of time, not to exceed 120 days.

(b) **Qualifications.** A Practitioner may be granted temporary privileges to meet an important patient care need only if the Practitioner has the following qualifications:

- (1) The Practitioner is licensed to practice in Wisconsin;
- (2) The Practitioner has training or experience relevant to the privileges being sought;
- (3) The Practitioner is currently competent to exercise the privileges being sought;
- (4) The Practitioner is able to perform the privileges being sought;
- (5) A query and evaluation of the National Practitioner Data Bank does not reveal disqualifying information;
- (6) The Practitioner has no current or previously successful challenges to licensure or registration;
- (7) The Practitioner has not been subject to involuntary termination of medical staff membership in another organization; and

- (8) The Practitioner is not subject to involuntary limitation, reduction, denial, or loss of clinical privileges in another organization.
- (c) **Application required.** An applicant for temporary privileges to meet an important patient care need must submit a complete application on a form provided by the Medical Staff Services Office. The application may be different from the application described in section 4.4 but must include at least the following:
- (1) Evidence that the Practitioner is legally eligible to exercise the privileges being sought in Wisconsin;
 - (2) Evidence that the Practitioner is covered by professional liability insurance of at least \$1 million per occurrence / \$3 million aggregate (or in another amount determined by the Board) that covers the clinical privileges the applicant seeks to exercise at the hospital, or is covered by the Federal Tort Claims Act;
 - (3) Evidence that the Practitioner is currently registered with the DEA in Wisconsin if the privileges sought includes prescribing drugs;
 - (4) A completed, legible request for privileges with all supporting documentation as may be required for the privileges being sought;
 - (5) The names and contact information for professional peers familiar with the applicant's current competence.
 - (6) A statement signed by the applicant that, if the temporary privileges are granted, the application agrees to abide by the Medical Staff's Governing Documents, and all policies of the Hospital and Medical Staff.
 - (7) A signed acknowledgement that denial of a request for temporary privileges does not entitle the applicant to a hearing under the Fair Hearing Policy.
- (d) **Primary source verification.** Upon receipt of a complete application the Credentials Committee or CVO must verify all applicable information provided in the application with a primary source of the information or a reliable secondary source. (Primary source verification of certain information may be waived in individual cases with the consent of the Credentials Committee chair.
- (e) **Approval.** The CVO must notify the COS and VPMA when it has completed verification and evaluation of the applicant's request for temporary privileges. If satisfied that temporary privileges should be granted, the COS and VPMA must notify the CEO in writing of their recommendation. If the CEO grants the request for temporary privileges, the CEO must notify the applicant in writing that temporary privileges have been granted. The CEO must also promptly notify the applicant if the CEO denies the request for temporary privileges. For purposes of this paragraph, the CEO's duties may be carried out by the CEO's authorized representative.

- (f) **No hearing.** A denial of a Practitioner’s application for temporary privileges to meet an important patient need does not entitle the Practitioner to a hearing under Article 7.

4.8.3 **Temporary privileges pending approval of the MEC and Board.** The CEO may grant an applicant for appointment and clinical privileges temporary privileges to practice at the hospital before the application has been acted on by the MEC or Board as provided in this section.

- (a) **Approval.** If an applicant’s application for appointment and clinical privileges is complete and classified as Class I, and the VPMA and COS agree that temporary privileges should be granted pending approval by the MEC and the Board, they must notify the CEO in writing of their recommendation.
- (b) **Notice.** If the CEO grants the request for temporary privileges, the CEO must notify the applicant in writing that temporary privileges pending approval by the MEC and the Board have been granted for a period of 120 days or until final Board action on the application, whichever is shorter. The CEO must also promptly notify the applicant if the CEO denies the request for temporary privileges.
- (c) **Application continues to be reviewed.** The application of a Practitioner granted temporary privileges must continue to be reviewed according to this Article without regard as to whether the CEO grants temporary privileges. If the Board approves the application, the Practitioner’s temporary privileges are automatically converted to standard privileges.
- (d) **No hearing for denial.** Refusal to grant temporary privileges pending MEC and Board approval does not entitle a Practitioner to a hearing Article 7.
- (e) **CEO’s authorized representative.** The duties of the CEO in this section 4.8.3 may be carried out by the CEO’s authorized representative.

4.8.4 **Disaster privileges.** During a disaster, the CEO, VPMA, or COS, have the authority grant temporary disaster response and recovery privileges (“Disaster Privileges”) to Volunteer Practitioners as follows.

- (a) **Disaster plan activation.** Disaster Privileges may be granted only when the Hospital activates its Disaster Plan (Emergency Management Plan) and the Hospital is unable to meet immediate patient needs without granting privileges to non-members of the Medical Staff.
- (b) **Identity verification.** Before Disaster Privileges are granted, the Hospital must obtain from the Practitioner a valid government-issued photo identification document identifying the Practitioner and at least one of the following:
 - (1) A current picture identification card from another health care organization that clearly identifies the Practitioner’s professional designation;

- (2) A copy of the Practitioner's current license to practice or primary verification with the licensing authority that the Practitioner is licensed;
 - (3) Identification indicating that the Practitioner is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal response organization or group;
 - (4) Identification indicating that the Practitioner has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or
 - (5) Confirmation by a Member of the Medical Staff currently privileged at the Hospital or another Hospital employee with personal knowledge of the Volunteer Practitioner's ability to act as a Volunteer Practitioner during a disaster.
- (c) **Medical Staff oversight.** The Medical Staff retains its obligation to oversee the performance of a Practitioner with Disaster Privileges as it does with any other Practitioner. Based on its oversight of the Practitioner, the Hospital must determine within 72 hours of the Practitioner's arrival whether Disaster Privileges should continue.
- (d) **Verification of credentials.** Medical Staff Services Office must begin the process of verifying the Practitioner's licensure, DEA registration, education and training, current employment, and malpractice coverage with primary sources as soon as possible and complete it within 72 hours from the time the volunteer Practitioner arrives at the Hospital. If extraordinary circumstances prevent primary source verification from being completed within this time, verification must be completed as soon as possible thereafter. If verification is not completed within 72 hours, the Medical Staff Services Office must document the following:
- (1) The extraordinary circumstances that made verification within 72 hours of arrival impossible.
 - (2) Evidence of the Volunteer Practitioner's demonstrated ability to continue to provide adequate care, treatment, and services.
 - (3) Evidence of the Hospital's attempts to perform primary source verification as soon as possible.
- (e) **Record retention.** The Medical Staff Services Department must maintain a permanent record of Practitioners who have been granted Disaster Privileges. The Department must distribute copies of the list to Division Heads, the Command Center, the Emergency Department, the Admissions Department, and Hospital Administration.

- (f) **Identification badges.** A Practitioner granted Disaster Privileges must wear identification at all times so that staff and other personnel are quickly able to identify the Practitioner as a health care worker assisting during the disaster.
- (g) **Malpractice coverage.** A Practitioner who is covered by the Federal Tort Claims Act is exempt from the requirement to have professional liability insurance. Disaster Privileges granted to Practitioners who are acting as agents of the federal government are limited in their privileges at the Hospital to the scope of their federal employment.
- (h) **Privileges terminate when plan deactivated.** When the hospital declares that the Emergency Management Plan is no longer in effect, all Disaster Privileges immediately terminate.

Section 4.9 Board consideration and action. The Board or its authorized representative(s) may adopt, reject, or modify any recommendation of the MEC with regard to appointment or privileges, in whole or in part.

