BYLAWS OF THE MEDICAL STAFF

Insight Chicago, Inc.
(Insight Hospital and Medical Center Chicago)

2525 South Michigan Avenue
Chicago, Illinois 60616

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TABLE OF CONTENTS

Page No.

I. NAME 2
II. DEFINITIONS 2
2.1 ADVANCED PRACTICE PROFESSIONAL or APP 2
2.2 APPELLANT 2
2.3 BOARD CERTIFIED or BOARD CERTIFICATION 2
2.4 BOARD ELIGIBLE or BOARD ELIGIBILITY 2
2.5 BOARD OF DIRECTORS or BOARD 3
2.6 CHAIR 3
2.7 CHIEF 3
2.8 CHIEF EXECUTIVE OFFICER or CEO 3
2.9 CHIEF MEDICAL OFFICER or CMO 3
2.10 CHIEF OF STAFF 3
2.11 CHIEF QUALITY OFFICER or CQO 3
2.12 CLINICAL PRIVILEGES 3
2.13 CONTRACT PRACTITIONER 3
2.14 DAY or “day” 3
2.15 DEPARTMENT 3
2.16 DUE PROCESS 3
2.17 EX OFFICIO 3
2.18 FOCUSED PROFESSIONAL PRACTICE EVALUATION or FPPE 4
2.19 HOSPITAL 4
2.20 HOSPITAL - BASED 4
2.21 HOUSE PHYSICIAN 4
2.22 MEDICAL EXECUTIVE COMMITTEE or MEC 4
2.23 MEDICAL STAFF or STAFF 4
2.24 MEDICAL STAFF POLICY or POLICIES 4
2.25 MEDICAL STAFF YEAR 4
2.26 MEMBER 5
2.27 ONGOING PROFESSIONAL PRACTICE EVALUATION or OPPE 5
2.28 PATENT CONTACT 5

Page No.

2.29 PRACTITIONERS 5
2.30 RULES 5
2.31 RULES AND REGULATIONS 5
2.32 SPECIAL NOTICE 5
2.33 SUPERVISING MEMBER 5
III. MEMBERSHIP 5
3.1 NATURE OF MEMBERSHIP 5
3.2 BASIC QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP 6
3.3 OTHER CRITERIA FOR MEDICAL STAFF MEMBERSHIP 6
3.4 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP 7
3.5 DURATION OF MEMBERSHIP 8
3.6 LEAVE OF ABSENCE 9
IV. APPLICATIONS FOR MEDICAL STAFF MEMBERSHIP 10
4.1 INITIAL APPLICATION 10
4.2 PROCEDURE FOR REAPPOINTMENT 11
V. CLINICAL PRIVILEGES 13
5.1 DELINEATION OF CLIN1CAL PRIVILEGES 13
5.2 PRIVILEGE MODIFICATION 13
5.3 FOCUSED PROFESSIONAL PRACTICE EVALUATION 13
5.4 TEMPORARY CLINICAL PRIVILEGES 14
5.5 EMERGENCY CLINICAL PRIVILEGES 15
5.6 DISASTER CLINICAL PRIVILEGES 15
5.7 EFFECT OF CONTRACTS ON CLINICAL PRIVILEGES 15
5.8 CONDITIONS TO CLINICAL PRIVILEGES 15
VI. PROVISION OF CARE BY NON-MEMBERS 16
6.1 ADVANCED PRACTICE PROFESSIONALS 16
6.2 HOUSE PHYSICIANS 17
VII. MEDICAL STAFF CATEGORIES 18
7.1 CATEGORIES 18
7.2 ACTIVE STAFF 18
7.3 COURTESY STAFF 20
7.4 CONSULTING STAFF 21

