

MEDICAL STAFF BYLAWS
OF THE
UNIVERSITY OF ILLINOIS
HOSPITAL AND HEALTH SCIENCES SYSTEM

[November 16, 2017, pending approval by The Board of Trustees]

**MEDICAL STAFF BYLAWS OF THE
UNIVERSITY OF ILLINOIS HOSPITAL AND HEALTH SCIENCES SYSTEM**

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DEFINITIONS

Titles and corresponding functions or definitions current at time of latest amendment to this Section are given below. If through future changes in titles or table or organization there is a change in title corresponding to a particular function or definition, the new title should be substituted for the old in interpretation of these Bylaws. Such changes could conceivably collapse two positions into one.

Governing Body or GB – The Board of Trustees of the University of Illinois

President of the University – Chief Executive Officer of the University of Illinois.

Hospital Chief Executive Officer or Hospital CEO or successor position – that line officer reporting to the Vice Chancellor for Health Affairs of the University of Illinois at Chicago and most senior officer of the Hospital.

Chief Medical Officer or CMO – that line officer, a physician, who reports to the Hospital CEO, and to whom Associate Medical Officers and Chiefs of Clinical Services are responsible relative to the delivery of professional care to patients.

Associate Chief Medical Officer – that line officer, a physician, reporting to the Chief Medical Officer.

Chief of Clinical Services – that line officer, a physician or dentist who is responsible for the delivery of healthcare in a clinical service, such services ordinarily corresponding organizationally to academic departments in a college or school which uses these clinical facilities.

Medical Staff year – The academic year, which is August 16 to August 15 of the following year.

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

Patient Safety Work Product (“PSWP”) – Any data, reports, records, memoranda, analyses, including root cause analyses, or oral or written statements which are assembled or developed by or on behalf of the Hospital for reporting to a patient safety organization or are

developed by a patient safety organization for the conduct of patient safety activities and which could result in improved patient safety, healthcare quality or healthcare outcomes or which identify the fact of reporting to a patient safety organization.

Peer Review – Any and all activities and conduct which involve efforts to reduce morbidity and mortality, improve patient care or engage in professional discipline. These activities and conduct include, but are not limited to: the evaluation of medical care, the making of recommendations for credentialing and delineation of privileges for physicians or allied health professionals (“AHPs”) seeking or holding such clinical privileges at the Hospital addressing the quality of care provided to patients, the evaluation of appointment and reappointment applications and qualifications of physicians, licensed independent professionals (“LIPs”), residents or AHPs, the evaluations of complaints, incidents and other similar communications filed against Members of the Medical Staff and others granted clinical privileges. They also include the receipt, review, analysis, acting on and issuance of incident reports, quality and utilization review functions, and other functions and activities related thereto or referenced or described in any peer review policy, as may be performed by the Medical Staff or the Governing Body directly or on their behalf and by those assisting the Medical Staff and GB in its peer review activities and conduct including, without limitation, employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other person or organization who assist in performing Peer Review functions, conduct or activities.

Peer Review Committee – A Committee, Section, Division, Department of the Medical Staff or the Governing Body as well as the Medical Staff and the Governing Body as a whole that participates in any peer review function, conduct or activity as defined in these Bylaws. Included are those serving as members of a peer review committee or their employees, designees, representatives, agents, attorneys, consultants, investigators, experts, assistants, clerks, staff and any other person or organization, whether internal or external, who assist the peer review committee in performing its peer review functions, conduct or activities. All reports, studies, analyses, recommendations, and other similar communications which are authorized, requested or reviewed by a peer review committee or persons acting on behalf of a peer review committee shall be treated as strictly confidential and not subject to discovery nor admissible as evidence consistent with those protections afforded under the Illinois Medical Studies Act. If a peer review committee deems appropriate, it may seek assistance from other peer review committees or other committees or individual inside or outside the Hospital. As an example, a peer review committee shall include, without limitation: the Medical Executive Committee, all Clinical Services, the Credentials Committee, the Committee on Infection Control, the committee on Pharmacy and Therapeutics, the Committee on Emergency Cardiac Care, the Governing Body and all other committees when performing peer review functions, conduct or activities.

Investigation – For purposes of these Bylaws and with respect to reporting requirements to the National Practitioner Data Bank, an Investigation does not commence until such time as a recommendation for Remedial Action is submitted in accordance with ARTICLE VII, Section 3 of the Bylaws.

INTRODUCTION

The University of Illinois is governed by The Board of Trustees of the University which is appointed by the Governor of the State of Illinois. The Governing Body upholds the Medical Staff bylaws, rules and regulations, and policies that have been approved by the Governing Body. The President of the University is responsible for the administration of the University within the lines of general policy approved by The Board of Trustees and submits to The Board of Trustees such matters as require their authority for accomplishment. The President delegates the responsibilities for administering the activities of the University of Illinois at Chicago to the Chancellor of the University of Illinois at Chicago. The Chancellor delegates the responsibilities for administering the activities of the University of Illinois Hospital and Health Sciences System and clinical enterprise to the Vice Chancellor for Health Affairs, who delegates the responsibilities for administering the University of Illinois Hospital to the Hospital CEO or successor position. The Hospital CEO or successor position is therefore responsible for all health care activities within the University of Illinois Hospital.

The Chief Medical Officer reports to the Hospital CEO or successor position and is responsible for all medical aspects of patient care in the Hospital. The Chief Medical Officer is nominated by the Hospital CEO with approval by the Executive Committee of the Medical Staff to the Board of Trustees, which is responsible for his/her appointment.

The Organized Medical Staff recognizes the need to operate within this administrative framework in attempting to fulfill its objectives under these Bylaws.

PREAMBLE

The University of Illinois Hospital strives to deliver exemplary and efficient care to its patients and to provide an appropriate setting for education, training, and research in the Health Professions. Recognizing their unique role in the achievement of such hospital objectives, and believing that cooperative efforts will facilitate such achievement, the Members of the Medical Staff of this Hospital hereby organize themselves in conformity with the following Bylaws in order to define its role within the context of its responsibilities in the oversight of care, treatment and services, subject to the ultimate authority and responsibilities of The Board of Trustees of the University.

**ARTICLE I.
NAME**

The name of this organization shall be the Medical Staff of the University of Illinois Hospital and Health Sciences System.

**ARTICLE II.
PURPOSE**

The purpose of the Medical Staff organization is:

- 1) To provide a mechanism by which the Medical Staff may promulgate rules and regulations for governing itself, and reports to and is accountable to the GB.
- 2) To provide a statement of the rights and privileges of the Medical Staff and to provide mechanisms through which these rights and privileges may be exercised.
- 3) To provide a formal mechanism through which the Medical Staff may advise administration on matters affecting patient care and vice versa.
- 4) To enforce the Medical Staff bylaws, rules and regulations, and policies by recommending action to the Governing Body in certain circumstances, and taking action in others.

**ARTICLE III.
PATIENTS**

The care and treatment of individual patients are the responsibility of the physician or dentist of the Medical Staff to whose service the patient is assigned. All patients admitted to the University of Illinois Hospital and Health Science System shall be encouraged to participate in the teaching programs of the University of Illinois Hospital.

**SECTION 1.
PERFORMANCE OF THE HISTORY AND PHYSICAL**

A patient's history and physical examination (H&P) are performed by:

- A. a physician, or
- B. a practitioner who is credentialed and privileged in accordance with applicable laws, policies and procedures and these Medical Staff Bylaws.

Each patient admitted for inpatient care, or to an inpatient unit for 23-Hour Observation, has a medical history taken and an appropriate physical examination performed and documented within 24 hours after admission to the unit. If a history and a physical examination have been performed and documented within 30 days before admission, this H&P is still relevant provided

that the patient condition has been reassessed and documented as the same or with relevant changes within 24 hours of the inpatient admission.

A history and physical examination is required for all patients who undergo invasive procedures or who will receive moderate sedation or anesthesia in any Hospital location. This includes procedures performed in clinic practice sites. Practitioners must complete and document the H&P prior to the procedure. When an H&P has been performed and documented within 30 days prior to the procedure, the patient must be re-examined, and the practitioner will sign a note indicating that they “have reviewed the H&P performed within the last 30 days, examined the patient, and found no changes unless otherwise noted.” The note will be signed, dated, and timed by the practitioner.

The content of a history and physical exam will vary based on the needs of the patient, but in most circumstances (excluding emergencies), the H&P will include:

- I. Inpatient Admission/23-Hour Observation
 - A. History:
 - Chief complaint/Present illness
 - When appropriate, relevant past, social, and family history
 - B. Physical Exam:
 - Cardiopulmonary examination and examination of relevant body systems and any relevant findings
- II. Procedures Involving Moderate Sedation OR Anesthesia (in all settings)
 - A. History:
 - Chief complaint/Present illness
 - When appropriate, relevant past, social, and family history
 - B. Physical Exam:
 - Weight
 - Cardiopulmonary examination and examination of relevant body systems and any relevant findings (Note: the cardiopulmonary exam may be performed by the anesthesiologist prior to the procedure)
- III. Invasive Procedures Without Sedation But Requiring Informed Consent
 - A. History:
 - Chief complaint/Present illness
 - B. Physical Exam:
 - Examination of relevant body system(s) and relevant findings

Exceptions to a History and Physical examination being performed or an H&P being completed within a 30-day timeframe include:

- I. In emergency surgical situations.
- II. Outpatient clinic visits without procedures (i.e.: routine follow-up visits, preventive health vaccinations, etc.).
- III. Ongoing outpatient renal dialysis treatments for patients who had a history and physical exam on their initial visit.
- IV. Other situations as defined in clinic/unit protocols.

SECTION 2. MEDICAL SCREENING EXAMINATION

The following are “Qualified Medical Persons” who are authorized to perform Medical Screening Examinations consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA), found at 42 U.S.C.§1395dd of the Social Security Act and regulations promulgated thereunder:

- A. Doctor of medicine or osteopathy;
- B. Certified nurse midwife who is a Staff Affiliate with Clinical Privileges that include obstetrical care; and
- C. Advance practice registered nurse or physician assistant who is a Staff Affiliate With Clinical Privileges.

A Medical Screening Examination is a process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist. Depending on the patient’s presenting symptoms, the medical screening examination represents a spectrum ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as, but not limited to lumbar punctures, clinical laboratory tests, CT scans, and/or diagnostic tests and procedures.

ARTICLE IV. MEMBERSHIP

SECTION 1. GENERAL QUALIFICATIONS

- A. Unless otherwise provided herein, in order to qualify for and remain as a Member of the Medical Staff, a practitioner must be a physician, dentist or podiatrist possessing demonstrated skills, knowledge, and experience in his/her chosen specialty; abiding by generally recognized and ethical standards of his/her profession; licensed by the Illinois Department of Financial and Professional Regulation (IDFPR); and, effective December 31, 2016, obtain and maintain certification in Basic Life Support (BLS). (See ARTICLE IV, Section 4 for information on Affiliate Categories of Membership).