- 4.9.1 **Favorable action.** If the Board approves a recommendation of the MEC to appoint an applicant to the Medical Staff or to grant new or expanded privileges, the CEO must promptly notify the new appointee in writing of the Board's action.
- 4.9.2 **Adverse action.** If the Board approves a recommendation of the MEC to deny an application, in whole or in part, the CEO must promptly notify the Practitioner of the Board's decision.
- 4.9.3 **Action not in accord with MEC recommendation.** The Board may, on its own initiative, approve an application for membership or privileges contrary to the MEC's recommendation, or it may deny or modify – in whole or in part – appointment or privileges that were recommended by the MEC. If either of these occur, the CEO must promptly notify the Practitioner of any action and, if the Board's decision constitutes adverse action, of any right the Practitioner may have to appeal the Board's decision.
- 4.9.4 **Board action is final.** Except as provided in the next paragraph an action by the Board on a credentialing matter is considered final professional review action.
- 4.9.5 **Referral back to MEC.** The Board may refer the matter to the MEC for further consideration before making a final decision. If the Board refers the matter to the MEC, the Board must indicate the reason for the referral and a brief explanation of what additional information it seeks. This action is not final professional review action and does not entitle the affected Practitioner to a hearing under Article 7.

Section 4.10 Leave of Absence. The MEC and Board may grant a leave of absence from Medical Staff and clinical responsibilities as follows.

- 4.10.1 A leave may be granted for any purpose approved by the Board, including to improve the Practitioner's physical or mental health, to improve the Practitioner's ability to care for

patients safely and competently, to obtain additional education, to provide voluntary medical service, or to fulfill a military obligation.

4.10.2 Except for a leave requested to satisfy a military obligation, or as otherwise expressly approved by the Board, a leave must not be for longer than one year.

4.10.3 A request for a leave be reviewed by the MEC and approved by the Board.

4.10.4 A Practitioner who has been granted a Leave of Absence may apply to the Credentials Committee for reinstatement to the Medical Staff or the restoration of clinical privileges. The Credentials Committee, MEC, and the Board must approve any reinstatement and restoration. Any such reinstatement is subject to Focused Professional Performance Evaluation.

4.10.5 If a Practitioner's appointment to the Medical Staff is due to expire before the Leave of Absence ends, the Practitioner must apply for and be granted reappointment to the Medical Staff before the appointment expires. If the appointment expires while the Practitioner is on leave, the Practitioner may reapply for appointment as a new applicant.

Section 4.11 Telemedicine-only privileges. The Board may grant a Practitioner Telemedicine privileges according to the procedures in this section.

4.11.1 For purposes of this section, "Telemedicine" means the transmission of a patient's medical information from the Hospital to a Practitioner at a distant site where the Practitioner reviews the information without the patient being present and the Practitioner reports on the Practitioner's findings to the Hospital, or the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment, and services.

4.11.2 Only a Practitioner who has asked for Telemedicine-only privileges is eligible for the privileging process described in this section. A Practitioner who desires Telemedicine privileges and other privileges at the Hospital must seek privileges as described elsewhere in this Article.

4.11.3 The Hospital may grant Telemedicine-only Privileges pursuant to a written agreement with another hospital ("Distant Site Hospital") at which the Practitioner has privileges similar to those being sought at the Hospital. In the agreement, the Distant Site Hospital must assure the Hospital of at least the following:

(a) The Distant Site Hospital participates in Medicare and is accredited by The Joint Commission.

(b) The Distant Site Hospital's credentialing and privileging procedures comply with and will continue to comply with all applicable Medicare Conditions of Participation and Hospital Accreditation Standards of The Joint Commission. This assurance includes that the Distant Site Hospital's governing body

- (1) Determines, in accord with state law, which categories of practitioners are eligible candidates for appointment to the Distant Site Hospital's Medical Staff;
- (2) Appoints members of the Medical Staff after considering the recommendations of the existing members of the Medical Staff;
- (3) Ensures that the Distant Site Hospital's Medical Staff has bylaws;
- (4) Approves the Distant Site Hospital's Medical Staff bylaws and other governing documents;
- (5) Ensures that the Distant Site Hospital's Medical Staff is accountable to that hospital's governing for the quality of care provided to patients;
- (6) Ensures that the criteria for selection for membership in the Distant Site Hospital's Medical Staff are individual character, competence, training, experience, and judgment; and
- (7) Ensures that under no circumstances is appointment to the Distant Site Hospital's Medical Staff or the grant of professional privileges dependent solely upon certification, fellowship or membership in a specialty body or society.

4.11.4 Pursuant to the agreement, if the Distant Site Hospital confirms in writing that an applicant for Telemedicine-only privileges is appointed to the Medical Staff of the Distant Site Hospital and has clinical privileges that are substantially the same as the Telemedicine privileges being sought, the applicant's request for clinical privileges may be forwarded to the Board for its approval without being independently evaluated and recommended by the Medical Staff.

4.11.5 A Practitioner with Telemedicine-only privileges may be appointed only to the Associate Staff.

4.11.6 A Telemedicine-only Practitioner is subject to all quality and peer review policies of the Medical Staff and Hospital as would any other Practitioner with similar privileges that are not Telemedicine privileges. The Hospital must provide to the Distant Site Hospital evidence of any internal review of a Telemedicine-only Practitioner's performance of telemedicine privileges at the Hospital, including at a minimum a report of all adverse events that resulted from the Telemedicine-only Practitioner's services and all complaints the Hospital has received about the Practitioner.

Article 5 QUALITY IMPROVEMENT AND PROFESSIONAL PRACTICE EVALUATION

Section 5.1 Quality improvement policy. The Medical Staff must undertake and oversee activities that measure, assess, and improve the quality of health care in the Hospital, including evaluation of Practitioners' professional practice. The Medical Staff must have a quality improvement and professional practice evaluation policy ("Policy") that sets forth the detailed steps of

how this process occurs. The Policy must be consistent with this Article and must be reviewed at least annually.

Section 5.2 Focused Professional Practice Evaluation (FPPE). The Policy must provide for Focused Professional Practice Evaluation (FPPE), a time-limited, privilege-specific process of evaluating a Practitioner’s ability to competently exercise clinical privileges that are being sought or have been granted. FPPE includes the gathering, review, and evaluation of information about a Practitioner’s performance and may include chart review, monitoring of clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of the Practitioner’s patients (including, for example, consulting physicians, assistants at surgery, nursing, and administrative personnel). FPPE is not an investigation under Article 6 but may result in an investigation being initiated.

5.2.1 The Policy must provide that FPPE be used to assess a Practitioner’s competence to perform requested privileges at the Hospital any time the Medical Staff does not have documentation of the Practitioner’s current ability to safely and competently exercise a requested privilege at the Hospital, including immediately following any of the following:

- (a) appointment to the Medical Staff,
- (b) granting a new or expanded privilege,
- (c) reinstatement of privileges after a leave of absence, and
- (d) whenever there is an incident or evidence of a clinical practice trend that calls into question the Practitioner’s current ability to exercise one or more specific privileges safely and competently at the Hospital.

5.2.2 When FPPE is required, the Policy must state:

- (a) How a monitoring plan specific to the privilege will be developed;
- (b) How the duration of performance monitoring will be determined; and
- (c) The circumstances under which additional monitoring, including by an external source, will be is required.

5.2.3 The Policy must specify how the measures used to evaluate the Practitioner’s competence in performing the specific privilege will be developed.

5.2.4 The Policy must provide for effective ways of communicating the results of FPPE and recommendations based on those results to the Practitioner and others and for implementing changes to improve the Practitioner’s performance.

Section 5.3 Ongoing Professional Practice Evaluation (OPPE). The Policy must provide for Ongoing Professional Practice Evaluation (OPPE) for all Practitioners with clinical privileges. OPPE is an on-going process of identifying a Practitioner’s professional practice trends that affect the quality of care and the safety of patients in the Hospital and improvement of the quality

of care. OPPE is not an investigation under Article 6 but may result in an investigation being initiated.