7.5 AMBULATORY CARE STAFF 22
7.6 COVERAGE STAFF 23
7.7 HONORARY STAFF MEMBERS 24
VIII. DEPARTMENTS DIVISIONS AND SECTIONS 25
8.1 IDENTIFICATION 25
8.2 CREATION 25
8.3 COMPOSITION 26
8.4 DUTIES 26
8.5 MEETINGS 27
8.6 CHAIR 27
8.7 POLICIES 29
8.8 DIVISIONS AND SECTIONS 29
IX. OFFICERS 30
9.1 GENERAL 30
9.2 CHIEF OF STAFF 31
9.3 VICE CHIEF OF STAFF 31
9.4 SECRETARY-TREASURER 32
9.5 METHOD OF ELECTION 32
9.6 RECALL 34
9.7 VACANCIES 34
9.8 IMMEDIATE PAST CHIEF OF STAFF 34
9.9 CHAIRMANSHIP SEQUENCE 34
X. COMMITTEES 35
10.1 COMMITTEE MEMBERSHIP 35
10.2 MEDICAL EXECUTIVE COMMITTEE 35
10.3 BYLAWS COMMITTEE 36
10.4 CANCER COMMITTEE 37
10.5 CREDENTIALS COMMITTEE 37
10.6 PROTECTION CONTROL COMMITTEE 38
10.7 HEALTH INFORMATION MANAGEMENT COMMITTEE 38
10.8 PHARMACY & THERAPEUTICS COMMITTEE 39
10.9 PHYSICIAN WELLNESS AND ASSISTANCE COMMITTEE 39
10.10 QUALITY & SAFETY COMMITTEE 41

10.11	TRANSFUSION COMMITTEE	42
10.12	CRITICAL CARE QUALITY IMPROVEMENT COMMITTEE	42
10.13	CME/LIBRARY COMMITTEE	43
10.14	PROFESSIONAL PRACTICE EVALUATION COMMITTEE (“PPEC”)	43
10.15	JOINT CONFERENCE COMMITTEE	45
XI.	GENERAL MEETINGS OF THE MEDICAL STAFF	45
11.1	REGULAR MEETINGS	45
11.2	SPECIAL MEETINGS	45
11.3	ATTENDANCE AT MEETINGS	46
11.4	LOCATION	46
11.5	QUORUM	46
11.6	VOTING	46
11.7	AGENDA	46
XII.	CORRECTIVE ACTION	48
12.1	GROUNDS FOR REQUEST	48
12.2	FORM OF REQUEST	48
12.3	NOTICE OF REQUEST	48
12.4	INVESTIGATION	48
12.5	OPTIONAL MEDICAL EXECUTIVE COMMITTEE INTERVIEW OF PRACTITIONER	49
12.6	MEDICAL EXECUTIVE COMMITTEE’S ACTION ON REQUEST	49
12.7	REPORT TO THE BOARD	50
12.8	MONITORING PRACTITIONER’S COMPLIANCE	50
XIII.	SUMMARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES	50
13.1	IMPOSITION	50
13.2	MEDICAL EXECUTIVE COMMITTEE REVIEW	50
13.3	FAVORABLE RECOMMENDATION	51
13.4	UNFAVORABLE RECOMMENDATION	51
13.5	CARE OF PATIENTS	51
XIV.	INVESTIGATIVE SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES	51
14.1	IMPOSITION	51
14.2	INTERIM NATURE	52
14.3	CARE OF PATIENTS	52

XV. AUTOMATIC SUSPENSION/TERMINATION OF CLINICAL PRIVILEGES/MEMBERSHIP 52

15.1 PROFESSIONAL LICENSE 52

15.2 15.2 DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION OR STATE CONTROLLED SUBSTANCES LICENSE 52

15.3 MEDICAL RECORDS 53

15.4 MALPRACTICE INSURANCE 53

15.5 FEDERAL PROGRAM EXCLUSION 53

15.6 DUES 53

15.7 LEAVE OF ABSENCE 53

15.8 REAPPOINTMENT 53

15.9 ADVANCED PRACTICE PROFESSIONALS 53

15.10 HEALTH EVALUATION 54

15.11 COMMUNICABLE DISEASE TEST RESULTS 54

15.12 REPORTS OF ADVERSE EVENTS 54

15.13 VACCINATION/IMMUNITY 54

XVI. HEARING AND APPELLATE REVIEW PROCESS - MEDICAL STAFF MEMBERS AND APPLICANTS 54

16.1 DUE PROCESS 54

16.2 RIGHT TO A HEARING 55

16.3 PRE-HEARING PHASE 56

16.4 HEARING PHASE 58

16.5 POST-HEARING PHASE 60

16.6 APPELLATE REVIEW 61

XVII. HEARING AND APPELLATE REVIEW PROCESS ADVANCED PRACTICE PROFESSIONALS AND APP APPLICANTS 63

17.1 DUE PROCESS 63

17.2 RIGHT TO A HEARING 63

17.3 PRE-HEARING PHASE 64

17.4 HEARING PHASE 65

17.5 POST-HEARING PHASE 66

17.6 APPELLATE REVIEW 67

XVIII. IMMUNITY CONFIDENTIALITY AND RELEASES 68

18.1 IMMUNITY 68

Page No.

