

~~May 2019~~Jan 2021

**MEDICAL STAFF BYLAWS**  
**OF THE**  
**UNIVERSITY OF ILLINOIS HOSPITAL AND CLINICS**

~~May 16, 2019~~January 16, 2021 approval by the Board of Trustees

**MEDICAL STAFF BYLAWS OF THE  
UNIVERSITY OF ILLINOIS HOSPITAL AND CLINICS**

**DEFINITIONS..... 1**

**INTRODUCTION..... 4**

**PREAMBLE ..... 4**

**ARTICLE I. NAME..... 5**

**ARTICLE II. PURPOSE ..... 5**

**ARTICLE III. PATIENTS..... 5**

    SECTION 1. PERFORMANCE OF THE HISTORY AND PHYSICAL ..... 5

    SECTION 2. MEDICAL SCREENING EXAMINATION..... 6

**ARTICLE IV. MEMBERSHIP ..... 7**

    SECTION 1. GENERAL QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP ..... 7

    SECTION 2. BASIC RESPONSIBILITIES OF THE MEDICAL STAFF..... 9

    SECTION 3. MEDICAL STAFF DUES..... 10

    SECTION 4. MEDICAL STAFF MEMBERSHIP CATEGORIES ..... 10

    SECTION 5. INITIAL APPOINTMENT TO THE MEDICAL STAFF ..... 14

    SECTION 6. REAPPOINTMENT TO THE MEDICAL STAFF ..... 16

    SECTION 7. EXPEDITED PROCESS FOR APPOINTMENT AND REAPPOINTMENT . 17

    SECTION 8. MODIFICATION OF CLINICAL PRIVILEGES..... 18

**ARTICLE V. ADVANCED PRACTICE PROFESSIONALS ..... 18**

    SECTION 1. GENERAL QUALIFICATIONS FOR ADVANCED PRACTICE PROFESSIONALS ..... 18

    SECTION 2. BASIC RESPONSIBILITIES OF THE ADVANCED PRACTICE PROFESSIONALS ..... 21

    SECTION 3. ADVANCED PRACTICE PROFESSIONALS CATEGORIES ..... 22

    SECTION 4. INITIAL CREDENTIALING AND/OR PRIVILEGING OF ADVANCED PRACTICE PROFESSIONALS ..... 24

    SECTION 5. RECREDENTIALING AND/OR PRIVILEGING OF ADVANCED PRACTICE PROFESSIONALS ..... 26

    SECTION 6. EXPEDITED PROCESS FOR CREDENTIALING AND/OR PRIVILEGING ..... 27

    SECTION 7. MODIFICATION OF CLINICAL PRIVILEGES..... 28

    SECTION 8. SUSPENSION AND REMOVAL OF ADVANCED PRACTICE PROFESSIONALS ..... 28

**ARTICLE VI. SPECIAL PRIVILEGES ..... 30**

    SECTION 1. TEMPORARY PRIVILEGES..... 30

    SECTION 2. TELEMEDICINE PRIVILEGES ..... 31

    SECTION 3. DISASTER PRIVILEGES ..... 32

<b>ARTICLE VII.</b>	<b>LEAVE OF ABSENCE AND RESIGNATION .....</b>	<b>34</b>
SECTION 1.	LEAVE OF ABSENCE .....	34
SECTION 2.	RESIGNATION .....	35
SECTION 3.	REINSTATEMENT AFTER LEAVE OF ABSENCE OR RESIGNATION ...	35
<b>ARTICLE VIII.</b>	<b>CORRECTIVE ACTION .....</b>	<b>35</b>
SECTION 1.	COLLEGIAL INTERVENTION .....	35
SECTION 2.	CAUSES FOR CORRECTIVE ACTION.....	36
SECTION 3.	PROCEDURES FOR CORRECTIVE ACTION.....	37
SECTION 4.	SUMMARY SUSPENSION .....	38
SECTION 5.	TERM OF SUSPENSION.....	39
SECTION 6.	REINSTATEMENT OF MEMBERSHIP OR PRIVILEGES.....	39
SECTION 7.	AUTOMATIC SUSPENSION AND/OR TERMINATION OF MEDICAL STAFF PRIVILEGES.....	39
<b>ARTICLE IX.</b>	<b>HEARING AND REVIEW.....</b>	<b>41</b>
SECTION 1.	GROUND FOR HEARING AND REVIEW .....	41
SECTION 2.	NOTIFICATION .....	42
SECTION 3.	INITIATION .....	42
SECTION 4.	HEARING PANEL AND REPRESENTATION .....	43
SECTION 5.	HEARING PROCEDURE.....	45
SECTION 6.	REVIEW BY THE GOVERNING BODY .....	46
SECTION 7.	REPORTABLE ACTIONS TO REGULATORY AGENCIES .....	47
<b>ARTICLE X.</b>	<b>OFFICERS.....</b>	<b>47</b>
SECTION 1.	QUALIFICATIONS .....	47
SECTION 2.	OFFICERS OF THE MEDICAL STAFF .....	48
SECTION 3.	DUTIES.....	48
SECTION 4.	SELECTION OF OFFICERS.....	48
SECTION 5.	REMOVAL OF OFFICERS.....	49
SECTION 6.	VACANCIES OF OFFICERS.....	49
SECTION 7.	COMPENSATION OF OFFICERS .....	50
<b>ARTICLE XI.</b>	<b>COMMITTEES OF THE MEDICAL STAFF.....</b>	<b>50</b>
SECTION 1.	MEDICAL STAFF EXECUTIVE COMMITTEE (MSEC) .....	50
SECTION 2.	STANDING AND SPECIAL COMMITTEES OF THE MEDICAL STAFF	53
<b>ARTICLE XII.</b>	<b>CLINICAL SERVICES .....</b>	<b>54</b>
SECTION 1.	MEMBERSHIP.....	54
SECTION 2.	THE CLINICAL SERVICES .....	54
SECTION 3.	CHIEFS OF THE CLINICAL SERVICES.....	55
<b>ARTICLE XIII.</b>	<b>MEDICAL STAFF MEMBERS WITH ADMINISTRATIVE RESPONSIBILITY IN THE HOSPITAL .....</b>	<b>58</b>
SECTION 1.	APPOINTMENT AND REMOVAL .....	58
SECTION 2.	CLINICAL PRIVILEGES.....	59

<b>ARTICLE XIV. REQUIREMENTS FOR ATTENDANCE AT MEETINGS.....</b>	<b>59</b>
<b>ARTICLE XV. GRADUATE MEDICAL EDUCATION PROGRAMS .....</b>	<b>59</b>
<b>ARTICLE XVI. AMENDMENTS TO THE BYLAWS.....</b>	<b>60</b>
<b>ARTICLE XVII. AMENDMENTS TO THE RULES AND REGULATIONS .....</b>	<b>61</b>
<b>ARTICLE XVIII.POLICIES.....</b>	<b>62</b>
<b>ARTICLE XIX. MANAGEMENT OF CONFLICTS BETWEEN THE ORGANIZED MEDICAL STAFF AND MSEC.....</b>	<b>62</b>
SECTION 1. REQUIREMENTS FOR CONFLICT MANAGEMENT PROCESS.....	62
SECTION 2. METHODOLOGY .....	62

## MEDICAL STAFF BYLAWS OF THE UNIVERSITY OF ILLINOIS HOSPITAL AND CLINICS

### 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.

*Advanced Practice Professionals (“APP”)* – Those practitioners credentialed and privileged through the Medical Staff but not eligible for Medical Staff Membership. This includes advanced practice registered nurses, optometrists, clinical psychologists, physician assistants, House Physicians, Scientific Staff, and other qualified professionals with patient care responsibilities.

*Associate Chief Medical Officer* – A physician, working in support of and reporting to the office of the Chief Medical Officer, with a defined scope of responsibility.

*Chief Medical Officer (“CMO”)* – That line officer, a physician appointed by the Hospital CEO who is the administrative officer of the Medical Staff and is responsible to the Hospital CEO for the execution of all medical policies and practices of the Hospital and Clinics.

*Chief of the Clinical Service (“Chief”)* – A physician or dentist reporting to the CMO, responsible for the delivery of healthcare in a Clinical Service, such services ordinarily corresponding organizationally to academic departments in a college or school that uses these clinical facilities. The Chiefs of the Clinical Services are responsible to the Hospital CEO for administrative matters and to the Hospital CEO through the CMO for the quality and effectiveness of care carried out in the various departments.

*Days* – Any reference to days, unless otherwise noted, shall mean calendar days rather than business days.

*Good Standing* – A Practitioner is considered in good standing if he/she is currently not under suspension or, if applicable, serving with any limitation of voting or other prerogatives imposed by operation of the Medical Staff Organizational Documents.

*Governing Body (“GB”)* – The Board of Trustees of the University of Illinois.

*Hospital* – The University of Illinois Hospital and Clinics.

*Hospital Chief Executive Officer (“Hospital CEO”) or successor position* – Most senior officer of the Hospital and Clinics, that line officer reporting to the Vice Chancellor for Health Affairs (“VCHA”) of the University of Illinois at Chicago.

*Investigation* – For purposes of these Bylaws and with respect to reporting requirements to the National Practitioner Data Bank (“NPDB”), an Investigation commences when a recommendation for Corrective Action is submitted in accordance with ARTICLE VIII, Section 3 of the Bylaws.

*Medical Staff Executive Committee (“MSEC”)* – The primary governance committee for the Organized Medical Staff. The MSEC, with input from the Organized Medical Staff, makes key leadership decisions related to Medical Staff policies, procedures, rules, and credentialing and privileging criteria, with a focus on patient care, treatment, and services.

*Medical Staff Member (“Member”)* – A Physician who meets all Membership criteria for at least one Membership category listed in these Medical Staff Bylaws.

*Medical Staff Organizational Documents* – The Medical Staff Bylaws, Rules and Regulations, and all accompanying Medical Staff policies and procedures.

*Medical Staff Services* – The administrative department that supports the functions of the Organized Medical Staff.

*Organized Medical Staff (“Medical Staff”)* – All Active, Courtesy, Consulting, Honorary, and Contract Members of the Medical Staff.

*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, all of the following: the evaluation of medical care, the making of recommendations for credentialing and delineation of privileges for physicians or APPs 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, residents or APPs, the evaluations of complaints, incidents and other similar communications filed against practitioners 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 GB 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, or Department of the Medical Staff or the GB—as well as the Medical Staff and the GB 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 that 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 may include, without limitation: the MSEC, the Peer & Exemplary Review Committee (PERC), all Clinical Services, the Credentials Committee, the Committee on Infection Control, the Committee on Emergency Cardiac Care, the GB, and all other committees when performing peer review functions, conduct or activities.

*Physician* – A doctor of allopathic or osteopathic medicine, a doctor of dental surgery or dental medicine, or a doctor of podiatric medicine.

*Practitioner* – Both Medical Staff Members and Advanced Practice Professionals of the Medical Staff.

*Professional Practice Evaluation (“PPE”)* – Both Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE), which are evaluative tools used to determine if care delivered by a privileged Practitioner falls below an acceptable level of performance.

## **INTRODUCTION**

The University of Illinois is governed by The Board of Trustees of the University (“GB”) which is appointed by the Governor of the State of Illinois. The GB upholds the Medical Staff Organizational Documents that have been approved by the GB. The President of the University is responsible for the administration of the University within the lines of general policy approved by the GB and submits to GB 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 Clinics (“Hospital”) and clinical enterprise to the Vice Chancellor for Health Affairs (“VCHA”), who delegates the responsibilities for administering the Hospital to the Hospital CEO or successor position.

The Chief Medical Officer (“CMO”) reports to the Hospital CEO or successor position and serves as the key liaison between Hospital leadership and the Medical Staff, the Chiefs of the Clinical Services, College of Medicine leadership, and outside parties and agencies for matters related to clinical delivery of care. The CMO is appointed by the Hospital CEO with approval by the MSEC to the GB, which is responsible for his/her appointment.

The Organized Medical Staff is responsible for establishing and maintaining patient care standards and oversight of the quality of care, treatment, and services rendered by practitioners privileged through the Medical Staff process. The Organized Medical Staff recognizes the need to operate within this administrative framework in attempting to fulfill its objectives under these Bylaws.

## **PREAMBLE**

The Hospital delivers exemplary and efficient care to its patients and provides 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 practitioners 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 GB of the University.



**ARTICLE I.  
NAME**

The name of this organized body shall be the Medical Staff of the University of Illinois Hospital and Clinics.