5.3.1 The Policy must specify how the information that will be used in conducting OPPE will be determined. Examples of information that may be gathered and evaluated as part of OPPE include:

5.3.2 The operative and clinical procedures performed by the Practitioner and their outcomes;

- (a) The Practitioner's pattern of blood and pharmaceutical usage;
- (b) The tests and procedures requested by the Practitioner;
- (c) The length of stay of the Practitioner's patients;
- (d) Morbidity and mortality data concerning the Practitioner's patients;
- (e) The Practitioner's use of consultants; and
- (f) Other relevant information as stated in the Policy.

5.3.3 The Policy must specify how the information used in OPPE will be gathered. Sources of information may include, as appropriate,

- (a) Periodic review of the Practitioner's patients' medical records;
- (b) Direct observation of the Practitioner;
- (c) Monitoring of the Practitioner's diagnostic and treatment techniques; and
- (d) Discussion with other individuals involved in the care of the Practitioner's patients, including, for example, consulting physicians, assistants at surgery, nursing, and administrative personnel.

5.3.4 The Policy must provide that information produced through OPPE be communicated to the Practitioner no less often than once every eight months, and that the information evaluated through OPPE will be used as a factor in determining whether the Practitioner will be reappointed to the Medical Staff and have privileges maintained, revised, limited, or revoked.

Section 5.4 Assurance of objectivity and fairness. The Policy must provide that OPPE and FPPE and other quality improvement activities of the Medical Staff be conducted in an objective, data-based, and fair manner, unaffected by personal, economic, or professional interests of those conducting OPPE and FPPE. The Policy must provide that Practitioners who are not members of the Hospital's Medical Staff and Practitioners who are not employees of the same organization as the Practitioner may participate in OPPE and FPPE when necessary and appropriate to ensure the objectivity of the evaluation.

Article 6 INVESTIGATIONS AND CORRECTIVE ACTION

Section 6.1 Purpose and definition

6.1.1 **Purpose.** The purpose of this Article is to state the grounds for initiating and the procedure for conducting an Investigation of the professional conduct or competence of a Practitioner, and for developing and implementing corrective action based upon the results of an Investigation.

6.1.2 **Definition.** An “Investigation” is a systematic inquiry into the professional conduct or competence of a Practitioner as a result of a specific allegation of conduct that constitutes a ground for an Investigation under section 6.2. For purposes of these Bylaws, quality improvement activities under Article 5 (including OPPE, FPPE, and case review) and credentialing activities under Article 4 do not constitute an Investigation, though any of these activities may lead to an Investigation being conducted.

Section 6.2 Grounds for an Investigation. An Investigation may be conducted if the MEC determines that there are reasonable grounds to believe that a Practitioner may have exhibited any of the following:

6.2.1 Violation of any standard of conduct established by the Medical Staff, the Hospital, the Practitioner’s professional society, or unit of government. Examples of such standards include Medical Staff Governing Documents, Hospital or Medical Staff policies, ethical standards of a Practitioner’s profession, and federal, state, or local statutes, rules, or regulations.

6.2.2 Conduct that adversely affects or could be reasonably anticipated to adversely affect the safe and orderly operation of the Hospital.

6.2.3 Conduct that adversely affects or could be reasonably anticipated to adversely affect the safety or welfare of one or more persons associated with the Hospital, including patients, staff, and visitors.

6.2.4 Substandard care or treatment of one or more specific patients, even if the alleged substandard care or treatment did not harm the patient.

6.2.5 General clinical incompetence.

Section 6.3 How an Investigation is initiated. An Investigation may be initiated only by the MEC according to the procedures in this section.

6.3.1 **Anyone may ask for an investigation.** Any person may ask the MEC to conduct an Investigation by submitting a request to any member of the MEC, the VPMA, or CEO of the Hospital.

(a) A person asking for an Investigation should include in the request as many facts as possible regarding the nature of the alleged misconduct in order to enable the MEC to determine whether an Investigation is warranted.

- (b) A request may be made orally or in writing and may be anonymous. If possible, the person receiving an anonymous request should notify the requestor that anonymity may impair the conduct of an Investigation and that the subject of the Investigation may be able to infer the identity of the requestor during the course of the Investigation.

6.3.2 Notice to the MEC. A person authorized to receive a request for an Investigation must notify members of the MEC that the request has been made and promptly arrange for the MEC to meet to consider the request and determine whether to initiate an Investigation.

- (a) If the request is for an Investigation of a member of the MEC, that member must not participate in the decision whether to initiate an Investigation or in the subsequent conduct of an Investigation. The COS (or, if the request is to investigate the COS, the VPMA or CEO) may temporarily appoint any member of the Active Staff to serve as an acting member of the MEC for purposes of considering the request and conducting the Investigation.
- (b) The person receiving the request must present the allegations and any relevant information to the MEC and the MEC must determine whether to initiate an Investigation of the allegations.
- (c) The MEC must initiate an investigation if, after consideration of the request, there are reasonable cause to believe that the allegations, if true, would constitute a ground for an Investigation under section 6.2.
- (d) Factors the MEC may consider in making the probable cause determination include the following:
 - (1) The seriousness of the conduct alleged.
 - (2) The credibility of the person making the allegation, including the extent to which the person has personal knowledge of the conduct.
 - (3) The need to develop additional facts.
 - (4) The likelihood that an informal inquiry or collegial consultation with the Practitioner involved will resolve the concern.
- (e) The MEC may meet more than once, if necessary, before determining whether to initiate an Investigation.

Section 6.4 Conduct of the investigation; investigating committee. If the MEC initiates an Investigation, the COS must promptly appoint an impartial investigating committee to conduct the Investigation. The COS may constitute the MEC as the investigating committee.

6.4.1 Composition of the committee. The investigating committee must consist of at least three persons, one of whom the COS must designate as the chair of the committee. The chair may vote on every matter voted upon by the committee.

- (a) The COS may appoint one or more persons who is not a member of the Active Medical Staff to the investigating committee, but a majority of the investigating committee must be members of the Active Medical Staff.
- (b) If feasible and appropriate, at least one member of the committee must practice in a specialty similar to that of the subject of the investigation.
- (c) The COS must not appoint to the committee a member who is in direct economic competition with the subject of the investigation. Each committee member must confidentially disclose to the COS prior to accepting appointment to the committee any conflict of interest (whether economic or otherwise) that may prevent the member from investigating impartially and the COS must consider any such conflicts or potential conflicts before appointing the member to the committee. The COS may remove or replace a member of an investigating committee at any time if the COS determines the committee member is not acting impartially.

6.4.2 **Notice to the subject.** As soon as possible after the investigation has been initiated, the COS must notify the subject of the investigation in writing that the MEC has initiated the Investigation. This notice may be delayed temporarily if, in the opinion of the COS, immediate notice would impede the committee’s ability to effectively conduct the investigation. The notice must include the following:

- (a) A description of the general nature of the alleged conduct being investigated;
- (b) Notice that if the Practitioner voluntarily resigns from the Medical Staff or relinquishes any privileges after the investigation has begun but before it has been concluded, the Hospital will report the resignation or relinquishment to any agency or organization to which a report is required by law, including the National Practitioner Data Bank (NPDB) as required by the Health Care Quality Improvement Act and its implementing regulations; and
- (c) A copy of this Article.

Section 6.5 Duty to cooperate. The subject of an investigation must cooperate with the investigating committee. Failure to cooperate with the Investigation constitutes independent grounds for disciplinary action that the committee may report and recommend to the MEC. Cooperation includes:

- 6.5.1 meeting personally with the committee upon request;
- 6.5.2 promptly providing written information and records requested by the committee;
- 6.5.3 consenting to a mental or physical examination, including a drug or alcohol screening examination (at the expense of the Hospital) if requested by the committee; and
- 6.5.4 executing documents the committee may require in order to obtain information from other parties.