18.2 CONFIDENTIALITY 68
18.3 ACTIVITIES AND INFORMATION COVERED 69
18.4 RELEASES 69
18.5 CUMULATIVE EFFECT 69
XIX. AMENDMENTS 70
19.1 NO UNILATERAL AMENDMENT 70
19.2 COMPLIANCE WITH FEDERAL AND STATE LAW 70
19.3 PROCESS 70
19.4 TECHNICAL AMENDMENTS 70
19.5 BOARD APPROVAL 70
XX. POLICIES. RULES AND REGULATIONS 71
20.1 ADOPTION 71
20.2 ROLE OF MEC 71
20.3 NO UNILATERAL AMENDMENT 71
20.4 CONFLICT MANAGEMENT 71
20.5 PRESENT RULES 71
XXI. ADOPTION OF BYLAWS AND RULES AND REGULATIONS AND POLICIES 71

APPENDIX A - HISTORY AND PHYSICAL EXAMINATIONS
EXHIBIT B - CREDENTIALS VERIFICATION
EXHIBIT C - MEDICAL STAFF CATEGORIES SUMMARY

INSIGHT HOSPITAL AND MEDICAL CENTER CHICAGO

CHICAGO ILLINOIS

BYLAWS

OF THE

MEDICAL STAFF

PREAMBLE

~~Insight Hospital and Medical Center is Chicago's first and oldest hospital and its physicians joined the Sisters of Mercy in their healing ministry to the people of Chicago. To carry on this ministry, Insight Hospital joined Trinity Health in 2012.~~ The Medical Staff oversees and strives to improve the quality of patient care at Insight Hospital, while working cooperatively with the Chief Executive Officer and the Board to fulfill the Hospital's commitments to its patients.

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Insight Hospital and to provide a framework for self-governance in order to permit the Staff to discharge its responsibilities in matters involving the quality of medical care, and its responsibility of accounting therefore to the Board. The Board has the final responsibility for the governance of the Medical Center. Neither the Staff nor the Board may unilaterally amend the Bylaws.

I. NAME

The name of this organization shall be the Medical Staff of Insight Hospital and Medical Center Chicago.

II. DEFINITIONS

II.1 ADVANCED PRACTICE PROFESSIONAL or APP

An individual, other than a physician, chiropractor, podiatrist, oral surgeon, or dentist, who has been granted Clinical Privileges at the Hospital. The Board of Directors, after soliciting the recommendation of the Medical Executive Committee, shall determine from time to time which licensed professionals are eligible for APP status. APP's are not ms of the Medical Staff. APPS include both individuals who are employed by the Hospital and those who are not.

II.2 APPELLANT

A Staff Member, a Practitioner who has been granted Clinical Privileges, or a Practitioner who is applying for Medical Staff membership or Clinical Privileges, who has requested Due Process pursuant to Article XVI or XVII, as applicable.

II.3 BOARD CERTIFIED or BOARD CERTIFICATION

Certification as a specialist or subspecialist by a certifying board that is recognized as such by the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, or the American Dental Association's Commission on Dental Accreditation or certification by the American Board of Podiatric Surgery. The Medical Executive Committee may add an equivalent, nationally-recognized association or board to the list of organizations authorized to recognize certifying boards or certify specialists or subspecialists.