**ARTICLE II.  
PURPOSE**

The purpose of the Medical Staff organization includes all of the following:

- A. To provide a mechanism by which the Medical Staff may promulgate rules and regulations for self-governance, and define accountability to the GB for the quality of medical care provided to the patients.
- B. To provide a means through which the Medical Staff may participate in the Hospital's policy-making and planning process to ensure compatibility with the Medical Staff Organizational Documents.
- C. To provide a formal mechanism through which the Medical Staff may advise administration and the GB on matters affecting patient care and vice versa.
- D. To enforce the Medical Staff Organizational Documents by recommending action to the GB in certain circumstances, and taking action in others.
- E. To provide a statement of the rights and privileges of the Medical Staff and APPs and to provide mechanisms through which these rights and privileges may be exercised.
- F. To promote ethical conduct and discipline of the Medical Staff and APPs.
- G. To delineate clinical privileges and conduct an ongoing review and evaluation of the clinical and Hospital activities of the Medical Staff and APPs.

**ARTICLE III.  
PATIENTS**

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

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

A patient's medical history and physical examination (H&P) is performed by the following providers:

- A. A physician, or

- B. A practitioner who is credentialed and privileged in accordance with applicable laws, policies and procedures, and these Medical Staff Organizational Documents.

The medical record must include documentation that an H&P was completed and documented for each patient no more than 30 days prior to hospital admission, or 24 hours after hospital admission, but in all cases prior to surgery or a procedure requiring anesthesia services. The H&P documentation includes all inpatient or same-day surgeries, plus procedures in any setting requiring anesthesia. In instances when an H&P is completed by a privileged non-physician practitioner, countersignature is not required.

The content of an H&P will vary based on the needs of the patient, but in most circumstances (excluding emergencies), the H&P will include all of the following:

- Inpatient Admission/23-Hour Observation and Procedures Involving Moderate Sedation or Anesthesia (in all settings)
  1. History:
    - a. Chief complaint/present illness
    - b. When appropriate, relevant past, social, and family history
  2. Physical Exam:
    - a. Cardiopulmonary examination and examination of relevant body systems and any relevant findings

Exceptions to an H&P being performed or an H&P being completed within a 30-day timeframe include all of the following:

- A. In emergency surgical situations.
- B. Outpatient clinic visits without procedures (i.e.: routine follow-up visits, preventive health vaccinations, etc.).
- C. Ongoing outpatient renal dialysis treatments for patients who had an H&P on their initial visit.
- D. Other situations as defined in clinic/unit policies.

## 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 an APP with clinical privileges that include obstetrical care; and
- C. Advanced practice registered nurse (APRN) or physician assistant (PA) who is an APP 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 H&P 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 FOR MEDICAL STAFF MEMBERSHIP**

Unless otherwise provided herein, in order to qualify for and remain as a Member of the Medical Staff, an applicant or Member must meet all of the following criteria. Failure to meet any of the below criteria may result in Member's termination or denial of application.

- A. Each applicant or Member must be a physician possessing demonstrated skills, knowledge, and experience in his/her chosen specialty; abide by generally recognized and ethical standards of his/her profession; hold and maintain a license by the Illinois Department of Financial and Professional Regulation (IDFPR); and have a current record free from exclusions of participation in federal or state healthcare programs, felony convictions, or other such occurrences that would raise questions of unprofessional conduct.
- B. Each applicant or Member must possess the background, experience and training, current competence, knowledge, judgment, and ability to perform the privileges requested with sufficient adequacy and be able to demonstrate to the Medical Staff and the GB that he/she will provide care to Hospital patients at the generally recognized professional level of quality, taking into account patients' needs, the availability of Hospital resources, and utilization standards in effect at the Hospital.
- C. Except as specifically otherwise provided herein, each applicant or Member must have an appointment to the faculty of one of the health science colleges of the University of Illinois at Chicago.
- D. Except as specifically otherwise provided herein, each applicant or Member must meet all established department/division criteria for appointment and reappointment to the Medical Staff, and documentation must be maintained to show continued compliance.

- E. No applicant or Member 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.
- F. Any Member engaged in clinical practice at an institution outside of the Hospital will provide evidence of professional liability coverage with limits that are acceptable to the University of Illinois Office of Risk Management. The Member shall submit a Certificate of Insurance and any accompanying endorsements, which address the extent or any limitations on coverages.
- G. Each applicant must consent to an inspection of all records and documents pertinent to his/her application for Membership and agree to appear for an interview if requested. The applicant shall have the burden of producing and fully disclosing all information as requested and/or material for a proper evaluation of his/her experience, professional ethics, background, training, demonstrated ability to perform the clinical privileges requested, and for resolving any doubts about these or any of the other basic qualifications specified in these Bylaws, or otherwise. He/she shall also have the burden of demonstrating his/her qualifications, competence, and fitness to the satisfaction of the Medical Staff and the GB. If the applicant fails to comply because the application is incomplete or he/she does not provide all requested information within 90 days of receiving written notice of such failure(s) to the satisfaction of the CMO, Credentials Committee, and Chief, the application for appointment and/or clinical privileges will be considered voluntarily withdrawn, and the applicant must wait for a period of one year before seeking to reapply. In addition, if it is determined that the applicant has provided false or misleading information during the appointment process, the application also will be considered withdrawn and could result in a report to the NPDB. If the false or misleading information is not discovered until after the applicant has been granted Membership, the Member will be subject to disciplinary action.
- H. Recommendations to waive any qualifications, requirements, or limitations in this ARTICLE or any other ARTICLE of these Bylaws not required by law or governmental regulation shall be requested by any Chief and may be waived at the discretion of the MSEC, upon determination that such waiver will serve the best interests of the patients and of the Hospital and will be subject to final GB review and approval.

## SECTION 2. BASIC RESPONSIBILITIES OF THE MEDICAL STAFF

The basic responsibilities of the Medical Staff include, but are not limited to, all of the following:

- A. Abide by the Medical Staff Organizational Documents as may be in effect at any time, including future revisions, once enacted.
- B. Work cooperatively and in a professional manner with Medical Staff Members, APPs, Hospital employees, patient families, and others on matters relating to patient care, patient and family satisfaction, patient safety, risk mitigation and the orderly operation of the business of the Hospital consistent with all applicable Code of Conduct and other Hospital policies and procedures, and Medical Staff Organizational Documents.
- C. Carry out such Medical Staff, department, committee, and Hospital functions for which he/she is responsible by appointment, election, or otherwise including, where applicable, participation in on-call duty, provision of medical care, teaching, and research responsibilities.
- D. Provide and maintain current direct-to-you contact information, including hospital-assigned pager number and telephone number(s), on file with Medical Staff Services. General service line numbers are not considered acceptable forms of direct contact information. Adhere to physician communication requirements as defined in hospital policies and/or Medical Staff Organizational Documents.
- E. Adhere to on-call responsibilities as defined within hospital and departmental policies.
- F. Comply with all applicable federal and state laws and regulations.
- G. Promptly notify the Chief, President of the Medical Staff, and CMO 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 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 state or the loss or reduction of professional liability coverage within five days from the receipt of notification to a Member of any of these actions. All other changes in demographic and credentialing elements shall also be reported.
- H. Maintain ethical standards for clinical care and research, and notify the CMO and Medical Staff Services if participation in clinical research is undergoing investigation, suspended unfavorably, or terminated.
- I. Participate in any OAE sexual misconduct investigation as requested.
- J. Participate in Peer Review activities that include PPE, performance monitoring, and performance improvement.
- K. Commit to personal health and the health of colleagues and assure patient safety by committing to one's own health and also maintaining sensitivity to the health

of fellow staff members. Expectations include reporting to both the CMO and the appropriate department or division heads any actual or suspected form of impairment or disability (whether based on reasonable suspicion from personal observations, a diagnosis or assessment by a health care professional, or other reliable information) that has or may adversely affect the practitioner's ability to exercise any of his/her clinical privileges or professional duties.

- L. Commit to personal responsibility by consenting to a physical, mental, toxicological, or other relevant examination to be conducted by University Health Services when there is reasonable suspicion that the Member is or may be suffering from an impairment or disability that has or may adversely affect patient care. Failure to consent to a requested examination may result in disciplinary action.
- M. Participate in Hospital-sponsored education and Continuing Medical Education (CME) activities.

### SECTION 3. MEDICAL STAFF DUES

- A. All Active and on-site Contract Members shall pay Medical Staff dues, payable beginning each July 1st. Nonpayment by each October 31st may result in a late fee and/or suspension of Medical Staff appointment.
- B. Medical Staff dues will be collected for all new applicants to the Active and on-site Contract Medical Staff during the initial application process and between July 1<sup>st</sup> and April 1<sup>st</sup> each year.
- C. The annual amount of dues and application fees will be determined by the MSEC as needed and reported to the Organized Medical Staff at its next regularly scheduled meeting.

### SECTION 4. MEDICAL STAFF MEMBERSHIP CATEGORIES

Unless otherwise stated, Membership in the Medical Staff shall be granted and renewed pursuant to procedures as provided in ARTICLE V below. The Medical Staff may grant Membership as Active, Courtesy, Honorary, Consulting, and Contract categories, as defined below:

- A. Active Medical Staff
  1. Active Members shall be appointed to a specific Clinical Service or Services and shall be granted clinical privileges, including admission of patients. The Active Staff shall perform duties assigned in the Hospital and shall be bound by all Medical Staff Organizational Documents.
  2. Members who hold a faculty appointment in the College of Medicine or College of Dentistry at the 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 are eligible for appointment to the Active Medical Staff.

3. Active Members shall participate in PPE, and where low and/or no volume instances occur, provide required documentation from an outside organization where the Member currently holds privileges.
4. Active Members shall be eligible to vote and hold office.
5. Active Members shall pay Medical Staff dues.
6. Active Members shall obtain and maintain certification in Basic Life Support (BLS) in accordance with the American Heart Association (AHA) guidelines.
7. Active Members are appointed for a period of up to two years, and subject to the reappointment process thereafter.

B. Courtesy Medical Staff

1. 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 Hospital. Specifically, for these designated patients, Courtesy Members will have access to the medical record to view clinically relevant data and discuss care with the attending physician of record or his/her designee. Courtesy Members will restrict their access to the medical record to view those records clinically applicable to their referred patients. They will not have the ability to write notes or to write orders. They shall not have admitting privileges and will not be granted clinical privileges to provide medical services in the Hospital, but shall be bound by all Medical Staff Organizational Documents.
2. Courtesy Membership includes Members who limit their clinical skills only for teaching purposes, but do not admit patients or derive economic benefit from patient care or professional activities at the Hospital.
3. Members who hold a faculty appointment 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.
4. Courtesy Members shall be exempt from participating in PPE.
5. Courtesy Members shall not be eligible to vote and may not hold office or serve on the MSEC.
6. Courtesy Members shall be exempt from paying Medical Staff dues.



7. Courtesy Members shall be exempt from obtaining and maintaining BLS certification.
8. Courtesy Members renew their Membership at least every two years, upon approval of the Chief for their clinical specialty. A Courtesy Member may be removed from Membership by action of the Hospital CEO or successor position based solely upon the recommendation of the CMO 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.

C. Consulting Medical Staff

1. Consulting Members shall consist of practitioners of recognized professional ability in a specialty field for which there is an identified need at the Hospital, who are board certified or board qualified in a designated specialty area, who are appointed to the Consulting Staff at the request of the Chief in their specialty field, and who may participate in the delivery and/or management of patient care services as needed, consistent with their specialty privileges. Consulting Members shall not have admitting privileges, but may attend meetings of the Medical Staff or any other Medical Staff matter.
2. Members may be appointed to the Consulting Medical Staff for a specific designated purpose, such as consultation. A faculty appointment is not required. Consulting Members will be bound by all Medical Staff Organizational Documents.
3. Consulting Members shall participate in PPE, and where low and/or no volume instances occur, provide required documentation from an outside organization where the Member currently holds privileges.
4. Consulting Members shall not vote or hold office.
5. Consulting Members shall be exempt from paying Medical Staff dues.
6. Consulting Members shall be exempt from obtaining and maintaining BLS certification.
7. Consulting Members must maintain active status and clinical privileges on the Medical Staff at another hospital where current clinical competence is evaluated.
8. Consulting Members are appointed for a limited period based on the identified needs requested by the Chief in their specialty field.

D. Contract Medical Staff



1. Duly licensed physicians may be appointed to the Contract Medical Staff 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. Contract Members are eligible to admit patients and hold clinical privileges, and can only perform those functions and engage in those activities permitted by their contract. Contract Members shall perform duties assigned in the Hospital and shall be bound by all Medical Staff Organizational Documents. [A faculty appointment is not required.](#)
3. Contract Members shall participate in PPE, and where low and/or no volume instances occur, required documentation from an outside organization where the Member currently holds privileges.
4. Contract Members shall not vote or hold office.
5. On-site Contract Members shall pay Medical Staff dues.
6. On-site Contract Members shall obtain and maintain certification in Basic Life Support (BLS) in accordance with the American Heart Association (AHA) guidelines.
7. Contract Members are appointed for a period of up to two years, and subject to the reappointment process thereafter. 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. In the event of such a termination of staff appointment or contract, the practitioner shall have no rights to hearing, process, or review as provided herein.