- B. Except as specifically otherwise provided herein, each Member must have an appointment to the faculty of one of the health science colleges of the University of Illinois at Chicago.
- C. No applicant or Member of the Medical Staff may be denied membership in the Medical Staff or any privileges resulting therefrom on the basis of race, color, sex, religion, national origin, ancestry, age, marital status, sexual orientation including gender identity, unfavorable discharge from the military or status as a protected or disabled veteran, disability or handicap not related to ability to perform or other legally protected status, and will comply with all Federal and State nondiscrimination, equal opportunity and affirmative action laws, orders, and regulations.
- D. No Member of this staff may receive from, or pay to, another physician, dentist, or staff member any part of a fee received for professional services.
- E. Any Member of the Medical Staff will promptly notify the Chief Medical Officer of the revocation or suspension of his/her professional license, or the imposition of terms of probation or limitation of practice, by any State, or of his/her loss of staff membership or loss or restriction of privileges at any hospital or other healthcare institution, or of the commencement of a formal investigation, or the filing of charges, by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or Illinois or the loss or reduction of professional liability coverage within five (5) days from the receipt of notification to a Member of any of these actions.
- F. Any Member of the Medical Staff engaged in private practice at an institution outside of the University of Illinois Hospital and Health Sciences System will provide evidence of professional liability coverage with limits that are acceptable to the University. The Member shall submit a Certificate of Insurance and any accompanying endorsements which address the extent or any limitations on coverages.
- G. No Member, eligible by their category to vote or hold office, will be allowed to vote or hold office until they have been a Member of the Medical Staff for one year.
- H. Each applicant must consent to an inspection of all records and documents pertinent to his/her application for Medical Staff membership and agree to appear for an interview if requested.
- I. Any qualifications, requirements, or limitations in this ARTICLE or any other article of these bylaws not required by law or governmental regulation, may be waived at the discretion of the Medical Staff Executive Committee, upon determination that such waiver will serve the best interests of the patient and of the Hospital and subject to final Governing Body review and approval.

SECTION 2. MEDICAL STAFF DUES

- A. All Active, Visiting and Contract Medical Staff Members shall pay medical staff dues, payable each January 1st. Nonpayment by September 1st may result in the suspension of medical staff appointment.
- B. At the Annual Meeting of the Medical Staff, the Secretary/Treasurer of the Medical Staff will present an annual budget for approval. A financial report listing expenditures for the previous year will be included. The Secretary/Treasurer may authorize expenditures as outlined in the annual budget as well as unbudgeted single expenditures of an amount up to \$5,000.00 with Medical Staff President and Vice President co-signatures. All other expenditures require Executive Committee approval.
- C. Increases in the annual amount of dues will be determined by the Medical Staff Executive Committee on a biennial basis and submitted to the General Medical Staff at its next regularly scheduled meeting.

SECTION 3. CATEGORIES OF MEMBERSHIP

Unless otherwise stated, membership in the Medical Staff shall be granted and renewed pursuant to procedures as provided in ARTICLE V below. The following classes of membership may be granted:

- A. Active Medical Staff
 - 1. Physicians, dentists, or podiatrists who hold a faculty appointment of 50 percent or more time in the College of Medicine or College of Dentistry, University of Illinois at Chicago, or with the discretion of the Credentials Committee an appointment with a school or college of the University of Illinois or whose combined time at the University of Illinois Hospital and other closely affiliated patient care institutions is 50 percent time or more, are eligible for appointment to the Active Medical Staff. Physicians or dentists spending less than 50 percent time, but with major clinical responsibilities, may be nominated for Active Membership by the appropriate Chief of Clinical Service. A separate letter of nomination is required.
 - 2. Active Members shall be appointed to a specific Clinical Service or Services and shall be eligible to admit and attend patients, vote, and hold office. They shall have regularly assigned duties and responsibilities and shall pay medical staff dues.
 - 3. Active Members are appointed for a period of two years.

B. Visiting Medical Staff

1. Physicians, dentists, or podiatrists who hold a faculty appointment of less than 50 percent time in the College of Medicine or College of Dentistry, University of Illinois, Chicago, or with the discretion of the Credentials Committee an appointment with a school or college of the University of Illinois are eligible for appointment to the Visiting Medical Staff, except as provided in A.1.
2. Visiting Members shall be appointed to a specific Clinical Service or Services and shall be eligible to admit and attend patients, will pay dues, shall be eligible to vote but may not hold office or serve on the Medical Staff Executive Committee. They are expected to participate in activities of the staff and of their service.
3. Except as provided in ARTICLE V below, Visiting Staff Members are appointed for a period of two years.

C. Courtesy Medical Staff

1. Physicians, dentists, or podiatrists who hold a faculty appointment of less than 50 percent time in one of the health care colleges at the University of Illinois at Chicago, are eligible for appointment to the Courtesy Medical Staff, except as provided in A.1.
2. Courtesy Members shall be appointed to a specific Clinical Service or Services and shall be eligible to follow the clinical course of their referred patients while in the University of Illinois Hospital and Health Sciences System. Specifically, for these designated patients, Courtesy Members will have access to the medical record, to view clinically relevant data (radiology, pathology, labs) and discuss care with the attending of record or his/her designee. They will restrict their access to the medical record to view those records clinically applicable to their referred patients. They will have the ability to write a note, but not to write orders. They shall not have admitting privileges, nor the authority to provide or direct patient care. This category will be exempt from paying dues, shall not be eligible to vote and may not hold office or serve on the Medical Staff Executive Committee.
3. Courtesy Staff Members are appointed for two year periods, renewable upon their request and approval of the Chief of Clinical Service for their clinical specialty, but are not otherwise subject to the appointment and reappointment process under ARTICLE V, Sections 1 and 6, respectively, of these Bylaws. A Courtesy Staff Member may be removed from membership in the Medical Staff by action of the Hospital CEO or successor position based solely

upon the recommendation of the Chief Medical Officer or President of the Medical Staff at any time. The practitioner so removed shall have no rights to a hearing, due process, or review as provided herein.

D. Teaching Medical Staff

1. This category shall consist of those physicians, dentists, or podiatrists who volunteer their clinical skills only for teaching, but do not admit patients or derive economic benefit from patient care or professional activities at the University of Illinois Hospital and Clinics. A faculty appointment in the College of Medicine or College of Dentistry at the University of Illinois, Chicago, or with the discretion of the Credentials Committee an appointment with a school or college of the University of Illinois is required.
2. Teaching Medical Staff Members may not admit patients, are exempt from Medical Staff dues, shall have no voting rights, and may not hold office. They are appointed to a specific Clinical Service or Services.
3. Teaching Medical Staff Members are appointed for two year periods, renewable upon their request and approval of the Chief of Clinical Service for their clinical specialty, but are not otherwise subject to the appointment and reappointment process under ARTICLE V, Sections 1 and 6, respectively, of these Bylaws.

E. Honorary Medical Staff

1. Physicians, dentists, or podiatrists who have retired from the Active or Visiting Staff and non-members who are honored by the Staff because of their outstanding reputation are eligible for appointment to the Honorary Medical Staff.
2. Candidates may be nominated by a Clinical Chief of Service and must be approved by the Executive Committee of the Medical Staff. Honorary Staff Members are not eligible to admit or attend patients, vote, or hold office, but they are encouraged to participate in activities of the staff and their service.
3. Honorary Medical Staff are appointed indefinitely.

F. Consulting Medical Staff

1. Duly licensed physicians, dentists, or podiatrists may be appointed to the Consulting Staff for a specific designated purpose, such as consultation. A faculty appointment is not required.

2. Consulting Staff Members are not eligible to admit patients, vote, or hold office; and can only perform those consulting functions and engage in those activities permitted by their appointment.
- G. Each appointment as a Member of the Consulting Staff shall be made for a period not to exceed three months and cannot be renewed. The practitioner so removed shall have no rights to a hearing, due process, or review as provided herein. Contract Practitioners
1. Duly licensed physicians, dentists, or podiatrists may be appointed to the Medical Staff as a contract practitioner if the individual is an employee, partner, or principal of, or in, an entity that has a contractual relationship with the Hospital, relating to providing services to patients at the Hospital.
 2. A Practitioner requesting appointment as a contract practitioner must submit a complete application.
 3. Contract practitioners are eligible to admit patients but may not vote or hold office and can only perform those functions and engage in those activities permitted by their contract.
 4. Their appointment shall terminate automatically and immediately upon the expiration or other termination of the contractual relationship with the Hospital or termination of their faculty appointment with a school or college of the University of Illinois.
 5. In the event of such a termination of staff appointment, the practitioner shall have no rights to hearing, process, or review as provided herein.

SECTION 4. AFFILIATES

- A. Resident or Fellow Affiliates
1. Physicians or dentists with appropriate professional degrees who are serving as residents or fellows with an appropriate Agreement with the “University of Illinois Hospital and Health Sciences System” and who hold licenses to practice in Illinois, if required to have such by law, are automatically considered as Resident Affiliates of the Medical Staff by virtue of such Agreement with The Board of Trustees of the University of Illinois on behalf of its College of Medicine at Chicago or College of Dentistry. The Graduate Medical Education (GME) Department of the University of Illinois confirms that the residents/trainees in the program meet, in full, the medical education and program requirements

established by the University of Illinois College of Medicine or the College of Dentistry, as appropriate, in their respective residency programs. Their credentials (diplomas, letters of reference, certificates of advanced training, all State professional licenses held prior to entry into the program or obtained during residency training, and, where applicable, DEA certification and ECFMG certification), have been reviewed and verified.

2. Appointment is for the duration of status as a resident/fellow. Provisions for termination of the Appointment are included in said Agreement.
3. Resident Affiliates have regular duties and responsibilities assigned by the Clinical Chief of Service. Clinical activities are commensurate with the Service, level of training, and individual's ability, as determined by the Clinical Chief of Service but always under supervision of a Member of the Active or Visiting Medical Staff. The conduct of Resident Affiliates is to be guided by the Rules and Regulations of the Medical Staff and in conformance with policies established by the Executive Committee.

B. Staff Affiliates

1. Limited Clinical Privileges may be granted to certain types of professionals including but not limited to Advanced Practice Nurses, Optometrists, Clinical Psychologists, Licensed Clinical Social Workers, Licensed Clinical Professional Counselors, Physician Assistants, and other qualified professionals with patient care responsibilities. At the discretion of the Credentials Committee, written standards and protocols may need to be developed for such purposes by the specific clinical services and approved by the Executive Committee.
2. In order to qualify as a Staff Affiliate, an individual must meet all of the following criteria:
 - Demonstrate ability to exercise independent judgment within the individual's area of competence, with the understanding that a Member of the Medical Staff shall exercise ultimate responsibility for patient care;
 - Demonstrate ability to participate directly in the management of patients under the general supervision or direction of a Member of the Medical Staff;

- Demonstrate ability to record reports and progress notes on patient's records and write orders as permitted by the Rules and Regulations of the Medical Staff.
3. Staff Affiliates may not vote or hold office in the Medical Staff. They shall be assigned to appropriate Clinical Services. Privileges specified for individual Staff Affiliates may be more but not less restricted than are specified in the appropriate approved general standards and protocols applying to their discipline.
 4. Appointment as a Staff Affiliate shall be for a period of two years.
 5. Unless otherwise provided in said general standards and protocols, a Staff Affiliate must hold faculty appointment with a School or College of the University of Illinois.