II.4 BOARD ELIGIBLE or BOARD ELIGIBILITY

A Practitioner's eligibility to sit for the certification examination offered by a

		certifying board that is recognized by an organization listed in Section 2.3.
II.5	**BOARD OF DIRECTORS or BOARD**	The governing body of the Hospital.
II.6	**CHAIR**	The head of a Department, unless otherwise stated.
II.7	**CHIEF**	The head of a division or section.
II.8	**CHIEF EXECUTIVE OFFICER or CEO**	The highest ranking executive position of the Hospital.
II.9	**CHIEF MEDICAL OFFICER or CMO**	The physician holding that office pursuant to appointment by the CEO.
II.10	**CHIEF OF STAFF**	The individual appointed to act as the Chief of Staff of the Medical Staff.
II.11	**CHIEF QUALITY OFFICER or CQO**	The individual holding that office pursuant to appointment by the CEO.
II.12	**CLINICAL PRIVILEGES**	The permission granted to an individual to provide specific patient care services in the Hospital, including access to those Hospital resources including equipment, facilities, and Hospital personnel, which are necessary to perform those services effectively.
II.13	**CONTRACT PRACTITIONER**	A Member who furnishes patient care services at the Hospital pursuant to a contract between the Member and the Hospital or on behalf of an entity that contracts with the Hospital.
II.14	**DAY or "day"**	Calendar day including Saturdays, Sundays and holidays.
II.15	**DEPARTMENT**	An organization composed of Staff Members engaged in a principal branch of medicine, operating under the direction of a Chair.
II.16	**DUE PROCESS**	The right to utilize the hearing and appellate review procedures described in Article XVI or Article VXII, as applicable.

II.17	**EX OFFICIO**	Service on a body by virtue of an office or position held. Unless otherwise expressly provided, ex officio members are without vote, are not counted in determining the existence of a quorum, and are not permitted to participate when such body meets in executive session.
II.18	**FOCUSED PROFESSIONAL PRACTICE EVALUATION or FPPE**	The time-limited evaluation of a Member's, APP's or House Physician's competence in performing specific Clinical Privileges and professional behavior.
II.19	**HOSPITAL**	Insight Hospital and Medical Center Chicago and all locations billed as inpatient or outpatient departments of Insight Hospital and Medical Center Chicago.
II.20	**HOSPITAL - BASED**	A Department, division, section or service staffed by Contract Practitioners.
II.21	**HOUSE PHYSICIAN**	A physician in good standing in a residency training or in a fellowship, who is under direct or indirect contract with the Hospital to provide specified limited services in the Hospital. House Physicians may provide services only within the scope of their Clinical Privileges, and are not members of the Medical Staff.
II.22	**MEDICAL EXECUTIVE COMMITTEE or MEC**	The executive committee of the Medical Staff.
II.23	**MEDICAL STAFF or STAFF**	The formally organized body of physicians, chiropractors, dentists, oral surgeons, and podiatrists who have been granted Medical Staff membership under the Medical Staff Bylaws and who are privileged to attend patients or provide other diagnostic, therapeutic, teaching or research services in the hospital.
II.24	**MEDICAL STAFF POLICY or POLICIES**	A policy adopted by the MEC that implements the standards stated in these Bylaws or establishes procedures to

accomplish the processes described in these Bylaws, and that is consistent with these Bylaws and approved by the Board.

II.25 MEDICAL STAFF YEAR	From January 1 to December 31.
II.26 MEMBER	When capitalized, a member of the Medical Staff
II.27 ONGOING PROFESSIONAL PRACTICE EVALUATION or OPPE	Ongoing collection, verification and evaluation of data relevant to a Member's, APP's or House Physician's clinical competence and professional behavior.
II.28 PATENT CONTACT	Any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital, including satellite sites and other outpatient facilities.
II.29 PRACTITIONERS	Physicians, chiropractors, dentists, oral surgeons, and podiatrists applying for or granted Staff membership, and APPs applying for or granted Clinical Privileges.
II.30 RULES	All Medical Staff Policies, the Rules and Regulations and Hospital policies applicable to Practitioners in the Hospital, collectively.
II.31 RULES AND REGULATIONS	The Rules and Regulations of the Medical Staff and of Medical Staff Departments, adopted in accordance with these Bylaws.
II.32 SPECIAL NOTICE	Written notification sent by (a) certified or registered mail, return receipt requested, (b) personally delivered by hand, or (c) sent by overnight delivery service.
II.33 SUPERVISING MEMBER	A Member of the Medical Staff who is approved pursuant to these Bylaws to supervise the exercise of Clinical Privileges by an Advanced Practice Professional.

References to the Chair, Chief, Chief of Staff, Chief Executive Officer, Chief Medical Officer, and Chief Quality Officer include their respective designee when the named individual is not available.