E. Honorary Medical Staff

1. Physicians who are and remain Members in good standing who have retired from clinical practice, and therefore do not hold clinical privileges, and who have requested or been nominated for Honorary status are eligible for appointment to the Honorary Medical Staff.
2. Candidates for Honorary Membership may be nominated by a Chief and must be approved by the MSEC. Honorary Members are not eligible to admit or attend patients, but may maintain a faculty appointment and are welcomed to participate in Medical Staff meetings and other activities of the Medical Staff and their department.
3. Honorary Members shall be exempt from participating in PPE.
4. Honorary Members shall not be eligible to vote and may not hold office or serve on the MSEC.

5. Honorary Members shall be exempt from paying Medical Staff dues.
6. Honorary Members shall be exempt from obtaining and maintaining BLS certification.
7. Honorary Members are appointed indefinitely and are not required to seek renewal. An Honorary 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 CMO 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.

## SECTION 5. INITIAL APPOINTMENT TO THE MEDICAL STAFF

Initial appointment of Physicians to the Medical Staff is made through procedures outlined below.

- A. Applications for the initial credentialing and/or privileging process shall be submitted to Medical Staff Services via the Chief in whose service the applicant will principally function, and shall contain the following:
  1. An application which shall conform with the mandated application under the Illinois Data Collections Act
  2. Any supplemental forms required by the Medical Staff and/or Hospital
  3. An appropriate delineation of privileges form indicating the applicant's request for the specific privileges desired and those for which he/she meets the requirements
  4. An agreement to abide by the Medical Staff Organizational Documents.
- B. Upon receipt of the application, the Credentials Committee through Medical Staff Services shall seek to verify, via primary source verification, the applicant's licensure status, training, experience, competence, and, if applicable, ability to perform requested privileges, among any other documentation the Committee may require.
- C. The Chair of the Credentials Committee via Medical Staff Services shall promptly notify the applicant of any failures in such collection or verification efforts including identification of erroneous information.
- D. 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.

- E. Following the verification of an applicant's information, the Chief shall review the application and recommend approval or disapproval of the Membership, category, and/or privileges requested by the applicant.
- F. The Chair of the Credentials Committee via Medical Staff Services shall provide the application and supporting material to the Credentials Committee for evaluation. As soon as practicable, with the goal of within 60 days after receipt of the completed application, the Credentials Committee shall make recommendations to the MSEC concerning Membership and privileges requested.
- G. At its next regular meeting after the receipt of recommendations from the Credentials Committee, the MSEC shall review the recommendations and any supporting material submitted and shall make its recommendation.
- H. Final appointments to the Medical Staff and decisions regarding Membership and/or privileging are made by the GB or authorized designee, and the GB shall determine whether, based solely on the supporting materials and/or recommendations, it may take favorable action on the application. An action is favorable only if the type of Membership and/or privileges approved are no more restrictive than those requested by the applicant. If the GB or authorized designee determines that it may take favorable action, it will grant the applicant Membership and/or privileges. If the GB determines that it cannot take favorable action, it shall make a preliminary finding as to what Membership and/or privileges may be recommended, if any, in the absence of further information, citing reasons for that determination.
- I. The GB or authorized designee will act upon the application within 30 days of receipt. An applicant not granted Membership and/or privileges may either accept the preliminary findings or request a hearing on the application to rebut the erroneous information.
- J. The President of the Medical Staff in conjunction with the CMO shall notify the applicant of the action taken within 15 days. If an unfavorable action, the notification shall include the reasons for such findings and the right to request a hearing as appropriate on the proposed action, including the timeframe and the process.
- K. An applicant not granted Membership and/or privileges may do either of the following:
1. Accept the preliminary findings, and in so doing, render the findings final. Membership and/or 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 pursuant to ARTICLE IX within 30 days from receipt of the preliminary findings.

2. Request a hearing pursuant to ARTICLE IX only if denial would require the Hospital to report the applicant to the NPDB. If entitled to an ARTICLE IX hearing, the applicant may request a hearing on the denied application in accordance with ARTICLE IX, Section 3.
- L. If an applicant is denied an application and requests a hearing on the denied application, the hearing shall be conducted pursuant to ARTICLE IX, Sections 4 through 6. In the case of a denied application, the hearing panel shall, in Executive session, recommend one of the following:
1. That favorable action be taken on the application;
  2. That another type of Membership and/or privileges be granted;
  3. That the applicant be denied Membership and/or privileges.

In any case, the hearing panel must provide reasons for its recommendations. The Panel must render this recommendation within 14 days of the close of the final hearing session and forward same to the GB or authorized designee.

- M. Within 14 days after receipt of the written recommendations of the hearing panel, the GB or authorized designee shall review the recommendations and take final action on the request for Membership and/or privileges. The GB or authorized designee may make any decision it deems appropriate without regard to any previous recommendations or preliminary findings. The President of the Medical Staff or authorized designee 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.

## SECTION 6. REAPPOINTMENT TO THE MEDICAL STAFF

To be eligible for reappointment, a Member of the Medical Staff must not only continue to qualify under Section 1 of this ARTICLE, but must continue to participate in Hospital-sponsored education and CME activities. Standards of the IDFPR on amount and type of CME required for maintenance of licensure for physicians are considered as satisfying the physician's requirements for continued Membership. Verification of current medical licensure will thus be considered evidence of satisfactory compliance with the Medical Staff's requirement for CME. The applicant must attest to completion of required CME.

Reappointment to the Medical Staff is made through procedures outlined below.

- A. 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. The CMO shall act in place of the Chief when a Chief is being thus considered. The application is not presented at the Credentials Committee until it is reviewed by the Chief and Medical Staff Services. Considered with such recommendations will be all of the following:

1. A statement that the applicant has been evaluated for physical, mental, and professional capabilities and performance, and that the Chief is unaware of any contraindication of reappointment and reaffirmation of privileges and/or Membership.
  2. A request by the applicant via the appropriate delineation of privileges for the specific privileges desired, if applicable, and those for which he/she meets the required criteria.
  3. Verification via primary source of the following: the applicant's licensure status, training, experience, competence, and, if applicable, ability to perform requested privileges, among any other documentation the Credentials Committee may require.
  4. Whenever the Chief 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.
- B. The Credentials Committee shall transmit its recommendations in writing to the MSEC to approve, modify and approve, revise, or deny Membership and/or privileges.
- C. The MSEC shall act upon the Credentials Committee's recommendations, and shall transmit its recommendations to approve, modify and approve, revise, or deny Membership and/or privileges to the GB or authorized designee for action.
- D. The MSEC shall transmit its recommendations in writing to the GB or authorized designee, who has final authority for granting, renewing, revising, or denying Membership and/or privileges. Membership and/or privileges are granted for a period of up to two years. Denial of Membership and/or privileges does not occur until after a fair hearing process, as outlined in ARTICLE IX, is completed, if exercised by the affected Practitioner.

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 5 of this ARTICLE, except that the MSEC shall be deemed to have taken "favorable action" on reappointment if privileges granted are no more restrictive than those currently requested or granted to the Member during the previous appointment.

#### SECTION 7. EXPEDITED PROCESS FOR APPOINTMENT AND REAPPOINTMENT

An expedited GB approval process may be used for initial appointment and reappointment to the Medical Staff when criteria for that process are met. In the event that an applicant qualifies for an expedited appointment or reappointment in accordance with requirements in this Section, the MSEC, after receiving positive recommendations from 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 GB for final decision. An applicant qualifies for this expedited review if he or she meets all of 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 MSEC makes a positive recommendation without any limitations.

In these following situations, an applicant will be evaluated on a case-by-case basis for eligibility for expedited review:

- A. There are no current or previously successful challenges to the applicant's licensure or registration.
- B. The applicant has not been subject to any involuntary termination or summary suspension of Medical Staff Membership at another hospital.
- C. The applicant has not been subject to any involuntary limitation, reduction, denial or loss of Membership at the Hospital or any other hospital.
- D. There has not been an unusual pattern or excessive number of professional liability actions resulting in a final adverse judgment entered against the applicant.

If expedited criteria is not met, the MSEC, after receiving positive recommendations from the Credentials Committee, shall forward its positive recommendation to the full GB.

## SECTION 8. 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 President of the Medical Staff via the Chief. The processing of such requests is the same as for initial appointments and/or credentialing and privileging under the previous Sections 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.

## **ARTICLE V. ADVANCED PRACTICE PROFESSIONALS**

### SECTION 1. GENERAL QUALIFICATIONS FOR ADVANCED PRACTICE PROFESSIONALS

The Illinois Hospital Licensing Act restricts Medical Staff Membership to MDs, DOs, dentists, and podiatrists. All APP patients are admitted under a Medical Staff Member with admitting privileges.

The attending Physician must determine the APP role in providing care for his/her patients, except as otherwise provided in the Medical Staff Organizational Documents. The Medical Staff shall periodically review the services of APP's granted privileges. This review shall be

conducted in accordance with Item 2, Subsection A of Section 10.8 of the Illinois Hospital Licensing Act for APPs employed by the hospital.

Unless otherwise provided herein, in order to qualify for and remain as an APP, an applicant or APP must meet all of the following criteria. Failure to meet any of the below criteria may result in an APP's termination or denial of application.

- A. Each applicant or APP must possess demonstrated skills, knowledge, and experience in his/her chosen specialty; abide by generally recognized and ethical standards of his/her profession; hold and maintain a license by the Illinois Department of Financial and Professional Regulation (IDFPR); and have a current record free from exclusions of participation in federal or state healthcare programs, felony convictions, or other such occurrences that would raise questions of unprofessional conduct.
- B. Each applicant or APP must possess the background, experience and training, current competence, knowledge, judgment, and ability to perform the privileges requested with sufficient adequacy and be able to demonstrate to the Medical Staff and the GB that he/she will provide care to Hospital patients at the generally recognized professional level of quality, taking into account patients' needs, the availability of Hospital resources, and utilization standards in effect at the Hospital.
- C. Except as specifically otherwise provided herein, each applicant or APP must have an appointment to the faculty of one of the health science colleges of the University of Illinois at Chicago.
- D. Except as specifically otherwise provided herein, each applicant or APP must meet all established department/division criteria for initial and subsequent credentialing and/or privileging, and documentation must be maintained to show continued compliance.
- E. In order to qualify as an APP, unless otherwise provided herein, an individual must meet all of the following criteria:
  1. Demonstrate ability to exercise clinical judgment within the individual's area of competence, ~~with the understanding that an Active Member shall exercise ultimate responsibility for patient care.~~
  2. If required per licensure, state law, or the Medical Staff Organizational Documents, must obtain and maintain appropriate supervisory or collaborative agreements.
  3. Demonstrate ability to record reports and progress notes on patient's records and write orders as permitted by the Medical Staff Organizational Documents and applicable Hospital policies.



- F. No applicant or APP may be denied 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.
- G. Any APP engaged in practice at an institution outside of the Hospital will provide evidence of professional liability coverage with limits that are acceptable to the University of Illinois Office of Risk Management. The APP shall submit a Certificate of Insurance and any accompanying endorsements, which address the extent or any limitations on coverages.
- H. Each applicant must consent to an inspection of all records and documents pertinent to his/her application for credentialing and/or privileging and agree to appear for an interview if requested. The applicant shall have the burden of producing and fully disclosing all information as requested and/or material for a proper evaluation of his/her experience, professional ethics, background, training, demonstrated ability to perform the clinical privileges requested, and for resolving any doubts about these or any of the other basic qualifications specified in these Bylaws, or otherwise. He/she shall also have the burden of demonstrating his/her qualifications, competence, and fitness to the satisfaction of the Medical Staff and the GB. If the applicant fails to comply because the application is incomplete or he/she does not provide all requested information within 90 days of receiving written notice of such failure(s) to the satisfaction of the CMO, Credentials Committee, and Chief, the application for credentialing and/or privileging will be considered voluntarily withdrawn, and the applicant must wait for a period of one year before seeking to reapply. In addition, if it is determined that the applicant has provided false or misleading information during the appointment process, the application also will be considered withdrawn and could result in a report to the NPDB. If the false or misleading information is not discovered until after the applicant has been credentialed and/or privileged, the APP will be subject to disciplinary action.
- I. Recommendations to waive any qualifications, requirements, or limitations in this ARTICLE or any other ARTICLE of these Bylaws not required by law or governmental regulation shall be requested by the Chief and may be waived at the discretion of the MSEC, upon determination that such waiver will serve the best interests of the patients and of the Hospital and will be subject to final GB review and approval.