Section 6.6 Use of outside experts. With the approval of the CEO or VPMA, the investigating committee may consult with medical, legal, ethics, and other experts to assist it in conducting the Investigation and evaluating evidence. The subject of the Investigation may not compel the committee to consult with outside experts or to pay for consultations obtained by the subject of the Investigation.

Section 6.7 Meeting with the committee. The committee may require the subject of an Investigation to meet with the committee by providing the subject a written request for a meeting at least 48 hours prior to the meeting.

6.7.1 The committee must schedule the meeting at a time that is agreeable to both the committee and the subject of the Investigation when doing so will not unreasonably delay completion of the investigation.

6.7.2 The request for a meeting must be accompanied with a notice reminding the Practitioner that he or she must cooperate with the Investigation, including attending a meeting if requested, and that failure to cooperate with the Investigation is itself independent grounds for disciplinary or corrective action.

6.7.3 If the committee does not require the subject of the Investigation to meet with it, the committee must offer the Practitioner an opportunity to meet personally with the committee before reporting its conclusions.

6.7.4 A meeting with the committee, whether at the request of the committee or the subject of the Investigation, is not a hearing under Article 7. Neither the committee nor the subject of the Investigation is entitled to be represented by an attorney at the meeting.

Section 6.8 Scope of the investigation. The investigating committee may investigate incidents or concerns that it discovers during the course of the Investigation and is not limited to investigating the allegations made in the request to initiate an investigation.

Section 6.9 Report and decision. When the investigating committee has completed its Investigation, it must report its findings and recommendation to the MEC. The MEC must receive and review the report and decide what, if any, action is appropriate. If the MEC determines that additional fact-finding is necessary, it may direct the investigating committee to gather additional facts before making a decision.

Section 6.10 Costs of the investigation. All costs of the Investigation are borne by the Hospital.

Section 6.11 Investigatory suspension or restriction. The CEO, VPMA, or COS may immediately suspend a Physician's membership on the Medical Staff or restrict some or all of a Practitioner's clinical privileges up to 14 days in order to investigate an unproven allegation of conduct which, if proven, has the potential to adversely affect the safe and orderly operation of the Hospital. The MEC must meet as soon as possible after the initiation of the investigatory suspension, and in any event, within 14 days, to consider and decide whether the suspension or restriction should be discontinued or continued or modified as a summary

suspension. An investigatory suspension does not imply any final finding regarding the circumstances that caused the suspension or restriction.

Section 6.12 Summary suspension. The CEO, VPMA, COS, or MEC may at any time, whether or not an investigation under this Article has been initiated, summarily suspend a Physician's membership on the Medical Staff or restrict some or all of a Practitioner's clinical privileges to the extent necessary to prevent an imminent danger to the health of any individual.

6.12.1 **Standard.** The standard is met if suspension or restriction of privileges is necessary to

- (a) Protect the life or well-being of an identifiable patient or patients generally; or
- (b) Reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person.

6.12.2 **Effective date; duration.** A summary suspension or restriction is effective immediately unless the person imposing it states otherwise. A summary suspension or restriction may be for a determinate or indeterminate period of time.

6.12.3 **Notice.** The person imposing the summary suspension or restriction must notify the Practitioner in writing as soon as possible of the suspension or restriction. This notice must notify the Practitioner

- (a) Of the general reason for the suspension or restriction;
- (b) Of the scope and expected duration of the suspension or restriction; and
- (c) That a summary suspension or restriction in itself is not a completed professional review action and does not entitle the Practitioner to a hearing unless it lasts more than 30 days.

6.12.4 **Care of patients.** Unless otherwise indicated by the terms of the suspension or restriction, the COS (or designee) must assign the suspended Practitioner's patients to another Practitioner and must consider, where feasible, the wishes of the affected Practitioner and the patient when choosing a substitute practitioner.

6.12.5 **Suspension for longer than 30 days.** If the suspension or restriction continues for more than 30 days, the Hospital must report the suspension to the National Practitioner Data Bank or any other authority to the extent required by law. If the suspension is later terminated and no professional review action is taken against the member, the Hospital must amend its report to reflect that fact.

6.12.6 **Right to request a hearing.** An investigatory or summary suspension or restriction that lasts more than 30 days constitutes a professional review action and the suspended or restricted member may request a hearing under Article 7.

Section 6.13 Automatic administrative suspension.

6.13.1 Grounds for administrative suspension. A Practitioner's clinical privileges are automatically and administratively suspended if any of the following occurs. A suspension under this section is not Professional Review Action and may not be challenged in a hearing under Article 7.

- (a) The Practitioner does not possess a current, valid license to practice in Wisconsin, including because a previously valid license has lapsed, expired, or has been suspended or revoked.
- (b) If the Practitioner's privileges require prescribing controlled substance, the Practitioner does not possess a current, valid registration with the Drug Enforcement Agency in Wisconsin, including because a previously valid registration has lapsed, expired, or been suspended or revoked.
- (c) The Practitioner does not currently have professional liability insurance in the amounts required by the Board.
- (d) The Practitioner does not submit proof of immunization status or testing for tuberculosis or other infectious disease when required.
- (e) The Practitioner fails to complete medical records in accord with Hospital policy after having been notified of the delinquency.
- (f) The Practitioner is excluded from participation in a federal or state health care program.
- (g) The Practitioner fails to appear at a meeting at which a special appearance is required.
- (h) The Practitioner fails to participate in an evaluation of the Practitioner's qualifications, including if the Practitioner refuses to undergo a mental or physical examination when requested by the Credentials Committee or the MEC.
- (i) The Practitioner fails to execute releases, consents, or other documents as required by the Governing Documents or the MEC.
- (j) The Practitioner's ability to access or use the Hospital's medical record system is suspended or revoked.
- (k) The Practitioner does not have adequate cross-coverage for the patients when the Practitioner is not available.

Section 6.14 Reinstatement. A Practitioner whose appointment or clinical privileges are administratively suspended under this Article may have the privileges reinstated without reapplying for appointment and clinical privileges if, within 30 days from the day the suspension started, the Practitioner supplies satisfactory evidence that the circumstance that caused the suspension no longer exists. If the Practitioner does not supply the evidence within 30 days of the suspension, the Practitioner is deemed to have voluntarily resigned from the Medical Staff and voluntarily relinquished clinical privileges, in which case the CEO must promptly notify the Practitioner in writing of the resignation and relinquishment. A Practitioner

deemed to have resigned under this paragraph may submit an application for appointment and request for clinical privileges at any time after the Practitioner is once again qualified to be appointed.

Article 7 FAIR HEARINGS

Section 7.1 Purpose. The purpose of this Article is to set forth procedures for the conduct of fair hearings.

Section 7.2 Definitions. For purposes of this Article, the following definitions apply.

7.2.1 **Practitioner** means any person who

- (a) has applied for appointment or reappointment to the Active or Associate Staff, or
- (b) has clinical privileges to practice at the Hospital granted by the Board upon the recommendation of the MEC, or
- (c) who has applied for new or expanded privileges.

7.2.2 **Review Organization** means either the MEC or the Board, respectively, depending on the organization that proposed the action that is the subject of a hearing under this Article.

7.2.3 **Responsible Person** means the person responsible for carrying out the duties of the Review Organization. If the MEC is the Review Organization, the Chief of Staff (COS) is the Responsible Person. If the Board is the Review Organization, the Board Chair or the Chair's designee is the Responsible Person.