III. MEMBERSHIP

III.1 NATURE OF MEMBERSHIP

Membership on the Medical Staff and Clinical Privileges (including temporary Clinical Privileges) are privileges, not rights, that are extended only to Practitioners whom the Hospital determines continuously meet the qualifications and satisfy the requirements stated in these Bylaws. Decisions on membership and Clinical Privileges are made by the Board, in its discretion, acting on the recommendation of the MEC. No Practitioner shall be entitled to Medical Staff membership or Clinical Privileges merely by virtue of licensure to practice a profession, Board Certification or Board Eligibility, membership in any professional organization, clinical privileges at another health facility, prior membership or Clinical Privileges at the Hospital, or contract. Decisions regarding Medical Staff membership and Clinical Privileges will not be based on race, color, sex, national origin, religion, sexual orientation, gender identity or any other criterion prohibited by law. A Member may furnish patient care at the Hospital only within the limits of the Clinical Privileges granted in accordance with these Bylaws, except as permitted by Sections 5.4 and 5.6.

III.2 BASIC QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP

A Practitioner's application for Medical Staff membership will be returned unprocessed if the Practitioner fails to any of the following basic qualifications for membership:

III.2.1 Holds an unrestricted license to practice his/her profession in Illinois.

III.2.2 Holds an unrestricted DEA registration and an Illinois controlled substances license, if the applicant seeks Clinical Privileges to prescribe controlled substances or if such registration or license is required by the Department to which the applicant likely would be assigned.

III.2.3 Maintains professional liability insurance as required by the Board.

III.2.4 If the applicant is a physician or podiatrist, has completed (or is about to complete) a residency that satisfies the Hospital's requirements.

III.2.5 Is not excluded from any federal health care program, such as Medicare or Medicaid.

III.2.6 Unless specifically exempted by the MEC because the applicant has comparable experience and training, is Board Certified in any specialty and subspecialty in which Clinical Privileges are requested or, if the applicant completed his/her training within the last five years,

is Board Eli* in such specialty and subspecialty. (Members who the Medical Staff prior to January 1, 1995 and general dentists are not required to be Board Certified or Board Eligible.)

III.3 OTHER CRITERIA FOR MEDICAL STAFF MEMBERSHIP

In addition to the basic qualifications stated in Section 3.2, the following criteria are evaluated in acting upon each application for Medical Staff membership:

III.3.1 The applicant's education, training, experience, judgment, health status, character, and demonstrated competence are sufficient to enable the applicant to provide high quality, efficient and ethical medical care and to exercise capably the Clinical Privileges requested. The evidence relevant to these criteria includes:

III.3.1.1 Challenges to any licensure or registration.

III.3.1.2 Voluntary and involuntary relinquishment of any license or registration.

III.3.1.3 Voluntary and involuntary termination of medical staff membership at any facility.

III.3.1.4 Voluntary and involuntary limitation, reduction, or loss of clinical privileges at any facility.

III.3.1.5 Professional liability actions, either pending or resulting in a final judgment or settlement payment with respect to the applicant.

III.3.1.6 Peer and/or faculty references.

III.3.1.7 Relevant Practitioner-specific data as compared to aggregate data, when available.

III.3.1.8 Morbidity and mortality data, when available.

III.3.2 The applicant is able and willing to work harmoniously with other health care professionals and Hospital personnel and to maintain a good relationship with his/her patients.

III.3.3 The applicant adheres to the ethics of the applicant's profession.

III.3.4 The applicant provides evidence of arrangements with another Member who holds appropriate Clinical Privileges and who will provide coverage for the applicant's patients when the applicant is unavailable.

III.3.5 The applicant's office and residence will be sufficiently close to the Hospital to enable the applicant to maintain continuity of care for the applicant's patients and be readily available to fulfill the responsibilities of Medical Staff membership.

III.3.6 The Hospital will also consider the needs of the Hospital and the community it serves, any relevant Hospital contractual obligations, and the availability at the Hospital of adequate facilities and resources to support each Clinical Privilege requested.