C. Scientific Staff Affiliates

1. Individuals not licensed to practice Medicine, Dentistry, or Podiatry in the State of Illinois, who by their academic qualifications, competence and ability, contribute to the patient care and educational goals of the Hospital may be appointed to the Scientific Staff. Each Member must have an academic appointment of at least 50 percent time on the faculty of a College or School of the University of Illinois.
2. Except as provided in ARTICLE V below, Scientific Members are appointed for a period of two years.
3. Members of the Scientific Staff shall be assigned to a Clinical Service or Services of the Hospital. They may not admit or treat patients, vote, nor hold office. Duties and responsibilities shall be assigned by the Chiefs of said Clinical Services as permitted by the scope of the Member's appointment.

SECTION 5.

CHANGES BETWEEN VISITING AND ACTIVE STAFF MEMBERSHIP

- A. A Member of the Visiting Medical Staff who becomes eligible for Active Medical Staff membership through a change in percent time commitment to patient care activities shall be granted Active Staff membership after notification of such change in commitment by the Chief of Clinical Service to the Chief Medical Officer. No additional review is required.
- B. A Member of the Active Medical Staff who, through a change in commitment, no longer fulfills the eligibility requirements for Active Staff membership but who does fulfill the eligibility requirements for Visiting

Staff membership shall be transferred to Visiting Staff membership after notification of such change in commitment by the Chief of Clinical Service to the Chief Medical Officer. The action does not require additional review and is not subject to appeal.

- C. Privileges granted, and other terms and conditions of membership will not be affected by any such change in class of membership.

ARTICLE V.

MEDICAL STAFF APPOINTMENT/REAPPOINTMENT/CLINICAL PRIVILEGES

SECTION 1.

INITIAL APPOINTMENT TO THE MEDICAL STAFF AND DELINEATION OF CLINICAL PRIVILEGES

- A. Applications for initial appointment which shall conform with the mandated application under the Illinois Data Collections Act, and any supplemental form required by the Hospital, shall be submitted to the Chief Medical Officer via the Chief in whose service the applicant will principally function. The applicant shall request the specific privileges desired on this form and shall sign an agreement to abide by the Bylaws and the Rules and Regulations of the Medical Staff. Thereafter, the Chief of Clinical Service shall maintain a departmental file on this information. The Chief of Clinical Service shall recommend approval or disapproval of the membership and privileges requested by the applicant. Whenever the applicant applies for privileges in more than one Service, the Chief of each Clinical Service wherein privileges are requested shall verify his/her qualifications for these privileges and recommend approval or disapproval of the additional privileges requested. Appropriate supporting documents should be maintained in file by such Chief of Clinical Service.
- B. The Chief Medical Officer shall transmit the application and supporting material to the Committee on Credentials for evaluation. As soon as practicable, with the goal of within 90 days after receipt of the completed application, the Credentials Committee shall make recommendations to the Executive Committee concerning membership and privileges sought.
- C. At its next regular meeting after the receipt of recommendations from the Credentials Committee, the Executive Committee shall review the recommendations and any supporting material submitted and shall make its recommendation. The Executive Committee may defer action but it must then make a final recommendation at the following regular meeting. The Chief Medical Officer shall transmit the supporting materials and recommendations to the GB or designee in accordance with the expedited process set forth in Section 7 below.

- D. The GB or designee shall determine whether, based solely on the supporting materials and/or recommendations, he/she may take favorable action on the application. An action is favorable only if the type of membership and privileges approved are no more restrictive than those requested by the applicant. If they determine that they may take favorable action, they will grant the applicant membership and privileges. If they determine that they cannot take favorable action, they shall make a preliminary finding as to what privileges and membership may be recommended, if any, in the absence of further information, citing reasons for that determination. The GB or designee will act upon the application within 60 days of receipt. An applicant not granted membership and privileges may either accept the preliminary findings or request a hearing on the application to rebut the erroneous information.
- E. The Chair of the Credentials Committee in conjunction with the Chief Medical Officer shall notify the applicant of the action taken in writing within 15 days. The notification shall include the reasons for such findings, the right to request a hearing as appropriate on the proposed action including the timeframe and the process.
- F. An applicant not granted membership and privileges as provided in D., immediately above, may either:
1. Accept the preliminary findings, and in so doing render the findings final. Membership and privileges shall be granted consistent with these final findings. An applicant shall be deemed to have accepted the preliminary finding if he/she does not request a hearing within thirty days from receipt of the preliminary findings.
 2. If entitled to an ARTICLE VIII hearing, request a hearing on the denied application. The applicant can only request a hearing if denial would require the Hospital to report the applicant to the National Practitioner Data Bank:
 - a. Within fourteen days from the receipt of a request for hearing, the Chief Medical Officer shall schedule and arrange a hearing and notify the applicant of same. In addition, the Chief Medical Officer shall provide the applicant a copy of the application reviewed by the GB or designee and the reasons provided for their determination. The hearing shall be conducted pursuant to procedures for a hearing as provided in ARTICLE VIII, Section 1, except that a Member of the Executive Committee shall present such information and witnesses as support of preliminary findings.

- b. After all parties have presented relevant information and after the panel on its own motion has obtained such additional information as it requires, the panel shall, in Executive session, recommend that favorable action be taken on the application; that another type of membership or privileges be granted; or that the applicant be denied membership or privileges or both. In any case, it must provide reasons for its recommendations. The panel must render this recommendation within seven days of the close of the final hearing session and forward same to the GB or designee.
- c. Within fourteen days after receipt of the written recommendations of the panel, the GB or designee shall review the recommendations and take final action on the request for Medical Staff membership and privileges. The GB or designee, may make any decision they deem appropriate without regard to any previous recommendations or preliminary findings. The Chief Medical Officer shall promptly notify the applicant of this final action and basis for his decision including whether based on economic factors unrelated to the practitioner's qualifications.

G. Verification of Information

Upon receipt of the application, the Credentials Committee through the Medical Staff Office shall seek to verify the applicant's references, licensure, medical, dental, podiatric or nursing school training, graduate medical education experience, current and previous hospital affiliations, current competence, work history, and other qualification evidence submitted. The National Practitioner Data Bank will also be queried as required by law. The Office of Inspector General (OIG) and System Award Management (SAM) will be queried as well. Verification of current licensure through The Joint Commission approved primary source Illinois Department of Financial and Professional Regulation (IDFPR) Internet site, or by telephone is acceptable if this verification is documented. Whenever feasible, verification should be obtained from the original source of the specific credential or previous hospital affiliation. Information from credentials verification organizations (CVOs) may also be used. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. A reliable secondary source can be another hospital that has documented primary source verification of the applicant's credentials.

The Chair of the Credentials Committee shall promptly notify the applicant of any failures in such collection or verification efforts including identification of erroneous information. Copies of any additional information secured by the Credentials Committee shall be provided to the Chief of Clinical Service

representing the service in which the applicant seeks privileges. The Credentials Committee may also conduct an interview of the applicant. The practitioner has the right, upon request, to review information submitted in support of their credentialing application and to rebut in writing any erroneous information within thirty (30) days. Documentation submitted to correct erroneous information is date stamped and included in the practitioner's file. If there is information that is obtained in any part of the Primary Source Verification process that varies from what was submitted, or is questionable in any way, the practitioner is notified and an interview may be arranged with the applicant to discuss the information further. The Chief of the Clinical Service in which the applicant seeks privileges may be invited to attend or participate.

The applicant at all times has the burden of producing any and all information requested during the appointment process. A failure to provide requested information within a reasonable period of time shall result in the withdrawal of the application from consideration. The physician will not be entitled to reapply for a twelve (12) month period from the date the application is considered withdrawn.

The applicant also shall be required to provide any updates or changes to the information provided in the application or as part of the appointment process as soon as these changes occur. A failure to provide this information in a timely basis may result in the withdrawal of the application from consideration.

If it is determined that the applicant has provided false, misleading, incomplete information which, if received, would or could have an effect on whether the Medical Staff or Hospital would have granted membership and/or all of the clinical privileges requested, the application will be denied and the applicant may be reported to the National Practitioner Data Bank. If not identified until after the applicant has been approved for membership by the GB, the physician may be subject to remedial action under ARTICLE VII of these Bylaws.

SECTION 2. MODIFICATION OF CLINICAL PRIVILEGES

A Member may request modification of his/her clinical privileges at any time. To do so, a Member shall submit the request with specific modifications requested, to the Chief Medical Officer via the Chief(s) of Clinical Service(s). The processing of such requests, including hearing appeal procedures, is the same as for initial appointments under Section 1 of this ARTICLE, except that in no case may a Member suffer a reduction in clinical privileges as a result of an application for modification in clinical privileges unless the Member requests such reduction.

SECTION 3. TEMPORARY PRIVILEGES

- A. Upon receipt of any application for Medical Staff membership, the Hospital CEO or successor position or authorized designee may, after review of the practitioner's application and with written recommendation of the Chief of the Clinical Service concerned and approval of the President of the Medical Staff and of the CMO, grant temporary admitting and/or clinical privileges to the practitioner.
- B. Three levels of approval required for temporary privileges to be granted are as follows:
- Upon recommendation of the Chief of Clinical Service or authorized designee
 - Upon recommendation of the President of the Medical Staff or authorized designee
 - Upon approval of the Hospital CEO or successor position, the Chief Medical Officer, or authorized designee of the Chief Medical Officer (CMO) in his/her absence.
- C. Temporary privileges shall be granted for a period not to exceed 120 days, and can only be renewed on a case by case basis when there is an important patient care, treatment, and service need that mandates an immediate authorization to practice, or when a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the GB while the full credentials information is verified and approved. Examples would include, but are not limited to: (1) situation where a physician becomes ill or takes a leave of absence and an LIP would need to cover his/her practice until he/she returns (2) a specific LIP has the necessary skills to provide care to a patient that an LIP currently privileged does not possess. Temporary privileges may also be granted when the new applicant for Medical Staff membership or privileges is waiting for a review and recommendation by the Medical Staff Executive Committee and approval by the GB. In this circumstance, they shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested. Special requirements of consultation and reporting may be imposed by the Chief of the Clinical Service responsible for supervision of a practitioner granted temporary privileges.
- D. Temporary privileges are granted if there is verification (which may be accomplished through a telephone call) of:
- Current Illinois licensure

- Relevant training or experience
 - Current competence
 - Ability to perform the privileges requested. Where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized Medical Staff.
 - Results of the National Practitioner Data Bank (NPDB) query have been obtained and evaluated
 - Any other criteria that may be required by the Medical Staff Bylaws
 - The applicant has submitted a completed application.
 - There are no current or previously successful challenges to licensure or registration.
 - Applicant has not been subject to involuntary termination of Medical Staff membership at another organization.
 - Applicant has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.
- E. The President of the Medical Staff or the Chief Medical Officer, after consultation with the Chief of Clinical Service, may recommend to the Hospital CEO or successor position or authorized designee that he or she terminate any or all of such practitioner's temporary privileges. The practitioner so removed shall have no rights to a hearing process or review as provided hereunder unless the decision is required to be reported to the National Practitioner Data Bank, but the regular application shall continue to be reviewed under regular application procedures.