## SECTION 2. BASIC RESPONSIBILITIES OF THE ADVANCED PRACTICE PROFESSIONALS

The basic responsibilities of the APPs include, but are not limited to, all of the following:



- A. Abide by the Medical Staff Organizational Documents as may be in effect at any time, including future revisions, once enacted.
- B. Work cooperatively and in a professional manner with Members, other APPs, Hospital employees, patient families, and others on matters relating to patient care, patient and family satisfaction, patient safety, risk mitigation and the orderly operation of the business of the Hospital consistent with all applicable Code of Conduct and other Hospital policies and procedures, and Medical Staff Organizational Documents.
- C. Carry out such department, committee, and Hospital functions for which he/she is responsible by role or otherwise including, where applicable, participation in on-call duty, provision of medical care, teaching, and research responsibilities.
- D. Provide and maintain current direct-to-you contact information, including hospital-assigned pager number and telephone number(s), on file with Medical Staff Services. General service line numbers are not considered acceptable forms of direct contact information. Adhere to provider communication requirements as defined in hospital policies and/or Medical Staff Organizational Documents.
- E. Adhere to on-call responsibilities as defined within hospital and departmental policies.
- F. Comply with all applicable federal and state laws and regulations.
- G. Promptly notify the Chief, President of the Medical Staff, and CMO 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 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 state or the loss or reduction of professional liability coverage within five days from the receipt of notification to an APP of any of these actions. All other changes in demographic and credentialing elements shall also be reported.
- H. Maintain ethical standards for clinical care and research, and notify Medical Staff Services if research is undergoing investigation, suspended unfavorably, or terminated.
- I. Participate in any OAE sexual misconduct investigation as requested.
- J. Participate in Peer Review activities that include PPE, performance monitoring, and performance improvement.
- K. Commit to personal health and the health of colleagues and assure patient safety by committing to one's own health and also maintaining sensitivity to the health of fellow staff Members. Expectations include reporting to both the CMO or the

appropriate department or division heads any actual or suspected form of impairment or disability (whether based on reasonable suspicion from personal observations, a diagnosis or assessment by a health care professional, or other reliable information) that has or may adversely affect the practitioner's ability to exercise any of his/her clinical privileges or professional duties.

- L. Commit to personal responsibility by consenting to a physical, mental, toxicological, or other relevant examination to be conducted by University Health Services when there is reasonable suspicion that the APP is or may be suffering from an impairment or disability that has or may adversely affect patient care. Failure to consent to a requested examination may result in disciplinary action.
- M. Participate in Hospital-sponsored education and discipline-specific continuing education activities, as required by the applicable licensing board.

### SECTION 3. ADVANCED PRACTICE PROFESSIONALS CATEGORIES

For the purposes of these Bylaws, Advanced Practice Professionals include the following:

- A. Advanced Practice Registered Nurses, Optometrists, Clinical Psychologists, Physician Assistants, and other qualified professionals with patient care responsibilities who may be granted clinical privileges
  - 1. These professionals shall be assigned to appropriate Clinical Services. Privileges specified for individual professionals in this category may be more but not less restricted than are specified in the appropriate approved general standards and protocols applying to his/her discipline. These professionals are not eligible to admit patients.
  - 2. These professionals must hold a faculty appointment with a school or college of the University of Illinois.
  - 3. Any privileged professionals in this category shall participate in PPE, and where low and/or no volume instances occur, provide required documentation from an outside organization where the professional currently holds privileges.
  - 4. These professionals shall not be eligible to vote and may not hold office.
  - 5. These professionals shall be exempt from paying Medical Staff dues.
  - 6. These professionals shall be exempt from obtaining and maintaining BLS certification unless his/her specific privileges or employment require it.
  - 7. These professionals are credentialed and privileged for a period up to two years, and subject to the recredentialing and privileging process.
- B. House Physicians

1. Physicians with active Illinois medical licensure participating in at least the third year of a residency training program at the University of Illinois at Chicago are privileged at the discretion of the Chief to carry out limited clinical privileges as House Physicians throughout the duration of their graduate medical education training program.
2. House Physicians have regular duties and responsibilities assigned by the Chief. The conduct of House Physicians is to be guided by the Medical Staff Organizational Documents.
3. House Physicians shall participate in PPE.
4. House Physicians shall not be eligible to vote and may not hold office.
5. House Physicians shall be exempt from paying Medical Staff dues.
6. House Physicians shall obtain and maintain certification in Basic Life Support (BLS) in accordance with the American Heart Association (AHA) guidelines.
7. If the House Physician's graduate medical education training program exceeds two years, he/she is subject to the recredentialing and privileging process.

C. Scientific Professionals

1. Scientific Professionals are 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. Each Scientific Professional must hold a faculty appointment in one of the health care colleges at the University of Illinois at Chicago.
2. Scientific Professionals shall be appointed to a specific Clinical Service or Services. They shall not have admitting privileges and will not be granted clinical privileges to provide medical services in the Hospital, but shall be bound by all Medical Staff Organizational Documents.
3. Scientific Professionals shall be exempt from participating in PPE.
4. Scientific Professionals shall not be eligible to vote and may not hold office or serve on the MSEC.
5. Scientific Professionals shall be exempt from paying Medical Staff dues.
6. Scientific Professionals shall be exempt from obtaining and maintaining BLS certification.

7. Scientific Professionals shall be exempt from obtaining and maintaining professional liability coverage.
8. Scientific Professionals renew their credentialing at least every two years, upon approval of the Chief for their clinical specialty.

#### SECTION 4. INITIAL CREDENTIALING AND/OR PRIVILEGING OF ADVANCED PRACTICE PROFESSIONALS

Initial credentialing and/or privileging of APPs is made through procedures outlined below.

- A. Applications for the initial credentialing and/or privileging process shall be submitted to Medical Staff Services via the Chief in whose service the applicant will principally function, and shall contain the following:
  1. An application that shall conform with the mandated application under the Illinois Data Collections Act.
  2. Any supplemental forms required by the Medical Staff and/or Hospital.
  3. An appropriate delineation of privileges form indicating the applicant's request for the specific privileges desired and those for which he/she meets the requirements.
  4. An agreement to abide by the Medical Staff Organizational Documents.
- B. Upon receipt of the application, the Credentials Committee through Medical Staff Services shall seek to verify, via primary source verification, the applicant's licensure status, training, experience, competence, and, if applicable, ability to perform requested privileges, among any other documentation the Committee may require.
- C. The Chair of the Credentials Committee via Medical Staff Services shall promptly notify the applicant of any failures in such collection or verification efforts including identification of erroneous information.
- D. 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.
- E. Following the verification of an applicant's information, the Chief shall review the application and recommend approval or disapproval of the credentialing and/or privileges requested by the applicant.
- F. The Chair of the Credentials Committee via Medical Staff Services shall provide the application and supporting material to the Credentials Committee 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 MSEC concerning credentialing and/or privileges requested.

- G. At its next regular meeting after the receipt of recommendations from the Credentials Committee, the MSEC shall review the recommendations and any supporting material submitted and shall make its recommendation.
- H. Final appointments to the Medical Staff and decisions regarding credentialing and/or privileging are made by the GB or authorized designee, and the GB shall determine whether, based solely on the supporting materials and/or recommendations, it may take favorable action on the application. An action is favorable only if status, credentialing, and/or privileges approved are no more restrictive than those requested by the applicant. If the GB or authorized designee determines that it may take favorable action, it will grant the applicant credentialing and/or privileges. If the GB determines that it cannot take favorable action, it shall make a preliminary finding as to what status, credentialing, and/or privileges may be recommended, if any, in the absence of further information, citing reasons for that determination.
- I. The GB or authorized designee will act upon the application within 60 days of receipt. An applicant not granted credentialing and/or privileges shall accept the findings without the right to request a hearing.
- J. The President of the Medical Staff in conjunction with the CMO shall notify the applicant of the action taken within 15 days. If an unfavorable action, the notification shall include the reasons for such findings.

During the initial application process of APPs, the Chair of the Credentials Committee via Medical Staff Services and the applicant have the following responsibilities:

- A. Whenever feasible, Medical Staff Services shall seek verification from the original source of the specific credential or previous hospital affiliation.
- B. The Chair of the Credentials Committee via Medical Staff Services shall promptly notify the applicant of any failures in such collection or verification efforts including identification of erroneous information.
- C. 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.
- D. 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.

## SECTION 5. RECREDENTIALING AND/OR PRIVILEGING OF ADVANCED PRACTICE PROFESSIONALS

To be eligible for recredentialing, an APP must not only continue to qualify under Section 1, but must continue to participate in Hospital-sponsored education and CE activities. Standards of the IDFPR on amount and type of CE required for maintenance of licensure for APPs are considered as satisfying the APP's requirements for continued credentialing and/or privileging. Verification of current medical licensure will thus be considered evidence of satisfactory compliance with the Medical Staff's requirement for CE. The applicant must attest to completion of required CE.

Recredentialing and/or privileging of APPs is made through procedures outlined below.

- A. Prior to the Hospital's two-year scheduled recredentialing time, the Chief shall submit recommendations for recredentialing in that department to the Credentials Committee. The CMO shall act in place of the Chief when a Chief is being thus considered. The application is not presented at the Credentials Committee until it is reviewed by the Chief and Medical Staff Services. Included with such recommendations will be all of the following:
  1. A statement that the applicant has been evaluated for physical, mental, and professional capabilities and performance, and that the Chief is unaware of any contraindication of recredentialing and/or reaffirmation of privileges.
  2. A request by the applicant via the appropriate delineation of privileges for the specific privileges desired, if applicable, and those for which he/she meets the required criteria.
  3. Verification via primary source of the following: the applicant's licensure status, training, experience, competence, and, if applicable, ability to perform requested privileges, among any other documentation the Credentials Committee may require.
  4. Whenever the Chief determines that, in the interest of patient care or the efficient operation of the Hospital, modification or non-renewal of credentialing and/or privileges is in order, he/she shall so indicate in a separate statement to the Credentials Committee, giving reasons.
- B. The Credentials Committee shall transmit its recommendations in writing to the MSEC to approve, modify and approve, revise, or deny recredentialing and/or privileges.
- C. The MSEC shall act upon the Credentials Committee's recommendations, and shall transmit its recommendations to approve, modify and approve, revise, or deny recredentialing and/or privileges to the GB or authorized designee for action.
- D. The GB or authorized designee has final authority for granting, renewing, revising, or denying credentialing and/or privileges. Credentialing and/or privileges are granted for a period of up to two years.

- E. The Credentials Committee shall transmit its recommendations in writing to the MSEC for action.
- F. The MSEC shall act upon the Credentials Committee's recommendations, and shall transmit its recommendations to the GB or authorized designee for action.
- G. The GB or authorized designee has final authority for granting, reviewing, renewing, or denying recredentialing and/or privileges. Privileges are granted for a period of up to two years.

Except as stated above, the processing of requests under A above, including burdens for verifying information, are the same as for corresponding initial appointments under Section 4 of this ARTICLE, except that the MSEC shall be deemed to have taken "favorable action" on recredentialing and/or privileging if privileges granted are no more restrictive than those currently requested or enjoyed by the APP during the previous credentialing and/or privileging.

#### SECTION 6. EXPEDITED PROCESS FOR CREDENTIALING AND/OR PRIVILEGING

An expedited GB approval process may be used for credentialing and/or granting privileges when criteria for that process are met. In the event that an applicant qualifies for expedited credentialing and/or privileging in accordance with requirements in this Section, the MSEC, after receiving positive recommendations from 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 GB for final decision. An applicant qualifies for this expedited review if he or she meets all of 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 MSEC makes a positive recommendation without any limitations.

In these following situations, an applicant will be evaluated on a case-by-case basis for eligibility for expedited review:

- A. There are no current or previously successful challenges to the applicant's licensure or registration.
- B. The applicant has not been subject to any involuntary termination or summary suspension of credentialing and/or privileges at another hospital.
- C. The applicant has not been subject to any involuntary limitation, reduction, denial or loss of credentialing and/or privileges at the Hospital or any other hospital.
- D. There has not been an unusual pattern or excessive number of professional liability actions resulting in a final adverse judgment entered against the applicant.

If expedited criteria is not met, the applicant shall be presented to the full GB.



## SECTION 7. MODIFICATION OF CLINICAL PRIVILEGES

An APP may request modification of his/her clinical privileges at any time. To do so, an APP shall submit the request with specific modifications requested to the President of the Medical Staff via the Chief. The processing of such requests is the same as for initial appointments and/or credentialing and privileging under the previous Sections of this ARTICLE, except that in no case may an APP suffer a reduction in clinical privileges as a result of an application for modification in clinical privileges unless the APP requests such reduction.

## SECTION 8. SUSPENSION AND REMOVAL OF ADVANCED PRACTICE PROFESSIONALS

A. Automatic suspension of credentialing and/or staff admitting, clinical, and consulting privileges may be imposed for the following infractions:

1. Failure to Maintain State Licensure

- a. If the license is not restored within six months, the APP's credentialing and/or privileging shall be automatically terminated.
- b. If an action by a state licensing board results in an APP's license being placed on probation, privileges may continue to be recommended at the discretion of the Credentials Committee.

2. Failure to Maintain Faculty Appointment

If any APP's faculty appointment is suspended, said individual shall automatically forfeit credentialing and/or privileging without any hearing, process, or review.