III.4 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Each Member shall continuously fulfill the following responsibilities:

III.4.1 Provide the Member's patients with care in the Hospital at the generally recognized level of quality and efficiency, including arranging for consultations when appropriate, providing daily care and supervision for Hospital inpatients who are under the Member's care, and providing coverage at all time for the Member's patients who are in the Hospital or who present at the Hospital (either personally or through arrangements with another qualified Member).

III.4.2 Abide by these Bylaws, the Rules, ~~Trinity Health's~~ Corporate Compliance Plan, and the ethical code of the Member's profession.

~~III.4.3 Comply with The Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops.~~

III.4.4 Participate in Staff at a level consistent with his/her Staff category, and carry out all duties for which the Member is responsible by appointment, election or otherwise.

III.4.5 Treat employees, patients, volunteers, visitors and other Practitioners at the Hospital in a dignified and courteous manner.

III.4.6 Timely complete medical and other records for which the Member is responsible, in accordance with the Rules.

III.4.7 Perform a timely inpatient consultation within the scope of the Member's Clinical Privileges at the request of the Member treating the patient.

III.4.8 Comply with applicable state and federal laws and regulations.

III.4.9 Be available to furnish emergency care at the Hospital in accordance with the Rules.

III.4.10Report any of the following events in writing to the Chief of Staff within fifteen (15) days after it occurs: (a) the Member is convicted of (or pleads guilty or no contest to) a felony, (b) disciplinary action is imposed on the Member by a licensed health facility, (c) the Member resig1S or limits the Member's clinical privileges at a licensed health facility while under investigation or in order to avoid an investigation or proceedings, (d) the Member's license to practice a health profession or to prescribe drugs in any jurisdiction is terminated, limited,

placed on probation, relinquished, or lapses, or (e) payment is made in settlement or judgment of a professional liability claim against the Member.

III.4.11 Comply with the requirements for completing and documenting a physical examination and medical history as set forth in Appendix A with respect to the Member' s patients:

III.4.12 Once Board Certified, all Members who are physicians, podiatrists or oral surgeons must maintain Board Certification in the specialty(s) and subspecialty(s) for which they hold Clinical Privileges. Compliance with this requirement is assessed at the time of reappointment.

III.4.13 Use the Hospital's name in advertising and otherwise only in accordance with applicable Board policy.

III.4.14 Timely pay Medical Staff dues as established by the Medical Staff.

III.5 DURATION OF MEMBERSHIP

III.5.1 All initial appointments and reappointments to the Medical Staff shall be for a term of up to twenty-four months.

III.5.2 A Contract Practitioner's Clinical Privileges to perform those patient care services covered by the contract with the Hospital shall terminate automatically, without Due Process, upon termination of the contract with the Hospital or upon termination of the Practitioner's association with the entity that contracts with the Hospital; if all of a Contract Practitioner's Clinical Privileges are terminated in this manner, the Contract Practitioner's Medical Staff membership shall also terminate automatically.

III.6 LEAVE OF ABSENCE

III.6.1 Request for Leave of Absence. Any Member who will be absent from active practice for more than thirty (30) days shall request a leave of absence from the Medical Staff for a period not to exceed one (1) year by written request to the Chief of Staff, stating the reason(s) for the leave. The Medical Executive Committee will grant or deny the request and may impose conditions and/or limitations on the leave of absence. All records for which the Member is responsible must be timely completed. Members on leave of absence may not exercise Clinical Privileges, and are not eligible to vote, hold office, or serve on committees, and will not be required to attend meetings. A Member may not appeal denial of a request for leave of absence or imposition of conditions and/or limitations on a leave of absence. The Chief of Staff shall inform the Board of leaves of absence granted by the MEC.

III.6.2 Reinstatement. At least 45 days prior to expiration of the leave of absence, or at any earlier time, the Member may submit to the Chief of Staff a written request for reinstatement of Clinical Privileges. In addition, the Member shall submit a written summary of the Member's relevant activities during the leave. If a leave of absence was due to illness, the Member shall

submit a letter from the Member's attending physician stating that the Member is physically and mentally able safely to resume full professional practice; the MEC or Board may require additional satisfactory evidence of physical and mental status. A request for reinstatement shall be submitted and processed in the manner specified for reappointment to the Medical Staff. Failure, without good cause, to request reinstatement at least 45 days prior to the expiration date of the leave of absence or failure to provide requested information shall result in automatic termination of Medical Staff membership and all Clinical Privileges. If the Board (a) denies a request for reinstatement from a leave of absence, (b) reinstates the but with reduced Clinical Privileges, or (c) takes any other action listed in Section 16.2.1 of these Bylaws with respect to the Member, the Member shall be entitled to Due Process.