SECTION 4. TELEMEDICINE PRIVILEGES

Telemedicine is 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.

Licensed Independent Practitioners (LIPs) who provide official readings of images, tracings, or specimens (interpretive services) through a telemedicine link are credentialed and privileged by the Hospital in the same manner as all other Medical Staff Members for those Hospital services that are provided by consultation, contractual arrangements, or other agreements as long as those decisions are made using the same credentialing and privileging process described below. The Hospital retains overall responsibility and authority for services furnished under a contract and ensures that the nature and scope of contracted services are defined in writing and meet applicable Joint Commission Standards. The Hospital evaluates the contracted care, treatment, and services to determine whether they are being provided according to the contract and the level of safety and quality that the Hospital expects.

If the Hospital has a pressing clinical need and a practitioner can supply that service through a telemedicine link, the Hospital can evaluate the use of temporary privileges for this clinical situation.

All LIPs must be licensed to practice medicine or telemedicine in Illinois and in the states where the originating sites and distant sites are located. All LIPs who have either total or shared responsibility for the patient's care, treatment, and services, (as evidenced by having the authority to write orders and direct care, treatment, and services) and diagnose or treat patients via a telemedicine link are credentialed and privileged to do so at the originating site (the site that receives the telemedicine service where the patient is located at the time the service is provided) through one of the following mechanisms:

LIPs must be fully privileged and credentialed in accordance with the standard policy and procedures of the distant site. A copy of the privileges which each LIP can exercise at the distant site shall be provided to the Hospital.

The distant site must meet the Medicare Conditions of Participation regarding governing body responsibilities concerning the Medical Staff (Section 482.12(a)(1)-(a)(2)).

The originating site must provide information to the distant site regarding the internal review of each LIP's performance that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided; and complaints about the distant site LIPs from patients, LIPs, or staff at the originating site. NOTE: This occurs in a way consistent with any Hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.

The Hospital, in turn, will provide the same information to the distant site for its LIPs who perform telemedicine services to patients at the distant site.

The Medical Staffs at both the originating and distant sites determine and recommend the clinical services that are to be provided by LIPs through a telemedicine link at their respective sites that are appropriately delivered through this medium, and are consistent with commonly accepted quality standards. Clinical privileging decisions encompass consideration of the appropriate use of telemedicine equipment by the telemedicine practitioner.

SECTION 5. EMERGENCY (DISASTER) PRIVILEGES

The organization may grant disaster privileges to volunteers eligible to be Licensed Independent Practitioners (LIPs). In a declared emergency, or in circumstances of disaster(s) in which the emergency management plan has been activated, the Chief Executive Officer or Medical Staff President or their designee(s) may grant emergency/disaster temporary privileges to a LIP not currently privileged by the institution. When the disaster (emergency management) plan has been implemented and the immediate needs of the patients cannot be met, the organization may implement a modified credentialing and privileging process for eligible volunteer LIPs.

Safeguards must be in place to assure that volunteer LIPs are competent to provide safe and adequate care, treatment, and services. Even in a disaster, the integrity of two parts of the usual credentialing and privileging process must be maintained:

1. Verification of licensure
2. Oversight of the care, treatment, and services provided

When privileges are granted, identification of the LIPs professional designation (ID Badge with credentials) must be displayed by the individual. Such designation (ID Badge) will be terminated when the emergency situation no longer exists. The individual will be assigned to an existing Member of the Medical Staff for supervision through direct observation as the mechanism to oversee the professional performance of volunteer LIPs who receive disaster privileges. Please refer to the Disaster Manual for additional information and for the procedures related to responsibilities for Non-Licensed Independent Practitioners.

The option to grant disaster privileges to volunteer LIPs is made on a case-by-case basis in accordance with the needs of the organization and its patients, and on the qualifications of its volunteer LIPs.

Volunteers considered eligible to act as LIPs in the organization must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current picture Hospital ID card that clearly identifies professional designation

OR

- A current license to practice. Primary source verification of the license is required via the Illinois Department of Financial and Professional Regulations (IDFPR) web site, which is The Joint Commission approved web site, or a documented phone call to IDFPR. NOTE: Primary source verification begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer LIP presents to the organization.

OR

- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups.

OR

- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster/emergency circumstances (such authority having been granted by a federal, state or municipal entity).

OR

- Identification by current Hospital or Medical Staff Member(s) who possesses personal knowledge regarding volunteer's ability to act as a LIP during a disaster

Any current Medical Staff Member with clinical privileges will be considered temporarily privileged to provide any type of patient care necessary as a life-saving measure, or to prevent serious harm regardless of his or her current medical staff status or clinical privileges if the care provided is within the scope of the individual's license. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer LIP presents to the organization. The Joint Commission approved web site or documented phone call to IDFPR is acceptable for license verification. A National Practitioner Data Bank (NPDB) query is also required to be completed within 72 hours from the time the volunteer LIP presents to the organization. The Medical Staff addresses the verification process as a high priority and begins the verification process of the credentials and privileges of LIPs who receive disaster privileges as soon as the immediate situation is under control. When the emergency situation no longer exists, these temporary, emergency/disaster privileges terminate. Members of the house staff, supervised as per policy and/or procedure, may provide such care within the scope of their license and qualifications.

Upon termination of an LIP's disaster privileges, the LIP will not be entitled to any fair hearing rights under ARTICLE VIII of these Bylaws.

Note: In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following: why primary source verification could not be performed in the required time frame; evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible. Primary source verification of licensure would not be required if the volunteer LIP has not provided care, treatment, and services under the disaster privileges.

SECTION 6.

REAPPOINTMENT TO THE MEDICAL STAFF AND RENEWAL OF CLINICAL PRIVILEGES

Reappointment to the Active, Visiting, and Scientific staffs are made through procedures outlined in this Section.

To be eligible for reappointment, a Member of the Medical Staff must not only continue to qualify under ARTICLES IV and V, but must continue to participate in a program of continuing education, should attend at least two meetings, or patient care conferences of the Hospital staff or his/her service each year, and must serve on at least one University of Illinois Hospital Committee if requested to do so. Standards of the Illinois Department of Financial and Professional Regulations (IDFPR) on amount and type of continuing education required for maintenance of licensure for

physicians are considered as satisfying this staff's requirements for continued Medical Staff membership. Verification of current medical licensure will thus be considered evidence of satisfactory compliance with the Medical Staff's requirement for continuing education. The application for reappointment also requires the applicant to attest to completion of CME. The applicant must sign and date the following statement "I attest to participation in continuing (medical) education activities that relate to my area of practice and agree that if requested, I will submit proof of attendance and program content." Completion of this requirement to attest to participation in CME activities is considered in the reappointment process.

Reappointment to any other staff category is accomplished by mechanisms of appointment specified in corresponding Sections of these Bylaws.

- A. Within three months prior to the Hospital's two-year scheduled reappointment time, the Chief of each Clinical Service shall submit recommendations for reappointment in that department to the Credentials Committee via the Chief Medical Officer. The GB or designee has final authority for granting, reviewing, renewing, or denying privileges. Privileges are granted for a period of up to two years. The application is not presented at the Credentials Committee until it is reviewed by the department and the Medical Staff Office staff. Included with such recommendations will be a statement that the applicant has been evaluated for physical, mental, and professional capabilities and performance, and that the Chief of Clinical Service is unaware of any contraindication of reappointment and reaffirmation of privileges. Whenever the Chief of any Clinical Service determines that, in the interest of patient care or the efficient operation of the Hospital, modification or non-renewal of clinical privileges or membership is in order, he/she shall so indicate in a separate statement to the Credentials Committee, giving reasons. The Credentials Committee shall transmit its recommendations in writing to the Executive Committee for action. The Executive Committee shall act upon those recommendations, and shall transmit its recommendations to the GB, or designee, for action.
- B. Except as stated above, the processing of requests under A above, including hearing and appeals procedures and burdens for verifying information, are the same as for corresponding initial appointments under Section 1 of this ARTICLE, except that the Executive Committee shall be deemed to have taken "favorable action" on reappointment if privileges granted are no more restrictive than those currently requested or enjoyed by the Member during the previous appointment.
- C. The Chief Medical Officer shall act in place of the Chief of Clinical Service when a Chief of Clinical Service is being thus considered.

SECTION 7.

EXPEDITED PROCESS FOR APPOINTMENT, REAPPOINTMENT AND PRIVILEGING

In the event that an applicant qualifies for an expedited appointment, reappointment, or privileging in accordance with requirements in this Section, the Executive Committee, after receiving positive recommendations from the Chief of the Clinical Service in which the applicant would be a Member, and the Chairman of the Credentials Committee, shall have the discretion of forwarding its positive recommendation to any two voting members of the University Healthcare System Committee of the Governing Body for final decision. An applicant qualifies for this expedited review if he or she meets the following standards:

- A. The applicant submits a complete and verified application which provides all necessary or required information and all primary source verification procedures have been completed.
- B. The Executive Committee makes a positive recommendation without any limitations.
- C. There are no current or previously successful challenges to the applicant's licensure or registration.
- D. The applicant has not been subject to any involuntary termination or summary suspension of Medical Staff membership or Clinical Privileges at another hospital.
- E. The applicant has not been subject to any involuntary limitation, reduction, denial or loss of membership or Clinical Privileges at the Hospital or any other hospital; and
- F. There has not been an unusual pattern or excessive number of professional liability actions resulting in a final adverse judgment entered against the applicant.

ARTICLE VI.

RESIGNATION/LEAVE OF ABSENCE

SECTION 1.

RESIGNATION AND LEAVE OF ABSENCE

The Chief(s) of Clinical Service(s) shall immediately forward to the Chief Medical Officer and Medical Staff Office, notice of faculty resignation or, upon approval, leave of absence. A leave of absence must be reported to the Executive Committee and the GB. A resignation from faculty status shall operate to terminate or, in the case of leave of absence (sabbatical excepted), to temporarily withdraw Medical Staff privileges. The next scheduled reappointment date, however, will still apply in the case of an approved leave of absence. In this case, failure to comply with the

next scheduled reappointment shall indicate the desire to voluntarily resign as of that date, and to voluntarily relinquish Medical Staff privileges.

SECTION 2.

REINSTATEMENT AFTER RESIGNATION OR LEAVE OF ABSENCE IN GOOD STANDING

- A. Unless otherwise restricted, a practitioner who has resigned shall be entitled to reinstatement to the same class of membership and the same privileges last held, provided:
1. The resignation was tendered while the practitioner was in good standing on the Medical Staff and was given no more than two years prior to the proposed date of reinstatement, and this practitioner was evaluated during their last scheduled Hospital reappointment cycle. The practitioner must also supply all relevant information related to his/her professional practice during the period of his/her absence.
 2. The resignation was not given after corrective action was recommended pursuant to ARTICLE VII, or Summary Suspension was imposed pursuant to ARTICLE VII, Section 4.
 3. The appropriate Chief(s) of Clinical Service(s) and the Chief Medical Officer approved the reinstatement in the class of membership and to the privileges previously held.
 4. The practitioner meets all qualifications for membership delineated in these Bylaws.

ARTICLE VII. REMEDIAL ACTION

SECTION 1.