Section 7.3 Professional Review Action that entitle a Practitioner to request a hearing. A Practitioner is entitled to request a hearing only if a Review Organization proposes to take a Professional Review Action that meets both of the following criteria:

- (a) The proposed action, if implemented, would adversely affect the Practitioner's ability to practice independently in the Hospital for more than 30 days; and
- (b) The reason for the proposed action is the Practitioner's clinical competence or professional conduct.

Section 7.4 Examples of actions that entitle a Practitioner to request a hearing. Examples of proposed actions that meet these criteria include the following when the reason for the action is based on the Practitioner's clinical competence or professional conduct:

- (a) Denial of appointment or reappointment to the Medical Staff.
- (b) Revocation of the Practitioner's Medical Staff appointment.
- (c) Denial in whole or in part of the Practitioner's requested clinical privileges.
- (d) Involuntary reduction in or revocation of the Practitioner's clinical privileges.

- (e) Suspension of the Practitioner's appointment to the Medical Staff or clinical privileges for more than 30 days.
- (f) Imposition or application of a mandatory concurring consultation requirement or an increase in the stringency of a pre-existing mandatory concurring consultation requirement when the requirement applies only to the individual Practitioner, is imposed for more than 30 days, and is based on the Practitioner's clinical competence or professional conduct.

Section 7.5 Examples of actions that cannot be challenged in a hearing. The following are examples of actions that do not entitle a Practitioner to ask for a hearing because they do not meet both of the criteria in section 7.3. The examples are illustrative and not exclusive.

- (a) Examples of actions or activities that do not limit the Practitioner's ability to practice independently in the Hospital and therefore do not give the Practitioner a right to ask for a hearing include:
 - (1) Conducting Focused Professional Practice Evaluation (FPPE), including imposition of performance monitoring requirements.
 - (2) Conducting Ongoing Professional Practice Evaluation (OPPE).
 - (3) Issuing a letter of guidance, warning, or reprimand to the Practitioner.
 - (4) Requiring that the Practitioner be observed by a proctor with no requirement of prior approval by the proctor or any other restriction on the Practitioner's privileges.
 - (5) Initiating an investigation into the Practitioner's clinical competence or professional conduct.
 - (6) Requiring that the Practitioner appear for a special meeting with the MEC or Investigating Committee.
 - (7) Granting privileges or appointment for a period of time shorter than that asked for or for less than the maximum 24 months.
 - (8) Denying a request for a leave of absence or extension of a leave.
 - (9) Requiring the Practitioner to complete an educational, physical, mental health, or substance abuse assessment.
- (b) Examples of reasons for actions that are not based on a Practitioner's clinical competence or professional conduct and therefore do not give the Practitioner a right to ask for a hearing, even though the effect of the action may limit the Practitioner's ability to practice independently in the Hospital for more than 30 days, include:
 - (1) The Practitioner submits an incomplete or untimely application.

- (2) The Practitioner makes a material omission or misrepresentation on an application for appointment or privileges.
- (3) The Practitioner fails to meet minimum requirements for appointment to the Medical Staff.
- (4) The Hospital enters into an exclusive provider agreement with an entity with which the Practitioner is not affiliated.
- (5) The Hospital decides to close or limit the number of practitioners privileged in a specialty under a Medical Staff development plan.
- (6) The Practitioner is a Hospital employee or has a contract with the Hospital and the Practitioner's employment or contract with the Hospital terminates.
- (7) The Practitioner's appointment expires.
- (8) The Practitioner's appointment or privileges are administratively suspended.

Section 7.6 Notice of Proposed Action. When a Review Organization proposes to take adverse professional action entitling a Practitioner to request a hearing, the Responsible Person must give the Practitioner written notice of the proposed action within five Business Days of the action.

7.6.1 Means of sending notice. The Notice must be sent by Certified Mail – Return Receipt Requested (or another means that requires a written acknowledgment of receipt) addressed to the Practitioner's current address on file with the Review Organization's Office, or to another address with the prior consent of the Practitioner.

7.6.2 Contents of the Notice. The Notice must include the following information:

- (a) The action that has been proposed to be taken and a statement that that the action constitutes professional review action.
- (b) The reason for the proposed action.
- (c) A statement that the Practitioner has the right to request a hearing on the proposed action by submitting a written request for a hearing.
- (d) The name and address of the person to whom the Practitioner must direct a request for a hearing.
- (e) A statement that the person named in the previous paragraph must receive the request a hearing within 30 days of the day the Practitioner received or is deemed to have received the Notice of Proposed Action, and that if the Practitioner does not request a hearing within this time the Board will proceed to take final action and the Practitioner will be deemed to have waived all rights to contest the action.
- (f) A summary of the rights the Practitioner would have in the hearing as listed in section 7.6.6.

- (g) A copy of the Medical Staff Bylaws.
- (h) A form that the Practitioner must sign to ask for the hearing that includes a statement by the Practitioner that, by requesting a hearing under the Medical Staff bylaws and this Policy, the Practitioner waives without qualification any cause of action or claim against the Hospital, the Medical Staff or any of its officers, members of the Hearing Panel, or Presiding Officer based on their participation in the hearing process.

7.6.3 Date of receipt. The Practitioner is deemed to have received the Notice of Proposed Action on the date the Practitioner signed an acknowledgement of receipt, or ten Business Days after the Notice was sent, whichever is earlier.

7.6.4 Request for Hearing; scheduling a hearing.

(a) **Contents of request.** A request for Hearing must (1) be in writing, (2) be directed to the CEO, (3) state unequivocally that the Practitioner requests a hearing, and (4) include the waiver described in section 7.4.2(h). The Practitioner may include in the Request for Hearing a request that the hearing be held sooner or later than the presumptive time period provided by this Article.

(b) **Timeliness of request.** A Request for Hearing is timely only if it is received by the CEO or the CEO's designee by 4:30 p.m. on or before the 30th day after the day the Practitioner received or is deemed to have received the Notice of Action. If the 30th day is a Saturday, Sunday, or hospital-recognized holiday, a Request received before 4:30 p.m. the next Business Day is timely.

7.6.5 Delivery of request to Responsible Person. Upon receiving a timely request for a hearing, the CEO must promptly deliver the request to the Responsible Person.

Section 7.7 Time limits for hearing. Upon receiving a timely Request for Hearing, the Responsible Person must promptly arrange for and schedule a hearing. Except as provided below, the Responsible Person must not schedule the hearing to begin sooner than 30 days or later than 60 days after the Notice of Hearing is sent to the Practitioner.

7.7.1 If the Practitioner's appointment or clinical privileges are under suspension at the time the Request for Hearing is received, the Responsible Person must schedule the hearing as soon as reasonably possible and it may be held fewer than 30 days after the Notice of Hearing if the Practitioner consents.

7.7.2 The Responsible Person may schedule a hearing outside of these time limits at the request of the Practitioner. The Responsible Person is under no obligation to grant such a request but may do so if granting the request is fair to all parties.

7.7.3 Failure to commence or conclude a hearing within these time limits does not preclude the hearing from proceeding or the Board from taking final action on the Review Organization's and Hearing Panel's recommendations.

Section 7.8 Notice of Hearing. When the hearing is scheduled, the Responsible Person must provide the Practitioner with a written Notice of Hearing that includes the following:

- 7.8.1 The date, time, and place of the hearing.
- 7.8.2 The list of witnesses expected to testify at the hearing on behalf of the Review Organization.
- 7.8.3 A statement of the specific reasons for the recommended action and a list of patient record numbers and other exhibits that the Review Organization intends to introduce as evidence in the proceeding.
- 7.8.4 The names of the members of the Hearing Panel and the Presiding Officer.
- 7.8.5 A statement that the right to a hearing will be forfeited if the Practitioner fails to attend the hearing without good cause.
- 7.8.6 That the Practitioner has the following rights at the hearing:
 - (a) To be represented by an attorney or other person of the Practitioner's choice.
 - (b) To have a record made of the proceedings and to purchase a copy of the record for the cost of having it prepared.
 - (c) To call, examine, and cross-examine witnesses.
 - (d) To present evidence that the Presiding Officer determines to be relevant even if the evidence may not be admissible in a judicial proceeding.
 - (e) To submit a written statement at the close of the hearing.
 - (f) To be given a copy of the written decision and recommendation of the Hearing Panel that includes the reasons for the decision and recommendation.