III.6.3 Expiration of Appointment. If a Member's term of appointment will expire during a leave of absence, the Member may apply for reappointment during the leave in accordance with Section 4.2. The Board may condition reappointment on the Member submitting, at the time of requested reinstatement, acceptable evidence of the Member's ability to perform the Clinical Privileges granted or satisfying other requirements specified by the Board; imposition of such a condition will not entitle the Member to Due Process. Reappointment of a Member does not guarantee that the Member's request for reinstatement from leave of absence will be granted: If a Member on leave of absence does not submit a timely application for reappointment, Medical Staff membership will expire; the individual may later apply for Medical Staff membership and will be treated as a new applicant.

IV. APPLICATIONS FOR MEDICAL STAFF MEMBERSHIP

IV.1 INITIAL APPLICATION

IV.1.1 Application Form. Each application for appointment to the Medical Staff shall be submitted on the form approved by the MEC and Board, and signed by the applicant. The application will elicit information relevant to the qualifications and criteria described in Sections 3.2 and 3.3 above, shall indicate the Medical Staff category and Clinical Privileges requested, and shall include the applicant's statement that no health problem exists that could affect the applicant's ability to perform safely the Clinical Privileges requested.

IV.1.2 Effect of an Application. Submission of an application for Medical Staff membership constitutes the applicant's agreement to be bound by the terms of these Bylaws if the applicant is granted membership, and by the terms of the Bylaws relating to consideration of the application (including Section 5.8) whether or not the applicant is granted Medical Staff membership.

IV.1.3 Applicant's Responsibilities. The applicant is responsible for producing adequate information for a proper evaluation of his/her qualifications and for resolution of any doubts about the applicant's qualifications. The applicant shall the Medical Staff Office immediately in writing of any change to information contained in the application that occurs while the application is pending. The applicant may be required by the Credentials Committee, MEC or

Board to appear for an interview regarding the application or related matters and/or to submit answers to questions posed by those bodies.

IV.1.4 Credentials Verification. An application is complete when the Hospital has and verified all information specified in Appendix B, which may be modified by the MEC from time to time. After the Hospital has verified the applicant's credentials and identity and obtained written peer recommendations and a National Practitioner Data Bank report, the complete application shall be referred to the Chair of the Department in which the applicant seeks Medical Staff membership and/or Clinical Privileges.

IV.1.5 Material Omission or Misrepresentation, Any material omission or misrepresentation by an applicant in connection with his/her application shall be grounds for return of the application, which shall be deemed a withdrawal of the application, with no right to Due Process.

IV.1.6 Chair Action. The Chair of the applicable Department shall review the applicant's qualifications. The Department Chair may interview the applicant. The Department Chair shall submit a written report and recommendation (as defined in Section 4.1.12) to the Credentials Committee.

IV.1.7 Credentials Committee Action. The Credentials Committee shall review the applicant's qualifications. The Credentials Committee may also interview the applicant. The Credentials Committee shall submit its written report and recommendation, along with the Department Chair's report and recommendation, to the Medical Executive Committee.

IV.1.8 Medical Executive Committee Action. Upon receipt of the report of the Credentials Committee, the Medical Executive Committee shall review the reports of the Credentials Committee and Department Chair and other relevant information. The MEC shall submit its written report and recommendation to the Board. If the MEC disagrees with the recommendation of the Credentials Committee, the MEC shall also deliver to the Board a copy of the reports and recommendations of the Credentials Committee and the Department Chair.

IV.1.9 Board Action. The Board has final authority for all appointments to the Medical Staff and for granting Clinical Privileges. It is the Hospital's and Medical Staffs goal that applications typically be acted on by the Board within one hundred and fifty (150) days after the application is complete, recognizing however that a longer period may be needed in some cases, for example, to evaluate an applicant's credentials or to complete Due Process. Clinical Privileges are determined in accordance with Article V. The Board shall either (1) adopt the recommendation of the Medical Executive Committee, or (2) refer it back to the MEC for further consideration with a statement of the reason(s) for such action. If an application is referred back, the MEC shall again make a written report and recommendation to the Board, which shall consider the recommendation before taking final action on the application.