COLLEGIAL INTERVENTION

- A. It is the policy of the Medical Staff leadership of the Hospital to work collegially with Medical Staff Members to assist them in delivering high quality and safe medical care, to continually improve their clinical skills, to comply with Medical Staff Bylaws and Rules and Regulations and Hospital Policies and Guidelines ("Bylaws and Policies"), and to meet all performance expectations as established from time to time by the Medical Staff. Bylaws and Policies, including those on peer review, performance improvement, conduct, and physician health describe some of the collegial interventions available to Medical Staff leaders in working with colleagues whose clinical performance or professional conduct is problematic but do not yet warrant a recommendation for remedial action as described in Section 2 below. Collegial intervention may include letters of

warning/concern, a reprimand, a notice that the Physician's conduct will be monitored for a period of time and/or that similar conduct in the future will result in remedial action. Collegial intervention shall not be considered an Investigation and shall not entitle a Member to a hearing or appeal under the fair hearing procedures set forth in this ARTICLE VIII.

SECTION 2. CAUSES FOR REMEDIAL ACTION

- A. Remedial action involving a Medical Staff or Staff Affiliate and/or privileges shall be considered for any of the following causes:
 - 1. The activities or professional conduct of any Member of the Medical Staff jeopardizes or may jeopardize the safety of a patient, the continued proper functioning of the Hospital, or the reputation of the Hospital.
 - 2. Unethical or unprofessional conduct or conduct detrimental to the Hospital or Medical Staff.
 - 3. Professional incompetence, or incapacity, including that caused by an impairing physical, psychiatric, or emotional illness.
 - 4. Failure to observe these Bylaws, the Rules and Regulations and the Hospital's policies, procedures and guidelines, including the Code of Conduct.
 - 5. Failure to carry out Medical Staff assignments, including committee or departmental assignments.

SECTION 3. PROCEDURES FOR REMEDIAL ACTION

- A. An Officer of the Medical Staff, Chief of any Clinical Service, the Chairman of any Committee of the Medical Staff, the Chief Medical Officer, an Associate Chief Medical Officer, the Hospital CEO, or a member of the GB, may recommend Remedial Action in writing as provided for in this Section including, but not limited to, those actions listed in ARTICLE VIII, Section 1(A) of these Bylaws.
- B. Such recommendation for Remedial Action shall be forwarded to the Chief Medical Officer who shall forward it to the appropriate Chief of the Clinical Service or Services wherein the Member has privileges. The Chief(s) of said Service(s) his/her own, or through an ad hoc committee appointed by the Chief(s) shall review the recommendation and, within 30 days, present findings to the Executive Committee. Such shall include a preliminary interview with the Member. The Member shall be given a

copy of the recommendation in addition to any supporting information or other materials collected as part of its review in advance of this interview.

- C. Within 30 days following the receipt of the report of the Chief of the Clinical Service, the Executive Committee shall either find that the recommendation has no substance and/or are not just cause for Remedial Action, or find that just cause for Remedial Action exists based upon the information then available. If it finds that Remedial Action is warranted, it shall recommend appropriate Remedial Action. Remedial Action may include, but it not limited to, any or all of the following: Temporary or permanent suspension of the Medical Staff or Staff Affiliate membership, temporary or permanent reduction or restriction of clinical privileges, issuance of a letter of warning, imposition of a period of probation, or establishment of a requirement for consultation.
- D. PROBATION
1. The Executive Committee of the Medical Staff may establish terms of probation up to and including forfeiture of Medical Staff appointment for violation of the terms of probation.
 2. Whenever a Staff Member is placed on probation, the Staff Member's voting and office holding prerogatives shall be automatically suspended effective upon and for at least the term of probation.
- E. If the Executive Committee determines that Remedial Action, as set forth under ARTICLE VIII, Section 1(A) is warranted, it shall immediately so inform the Member, by providing him/her with a copy of the original charges, the findings of the Chief(s) of the Clinical Service(s) and the Executive Committee recommendations for Remedial Action. The Member shall have thirty (30) days upon receipt of charges to request a hearing and other rights as provided in ARTICLE VIII. If within thirty (30) days said Member does not so request a hearing, the recommendations of the Executive Committee shall be final and shall be implemented subject to final GB review and approval. If the Member requests a hearing, the final decision concerning the recommended Remedial Action shall be made in accordance with ARTICLE VIII. Implementation of the recommendation of the Executive Committee shall be stayed pending the outcome of the hearing as provided therein.
- F. Nothing contained in this ARTICLE shall be construed as limiting or altering the power to summarily suspend any Temporary or Consulting Member nor to exercise any other authority granted to them elsewhere herein.

SECTION 4.
SUMMARY SUSPENSION

- A. Whenever continuation of a Member's practice constitutes immediate danger to the public, including patients, visitors, employees or Medical Staff Members, any two individuals including the Hospital CEO or successor position, the President of the Medical Staff, or their respective designees, or the Chief Medical Officer (which shall operate as an Emergency Action Committee), or the GB Directors, or a Committee of the GB, shall have the authority to summarily suspend all or part of the Member's privileges or Medical Staff membership. A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists. The documentation or information must be available at the time the summary suspension is made. The Chief Medical Officer shall promptly give written notice of the suspension which sets forth the grounds for the suspension to the Physician, the Hospital CEO or successor position, the Chief of the involved Clinical Service, and the President of the Medical Staff. In the event of any such suspension, the Member's patients then hospitalized shall be assigned to the Chief who will assume responsibility for the patient(s) care or may designate a substitute physician. The substitute Member shall have the right to refuse to accept such patient assignment. The wishes of the patient and family shall be considered, where feasible, in choosing a substitute physician. The Member shall be advised of his/her right to have a fair hearing under ARTICLE VIII which shall be convened within fifteen (15) days from the date the summary suspension is imposed unless the hearing date is extended by mutual agreement of the parties.
- B. Within four (4) days of the date a summary suspension is imposed, or as soon thereafter as possible, the Executive Committee shall review the suspension to recommend whether it should be affirmed, lifted, expunged, or modified. The Physician may be invited to present a statement as to why the suspension should be lifted, expunged or modified and answer any questions the Executive Committee may have. Given the exigent circumstances of a summary suspension, a quorum of the Executive Committee for purposes of a summary suspension shall consist of a least five (5) Members excluding any Member who participated in the initial decision to impose the summary suspension.
- C. A Member whose privileges or Medical Staff membership have been summarily suspended shall be entitled to a fair hearing under ARTICLE VIII. Such hearing shall be held within fifteen (15) days of imposition of the summary suspension unless the Member and the Executive Committee agree in writing to a later date or the Member waives his/her right to a fair hearing.

- D. An Executive Committee recommendation to lift, expunge or modify a summary suspension shall be reported by the Chief Medical Officer to the Vice President and to the GB on an expedited basis. The GB, or a committee of the GB, shall consider the matter within five (5) days of receipt of the recommendation. If the Executive Committee's recommendation is accepted and the GB's decision does not otherwise entitle the Member to fair hearing procedures under ARTICLE VIII, the decision will be final and notice will be provided to the Member and the Executive Committee. If the summary suspension is affirmed, or some other decision that entitles the Member to a fair hearing under ARTICLE VIII is imposed, the procedures set forth under this ARTICLE shall be followed consistent with these Bylaws.
- E. If a Member subject to a summary suspension has requested a fair hearing in accordance with ARTICLE VIII, no action need to be taken until the matter is resubmitted to the GB after the hearing. A summary suspension once imposed shall remain in effect pending final action by the GB.

SECTION 5. TERM OF SUSPENSION

Any suspension may be of definite or indefinite duration, except that a suspension of indefinite duration which is imposed or sustained pursuant to the procedure outlined in ARTICLE VIII, or which is not timely appealed, shall thereafter be made permanent. A practitioner for whom all privileges have been permanently suspended shall then no longer be considered a Member or Affiliate of the Medical Staff and shall be removed from membership.

SECTION 6. REAPPLICATION FOR MEMBERSHIP OR PRIVILEGES

Any practitioner suspended may reapply for membership or for additional privileges following a two-year period from the effective date of the suspension, but the entire record of the suspension or any other Corrective Actions shall be included as part of that application.

SECTION 7. AUTOMATIC SUSPENSION AND/OR TERMINATION OF MEDICAL STAFF PRIVILEGES:

- A. Action by any state licensing body revoking, terminating, or suspending the license of a practitioner shall automatically lead to the suspension all of his or her clinical privileges, without benefit of Remedial Action and fair hearing procedures provided herein if revoked or terminated. If the license is not restored within 90 days, the practitioner's staff membership shall be automatically terminated. If an action by a state licensing board results in a

Member's license being placed on probation, privileges may continue to be recommended at the discretion of the Credentials Committee.

B. If any Member of the Medical Staff, or any Staff Affiliate required to hold faculty status ceases to possess a faculty appointment, said individual shall automatically forfeit membership in the Medical Staff without any further hearing, process, or review.

C. **AUTOMATIC SUSPENSION**

1. Automatic suspension of privileges may be imposed for the infractions contained in this subsection. They shall be imposed immediately by the Chief Medical Officer after hearing from the responsible authority.

2. A practitioner under automatic suspension by operation of this Section shall be advised of their right to request a hearing consistent with the notice requirements on ARTICLE VIII and that it be convened within fifteen (15) days from the date of the suspension unless the parties mutually agree to an extension. The scope of the hearing will be limited to whether the basis of the suspension is factually accurate. If the practitioner fails to request a hearing within four (4) days from the date of the suspension, the hearing rights will be considered waived. The practitioner shall not be entitled to any appeal rights.

3. Regarding "Continuity of Patient Care", upon the occurrence of an automatic suspension, the Chief Medical Officer shall notify the Chief of Clinical Service to provide alternative coverage for the suspended Staff Member's patients in the Hospital. The suspended Staff Member shall confer with the substitute practitioner to the extent necessary to safeguard and continue the care of the patient.

D. **FAILURE TO COMPLETE MEDICAL RECORDS**

1. Staff admitting, clinical and consulting privileges shall be automatically suspended 7 days after warning of delinquency is issued by the responsible administrative authority if the records have not been dictated or entered directly into the EMR.

2. The physician's privileges shall be reinstated following completion of all medical records; however, two or more automatic suspensions hereunder may constitute grounds for corrective action, including termination of staff appointment and privileges.

3. The Medical Records Committee of the Medical Staff shall make recommendations to the Executive Committee of the Medical Staff for corrective action.

E. **EXCLUSION FROM THE MEDICARE OR MEDICAID PROVIDER LISTS**

- Exclusion from the Medicare or Medicaid provider lists shall result in automatic suspension. Re-instatement shall then be at the discretion of the Executive Committee of the Medical Staff.

F. **LOSS OF MALPRACTICE COVERAGE**

- The clinical privileges of a practitioner shall be automatically suspended in the event of a lapse in professional liability insurance coverage, and shall be reinstated when the practitioner produces satisfactory evidence of coverage.

G. **FAILURE TO COMPLETE BASIC LIFE SUPPORT TRAINING**

Effective December 31, 2016, the failure to complete basic life support training shall result in the automatic suspension of the practitioner's admitting, clinical and consulting privileges which shall be reinstated when training has been completed and the practitioner is certified.