3. Failure to Complete ~~Inpatient~~ Medical Records

~~a. — APPs with inpatient or outpatient documentation lags beyond 14 days will be referred for automatic suspension of clinical privileges. Privileges shall be automatically suspended seven 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.~~

~~a. \_\_\_\_\_~~

b. The APP's privileges shall be reinstated following completion of all medical records; however, two or more automatic suspensions hereunder may constitute grounds for action, including termination of credentialing and/or privileges.

~~e. — The Medical Records Committee may make recommendations to the MSEC for action.~~



~~4. Failure to Complete Outpatient Medical Records~~

~~APPs with outpatient documentation lags beyond 1430 days will be referred for automatic suspension of clinical privileges.~~

5.4. Exclusion from the Medicare or Medicaid Provider Lists

Exclusion of participation in federal or Illinois state healthcare programs shall result in automatic suspension. Consideration will be made if the exclusion occurs outside the state of Illinois.

~~6.5.~~ Loss of Malpractice Insurance Coverage

Privileges shall be reinstated when the practitioner produces satisfactory evidence of coverage.

7.6. Felony Conviction

Reinstatement shall be at the discretion of the MSEC.

~~8.7.~~ Loss of Certification, if Required Per Clinical Privileges

Loss of certification, if required per departmental clinical privileges, will result in the automatic suspension of the APP's specific admitting, clinical, and consulting privileges, which may be reinstated when APP has been re-certified.

- B. Automatic suspension of privileges for any of the above infractions shall be imposed immediately by the President of the Medical Staff or authorized designee after hearing from the responsible authority. The APP shall be immediately notified of the automatic suspension.
- C. Within 7 days of notification, an APP may contest the factual accuracy of the Automatic Suspension by submitting to the Credentials Committee or designated committee his/her written request with supporting documentation. The Credentials Committee shall review the documentation and make a final determination as to whether to lift or uphold the automatic suspension.
- D. Upon the occurrence of an automatic suspension, the President of the Medical Staff or authorized designee shall notify the CMO and the Chief to provide alternative coverage for the suspended APP's patients. The suspended APP shall confer with the substitute APP to the extent necessary to safeguard and continue the care of the patient.
- E. The MSEC retains the right to suspend or terminate any or all of the privileges or functions of any category of APP, for any of the reasons in A. above, without recourse on the part of such person or others to the review and hearing process of these Medical Staff Bylaws, except as provided below:

1. APPs whose privileges are terminated, suspended, or restricted shall be told the reasons for such action and, if they so request, shall be entitled to have a meeting with the MSEC or, if designated, the Credentials Committee to present their position on the matter.
  2. If the APP objects to the termination, suspension, or restriction of privileges, and requests a meeting, the APP shall be given any and all information on which the adverse recommendation was based in advance of that meeting.
  3. If the MSEC appoints a committee to hear the APP's objections to termination, suspension, or restriction, that committee shall report to the MSEC. The affected APP may not appeal the MSEC's recommendation.
- F. Final actions regarding an APP's termination, suspension, or restriction will be reported to the NPDB or IDFPD only if reporting is required by law.

## **ARTICLE VI. SPECIAL PRIVILEGES**

### **SECTION 1. TEMPORARY PRIVILEGES**

Upon receipt of any application for clinical privileges, the Hospital CEO or authorized designee may grant temporary admitting and/or clinical privileges to the practitioner following the requirements below.

- A. Temporary privileges shall be granted in the following situations for a period not to exceed 120 days, and can only be renewed on a case by case basis:
1. An important patient care, treatment, and/or service need mandates an immediate authorization for a practitioner to practice. Examples would include, but are not limited to, the following:
    - a. A situation in which a credentialed Practitioner becomes ill or takes a leave of absence and another practitioner would need to cover his/her practice until he/she returns.
    - b. A specific practitioner has the necessary skills to provide care to a patient that a Practitioner currently privileged does not possess.
    - c. A situation is considered life threatening and a patient's health and safety may be in jeopardy without immediate care.

In these situations, temporary privileges require primary source verification (which may be accomplished through a telephone call) of the applicant's current licensure and current competence, among any other documentation the Medical Staff Organizational Documents may require.

2. A new applicant with a complete application that raises no concerns is awaiting review and approval of the MSEC and the GB while the full credentials information is verified and approved. In this circumstance, temporary privileges 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.
- B. Temporary privileges require the following three levels of recommendation and approval:
1. Recommendation of the Chief or authorized designee.
  2. Recommendation of the President of the Medical Staff or authorized designee.
  3. Approval of the Hospital CEO or authorized designee.
- C. The President of the Medical Staff or authorized designee, after consultation with the Chief, may recommend to the Hospital CEO or authorized designee that he/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 NPDB. If the practitioner is applying for privileges through the regular application process, such process shall continue to be reviewed under regular application procedures.

## SECTION 2. TELEMEDICINE PRIVILEGES

Telemedicine, for the purpose of this document, refers to the provision of clinical services to patients by credentialed Practitioners from a distance via electronic communications. The Hospital may be the originating site (the site where the patient is located at the time the service is provided) or may be the distant site (the site where the practitioner providing the professional service is located). The originating site retains responsibility for overseeing the safety and quality of services provided to its patients.

Credentialed Practitioners who provide clinical services via a telemedicine link must have a license that is issued or recognized by the state in which the patient is receiving telemedicine services.

Credentialed Practitioners who provide clinical services via a telemedicine link are subject to the credentialing and privileging decisions of the originating site. When telemedicine services are furnished to the Hospital's patients, the Hospital as the originating site has a written agreement with the distant site that specifies all of the following:

- A. The contractor (distant site) furnishes services in a manner that permits the hospital to be in compliance with the Medicare Conditions of Participation at 42 CFR 482.12 and 482.22.

- B. The Hospital (originating site) retains the option to either fully privilege and credential the contractor's practitioners via the Hospital medical staff process, or can privilege practitioners by proxy, using credentialing information from the distant site if the distant site is a Joint Commission-accredited hospital or ambulatory care organization. The GB must grant privileges to each telemedicine physician or credentialed practitioner before they may provide telemedicine services. The scope of the privileges in the Hospital must reflect the provision of the services via a telecommunications system.
- C. The distant site (contractor) will provide the Hospital with a current list of the credentialed Practitioner's privileges prior to initiation of services.
- D. The Hospital (originating site) conducts and retains evidence of an internal review of the contracted service practitioner performance, and will minimally provide the contractor with any information on adverse outcomes related to sentinel events that result from telemedicine services provided and complaints about the distant site practitioner received from patients, physicians, or staff at the hospital.
- E. The distant site practitioner must have a license that is issued or recognized by the state of Illinois where the patient is receiving the telemedicine services.

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.

The Medical Staff recommends which clinical services are appropriately delivered by physicians through a telemedicine link at either an originating or distant site.

### SECTION 3. DISASTER PRIVILEGES

The organization may grant disaster privileges to volunteers eligible to be Practitioners. In a declared emergency, or in circumstances of disaster(s) in which the emergency management plan has been activated, the Hospital CEO or Medical Staff President or their authorized designee(s) may grant Disaster privileges to a practitioner not currently privileged by the institution. When the disaster (emergency management) plan has been implemented and/or the immediate needs of the patients cannot be met, the organization may implement a modified credentialing and privileging process for eligible volunteer practitioners. Safeguards must be in place to assure that volunteer practitioners 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:

- A. Verification of licensure
- B. Oversight of the care, treatment, and services provided

When privileges are granted, identification of the practitioner's professional designation (ID badge with credentials) must be displayed by the individual. Such designation (ID badge) will be terminated when the disaster 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 practitioners who receive disaster privileges.

The option to grant disaster privileges to volunteer practitioners 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 practitioners

Volunteers considered eligible to act as practitioners 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. A current picture Hospital ID card that clearly identifies professional designation.
- B. A current license to practice. Primary source verification of the license is required via the IDFPR website, which is The Joint Commission-approved website, or a documented phone call to IDFPR. Primary source verification begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization.
- C. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), 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.
- D. 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).
- E. Identification by current Hospital employee or Medical Staff Member(s) who possesses personal knowledge regarding volunteer's ability to act as a practitioner during a disaster

Any current Practitioner 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/her current Medical Staff status or clinical privileges if the care provided is within the scope of the individual's license. Participants in GME programs may provide care within the scope of their licensure, qualifications, and training during an identified disaster.

Primary source verification of the volunteer practitioner's credentials begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. The Medical Staff addresses the verification process as a high priority and begins the verification process of the credentials and privileges of practitioners who receive emergency privileges as soon as possible following the emergent situation. The following credentials must be verified via primary source:

- A. State license verification via the Joint Commission-approved website or documented phone call to IDFPR

B. NPDB query

When the emergency situation no longer exists, these disaster privileges terminate. Upon termination of a practitioner's disaster privileges, the practitioner will not be entitled to any fair hearing rights under ARTICLE IX of these Bylaws.

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 all of the following:

- A. Why primary source verification could not be performed in the required time frame
- B. Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services
- C. An attempt to rectify the situation as soon as possible.

Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment, and services under the disaster privileges.

## **ARTICLE VII. LEAVE OF ABSENCE AND RESIGNATION**

### **SECTION 1. LEAVE OF ABSENCE**

The Chief, upon approval, shall immediately forward to the President of the Medical Staff or authorized designee written notice of a Practitioner's leave of absence, which specifically states the basis for the request. A leave of absence must be reported to the MSEC and the GB, and the Practitioner granted leave shall temporarily withdraw clinical privileges during the leave of absence. If the Practitioner requests a leave of absence while under Corrective Action or Investigation, that leave would be reportable to the NPDB.

A leave of absence may be granted for an initial period of up to one year. The next scheduled reappointment date will still apply. 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 and/or credentialing and privileging. The requirement for malpractice insurance coverage is waived during leave of absence.

Prior to the conclusion of the granted leave of absence, the Chief request an extension of the leave, not to exceed a total of two years.

### **SECTION 2. RESIGNATION**

The Chief shall immediately forward to the President of the Medical Staff or authorized designee notice of faculty resignation. A resignation from faculty status shall result in the termination of Medical Staff appointment, credentialing, and/or privileging. If the Practitioner resigns while under Corrective Action or Investigation, that resignation would be reportable to the NPDB.

### SECTION 3. REINSTATEMENT AFTER RESIGNATION OR LEAVE OF ABSENCE

- A. Unless otherwise restricted, a Practitioner who has resigned or taken a leave of absence shall be entitled to reinstatement in a class of Membership, if applicable, and with privileges deemed appropriate by the Chief, provided all of the following criteria are met:
1. The Practitioner was in good standing at the time of resignation or leave of absence.
  2. The Practitioner was not under Corrective Action or remedial action at the time of resignation or leave of absence.
  3. The resignation or leave of absence was given no more than one year prior to the proposed date of reinstatement, and this Practitioner was evaluated during their last scheduled reappointment cycle. This time frame may be extended up to two years at the discretion of the department. In this case, the reappointment may not have lapsed, as reappointments cannot exceed a two-year period.
  4. The Practitioner meets all qualifications for Membership and/or credentialing and privileging delineated in the Medical Staff Organizational Documents.
- B. The Practitioner must supply all requested information related to his/her professional practice during the period of his/her absence.

## **ARTICLE VIII. CORRECTIVE ACTION**

### SECTION 1. COLLEGIAL INTERVENTION

- A. It is the goal 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 Organizational Documents, and to meet all performance expectations. An Officer of the Medical Staff, Chief, the CMO, or the Peer & Exemplary Review Committee (PERC) may initiate Collegial Intervention. The Medical Staff Organizational Documents 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 Corrective Action as described in Section 2 below. Collegial Intervention may include coaching, education, training, letters of concern, or a notice that the Physician's conduct will be monitored for a period of time and/or that similar conduct in the future may result in Corrective Action. Based on the outcomes of the Collegial Intervention, it may be determined that the Physician be referred to the following areas including, but not limited to, the PERC, University Health



Services, Practitioner's Assistance Committee, the Employee Assistance Program, and the Office for Access and Equity.

- B. Collegial Intervention shall not be considered an Investigation nor as part of the Corrective Action process described below and shall not entitle a Physician to a hearing or appeal under the fair hearing procedures set forth in this ARTICLE VIII. Collegial Intervention shall be considered as part of the Physician's PPE. The success of Collegial Intervention relies on the willingness of the Physician to voluntarily participate. If a Physician refuses to participate in Collegial Intervention, or does not demonstrate acceptable performance following such efforts, he/she may be subject to Corrective Action as described below.
- C. The Hospital and Medical Staff are not required to engage in Collegial Intervention if more immediate Corrective Action is needed, but not limited to Summary Suspension, in order to protect patients, employees, and the general public.