Section 7.9 Appointment of a Hearing Panel. The Responsible Person must appoint a Hearing Panel of at least three members to hear and decide the case.

- 7.9.1 **Composition.** When the MEC is the Review Organization, a majority of the Panel must be members of the Active Staff. When the Board is the Review Organization, the Hearing Panel must include at least one member of the Board and one member of the Active Staff, with no more than a simple majority of the Panel belonging to either the Board or the Active Staff.
- 7.9.2 **Qualifications of Hearing Panel Members.** The Responsible Person must appoint to the Panel individuals who are impartial and capable of understanding and interpreting the evidence that is anticipated to be presented.
 - (a) If the MEC is the Review Organization, the Responsible Person must not appoint to the Panel any member of the MEC at the time the decision under review was made.

- (b) The Responsible Person must not appoint anyone to the Hearing Panel who is in direct economic competition with the Practitioner.
- (c) The Responsible Person must not appoint anyone who actively participated in the consideration of the matter under review, but no one is disqualified from being appointed to the Hearing Committee solely because the person has some knowledge of the facts of the case.
- (d) When a material portion of the question under review involves the Practitioner's clinical competence and the MEC is the Review Organization, all members of the Hearing Panel must be clinical practitioners, but they need not be clinicians in the same specialty as the Practitioner. When the Board is the Review Organization, a majority of the Panel must be clinical Practitioners.
- (e) The Responsible Person may appoint individuals who are not members of the Active Staff to the Hearing Panel.

7.9.3 Objections to Hearing Panel. A Practitioner may object to the appointment of any member of the Hearing Panel by submitting a written objection that explains the reasons for the objection to the Responsible Person within two Business Days of receiving the Notice of Hearing. The Responsible Person must respond to the objection in writing within three Business Days of receiving it. If the Responsible Person agrees with the Practitioner's objection and removes a member of the Hearing Panel, the Responsible Person must appoint a replacement and promptly notify the Practitioner.

Section 7.10 Presiding officer. The Responsible Person must appoint a Presiding Officer to oversee the overall conduct of the hearing process.

7.10.1 Appointment. The Responsible Person may designate one of the members of the Hearing Panel as Presiding Officer, or may appoint an attorney or other person experienced in due process and conducting proceedings to serve as Presiding Officer. An attorney appointed as Presiding Officer may be engaged by and paid for by the Hospital but does not represent the Hospital, the MEC, or the Board in the hearing.

7.10.2 Duties and prerogatives. The Presiding Officer has the following duties and prerogatives:

- (1) Manage the administrative details of arranging and preparing for and conducting the hearing on behalf of the Hearing Committee. The Medical Hospital may provide administrative assistance to the Presiding Officer in performing these tasks.
- (2) Maintain decorum and ensure that all participants have a fair opportunity to present relevant evidence at the hearing.
- (3) Determine the order of presentation of evidence during the hearing and rule on matters of law, interpretation of the Medical Staff Bylaws and other governing documents, questions of procedure, and admissibility of evidence.

- (4) Prohibit undue delay, expense, or embarrassment in the conduct of the hearing.
- (5) Protect the confidentiality of evidence and testimony.
- (6) Supply additional rules of procedure that are not specifically addressed by this Policy as necessary to provide a fair and efficient hearing.

Section 7.11 Pre-hearing procedures.

7.11.1 **Practitioner's evidence.** The Practitioner must provide the Review Organization with a list of witnesses the Practitioner intends to call and copies of documentary exhibits the Practitioner intends to present no later than 10 Business Days before the hearing, or at another time as determined by the Presiding Officer. The Practitioner must supplement this information as necessary.

7.11.2 **Supplementing information.** Each party must promptly supplement its witness and exhibit lists if the party adds to or eliminates a witness or exhibit.

7.11.3 **No general right to discovery.** Other than a right to notice of the identity of witnesses and access to documentary evidence the other party intends to introduce at the hearing, neither party has a general right discovery of information or documents from the other party.

- (a) Upon request, the Presiding Officer may order disclosure of documents not already disclosed if necessary to ensure a reasonable, fair, and efficient hearing, provided that satisfactory safeguards are imposed to prevent further disclosure of peer review, protected health, and other confidential information.
- (b) The Presiding Officer must not order disclosure of information regarding any other Practitioner or evidence unrelated to the reasons for the specific recommendation under review.
- (c) The Presiding Officer may require that all disclosures be made by a date set by the Presiding Officer or agreed to by the Parties.

7.11.4 **Pre-hearing conference.** The Presiding Officer may require the parties or the parties' attorneys to attend a pre-hearing conference to discuss the conduct of the hearing and resolve all procedural questions, including objections to exhibits or witnesses and to determine the time allotted to each witness' testimony and cross examination. The pre-hearing conference may be held in person, by telephone, or by any other means approved by the Presiding Officer.

Section 7.12 Representation by counsel. The Review Organization may be represented by counsel provided by the Hospital and may designate one of its members to act on the organization's behalf during the hearing. The Practitioner may be represented by counsel at all stages of the proceeding after the Notice of Action at the Practitioner's expense. If represented by counsel, all communication by a party to the Presiding Officer, the Hearing Panel, or the other party must be through the party's counsel.

Section 7.13 Conduct of the hearing.

- 7.13.1 **Burden of production and proof.** The Review Organization bears the initial burden of producing evidence at the hearing which, if not refuted, would constitute sufficient grounds to sustain the decision under review. If the Review Organization satisfies this burden, the burden shifts to the Practitioner to prove by clear and convincing evidence that the adverse recommendation or action (1) lacks any substantial factual basis or (2) is arbitrary or capricious. If the Practitioner does not meet this burden, the Hearing Panel must recommend that the action be forwarded to the Board for final action in accord with the Review Organization's recommendation.
- 7.13.2 **Attendance by the Practitioner.** The Practitioner must attend the hearing unless excused for good cause by the Presiding Officer. If the Practitioner is not present when the hearing is scheduled to begin without good cause, or if the Practitioner leaves the hearing without good cause before it is over, the Presiding Officer must terminate the hearing and announce that the Practitioner has by absence waived the right to a hearing.
- 7.13.3 **Record of the hearing.** The Review Organization must arrange and pay for someone to make a written, verbatim record of the hearing. The record may be made by a court reporter, an electronic recording of the hearing with subsequent transcription, or other means of reliably preserving and transcribing the testimony. The Practitioner has the right to purchase a copy of the record from the court reporter or Review Organization by paying the cost of having it prepared.
- 7.13.4 **Witnesses.** The Practitioner and the Review Organization have the right to call, examine, and cross-examine witnesses, subject to reasonable limitations imposed by the Presiding Officer. The Hearing Panel has the discretion to require witnesses to testify under oath or affirmation of the truth of their testimony.
- (a) **Practitioner as witness.** If the Practitioner does not testify on his or her own behalf, the Review Organization may call the Practitioner as a witness and examine the Practitioner as if under cross examination. If the Practitioner refuses to testify, the Hearing Panel may terminate the hearing and deem the Practitioner to have waived his or her right to a hearing.
 - (b) **Hearing panel witnesses.** The Hearing Panel may call any witness it deems necessary, even if not listed or called by a party, and may examine or cross-examine any witness.
 - (c) **Remote testimony.** The Hearing Panel may in its discretion permit any witness other than the Practitioner to testify by telephone, video conference, or other means.
- 7.13.5 **Evidence.** The Presiding Officer must admit only evidence and testimony relevant to contested issues of fact or law in the hearing and helpful to the Hearing Panel. The Presiding Officer must not refuse to admit any evidence upon which a professional customarily relies in the conduct of his or her profession solely because the evidence is inadmissible under the rules of evidence applicable to judicial proceedings. However, the

Presiding Officer must not admit evidence that is irrelevant, cumulative, duplicative, speculative, or otherwise not helpful to the Hearing Panel's consideration of the contested issues.