**ARTICLE VIII.
HEARING AND REVIEW**

**SECTION 1.
RIGHT TO HEARING AND REVIEW**

- A. Only the following recommendations or actions shall serve as grounds for a hearing and appellate review under this ARTICLE:
 1. Denial of initial appointment if reportable to the Data Bank.
 2. Involuntary reduction of membership or clinical privileges.
 3. Involuntary termination of membership.
 4. Summary suspension of membership or clinical privileges.
 5. Mandatory consultation requiring prior approval.
- B. Any right to hearing and appellate review shall be conducted according to the following procedures:

1. In all cases, the Chief Medical Officer shall ensure that the Member is notified in writing through certified mail, return receipt requested, of any adverse action or recommended adverse action and is provided with the following: (a) a copy of the Charges or Notification of Action; (b) a copy of these Bylaws; and (c) or copies of all documents and reports utilized or relied upon to make said recommendations or take said action.
2. The practitioner shall have thirty (30) days from the date the written notice was received to submit a written request for a hearing. A practitioner's hearing rights shall be waived if a timely request is not received within such thirty (30) day period.
3. Within fourteen days from the receipt of a request for hearing, the Chief Medical Officer shall schedule and arrange a hearing and notify the Member or Applicant of same. The hearing date shall not be less than thirty (30) days or more than sixty (60) days from the date of receipt of the request for hearing; provided, however, that a hearing for a Member or Applicant who has received a Summary Suspension shall be held no later than fifteen (15) days from the date the Summary Suspension was imposed unless the date is extended by mutual written agreement of the Member and the Executive Committee.
4. All hearings shall be conducted by a hearing panel composed of five impartial Members of the Medical Staff to be selected by the President of the Medical Staff and the Hospital CEO or successor position. No hearing panel Member may be a direct competitor of the Member.
5. All Members of the panel must be present for all hearing proceedings except that any Member may be excused by the Chairperson from any portion of the hearing for good cause shown so long as that Member reviews the record of the portion of the hearing not attended. At least a majority of the Members of the panel must be present at all times during the hearing. No Member may vote by proxy but all Members must be present and vote when a final decision is made.
6. The Chairperson shall convene the hearing. A transcript of all sessions shall be made by a court reporter and retained for a period of at least six years from the time a decision is reached. The costs of all transcripts prepared hereunder shall be borne equally by the Member and the University. The hearing shall be informal in nature and any information may be presented so long as it is relevant to the charges or to the action recommended or instituted.

Any party may submit, at any time, objections, motions, and supporting memoranda or documents concerning any issue of procedure or fact. The panel shall be entitled to consider any pertinent material whether formally presented at the hearing or not, including the Member's application and file.

7. The Member may be represented by a single representative of his/her own choosing. A single representative from the Executive Committee shall present such information and witnesses as support the action or recommended action. Thereafter, the Member or his/her representative may present such information and witnesses as support his/her challenge to the action or recommended action. Either counsel or any panel member may ask questions of any witnesses but must do so in an orderly fashion under the direction of the Chairperson. At the request of any party, all witnesses will be sworn.
8. The Member requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the Member's behalf, together with accurate and complete copies of all exhibits the individual intends to offer at the hearing, within fifteen (15) days of receiving the notice of the hearing. The witness list and exhibits of either party may, in the discretion of the Chairperson, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party and does not unduly surprise or prejudice the other party. In addition, any individual who requests a hearing but who does not testify in his or her own behalf may be called and examined as if under cross-examination.
9. Failure, without good cause, of the practitioner requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of the right to a hearing under these Bylaws and a voluntary acceptance of the recommendations or actions pending. The hearing panel shall report the failure to appear to the Hospital CEO or successor position, who shall notify the Chair of the GB and the President of the Medical Staff, and in such event the proposed action of the Executive Committee or GB, as applicable, shall become final without further action by the Executive Committee or the GB and without any further rights to a hearing and/or appeal. If such action was initiated by the Executive Committee it shall forward its recommended adverse action to the GB for final review and approval.

10. The fair hearing provided for in these Bylaws is for the purpose of intraprofessional resolution of matters bearing on conduct or professional competence. The Member requesting the hearing may be represented by an attorney, or another person of the practitioner's choice. If the Member is represented by legal counsel, then both the Executive Committee and the hearing panel shall be entitled to be represented and advised by legal counsel. Under these circumstances, the Hearing Panel Officer shall determine the scope of the role of attorneys at the hearing. As a general matter, attorneys will be permitted to advise and consult with their respective clients during the hearing, but shall not be allowed to direct and cross-examine witnesses unless otherwise permitted by the Hearing Panel Officer.

If the hearing panel decides to be represented by legal counsel, it shall have the option of choosing an attorney who is experienced in handling these matters. The role of this attorney will be limited to advising the hearing panel on procedural matters as they arise during the course of the hearing and to inform the panel of its role and responsibilities consistent with these Bylaws.

11. The Chairperson, in his discretion, may recess the hearing and later reconvene the same for the convenience of the parties or for any other reasonable purpose. The Chairperson shall rule on the relevancy of any matter sought to be presented at the hearing and any other procedural question concerning the conduct of the hearing or the rendering of a decision. His/her decisions shall be final. Dilatory tactics on the part of either party shall not be tolerated and may be considered by the panel in reaching a decision. Any continuance granted with the reason therefore must be shown on the record.
12. After all parties have presented all relevant information and after the panel, on its own motion, has obtained such additional information as it requires, the panel shall adjourn to Executive Session to reach a decision. The panel may: 1) affirm the action as previously taken or direct that a previous recommendation be implemented; 2) modify, as in their exclusive discretion they deem appropriate, said recommendation or action previously taken and direct that same be carried out; or 3) return the Member to the same membership status as previously enjoyed prior to the adverse action. The panel must render a recommendation which includes findings supported by the evidence within seven days of the close of the final hearing session.

13. The hearing held hereunder shall be considered a de novo determination and the panel may make any decision appropriate as long as that decision is supportable by a preponderance of the evidence considered by the panel.
14. A copy of the hearing panel's recommendation shall be given to the Member, the Executive Committee, the Vice President and the President of the Medical Staff. The Chief Medical Officer shall also transmit a copy to the GB.
15. Any Member or Applicant who does not request a hearing as provided pursuant to these Bylaws within the time limitation provided shall be deemed to have waived his rights hereunder. A Member or Applicant who requests a hearing but, without good cause, fails to appear shall be deemed to have waived his right under Paragraph B.8, above.

SECTION 2. REVIEW BY THE GOVERNING BODY

- A. Within fourteen days after receipt of the written decision of the panel, the Member and/or the Executive Committee may, in writing to the GB or designee request review of the panel's decision. Upon receipt of this request, the GB or designee shall direct the panel to certify and immediately provide to it the complete record of the hearing. The record shall include the Charges or Notification of Action or Bill of Particulars, if provided, the transcript of the hearing, and other evidence used by the hearing panel to reach a decision. The record shall be made available to the Member or Applicant for review and copying, at his/her election and cost.
- B. The Member and/or Executive Committee may, within seven days of notification by the GB or designee of the certification and forwarding of the record, submit written arguments. Said written arguments must be based on the record and may not raise new issues or present new information unless said information could not have been known at the time of the hearing. The Chairperson of the panel or the Executive Committee may also present a similar argument; but no reply arguments shall be permitted.
- C. The GB or designee shall review the record and determine whether:
 1. The procedures as established by these Bylaws and by appropriate University regulations and policies have been met.
 2. The findings of the panel are not against the preponderance of the evidence or arbitrary and capricious.

If, upon its review, the GB or designee determines that any of these standards has been violated, he/she shall:

1. Reinstatement the Member to the same status as he/she enjoyed prior to the unfavorable action, or
2. Return the matter to the Executive Committee for rehearing with a new panel, or
3. Without regard to previous recommendations or actions, take any other action concerning the Member's status which it deems appropriate.

If the GB or designee determines that the foregoing standards were fully met, he/she shall affirm the decision of the panel. Any decision by the GB or designee must be made and a copy provided to the Member or Applicant within fourteen days of the time the record is certified and forwarded to him/her.

- D. The decision of the GB or designee shall in all cases be final.

SECTION 3.

ACTIONS FOLLOWING FINAL DETERMINATION OF REVIEW BY THE GB OR DESIGNEE

Mandatory Reporting to all regulatory agencies, including the National Practitioner Data Bank (NPDB) and Illinois Department of Financial and Professional Regulations (IDFPR) occurs under the following circumstances.

NPDB is notified when a litigated case is settled or otherwise finally adjudicated and payments are made based on the practitioners "professional conduct or competence".

NPDB is also notified following a formal peer review process when an adverse action, based on clinical competence, affects clinical privileges for more than 30 calendar days and is required to be reported to the NPDB or the practitioner's surrender of clinical privileges is accepted while under Investigation regarding possible professional misconduct or incompetence. Voluntary restriction or resignation of clinical privileges to avoid investigation is also reportable. Reports will be filed with NPDB and the IDFPR as well as any other regulatory agencies as applicable.

The NPDB report will be submitted electronically, in accordance with NPDB requirements: www.npdb-hrsa.gov.

**ARTICLE IX.
COMMITTEES OF THE MEDICAL STAFF**

**SECTION 1.
EXECUTIVE COMMITTEE OF THE MEDICAL STAFF**

A. Duties:

The Executive Committee of the Medical Staff shall have the following responsibilities:

1. Act on behalf of the Medical Staff between meetings of the Staff.
2. Receive, review and act on reports of Medical Staff standing committees, other assigned activity groups, departments and clinical services.
3. Communicates proposals to adopt a rule or regulation, or an amendment thereto, to the Medical Staff for review, as set forth under ARTICLE XIV, Section A of these Bylaws.
4. The Executive Committee has the authority to adopt policies without Medical Staff approval but must communicate this policy to the Medical Staff.
5. The Executive Committee may provisionally adopt an urgent amendment to the Rules and Regulations without prior notification to the Medical Staff in cases of a documented necessity to comply with laws or regulations, as set forth in ARTICLE XIV, Section B of these Bylaws. The amendment then shall be communicated to the Medical Staff subject to the conflict management procedures under ARTICLE XVII, as set forth in ARTICLE XIV, Section B of these Bylaws.
6. Appoint a Credentials Committee of which a majority of its members are members of the Executive Committee and the Hospital CEO or successor position (non-voting member) or his designee to review and recommend action concerning appointments to the Medical Staff. The Vice President of the Medical Staff functions as the Chair of the Credentials Committee.
7. Act on recommendations of the Credentials Committee. Make recommendations to the GB or designee regarding applications for membership to the Medical Staff and

delineated clinical privileges (subject to any applicable state law). Negative recommendations shall specify cause.

8. Appoint a Nominating Committee for the election of Officers of the Medical Staff.
9. Participate in Remedial Action and hearing and appellate review procedures.
10. Call meetings of the Medical Staff.
11. Have the right of review and consultation regarding proposed changes in operational aspects of professional care. No substantial changes affecting professional health care delivery should be made without consulting the Executive Committee. Upon request, the Executive Committee shall be granted the right of consultation with the GB or designee on any aspects of professional activity.
12. Account to the GB of the Board of Trustees and to the Medical Staff for the overall quality and efficiency of care rendered to patients in the Hospital.
13. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.
14. Recommend or participate in recommending, as necessary or appropriate, the clinical services to be provided by telemedicine.