## SECTION 2. CAUSES FOR CORRECTIVE ACTION

Corrective Action involving a Practitioner shall be considered for any of the following causes:

- A. The activities or professional conduct of any Practitioner jeopardizes or may jeopardize the safety of a patient, visitor, or employee, or the continued proper functioning of the Hospital, or the reputation of the Hospital.
- B. Unethical or unprofessional conduct or conduct detrimental to the Hospital or Medical Staff, including failure to observe the Hospital's Code of Conduct.
- C. Professional incompetence, or incapacity, including that caused by an impairing physical, psychiatric, or emotional illness.
- D. Failure to observe the Medical Staff Organizational Documents, or University, college(s), or Hospital guidelines and policies.
- E. Failure to carry out Medical Staff or other clinical assignments, including committee or departmental assignments.
- F. Unsuccessful Collegial Intervention.
- G. Other reasonable causes.

## SECTION 3. PROCEDURES FOR CORRECTIVE ACTION

- A. Criteria for Initiation and Notification

An Officer of the Medical Staff, the CMO, the Hospital CEO, or a member of the GB may recommend Corrective Action as provided for in this Section including,



but not limited to, those actions listed in ARTICLE VIII, Section 2 of these Bylaws.

Such recommendation for Corrective Action shall be presented to the President of the Medical Staff or the CMO. The recommendation for Corrective Action shall, additionally, be shared with the Chief and the Member in addition to any supporting information and other materials collected as part of its review in advance of this interview.

B. MSEC Deliberation

Within 30 days of receipt of the recommendation, the President or the CMO, or designee, will bring forth the recommendation for Corrective Action to the MSEC.

The MSEC may recommend formation of an ad hoc committee to further review the recommendation for Corrective Action. The ad hoc committee shall present its recommendations to the MSEC within 30 days.

Corrective Action may include, but is not limited to, any and all of the following:

1. Issuance of a letter of warning.
2. Imposition of a period of probation. The MSEC shall establish terms of probation up to and including forfeiture of Medical Staff appointment for violation of the terms of probation.
3. Imposition of temporary or permanent reduction or restriction of clinical privileges.
4. Imposition of temporary or permanent suspension of the Medical Staff Membership.

If the MSEC determines that Corrective Action is warranted, it shall immediately inform the Member by providing him/her with a copy of the original charges, the findings, and the MSEC recommendations for Corrective Action. The Member shall have 30 days upon receipt of charges to request a hearing and other rights as provided in ARTICLE IX. If within 30 days said Member does not request a hearing, the recommendations of the MSEC 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 Corrective Action shall be made in accordance with ARTICLE IX. Implementation of the recommendation of the MSEC shall be stayed pending the outcome of the hearing as provided therein.

Nothing contained in this ARTICLE shall be construed as limiting or altering the power to summarily suspend any Membership or to terminate temporary privileges.

## SECTION 4. SUMMARY SUSPENSION

### A. Criteria for Initiation and Notification

Whenever continuation of a Member's practice constitutes immediate danger to the public, including patients, visitors, employees, or Medical Staff Members, two individuals as defined below have the authority and agree to summarily suspend the Medical Staff Membership status or any portion of the Member's clinical privileges:

1. The President of the Medical Staff or authorized designee.

AND

2. Hospital CEO or authorized designee OR CMO or authorized designee.

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 and such Summary Suspension shall become effective immediately upon imposition.

The President of the Medical Staff shall promptly give written notification of the Summary Suspension to the Member, the Hospital CEO or authorized designee, the Chief or authorized designee, and the CMO or authorized designee, which sets forth the grounds for the suspension and right to a hearing. The Member shall be advised of his/her right to have a fair hearing under ARTICLE IX, which shall be convened within 15 days from the date the Summary Suspension is imposed unless the hearing date is extended by mutual agreement of the parties.

In the event of any such Summary Suspension, the Member's patients shall be assigned by the Chief or authorized designee to another Member of the Medical Staff with similar clinical privileges. The wishes of the patient and family shall be considered, where feasible, in choosing a substitute Member.

### B. MSEC Deliberation

Within five days of such Summary Suspension, or as soon thereafter as possible, the MSEC shall review the suspension to recommend whether it should be affirmed, lifted, expunged, or modified. The affected Member may be invited to present a statement as to why the Summary Suspension should be lifted, expunged, or modified as well as answer any questions the MSEC may have. Given the exigent circumstances of a Summary Suspension, a quorum of the MSEC for purposes of a Summary Suspension shall consist of a least five Members, excluding any Member who participated in the initial decision to impose the Summary Suspension.

An MSEC recommendation to terminate or modify the Summary Suspension to a lesser sanction that does not trigger fair hearing procedures under ARTICLE IX, is

transmitted immediately, together with all supporting documentation, to the GB or a committee of the GB for review on an expedited basis. If the Summary Suspension is reimposed, or other adverse action under this ARTICLE VIII is taken, the Member shall be entitled to those hearing rights outlined in ARTICLE IX.

C. Hearing Rights

A Member whose privileges or Medical Staff Membership have been summarily suspended shall be entitled to a fair hearing under ARTICLE IX, and such request for a hearing must be submitted in writing to the President of the Medical Staff within 10 days from the date the Summary Suspension was imposed. Such hearing shall be held within 15 days of imposition of the summary suspension unless the Member and the MSEC agree in writing to a later date or the Member waives his/her right to a fair hearing.

If a Member subject to a Summary Suspension has requested a fair hearing in accordance with ARTICLE IX, 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 other than an Automatic Suspension outlined in Section 7 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 IX, or which is not timely appealed, shall thereafter be made permanent. A Physician for whom all privileges have been permanently suspended shall then no longer be considered a Member of the Medical Staff and shall be removed from Membership.

## SECTION 6. REINSTATEMENT OF MEMBERSHIP OR PRIVILEGES

Any Member suspended may have Membership or privileges reinstated following recommendation by the MSEC except for Summary or Automatic Suspensions. The entire record of the suspension or any other Corrective Actions shall be included as part of the Member's credentialing record.

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

- A. Automatic Suspension of staff admitting, clinical, and consulting privileges may be imposed for the following infractions:
  - 1. Failure to Maintain State Licensure
    - a. If the license is not restored within six months, the Member's Medical Staff Membership shall be automatically terminated.

- b. 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.

2. Failure to Maintain Faculty Appointment

If any Member of the Medical Staff ceases to possess a faculty appointment, said individual shall automatically forfeit Membership in the Medical Staff without any further hearing, process, or review.

3. Failure to Complete ~~Inpatient~~ Medical Records

~~a. Members with inpatient or outpatient documentation lags beyond 14 days will be referred for automatic suspension of clinical privileges. Privileges shall be automatically suspended seven 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.~~

~~a.~~

- b. The Member'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 Medical Staff appointment and privileges.

~~e. The Medical Records Committee may make recommendations to the MSEC for Corrective Action.~~

~~4. Failure to Complete Outpatient Medical Records~~

~~Members with outpatient documentation lags beyond 30-14 days will be referred for Automatic Suspension of clinical privileges.~~

~~5.4.~~ Exclusion from the Medicare or Medicaid Provider Lists

Exclusion of participation in federal or Illinois state healthcare programs shall result in Automatic Suspension.

~~6.5.~~ Loss or Reduction of Malpractice Insurance Coverage

Privileges shall be reinstated when the Member produces satisfactory evidence of coverage.

~~7.6.~~ Failure to Complete BLS Certification

Members failing to maintain BLS certification will be referred for Automatic Suspension of clinical privileges. If Automatic Suspension occurs, privileges shall be reinstated when required training has been completed and the Member is certified.

~~8.7.~~ 8.7. Felony Conviction

Reinstatement shall be at the discretion of the MSEC.

~~9.8.~~ 9.8. Loss of Board Certification, if Required Per Clinical Privileges

Loss of Board certification, if required per departmental clinical privileges, will result in the Automatic Suspension of the Member's specific admitting, clinical, and consulting privileges, which may be reinstated when Member has been re-certified.

- B. Automatic Suspension of privileges for any of the above infractions shall be imposed immediately by the President of the Medical Staff or authorized designee after hearing from the responsible authority. The Member shall be immediately notified of the Automatic Suspension.
- C. Within 7 days of notification, a Member may contest the factual accuracy of the Automatic Suspension by submitting to the Credentials Committee or designated committee his/her written request with supporting documentation. The Credentials Committee shall review the documentation and make a final determination as to whether to lift or uphold the Automatic Suspension.
- D. Upon the occurrence of an Automatic Suspension, the President of the Medical Staff or authorized designee shall notify the CMO and the Chief to provide alternative coverage for the suspended Member's patients. The suspended Member shall confer with the substitute Member to the extent necessary to safeguard and continue the care of the patient.

## **ARTICLE IX. HEARING AND REVIEW**

### SECTION 1. GROUNDS FOR HEARING AND REVIEW

The fair hearing provided for in these Bylaws is for the purpose of intraprofessional resolution of matters bearing on conduct or professional competence. Only the following recommendations or adverse actions shall serve as grounds for a hearing and appellate review under this ARTICLE:

- A. Denial of initial appointment or reappointment, if reportable to the NPDB.
- B. Involuntary reduction or restriction of Membership or clinical privileges.
- C. Involuntary termination of Membership.

- D. Summary Suspension of Membership or clinical privileges.
- E. Mandatory Concurring Obligation, in which a Physician must obtain a consult and be approved for proposed procedures or courses of treatment in advance.
- F. In position of a mandatory proctorship which exceeds 30 days and in which the practitioner cannot exercise privileges unless the proctor is physically present.

## SECTION 2. NOTIFICATION

In all cases, the President of the Medical Staff and CMO shall ensure that the Member or applicant is notified in writing. Such notification shall include the following:

- A. Any adverse action or recommended adverse action;
- B. Documentation of charges;
- C. The applicable Medical Staff Organizational Documents;
- D. The Member or applicant's right to request a fair hearing, as outlined below; and
- E. The Member or applicant's right to review all pertinent documents and reports utilized or relied upon to make said recommendations or take said action.

## SECTION 3. INITIATION

- A. The Member or applicant shall have 30 days from the date the written notification was received to submit a written request for a hearing. A Member or applicant's hearing rights shall be waived if a timely request is not received within such 30-day period.
- B. Within 14 days from the receipt of a request for hearing, the President of the Medical Staff or CMO shall schedule a hearing and notify the Member or applicant and the MSEC, who shall choose a single representative to act on its behalf during the hearing. Except in the case of a Summary Suspension, the hearing date shall not be less than 30 days or more than 60 days from the date of receipt of the request for hearing. All parties may agree to an alternate time frame, if necessary.
  - 1. A hearing for a Member who has received a Summary Suspension shall be held no later than 15 days from the date the Summary Suspension was imposed unless the date is extended by mutual written agreement of the Member and the MSEC.
- C. Within 21 days of receiving the notice of the hearing, both the Member or applicant and the MSEC representative shall provide written lists of the names and contact information of the individuals expected to offer testimony or evidence

on the Member or applicant or MSEC's behalf, together with accurate and complete copies of all exhibits said individuals intend to offer at the hearing.

1. The witness list and exhibits of either party may, at the discretion of the Chairperson of the Hearing Panel, 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.
2. Any individual who requests a hearing but who does not testify on his/her own behalf may be called and examined as if under cross-examination.

#### SECTION 4. HEARING PANEL AND REPRESENTATION

##### A. Hearing Panel

1. The President of the Medical Staff and the Hospital CEO shall select five impartial Members of the Medical Staff to compose the hearing panel. The hearing panel members shall meet the following criteria:
  - a. Shall be an Active Medical Staff Member.
  - b. Shall not be an initiator of the adverse action.
  - c. Shall not have had any prior significant involvement in the decisions leading up to the recommended adverse action.
  - d. Shall not be in direct competition or otherwise have a conflict of interest with the Member or applicant under review.

The Member or applicant has the right to object to any member of the hearing panel. Such objection must be supported by written or other information to be reviewed by the President of the Medical Staff and the Hospital CEO. If the objection is accepted, a replacement member meeting the above criteria shall be found.

2. The hearing panel shall identify one of its five members as the Chairperson of the Hearing Panel or, at the panel's discretion, may appoint a Hearing Officer to preside at the hearing. The Hearing Officer shall gain no financial benefit from the outcome of the hearing, nor have any conflicts of interest and shall not have previously represented the Medical Staff, the Hospital, or the Member or applicant. His/her duties will be limited to presiding over the hearing.
3. All Members of the hearing 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 hearing panel must be present at all times during the hearing. No Member may vote by proxy.

B. Member or Applicant Participation and Representation

1. The Member or applicant may be accompanied by a single individual of his/her own choosing, but the Member or applicant must be present at all times during the hearing.
2. The Member or applicant's accompanying individual may be an attorney. If the Member or applicant is represented by legal counsel, then both the MSEC and the hearing panel shall be entitled to be represented and advised by legal counsel.
3. Failure, without good cause, of the Member or applicant 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 authorized designee, who shall notify the University Healthcare System Committee of the GB and the President of the Medical Staff. In such event, the proposed action of the MSEC or GB shall become final without further action by the MSEC or the GB and without any further rights to a hearing and/or appeal.

C. MSEC Representation

1. The MSEC shall be represented by a single MSEC member to support the MSEC's action or recommended action that initiated the hearing.
2. The MSEC may designate an attorney as a representative if the Member or applicant has first designated an attorney as a representative.