- (a) **Official notice.** On its own initiative or upon the suggestion of any party, the Hearing Panel may take official notice, before or after the matter is submitted for decision, of generally accepted technical or scientific matters relating to the issues under consideration, and on any facts that may be judicially noticed by a court in Wisconsin, even if no affirmative evidence of the fact was introduced at the hearing.
 - (1) If official notice is taken at the hearing, the parties must be informed of the facts to be noticed and the facts must be noted in the record. Any party may present evidence to refute any officially noticed fact, orally or by presentation of written authority. The Hearing Panel must then determine whether the officially noticed fact has been refuted or not.
 - (2) If official notice is taken after the hearing is concluded, facts officially noticed must be noted in the Hearing Panel's report. The Practitioner may offer a written objection to any officially noticed fact to the Board by submitting an appeal of the Hearing Panel's report to the Board under section 7.15.
- (b) **Evidence considered in credentialing decision admissible.** The Hearing Panel may consider all information that the Medical Staff Bylaws or other Governing Documents permit to be considered in connection with an application for appointment or reappointment to the Medical Staff and for clinical privileges.

7.13.6 **Recesses.** The Presiding Officer or the Hearing Panel may recess the hearing and reconvene it for the convenience of the parties or the Panel, or for the purpose of obtaining new or additional evidence.

7.13.7 **Record closed; concluding statement.** At the conclusion of the presentation of oral and written evidence, the evidentiary record is closed. The Practitioner and Review Organization have the right to submit a written statement at the close of the hearing or shortly after the close of the hearing advocating for or against the Review Organization's action, but may not submit new evidence without the consent of the Hearing Panel. Either party may waive submission of a written statement.

Section 7.14 Deliberations. At the conclusion of the hearing, the Hearing Panel must, at a time and place convenient to itself, meet to deliberate outside the presence of the parties.

7.14.1 **May begin deliberations before final statement.** The Panel need not wait to receive the parties' written concluding statements before beginning deliberation, but must not make a final decision until it receives and considers the concluding statements.

7.14.2 **Deliberations need not be in person.** The Panel may deliberate in person or by any other means by which all Panel members are able to participate simultaneously.

7.14.3 **Role of Presiding Officer.** If the Presiding Officer is an attorney or other person who is not a member of the Hearing Panel, the Presiding Officer may advise the Hearing Panel, participate in its deliberations, and assist the Hearing Panel in writing its final report, but has no vote on the outcome of the matter. A Presiding Officer who is a member of the Hearing Panel may vote on the outcome.

7.14.4 **Majority required to reverse.** At the conclusion of its deliberations, the Hearing Panel must vote on whether the Practitioner has met the burden of proof to reverse the Review Organization's proposed action. The proposed action is affirmed unless a majority of the Hearing Panel votes to reverse it.

Section 7.15 Report. The Hearing Panel must prepare a written report and recommendation summarizing its findings of facts and stating conclusions and recommendations agreed to by a majority of the Panel. The Panel must support facts recited in its report by citation to the record. Each panel member must sign the report and indicate whether he or she agrees with the report's conclusions. A Panel member who dissents from the majority report may prepare a minority report. The Panel must forward the majority's report, the minority's report (if any), the transcript, and all documentary evidence admitted at the hearing to the Responsible Person.

Section 7.16 Communication of decision; appeal; final action. The Responsible Person must promptly submit the Panel's Report and the record of the hearing to the Board, with a copy of the Report to the MEC and the Practitioner. The Responsible Person must also notify the Practitioner in writing of the Practitioner's right to appeal the Hearing Panel's recommendation as provided in section 7.14.1.

Section 7.17 Appeal of Hearing Panel's decision. Either party may appeal a decision of the Hearing Panel adverse to that party by submitting to the Chair of the Board or the Chair's designee and to the other party a written notice of intention to appeal within three Business Days of receiving the report.

- (a) The appellant must submit a written argument to the Board and the other party no later than ten Business Days of receiving the Hearing Panel's report, and the other party must submit its written response, if any, within five Business Days of receiving the appellant's written argument.
- (b) The appeal must be based on the hearing record and must not include evidence not offered to the Hearing Panel.
- (c) The only issue in the appeal is whether the Hearing Panel's recommendation and report lacks any substantial factual basis or is arbitrary or capricious.

Section 7.18 Board's action. The Board or a committee of the Board to which the Board has delegated authority to act on its behalf must consider the Review Organization's recommended action, the Hearing Panel's report(s), and any party's appeal or response, if any, and take final action within 30 days of receiving the last of these.

7.18.1 **Appearance before the Board.** The Board may, but is not required to, offer either or both parties an opportunity to appear personally before the Board or any subcommittee of the Board to explain the appeal and response and to answer any questions the Board members may have.

7.18.2 **Board's final action.** The Board may take any action on the Hearing Panel's recommendation that it could have taken had a hearing not been held, including affirming, denying, or modifying the recommendation. Any such action is final.

7.18.3 **Non-final action.** The Board may decline to take final action and refer the matter back to the Hearing Panel with specific instructions for further fact-finding, clarification or deliberation.

Section 7.19 Notice of Board's action. The Board must notify the Practitioner, the Hearing Panel, and the MEC in writing of any action it takes on the Hearing Panel's recommendation.

Section 7.20 Only one hearing. Notwithstanding any other provision of these Bylaws or any other Governing Document, a Practitioner is entitled as a right to no more than one evidentiary hearing with respect to an adverse recommendation or proposed action.

Section 7.21 Reports of final professional review actions. The Hospital will make any reports of final adverse professional review actions to the National Practitioner Data Bank, the Wisconsin Medical Examining Board, and any other organization, as required by law.

Article 8 GOVERNING AND OPERATIONAL DOCUMENTS; AMENDMENTS

Section 8.1 The Medical Staff may propose and adopt documents to assist it in carrying out its duties as provided in this Article.

8.1.1 **Governing Documents.** The Governing Documents of the Medical Staff are these Bylaws. The Medical Staff may propose, and the Board may approve, additional Governing Documents. Governing Documents must be promulgated and amended as provided in this section 9.1.1 and are effective only when approved by the Board.

8.1.2 **Review of Governing Documents.** The Medical Staff must review Governing Documents at least every two years and recommend to the Board any new Governing Documents or amendments that it finds necessary or advisable. The COS may appoint an ad hoc committee to conduct this review.

8.1.3 **Amendments to Governing Documents.** The Medical Staff grants the MEC the authority to propose and recommend new Governing Documents or amendments to Governing Documents to the Board as provided in this section.

8.1.4 **Notice by MEC of proposed amendment; request for a vote.** The COS must provide written notice to the Medical Staff of the MEC's intention to recommend that the Board

adopt a new Governing Document or an amendment to a Governing Document. The notice must be given at least 7 days before submitting the proposal to the Board.

(a) If, before the expiration of notice period, the COS receives a written petition signed by five or more members of the Active Staff asking for a vote by the Medical Staff on the proposed amendment, the MEC must arrange for a vote on the proposed amendment before the proposal is presented to the Board. The proposed amendment will be deemed approved by the Medical Staff unless a majority of the entire Active Staff votes against it.