The responsibilities of the Executive Committee can be expanded or reduced pursuant to the process for amending Bylaws under ARTICLE XV.

B. Composition

The Committee shall be composed of:

1. Hospital CEO or successor position or his/her designee (without a vote)
2. President of the Medical Staff or Presiding Officer of the Medical Staff Executive Committee
3. Vice President of the Medical Staff

4. Treasurer/Secretary of the Medical Staff
5. Immediate Past President of the Medical Staff
6. All Chiefs of Clinical Services or designees
7. Six active Members of the Medical Staff who are not Chiefs of Clinical Services. There should not be more than two of these six Members from one clinical service on the committee at the same time.
8. Chief Medical Officer
9. Dean of the College of Medicine (without a vote)

In order for there to be a duly constituted meeting, a quorum must be present. A quorum, for this purpose, shall be defined as 1/3 of the voting Members of the committee who must be present, in person, at least one of whom must be one of the elected officers of the committee.

- C. Election Procedure for Active Members of the Medical Staff who are not Chiefs of Clinical Services.

Voting at elections shall be by secret ballot by those present at the meeting and eligible to vote.

A preliminary ballot listing all Members of the Active Staff of the University of Illinois Hospital who are not Chiefs of Clinical Services shall be sent to all Members having the right to vote with the request that they vote for the ultimate number of elected representatives to be Members of the Executive Committee. The names of those Staff Members (three times the ultimate number to be elected) receiving the most votes in the preliminary balloting will appear on a second ballot to be distributed at the annual meeting of the Medical Staff of the University of Illinois Hospital and Health Sciences System held between July 1 and November 30. One-third of those on this ballot receiving the most votes from those present at the meeting and eligible to vote shall be elected representatives to the Executive Committee for staggered three-year terms. Two of the remaining individuals receiving the next highest number of votes on this second ballot (or more if required) shall be designated "alternate delegates" for a one-year term.

The individuals receiving the highest number of votes will be elected, the two receiving the next highest will become the top two alternate delegates, and so on if more than two are required, for the ensuing year. If a duly elected Member is unable to attend a meeting of the Executive Committee,

an alternate representative may be called to attend. More than one alternate may be required, or is welcome, to attend at any given time.

All elected Members may succeed themselves only once, but may be re-elected following a one-year lapse. Vacancies in the ranks of the elected delegates which occur prior to the next election shall be filled for the remainder of the year by the alternate delegates in the sequence determined by the number of votes each had gathered in the preceding annual election.

D. Removal of Executive Committee Members

Any elected Executive Committee Member of the Medical Staff may be removed from office for failure to carry out the duties of membership, for reasons of incapacity or for other good cause in accordance with the provisions of this Section. To initiate the process for removing a Medical Executive Committee Member of the Medical Staff, a written petition signed by not less than 100 of the eligible voting Members of the Medical Staff supporting removal of an Executive Committee Member must be submitted to the Chief Medical Officer. A special meeting of the Medical Staff must be called and held within not less than two weeks nor more than four weeks of such submission for the sole purpose of voting on the removal issue. The affected Executive Committee Member shall be given the opportunity to address the special staff meeting on the matter of his/her removal. An Executive Committee Member may be removed by a majority vote of those voting Members of the Medical Staff present at a special meeting at which a quorum is present. A quorum for this purpose is defined as 100 voting Members. The vote will be conducted by secret ballot. A vote of no confidence will be forwarded to the Governing Body for consideration and action.

E. Meetings

The Executive Committee of the Medical Staff shall meet monthly and shall maintain a record of its proceedings and actions. Special meetings may be called by the Chair. Meetings shall be conducted according to the latest edition of Robert's Rules of Order.

SECTION 2.

STANDING AND SPECIAL COMMITTEES OF THE MEDICAL STAFF

The Executive Committee shall establish those standing committees required by the Joint Commission or Committees which are in the best interests of patient care. Each committee should maintain adequate records of deliberation and should report at least once a year to the Executive Committee. Committees are required to meet at a minimum of once a year. At the discretion of the Chair, additional meetings may be held. Meetings may be held in person or electronically, at the discretion of the Chair, and committee members may vote by e-mail or other electronic means.

ARTICLE X. CLINICAL SERVICES

SECTION 1. MEMBERSHIP

Each Member of the Medical Staff shall be a member of the Clinical Service(s) through which his/her Medical Staff privileges were approved.

SECTION 2. THE CLINICAL SERVICES

The Hospital Clinical Services are:

- A. Anesthesiology
- B. Dentistry, Oral/Maxillofacial Surgery
- C. Dermatology
- D. Emergency Medicine
- E. Environmental and Occupational Medicine
- F. Family Medicine
- G. Medicine
- H. Neurology and Rehabilitation
- I. Neurosurgery
- J. Obstetrics and Gynecology
- K. Ophthalmology
- L. Orthopaedics
- M. Otolaryngology - Head and Neck Surgery
- N. Pathology
- O. Pediatrics
- P. Psychiatry
- Q. Radiation Oncology
- R. Radiology
- S. Surgery
- T. Urology

SECTION 3. CHIEFS OF CLINICAL SERVICE

All Chiefs of Clinical Service and/or their designees and the Chief Medical Officer shall be ex-officio members of all committees of the Medical Staff and Hospital that are responsible for internal quality improvement or medical studies for the purpose of reducing morbidity and mortality, or for improving patient care. In addition, Chiefs of Clinical Service and/or their designees and the Chief Medical Officer are authorized to conduct interviews or investigations into such matters when the committees are not in session.

Chiefs of Clinical Services report to the Chief Medical Officer for all medical and professional programs dealing with patient care in the Medical Center. The Chief of Clinical Service of each

Medical Staff department is either Board Certified by an appropriate specialty board, or the Medical Staff affirmatively determines, through the privilege delineation process, that he/she possesses comparable competence.

Responsibilities as Chief of Clinical Service include:

1. Accountability for all professional and administrative activities within the service;
2. Integration of the service into the primary function of the Hospital and Clinics;
3. Development of relevant service policies and procedures;
4. Coordination and integration of interdepartmental and intradepartmental services;
5. Recommendations for the sufficient number of qualified and competent professional staff necessary to provide quality care and service;
6. Continuing review of the performance of all members of the service, including Focused Professional Practice Evaluations and On-going Professional Practice Evaluations (FPPE & OPPE) based on criteria established by the Chief of Clinical Service and approved by the Executive Committee consistent with accreditation standards;
7. Developing criteria for clinical privileges in the service;
8. Recommending clinical privileges for each member of the service;
9. Assuring that the qualifications and competence of other service staff who provide patient care services but who are not licensed independent practitioners are determined;
10. Assuring that the service has an effective quality improvement program which includes all necessary quality control mechanisms;
11. Orientation and education of the service's staff as required;
12. Preparation of recommendations for space and other required resources needed for the provision of care and services;
13. Participating in the selection of sources for needed services not provided by the department or the organization.

SECTION 4.

CLINICAL SERVICE MEETINGS

The Chiefs of the Clinical Services and/or sections within services shall arrange for meetings of their respective professional staff on an ongoing basis. There is no required format except each meeting should review the quality of patient care provided by the service.

ARTICLE XI.

MEDICAL STAFF MEMBERS WITH ADMINISTRATIVE RESPONSIBILITY IN THE HOSPITAL

SECTION 1.

APPOINTMENT AND REMOVAL

- A. Medical Staff Members may hold positions involving administrative responsibility in the Hospital. Such appointments shall be to the Academic Staff and/or to the Administrative Staff of the University, as those terms are defined in the University of Illinois Statutes and the General Rules Concerning University Organization and Procedure. Medical Staff

Members holding appointments to the Academic Staff will perform administrative duties as may be required of them. Appointees to the Administrative Staff shall be named to specific administrative positions within the Hospital. All such appointments including the prerogatives, rights, and obligations thereof and removal and suspension therefrom, shall be governed by said University of Illinois Statutes, said General Rules Concerning University Organization and Procedure, and pertinent policies and statements of The Board of Trustees of the University of Illinois.

- B. Appointment and removal of the Chief of a Clinical Service shall be governed by the following procedures:
1. A Member serving as a Department Head in the College of Medicine in Chicago shall automatically be considered as the nominee for Chief of the corresponding Clinical Service unless he/she nominates an alternate. The Dean of the College of Dentistry shall nominate a candidate for Chief of the Dentistry Service. The nominee shall be named to the position by the Chief Medical Officer with approval by the Executive Committee. If such consent and approval is not granted, the Chief Medical Officer may designate any properly qualified Member of said Clinical Service to fill this position until such time as consent and approval is granted for an individual nominated as above.
 2. If a Department Head in the College of Medicine also serves as Chief of the corresponding clinical service in the University of Illinois Hospital and if, through proper University procedure that Head is relieved of title and duties as Department Head, the Chief Medical Officer may remove him/her as the Chief of Clinical Service solely on the basis of this prior action. There shall be no appeal of this removal.
 3. If the Chief of a Clinical Service was originally nominated by the Head of the corresponding College of Medicine Department, or Dean of the College of Dentistry, an incumbent in the nominator position may, in the best interests of the University, introduce a new nomination, and when consent and approval is granted under B.,1. of this Section, the Chief of CLINICAL Service being replaced shall be relieved of this position. There shall be no appeal of this removal.
 4. The Chief of a Clinical Service may also be removed from such position by the procedures specified under ARTICLE VII and ARTICLE VIII of the Bylaws, except that the following changes are made for this purpose.

Substitute “Chief of Clinical Service” for “Medical Staff Member” or “Member” in ARTICLES VII and VIII wherever these terms refer to the individual against whom corrective action is being considered.

Add “Removal as Chief of Clinical Service” to other corrective actions listed in ARTICLE VII, Section 3, clause (C).

Add “Administrative irresponsibility or incompetence” to other just cause for corrective actions in ARTICLE VII, Section 2.

SECTION 2. CLINICAL PRIVILEGES

Clinical privileges of Medical Staff Members with Hospital administrative responsibilities are granted, modified, or withdrawn independently of appointment to or removal from these administrative positions. Actions affecting clinical privileges are handled in the same manner for Members holding administrative appointments or designations as they are for all other Medical Staff Members.

ARTICLE XII. REQUIREMENTS FOR ATTENDANCE AT MEETINGS

SECTION 1. REGULAR ATTENDANCE

Each Member of a staff category required to attend meetings under ARTICLE IV shall be encouraged to attend:

- A. The annual Medical Staff meeting.
- B. At least 50 percent of all other Medical Staff meetings duly convened pursuant to these Bylaws.
- C. At least 50 percent of all meetings of each clinical service and committee in which membership is held.

SECTION 2. ABSENCE FROM MEETINGS

Failure to meet the attendance requirements of ARTICLE XII, Section 1 may be grounds for any of the corrective actions specified in ARTICLE VII, Section 3C including, in addition, removal from such clinical service or committee. Reinstatement of a Staff Member whose membership has been revoked because of absence from meetings shall be made only on application, and any such application shall be processed in the same manner as an application for initial appointment.