D. Legal Representation

1. If any parties are represented by legal counsel, the Chairperson of the Hearing Panel or the Hearing 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 Chairperson of the Hearing Panel or the Hearing Officer.
2. 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.



## SECTION 5. HEARING PROCEDURE

The Hearing shall be conducted in the following manner:

- A. The Chairperson of the Hearing Panel or the Hearing Officer shall convene the hearing, and shall preside over the hearing and rule on the admissibility of evidence. The entity that made the adverse recommendation shall proceed first followed by the Member or applicant to present evidence. The Chairperson of the Hearing Panel or Hearing Officer 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 on the above matters shall be final. All procedural issues shall be addressed prior to the commencement of the Hearing.
- B. Prior to or during the hearing, either party may submit objections and supporting documents concerning any issue of procedure or fact. The hearing panel shall be entitled to consider any pertinent material, whether formally presented at the hearing or not, including the Member or applicant's application and file.
- C. The Member or applicant and/or his/her representative, if allowed, may present such information and witnesses as support his/her challenge to the action or recommended action. Either party or any hearing panel member may ask questions of any witnesses, but must do so in an orderly fashion under the direction of the Chairperson of the Hearing Panel or the Hearing Officer.
- D. The Chairperson of the Hearing Panel or Hearing Officer, in his/her discretion, may recess the hearing and later reconvene the same day for the convenience of the parties or for any other reasonable purpose. Delay tactics on the part of either party shall not be tolerated and may be considered by the hearing panel in reaching a decision. Any continuance granted with the reason therefore must be shown on the record.
- E. After all parties have presented all relevant information and after the hearing panel, on its own motion, has obtained such additional information as it requires, the hearing panel shall adjourn to Executive Session to reach a decision. The hearing panel may do any of the following:
  1. Affirm the action as previously taken or direct that a previous recommendation be implemented.
  2. Modify, as in its exclusive discretion it deems appropriate, said recommendation or action previously taken and direct that same be carried out.
  3. Return the Member or applicant to the same status as prior to the adverse action.

The hearing panel must render a recommendation that includes findings supported by the evidence within seven days of the close of the final hearing session.

- F. The hearing held hereunder shall be considered a de novo determination and the hearing panel may make any decision appropriate as long as that decision is supportable by a preponderance of the evidence considered by the hearing panel.
- G. A copy of the hearing panel's recommendation shall be given to the Member or applicant, the MSEC, the CMO, the Vice President, and the President of the Medical Staff. The CMO shall also provide a copy to the GB and the VCHA.
- H. An official transcript of all hearing sessions, recorded by a court reporter, must be retained for a period of at least six years from the time a decision is reached.

#### SECTION 6. REVIEW BY THE GOVERNING BODY

- A. Within 14 days after receipt of the written decision of the hearing panel, the Member or applicant and/or the MSEC may, in writing to the GB or authorized designee, request review of the hearing panel's decision. Upon receipt of this request, the GB or authorized designee shall direct the hearing 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. This record shall be made available to the Member or applicant for review and copying, at his/her request and cost.
- B. The Member or applicant and/or MSEC may, within seven days of notification by the GB or authorized 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.
- C. The GB or authorized designee shall review the record and determine the following:
  - 1. If the procedures as established by these Bylaws and by appropriate University regulations and policies have been met.
  - 2. If the findings of the hearing panel are not against the preponderance of the evidence or arbitrary and capricious.
- D. If, upon its review, the GB or authorized designee determines that any of these standards has been violated, it shall do any of the following:
  - 1. Reinstate the Member to the same status as he/she enjoyed prior to the unfavorable action. In this case, an applicant may continue through the application and approval process.

2. Return the matter to the MSEC for rehearing with a new hearing panel.
  3. Without regard to previous recommendations or actions, take any other action concerning the Member or applicant's status that it deems appropriate.
- E. If the GB or authorized designee determines that the foregoing standards were fully met, it shall affirm the decision of the hearing panel. Any decision by the GB or authorized designee must be made and a copy provided to the Member or applicant within 14 days of the time the record is certified and forwarded to him/her.
- F. The decision of the GB or authorized designee shall in all cases be final.

## SECTION 7. REPORTABLE ACTIONS TO REGULATORY AGENCIES

Mandatory Reporting to all regulatory agencies, including the NPDB and IDFPR, occurs as required by law and/or the Medical Staff Organizational Documents under the following circumstances:

- A. The 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."
- B. The 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.
- C. Voluntary restriction or resignation of clinical privileges to avoid Investigation is also reportable.
- D. Reports will be filed with the 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](http://www.npdb-hrsa.gov).

## **ARTICLE X. OFFICERS**

### SECTION 1. QUALIFICATIONS

Only Active Members of the Medical Staff holding a faculty appointment of 50 percent or higher may be Officers or delegates of the MSEC.

## 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

### A. President of the Medical Staff

The President of the Medical Staff shall be Chair of the MSEC, shall preside over all meetings of the Medical Staff, shall appoint the chairpersons of the standing committees of the Medical Staff, and shall have such other duties as are provided by these Bylaws or as are delegated by higher University authority.

### B. Vice President of the Medical Staff

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.

### C. Secretary/Treasurer

The Secretary/Treasurer of the Medical Staff shall keep, or shall delegate responsibility for keeping, the official minutes of the Medical Staff and shall maintain the official roster of voting Members. He/she shall also be responsible for, or delegate responsibility for, the collection of Medical Staff dues and all associated recordkeeping, and shall be responsible for presenting an annual budget including a detailed financial report to the Medical Staff. In the absence of the President and Vice President, the Secretary/Treasurer shall carry out their responsibilities.

### D. Immediate Past President

The Immediate Past President of the Medical Staff shall be a Member of the MSEC, serve as an advisor to the President of the Medical Staff, and perform those functions delegated to him/her by the MSEC, including serving as Chair of the Bylaws Committee.

## SECTION 4. SELECTION OF OFFICERS

A. Nomination of Officers of the Medical Staff shall be made every two years by the Nominating Committee appointed by the MSEC.

B. Elections shall be held every two years at the Annual Meeting.

C. 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.

- D. Under ordinary circumstances, the Nominating Committee should make nominations consistent with a two-year tenure of an individual as Secretary/Treasurer, followed immediately by two years as Vice President, followed immediately by two years as President.
- E. Voting may be by secret ballot if requested.
- F. The candidate receiving the highest number of votes for the office shall be elected.

#### SECTION 5. REMOVAL OF OFFICERS

- A. Any elected officer of the Medical Staff may be removed from office for any of the following reasons:
  - 1. Gross neglect or malfeasance, or failure to carry out the duties of his/her office.
  - 2. For reasons of incapacity.
  - 3. For other good cause.
- B. The following criteria must be met to initiate the process for removing an officer of the Medical Staff:
  - 1. A written petition signed by not less than 10 percent of the eligible voting Members of the Medical Staff supporting removal of an incumbent officer must be submitted to the President of the Medical Staff or CMO.
  - 2. A special meeting of the Medical Staff must be called and held within not less than two weeks or 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.
  - 3. 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 10 percent of the voting Members. The vote shall be conducted by secret ballot.

#### SECTION 6. VACANCIES OF OFFICERS

- A. 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.
- B. 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.

- C. In the event there is a vacancy in the office of the Secretary/Treasurer, with no successor as set forth in this Section 6, an election shall be conducted to fill such office. The MSEC may, at its discretion, appoint an individual to fill the office until such an election can be held.
1. 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 MSEC. 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 conducted by secret ballot if requested.
  2. Election shall be by the affirmative vote of either of the following:
    - a. Voting Medical Staff Members present at a meeting.
    - b. 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 percent of the Medical Staff Members eligible to vote submit votes.
  3. 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 MSEC every two years and submitted to the Medical Staff at its next regularly scheduled meeting.

## **ARTICLE XI. COMMITTEES OF THE MEDICAL STAFF**

### SECTION 1. MEDICAL STAFF EXECUTIVE COMMITTEE (MSEC)

The Medical Staff Executive Committee (MSEC) has the primary authority for activities related to the Medical Staff. The Medical Staff delegates authority to the MSEC to carry out Medical Staff responsibilities as defined in the Medical Staff Organizational Documents.

- A. Composition of the MSEC
1. President of the Medical Staff, Chair of the MSEC
  2. Vice President of the Medical Staff
  3. Treasurer/Secretary of the Medical Staff
  4. Immediate Past President of the Medical Staff

5. All Chiefs or authorized designees
6. ~~Six-Eight~~ active Members of the Medical Staff who are not Chiefs. There should not be more than two of these ~~six-eight~~ Members from one Clinical Service on the committee at the same time.
7. Hospital CEO (without a vote)
8. CMO (without a vote)
9. VCHA (without a vote)
10. Dean of the College of Medicine (without a vote)

B. Election of MSEC Members

Active Members of the Medical Staff who are not Chiefs shall be elected to the MSEC via the following process:

1. The Nominating Committee shall seek nomination from all Members of the Medical Staff and vet the interest and good standing of those nominated.
2. The ballot of nominees shall be presented at the annual Medical Staff Meeting where election will occur.
3. Voting at elections shall be conducted by secret ballot by those present at the meeting and eligible to vote.
4. The members receiving the highest number of votes will be elected to the MSEC into the open delegate positions to fulfil the staggered three-year terms. The next two members receiving the highest votes will become the alternate delegates for a one-year term. Alternates are welcome to attend the MSEC meetings at any time and may vote if a delegate is absent.
5. 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 that occur prior to the next election shall be filled for the remainder of the term by the alternate delegates in the sequence determined by the number of votes each had gathered in the preceding annual election.

C. Removal of Elected Delegates of the MSEC

1. Any elected delegates of the MSEC may be removed from office for failure to carry out the duties of MSEC membership, for reasons of incapacity, or for other good cause in accordance with the provisions of this Section.

2. To initiate the process for removing an elected delegate of the MSEC, a written petition signed by at least 10 Active Members must be submitted to the President of the Medical Staff. At the next meeting of the MSEC, the affected MSEC delegate shall be given the opportunity to address the MSEC on the matter of his/her removal.
3. An MSEC delegate may be removed by a simple majority vote of those voting Members of the MSEC present at the meeting. A quorum must be present and the vote shall be conducted by secret ballot.

D. Meetings of the MSEC

1. The MSEC shall meet monthly and shall maintain a record of its proceedings and actions.
2. Special meetings may be called by the President of the Medical Staff.
3. Meetings shall be conducted according to the latest edition of Robert's Rules of Order.
4. 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 MSEC who must be present, in person; at least one of whom must be one of the elected officers of the MSEC.

E. Responsibilities of the MSEC

The responsibilities of the MSEC include the following but may be expanded or reduced pursuant to the process for amending Bylaws under ARTICLE XVII.

1. Act on behalf of the Medical Staff between meetings of the Medical Staff.
2. Receive, review, and act on reports of Medical Staff standing committees, other assigned activity groups, departments, and Clinical Services.
3. Communicate proposals to adopt a rule or regulation, or an amendment thereto, to the Medical Staff for review, as set forth under ARTICLE XVII, Section A of these Bylaws.
4. Adopt policies without Medical Staff approval, but communicate the policy or policies to the Medical Staff.
5. 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 to review and recommend action concerning appointments to the Medical Staff, of which a majority of its Members are members of the MSEC.
7. Act on recommendations of the Credentials Committee. Make recommendations to the GB or authorized designee regarding applications for Membership to the Medical Staff, credentialing, and/or 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 Corrective Action and hearing and appellate review procedures.
10. Call meetings of the Medical Staff.
11. Have the right of review and approval regarding proposed changes in operational aspects of delivery of care. No substantial changes affecting professional health care delivery should be made without consulting the MSEC.
12. Account to the GB 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.

## SECTION 2. STANDING AND SPECIAL COMMITTEES OF THE MEDICAL STAFF

The MSEC shall establish those standing committees and their composition of the Medical Staff that are in the best interests of patient care.

- A. Each committee should maintain adequate records of deliberation and should report at least once a year to the MSEC.
- B. Committees are required to meet at a minimum of once a year. At the discretion of the Chair of each committee, additional meetings may be held.
- C. Meetings may be held in person or electronically, at the discretion of the Chair of the committee, and committee members may vote by e-mail or other electronic means.

Other than the MSEC, the standing committees of the Medical Staff include:

- A. Committee on Credentials
- B. Committee on Committees
- C. Nominating Committee
- D. Committee on Medical Staff Bylaws
- E. Committee on Practitioners' Assistance
- F. Medical Staff Review Board
- G. Peer and Exemplary Review Committee

The Rules and Regulations include detailed purpose and responsibilities of the standing committees of the Medical Staff.