(b) If no petition signed by the required number of members is filed during the notice period, the MEC's proposed amendment will be deemed approved by the Medical Staff and forwarded to the Board for final action. The amendment is not effective until approved by the Board.

8.1.5 Amendments proposed by Active Staff. Any member of the Active Staff may propose an amendment to a Governing Document directly to the MEC by presenting a proposed amendment to the MEC in writing.

(a) If the MEC approves the amendment, either as originally proposed or as modified by the MEC, the proposed amendment must be forwarded to the Board for approval in accord with the section 8.1.3.

(b) If the MEC does not approve the proposed amendment, five or more members of the Active Staff may call a special meeting of the Medical Staff to vote on recommending the proposed amendment to the Board. If a meeting is called and a majority of the entire Active Staff votes in favor of the proposed amendment, it must be forwarded to the Board for its consideration with a recommendation of approval.

8.1.6 Special procedure for regulatory amendments. Notwithstanding any previous section of this Article, the MEC may submit a proposed amendment of any Governing Document other than these Bylaws to the Board without providing prior notice to the Medical Staff when the amendment is required by law, regulation, or other authority and it is not practical to provide notice and the opportunity for a vote by the Medical Staff before forwarding the amendment to the Board. In such a case, the MEC may submit the proposed amendment to the Board and notify the Medical Staff as soon as practicable. If the Board approves and adopts the amendment, it is effective. Any member of the Active Staff who opposes the amendment may subsequently propose to repeal or amend the amendment under the procedures in this Article.

8.1.7 Operational Documents. The Medical Staff delegates to the MEC the authority to enact Operational Documents.

(a) Operational Documents include rules, regulations, policies, procedures, guidelines, protocols, and other documents, however named, adopted by the Medical Staff that apply to the Medical Staff and Practitioners and are not Governing Documents.

- (b) Operational Documents become effective upon approval of the MEC and do not require Board approval unless Board approval is required by law, regulation, or accrediting standards.
- (c) The MEC must provide at least 7 days written notice to the Medical Staff of its intention to consider adopting or amending an Operational Document. Any member of the Active Staff, and any Practitioner directly affected by the proposal, may submit written comments or objections to the proposed adoption or amendment to MEC prior to its decision on the proposal. The MEC must consider any such comments or objections before adopting an Operational Document or amendment to an Operational Document.
- (d) Notwithstanding the previous paragraph, the MEC may adopt an amendment to an Operating Document without providing prior notice to the Medical Staff when the amendment is required by law, regulation, or other authority and it is not practical to provide notice and the opportunity for a vote by the Medical Staff. In such a case, the MEC may adopt the amendment, effective upon adoption, and must notify the Medical Staff as soon as practicable of the amendment. Any member of the Active Staff who opposes the amendment may subsequently propose to repeal or amend the amendment under the procedures under section A.2 of this Article. An amendment adopted by the MEC under this paragraph remains effective until changed.

Article 9 GOVERNING PROVISIONS

9.1.1 Definitions and acronyms

“Adverse Licensing Action” means any of the following when the reason for the action is related to the Practitioner’s professional competence or conduct:

- (a) Any unfavorable action taken by a governmental licensing agency against a Practitioner’s professional license or certificate, including denial, nonrenewal, revocation, suspension, conditioning, limitation, or imposition of probation or supervision; or
- (b) Voluntary relinquishment of a license or certificate in lieu of Adverse Licensing Action; or
- (c) Voluntary relinquishment of a license while under an investigation that could lead to Adverse Licensing Action; or
- (d) Any limitation or condition on a license pursuant to a stipulation or agreement between the Practitioner and the licensing agency.

“Board” means the Board of Directors of Westfields Hospital.

“Business day” means any day other than a Saturday, Sunday, or holiday recognized by the Hospital.

“**Day**” means a calendar day.

“**CEO**” means the Chief Executive Officer of the Hospital.

“**COS**” means the Chief of Staff.

“**COS-E**” means the Chief of Staff – Elect.

“**COS-P**” means the Chief of Staff-Past.

“**Disciplinary Action**” means any action taken by a Health Care Organization to deny or limit the Practitioner’s membership or participation in the organization – including the exercise of clinical privileges – when the reason for the action is related to the Practitioner’s professional competence or conduct. Disciplinary Action includes the following:

(a) Termination, revocation, suspension, conditioning, or imposition of probation or supervision; or

(b) Voluntary resignation or separation in lieu of other Disciplinary Action or while under investigation that could lead to Disciplinary Action.

“**FPPE**” means Focused Professional Practice Evaluation.

“**Governing Document(s)**” means document adopted by the MEC and approved by the Board that relate to the governance of the Medical Staff and are listed in Article 8.

“**Health Care Organization**” means an organization engaged in providing, financing, improving, supervising, evaluating, or other activity related to health care. The term includes a hospital, clinic, organized Medical Staff, medical group, health maintenance organization, health insurer or other third-party payor, medical or other professional organization, peer review organization, and specialty board.

“**Hospital**” means Westfields Hospital.

“**MEC**” means the Medical Executive Committee.

“**OPPE**” means Ongoing Professional Practice Evaluation.

“**Operational Documents**” means any document, however denominated, that is adopted by the Medical Staff pursuant to a Governing Document and applies to the Medical Staff and Practitioners.

“**Physician**” means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, and a doctor of podiatric medicine who is licensed to practice in Wisconsin.

“**Practitioner**” means a person who has or has applied for (a) appointment or reappointment to the Medical Staff or (b) new or expanded clinical privileges through the Medical Staff credentialing and privileging process described in Article 4.

Professional Review Action means an action or recommendation of the Medical Staff or Hospital (a) taken in the course of Professional Review Activity; (b) is based on the professional competence or professional conduct of a Practitioner that affects or could adversely affect the health or welfare of a patient or patients; and (c) that adversely affects or may adversely affect the clinical privileges of the Practitioner.

Professional Review Activity means the activity of the Medical Staff to (a) determine whether to grant clinical privileges or Medical Staff Membership to a Practitioner; (b) determine the scope or conditions of such privileges or membership; or (c) to change or modify such privileges or membership.

“VPMA” means the Vice President for Medical Affairs of the Hospital.

9.1.2 **General Governing Provisions.** The following apply to the interpretation and application of Governing Documents.

9.1.3 **Interpretation.** The provisions of Governing Documents must be interpreted and applied in a manner that furthers the practical purpose of the provisions and which favors substance over form.

9.1.4 **Including.** The word “including” or “includes” means “including but not limited to.”

9.1.5 **Conflicts between documents.** Any purported discrepancy or conflict between the Bylaws and any other Governing or Operational Document must be resolved by giving effect to both documents as far as possible. If not possible, then a Governing Document must be interpreted in light of the Bylaws and an Operating Document must be interpreted in light of Governing Documents.

9.1.6 **Delegation of duties.** Unless specified otherwise, whenever a duty is assigned to an individual, the duty may be performed by that individual’s designee.

9.1.7 **Vote needed to take action.** Unless specified otherwise, whenever a Governing Document refers to a body or group of individuals taking some action by vote, it means a majority of those present and voting or, in the case of a vote by written ballot, a majority of the ballots cast.

9.1.8 **Time limits.** Any time limit referred to in these Bylaws or any other Governing Document is advisory only and not mandatory unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

9.1.9 **Consistency with Hospital bylaws.** These Bylaws, other Governing Documents, and Operational Document must be interpreted consistent with the Hospital’s Bylaws and policies as adopted by the Board.

APPROVED BY:

Medical Executive Committee: March 15, 2017

Medical Staff: April 4, 2017

Board of Directors: July 25, 2017