ARTICLE XIII. OFFICERS

SECTION 1. QUALIFICATIONS

Only Active Members of the Medical Staff may be Officers.

SECTION 2. OFFICERS OF THE MEDICAL STAFF

The Officers of the Medical Staff shall be the President, Vice President, Secretary/Treasurer, and Immediate Past President.

SECTION 3. DUTIES

The President of the Medical Staff shall be Chairman of the Executive Committee of the Medical Staff, shall preside over all meetings of the Medical Staff, and shall have such other duties as are provided by these Bylaws or are delegated by higher University authority. In the absence of the President, the Vice President of the Medical Staff shall carry out each of the above responsibilities. The Vice President shall be Chair of the Credentials Committee of the Medical Staff and shall preside over all meetings. The Secretary/Treasurer shall keep, or shall delegate responsibility for keeping, the official minutes of the Medical Staff and maintaining the official roster of voting Members. He/she shall also be responsible, or delegate responsibility, for the collection of Medical Staff dues and all associated recordkeeping and be responsible for presenting an annual budget including a detailed financial report to the Medical Staff Executive Committee. In the absence of the President and Vice President, the Secretary/Treasurer shall carry out their responsibilities. The Immediate Past President of the Medical Staff shall be a Member of the Medical Staff Executive Committee; serve as an advisor to the President of the Medical Staff; and perform those functions delegated to him/her by the Medical Executive Committee.

SECTION 4. SELECTION OF OFFICERS

Nomination of Officers of the Medical Staff shall be made bi-annually by a Special Nominating Committee appointed by the Executive Committee of the Medical Staff. Elections shall be held bi-annually at the Annual Meeting and additional candidates may be nominated from the floor. Officers may succeed themselves once and each are eligible again for election to the office held after each has ceased to hold that office for a period of two years. Under ordinary circumstances, the Nominating Committee should make nominations consistent with a two-year tenure of an individual as Vice President followed immediately by two years as President and of Secretary/Treasurer followed immediately by two years as Vice President. Voting may be by secret ballot if requested. The candidate receiving the highest number of votes for the office shall be elected.

SECTION 5. REMOVAL OF OFFICERS

Any elected officer of the staff may be removed from office for failure to carry out the duties of his/her office, for reasons of incapacity or for other good cause in accordance with the provisions of this Section. To initiate the process for removing an officer of the Medical Staff, a written petition signed by not less than 100 of the eligible voting Members of the Medical Staff supporting removal of an incumbent officer must be submitted to the Chief Medical Officer. A special meeting of the Medical Staff must be called and held within not less than two weeks nor more than four weeks of such submission for the sole purpose of voting on the removal issue. The affected officer shall be given the opportunity to address the special staff meeting on the matter of his/her removal. An officer may be removed by a two-thirds vote of those voting Members of the Medical Staff present at a special meeting at which a quorum is present. A quorum for this purpose is defined as 100 voting Members. The vote will be conducted by secret ballot.

SECTION 6. VACANCIES OF OFFICERS

A vacancy in the office of the President of the Medical Staff shall be filled by the Vice President, who shall serve until the end of the President's unexpired term, followed immediately by a two-year tenure as President. A vacancy in the office of the Vice President of the Medical Staff shall be filled by the Secretary/Treasurer, who shall serve until the end of the Vice President's unexpired term, followed immediately by a two-year tenure as Vice President. In the event there is a vacancy in an office, other than the Immediate Past President, with no successor as set forth in this Section 6, an election shall be conducted to fill such office. The Executive Committee may, at its discretion, appoint an individual to fill the office until such an election can be held.

In the case of such an election, nomination of an officer to fill a vacancy shall be made by a Special Nominating Committee appointed by the Executive Committee of the Medical Staff. An election by the Members of the Medical Staff eligible to vote shall be held either at a meeting of the Medical Staff or by e-mail or other electronic method, and additional candidates may be nominated from the floor or electronically. Voting may be by secret ballot if requested.

Election shall be by the affirmative vote of either: (i) voting Medical Staff Members present at a meeting or (ii) the Medical Staff eligible to vote who submit votes by e-mail or electronically, in the manner designated in the notice or electronic ballot, provided that a quorum of at least 10% of the Medical Staff Members eligible to vote submit votes. The candidate receiving the highest number of votes for the office shall be elected.

SECTION 7. COMPENSATION OF OFFICERS

The Officers of the Medical Staff shall be eligible for compensation for time spent in discharge of duties of the office. The amounts will be determined by the Medical Staff Executive Committee on a biennial basis and submitted to the Medical Staff at its next regularly scheduled meeting.

**ARTICLE XIV.
AMENDMENTS TO RULES AND REGULATIONS**

The Rules and Regulations are reviewed every three years, or as otherwise necessary or required. Rules and regulations, or amendments thereto, necessary for the proper conduct of the work of the Medical Staff, can be adopted by any of the following methods:

- A. The Executive Committee of the Medical Staff can adopt such rules and regulations after proposed amendments are either submitted for discussion at a meeting of the Medical Staff or presented by e-mail or other electronic method to the Medical Staff. If not submitted by a committee on Medical Staff Bylaws, it is referred to such a Committee for review and subsequent report either at any Medical Staff meeting or by e-mail or other electronic method to the Medical Staff. To be adopted, an amendment requires an affirmative vote of two-thirds of the Members of the Executive Committee of the Medical Staff present at the Medical Staff Executive Committee Meeting of those eligible to vote. Amendments so made through this Section A shall become effective when approved by the Executive Committee;
- B. In cases of a documented need for an urgent amendment to the Rules and Regulations necessary to comply with law or regulation, the Executive Committee may provisionally adopt an urgent amendment to the Rules and Regulations without prior notification to the Medical Staff. The amendment then shall be communicated to the Medical Staff for review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, such conflict shall be subject to the conflict management procedures under ARTICLE XVII; or
- C. The voting Members of the organized Medical Staff can adopt rules and regulations, and policies, and amendments thereto, but must first notify the Executive Committee which shall have the right to review and provide its comment prior to its final review and approval.

Up-to-date compendia of these Rules and Regulations are available on the Hospital intranet home page.

**ARTICLE XV.
AMENDMENTS TO BYLAWS**

The Bylaws are reviewed at least every year, or as otherwise necessary or required. Amendments to Bylaws can be adopted by either of two methods:

- A. Proposed amendments can either be submitted for discussion at a meeting of the Medical Staff or presented by e-mail or other electronic method to the medical staff eligible to vote on the proposed amendments. If not submitted by a Committee on Medical Staff Bylaws, it is referred to such a committee for review and subsequent report to the Medical Staff Executive Committee and then to the Medical Staff either at any Medical Staff meeting or by e-mail or other electronic method to the Medical Staff eligible to vote on the proposed amendments. To be adopted, an amendment to the Bylaws requires an affirmative vote of either: (i) two-thirds of the Medical Staff eligible to vote present at a meeting or (ii) two-thirds of the Medical Staff eligible to vote who submit votes by e-mail or electronically, in the manner designated in the notice or electronic ballot, provided that a quorum of at least 10% of the Medical Staff Members eligible to vote submit votes on such amendments by e-mail or electronically; or
- B. The organized Medical Staff can adopt Medical Staff bylaws and amendments thereto in accordance with the voting requirements set forth above, and to propose them directly to the GB, but must first notify the Committee on Medical Staff Bylaws and the Executive Committee which shall have the right to review and provide its comments to the GB prior to its final review and approval.

Amendments made become effective when approved by the GB. Up-to-date compendia of these Bylaws are available on the Hospital intranet home page.

ARTICLE XVI. ADOPTION OF RULES & REGULATIONS AND BYLAWS

The final version of the amended Medical Staff Rules and Regulations was duly approved in accordance with these Bylaws, and may be amended from time to time in accordance with ARTICLE XIV.

ARTICLE XVII. MANAGEMENT OF CONFLICTS BETWEEN THE ORGANIZED MEDICAL STAFF AND EXECUTIVE COMMITTEE

The purpose of this Section is to establish a process for conflict management between the organized Medical Staff and the Executive Committee on issues including proposals to adopt a bylaw, rule, regulation or policy.

SECTION 1. REQUIREMENTS FOR CONFLICT MANAGEMENT PROCESS

In the event that twenty (20) percent of the voting Members of the Medical Staff each signed a petition or otherwise evidence disagreement with any action taken by the Executive Committee including, but not limited to, any proposed Bylaw, Rule, Regulation or policy, but excluding any

appointment, reappointment or remedial action recommendations or decisions, these Members can require that the conflict management process under this ARTICLE be followed.

SECTION 2. METHODOLOGY

The petition should clearly state the basis of the disagreement and may include any other information by way of additional explanation to Medical Staff Members. The petitioner must acknowledge that they he/she has read the petition and all attachments, if any, in order for their signature to be considered valid.

If the conflict management threshold has been achieved, the petition and any attachments and a list of petitioners shall be forwarded to the Executive Committee. Within thirty (30) days of the Executive Committee's receipt of the petition, a meeting between representatives of both the Executive Committee, as determined by the President of the Medical Staff, and the petitioners shall be scheduled. The parties shall act in good faith and shall take reasonable steps to resolve the conflict in question.

If the Executive Committee and the petitioners are able to resolve the conflict, the resolution shall be submitted to the voting Members of the Medical Staff. If two-thirds (2/3) of the voting Members approve the proposed resolution at a general or special meeting, the proposal will be forwarded to the GB for its review and consideration.

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

If, on the other hand, the voting Members accept the conflict resolution as proposed by the petitioners and the Executive Committee, the resolution, the initial petition and all accompanying materials shall be forwarded to the GB for its review and consideration. If approved by the GB, the decision shall be final. If not approved, the Executive Committee and/or the petitioning representatives of the Medical Staff shall each have the option of requesting that the conflict management process under the corporate bylaws be pursued.

Such communication shall be forwarded to the Executive Committee of the GB through the CEO of the Hospital and to the Executive Committee through the President of the Medical Staff. The Chairperson of the GB shall determine the manner and method of responding to any Physician(s) communicating to the GB under this Section.

All Medical Staff Members, meaning anyone on the Medical Staff even if they do not have voting rights, are free to communicate with the GB regarding a rule, regulation or policy adopted by the Organized Medical Staff or Medical Staff Executive Committee. (Hospital Management Policy and Procedure LD 4.08 addresses this procedure).

Reviewed/Amended:

May 19, 1983
August 17, 1988
December 19, 1989
August 23, 1990
August 22, 1991
January 22, 1992
May 6, 1992
February 9, 1992
December 14, 1993
January 1996
January 2, 1997
December 22, 1997
December 29, 1998
September 14, 2000
September 25, 2001
September 26, 2002
October 30, 2003
October 28, 2004
October 20, 2005
October 26, 2006
January 17, 2008
November 7, 2008
March 19, 2009
October 28, 2009

October 28, 2010
October 13, 2011
November 14, 2013
November 13, 2014
March 16, 2016
July 21, 2016
[November 16, 2017]