## **ARTICLE XII. 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 credentialing and/or 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 THE CLINICAL SERVICES

#### A. Qualifications

1. The Chief for each of the Clinical Services listed in Section 2 must be an Active Member of the Medical Staff in good standing and Board certified by an appropriate specialty board unless the Medical Staff affirmatively determines, through the privilege delineation process, that he/she possesses comparable competence.
2. If the entire Clinical Service is under exclusive contract, the Chief may be a Contract Member of the Medical Staff in good standing and Board certified by an appropriate specialty board unless the Medical Staff affirmatively determines, through the privilege delineation process, that he/she possesses comparable competence.

#### B. Appointment and Removal

Appointment and removal of the Chief shall be governed by the following procedures:

1. A Member serving as a Department Head in the College of Medicine shall automatically be considered as the nominee for Chief of the corresponding Clinical Service unless he/she nominates an alternate, which is to be discussed in consultation with the CMO. The Dean of the College of Dentistry shall nominate a candidate for Chief of the Dentistry Service. The Dean of the School of Public Health shall nominate a candidate for Chief of Environmental and Occupational Medicine. The nominee shall be named

to the position by the CMO with approval by the MSEC. If such consent and approval is not granted, the CMO 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, College of Dentistry, or School of Public Health also serves as Chief of the corresponding Clinical Service in the Hospital and if, through proper University procedure, that Head is relieved of title and duties as Department Head, the CMO may remove him/her as the Chief solely on the basis of this prior action. In this case, the removed Chief shall have no appeal or hearing rights as a result of this removal. A vacancy may then be filled following the process outlined in 1 above.
3. If the need to elect a replacement Chief occurs, and that Chief is not also the Department Head, a new nomination may be made by the Department Head as in 1 above. In this case, the removed Chief shall have no appeal or hearing rights as a result of this removal.
4. The Chief may also be removed from such position for the reasons listed below:
  - a. The activities or professional conduct jeopardizes or may jeopardize the safety of a patient, visitor, or employee, or the continued proper functioning of the Hospital, or the reputation of the Hospital.
  - b. Unethical or unprofessional conduct or conduct detrimental to the Hospital or Medical Staff, including failure to observe the Hospital's Code of Conduct.
  - c. Professional incompetence, or incapacity, including that caused by an impairing physical, psychiatric, or emotional illness.
  - d. Failure to observe the Medical Staff Organizational Documents, or University, college(s), or Hospital guidelines and policies.
  - e. Failure to carry out Medical Staff or other clinical assignments, including committee or departmental assignments.
  - f. Failure to carry out the duties listed in Section C below.
  - g. Other reasonable causes.
5. Two of the individuals defined below have the ability to recommend the removal of a Chief for any of the reasons listed in 4 above.
  - a. The President of the Medical Staff.

AND

b. Hospital CEO OR the CMO.

6. The CEO shall provide written notification of the recommendation and reasons for removal to the Chief and to the MSEC. If the Chief agrees with or does not appeal the removal, the CMO shall nominate an alternate Chief until a new nomination will be made following the process outlined in 1 above
7. If the Chief does not agree with the recommendation for remove, the Chief has 15 days to request a special meeting with the MSEC to discuss.
8. The MSEC has 15 days after the Chief's request is received to schedule a special meeting at which the Chief shall be given the opportunity to address the MSEC on the matter of his/her removal. The President of the Medical Staff, the Hospital CEO, or the CMO shall also present supporting documentation of their recommendation.
9. At the end of the special meeting, the MSEC shall vote via secret ballot on the recommendation for removal. The Chief may be removed by a simple majority vote of those voting Members of the MSEC present at the special meeting.

C. Duties

Each Chief has ultimate responsibility for patient care with respect to his/her Clinical Service affairs. In addition, each Chief has the below-listed duties. These duties are evaluated by the CMO annually and a report is given to the CEO.

1. Accountability to the MSEC and the GB for all professional, administrative, clinically related, and quality improvement functions within his/her Clinical Service.
2. Integration of the Clinical Service into the primary functions of the organization.
3. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
4. Coordination and integration of interdepartmental and intradepartmental services.
5. Recommendation of sufficient number, qualifications, and competence of healthcare personnel necessary to provide quality care and service.

6. Recommendation of clinical privileges for each Member of the department, and recommendation to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department.
7. Continuing review of the performance of all members of the Clinical Service, including PPE based on criteria established by the Chief and approved by the MSEC consistent with accreditation standards.
8. Transmission, on a timely basis, of the Clinical Service's recommendations concerning the appointment and category, reappointment, delineation of clinical privileges, and corrective action with respect to applicants to and members of the Clinical Service.
9. Establishment of rules and schedules for the appropriate supervision of House Staff by the members of the Clinical Service.
10. Assurance that the Clinical Service has an effective quality improvement program that includes all necessary quality control mechanisms.
11. Orientation and continuing education of the Clinical Service's staff.
12. Preparation of recommendations for space and other required resources needed for the provision of care and services.
13. Assessment and recommendation to the Hospital off-site sources for needed patient care, treatment, and services not provided by the Clinical Service or the organization.
14. Participation in budgetary planning as applicable to patient care within the Clinical Service.
15. Enforcement of the Medical Staff Organizational Documents and Hospital policies applicable to the Clinical Service.
16. Implementation within the Clinical Service of actions taken and initiatives presented by the MSEC and Hospital leadership.
17. In addition, the Chiefs of the Clinical Services and/or their authorized designees and the CMO are authorized to conduct interviews or investigations into such matters when the committees are not in session.
18. Communicate relevant patient care and Clinical Service information to Members in a routine and timely manner.

**ARTICLE XIII.  
MEDICAL STAFF MEMBERS WITH  
ADMINISTRATIVE RESPONSIBILITY IN THE HOSPITAL**

**SECTION 1. APPOINTMENT AND REMOVAL**

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. 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 GB.

**SECTION 2. CLINICAL PRIVILEGES**

Clinical privileges of 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 Members.

**ARTICLE XIV.  
REQUIREMENTS FOR ATTENDANCE AT MEETINGS**

Medical Staff Members are encouraged to attend the following meetings:

- A. The annual Medical Staff meeting.
- B. Meetings of each Clinical Service and committee(s) in which Membership is held.

**ARTICLE XV.  
GRADUATE MEDICAL EDUCATION PROGRAMS**

Residents or fellows training in the Graduate Medical Education (GME) programs shall not hold Membership on the Medical Staff and shall not be granted specific privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by GME. These residents and fellows shall be governed by the requirements listed below:

- A. Physicians with appropriate professional degrees who are serving as residents or fellows with an appropriate Agreement with the Hospital and who hold licenses to practice in Illinois are automatically considered as residents or fellows by virtue of such Agreement with the GB 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. The residents or fellows' qualifications and training have been reviewed and verified, and are maintained by, the GME.

- B. Residents or fellows are appointed for the duration of status as a resident/fellow. Provisions for termination of the appointment are included in said GME Agreement.
- C. Residents or fellows have regular duties and responsibilities assigned by the Chief. Clinical activities are commensurate with the service, level of training, and individual's ability, as determined by the Chief, but always under supervision of a Member of the Active Medical Staff. The conduct of residents or fellows is to be guided by the Medical Staff Organizational Documents, appropriate Hospital policies, and policies of the GME.
- D. It is the responsibility of each Chief to assume, directly or through delegation, the task of assigning appropriate Department members who are also Medical Staff Members to provide appropriate supervision of residents and fellows assigned to the Department for the rendering of patient care in the hospital.
- E. The Chief shall assure that supervision of residents and fellows complies with the Essentials of Accredited Residencies in GME established by the Accreditation Council for Graduate Medical Education.
- F. Attending Staff Members are responsible for ascertaining all diagnostic, therapeutic, and surgical procedures performed by residents and/or fellows are medically indicated and executed by residents or fellows with a sufficient degree of training and experience for the procedure(s) involved.
- G. Each department shall assure that all elements of the Hospital policy concerning resident and fellow supervision and the respective Departmental policies concerning resident and fellow supervision are adhered to by all Members.

#### **ARTICLE XVI. AMENDMENTS TO BYLAWS**

The Bylaws are reviewed at least every three years or as otherwise necessary or required. Amendments to Bylaws can be adopted by either of the following methods:

- A. Proposed amendments to the Bylaws 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 the Bylaws Committee, it is referred to the Bylaws Committee for review and subsequent report to the MSEC. Approval by two-thirds of the MSEC is required for the amendment to be presented to the Medical Staff.



- B. The amendment is presented 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 of the following:
1. Two-thirds of the Medical Staff eligible to vote present at a regular or annual Medical Staff meeting.
  2. 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 percent of the Medical Staff Members eligible to vote submit votes on such amendments by e-mail or electronically.
- C. 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 Bylaws Committee and the MSEC, which shall have the right to review and provide its comments to the GB prior to its final review and approval.

Amendments made to the Bylaws become effective when approved by the GB. Up-to-date compendia of these Bylaws shall be available through a web-based Hospital platform.

## **ARTICLE XVII. AMENDMENTS TO RULES AND REGULATIONS**

The Rules and Regulations are reviewed by the Bylaws Committee and the MSEC at least every three years, or as otherwise necessary or required. The Organized Medical Staff delegates the authority over the Rules and Regulations to the MSEC. Amendments to the 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. Proposed amendments to the Rules and Regulations can either be submitted for discussion at a meeting of the MSEC or presented by e-mail or other electronic method to the MSEC. If not submitted by the Bylaws Committee, it is referred to the Bylaws Committee for review and subsequent report to the MSEC and then to the MSEC either at an MSEC meeting or by e-mail or other electronic method to the MSEC. Prior to adoption, the proposed amendment must also be communicated to the Medical Staff at a meeting of the Medical Staff or presented by e-mail or electronic method to the Medical Staff. To be adopted, an amendment to the Rules and Regulations requires an affirmative vote of either of the following:
1. Two-thirds of the MSEC eligible to vote present at meeting.

2. Two-thirds of the MSEC eligible to vote who submit votes by e-mail or electronically, in the manner designated in the notice or electronic ballot.
- B. In cases of a documented need for an urgent amendment to the Rules and Regulations necessary to comply with law or regulation, the MSEC may provisionally adopt an urgent amendment to the Rules and Regulations without prior notification to the Medical Staff. The amendment shall be communicated to the Medical Staff for review and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MSEC, the amendment stands. If there is conflict over the provisional amendment, such conflict shall be subject to the conflict management procedures under ARTICLE XIX.
  - C. The organized Medical Staff can adopt Rules and Regulations and amendments, and propose them directly to the GB, by a petition signed by at least 51% of voting Members, but must first notify the Bylaws Committee and the MSEC, which shall have the right to review and provide its comments to the GB prior to its final review and approval.

Amendments made to the Rules and Regulations become effective when approved by the MSEC. Up-to-date compendia of these Rules and Regulations shall be available through a web-based Hospital platform.

### **ARTICLE XVIII. POLICIES**

Policies may be developed as necessary to implement more specifically the general principles found within the Medical Staff Organizational Documents. New or revised policies may emanate from any responsible committee, Clinical Service, Medical Staff Officer, or by petition signed by at least 51% of the voting Members of the Medical Staff. The policies must be consistent with the Medical Staff Organizational Documents and shall not supersede or materially alter their interest.

### **ARTICLE XIX. MANAGEMENT OF CONFLICTS BETWEEN THE ORGANIZED MEDICAL STAFF AND MSEC**

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

#### **SECTION 1. REQUIREMENTS FOR CONFLICT MANAGEMENT PROCESS**

In the event that 33 percent of the voting members of the Medical Staff each sign a petition or otherwise provide evidence of disagreement with any action taken by the MSEC including, but not limited to, any proposed bylaw, rule, regulation, or policy, excluding any appointment,

reappointment, or Corrective Action or decisions, these Members can require that the conflict management process under this ARTICLE be followed.

## SECTION 2. METHODOLOGY

- A. A petition stating disagreement with any action taken by the MSEC should clearly state the basis of the disagreement and may include any other information by way of additional explanation to Medical Staff Members. The petitioner must acknowledge that he/she has read the petition and all attachments, if any, in order for his/her signature to be considered valid.
- B. If the conflict management threshold has been achieved, the petition, any attachments, and a list of petitioners shall be forwarded to the MSEC. Within 30 days of the MSEC's receipt of the petition, a meeting between representatives of both the MSEC, 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.
- C. If the MSEC 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 of the voting Members approve the proposed resolution at a general or special meeting, the proposal will be forwarded to the VCHA for his/her review and consideration. The VCHA will then forward the proposal to the GB.
- D. 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 MSEC, the petition and all accompanying materials will be forwarded to the VCHA to arbitrate the conflict. The VCHA, at his/her discretion, may escalate the proposal to the GB for resolution. The decision of the GB shall be final and communicated as appropriate to the involved parties.

All voting Medical Staff Members are free to communicate with the GB in writing regarding conflict or discrepancy as it relates to any rule, regulation, or policy adopted by the Organized Medical Staff or MSEC. Such communication shall be forwarded to the GB through the CMO and VCHA and to the MSEC through the President of the Medical Staff. The Chair of the GB shall determine the manner and method of responding to any Member communicating to the GB.

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