IV.1.10 Adverse Recommendations. If the MEC makes an adverse recommendation or the Board makes a preliminary adverse decision with respect to an application, the applicant may

request a hearing to the extent available under Article XVI. If an applicant who is the subject of an adverse preliminary decision does not make a timely request for a hearing or is not to a hearing, the application is considered to have been withdrawn and shall not receive further consideration. If a decision is unfavorable with respect to scope of Clinical Privileges only, an applicant who either does not timely request a hearing or is not entitled to a hearing, will be deemed to have requested only those Clinical Privileges the Board is willing to grant.

IV.1.11 Reapplication. A Practitioner whose application for Medical Staff membership is deemed withdrawn pursuant to 4.1.5 or 4.1.10 or whose application is denied shall not be eligible to reapply to the Medical Staff for a period of one (l) year from the date of withdrawal or denial, as applicable, unless the Board specifies otherwise.

IV.1.12 Reports and Recommendations. As used in this Article, "written report and recommendation" means a written recommendation regarding Medical Staff appointment and, if appointment is recommended, Staff category, Clinical Privileges to be granted, and any special conditions to be attached to the appointment with the reasons for any unfavorable recommendation stated in writing.

IV.2 PROCEDURE FOR REAPPOINTMENT

IV.2.1 Reappointment Application. Each Member who desires reappointment to the Medical Staff shall submit a timely, signed and complete reappointment application to the Hospital by July 1 on a form approved by the MEC and Board. The application will indicate the Medical Staff category and Clinical Privileges requested. If a timely and complete reappointment application is not submitted, the Member's Medical Staff membership and Clinical Privileges will expire at the end of the current term of appointment. The reappointment application will require submission of information that will allow a determination of whether the Manber meets the ongoing qualifications for Medical Staff membership and for requested Clinical Privileges, including providing reasonable evidence of current ability to perform capably the Clinical Privileges requested and information concerning any changes in the Member's qualifications since his/her last reappointment.

IV.2.2 Reappointment Criteria. The reappointment process will include evaluation of:

IV.2.2.1 The Member's professional performance and judgment.

IV.2.2.2 The Member's current clinical and technical skills and competence to perform the Clinical Privileges requested, as measured in part by the results of the Hospital's performance improvement activities and ongoing professional practice evaluation, and as assessed by the applicable Department Chair.

IV.2.2.3 Professional ethics and conduct, including compliance with the Bylaws and Rules, and working relationships with others at the Hospital.

IV.2.2.4 Current appraisal of the Member's physical and mental health.

IV.2.2.5 Participation in continuing education.

IV.2.2.6 Compliance with Patient Contact requirements applicable to the Medical Staff category requested by the Member.

IV.2.2.7 All information supplied in the Member's reappointment application.

IV.2.3 Processing Reappointment Applications. Applications for reappointment shall be processed in the same manner as initial applications, using the procedures described in relevant portions of Section 4.1 of these Bylaws, except interviews of the applicant are not routinely required. The consequences of failure to complete or follow Bylaw requirements during the reapplication process shall be identical to the consequences of failure to complete or follow requirements during initial application for membership and Privileges.

IV.2.4 Medical Executive Committee Input Required. The Board will not take action on an application for reappointment without first seeking the recommendation of the Medical Executive Committee with respect to the application.

IV.2.5 Board Action. The Board shall take final action on applications for reappointment and renewal of Clinical Privileges, except that no final action may be taken with respect to any Member as to whom an adverse recommendation or decision has been made who has not either waived or completed the Due Process provided for in Article WI, if applicable.

V. CLINICAL PRIVILEGES

V.1 DELINEATION OF CLIN1CAL PRIVILEGES

V.1.1 Clinical Privileges Are Required. Each Member shall exercise only those Clinical Privileges granted to him by the Board upon recommendation of the MEC, except as otherwise permitted by Sections 5.4 and 5.6.

V.1.2 Criteria. Requests for Clinical Privileges shall be evaluated on the basis of the factors and categories of information listed in Sections 3.2, 3.3, and 4.2.2. Privilege determinations shall take into account pertinent information concerning clinical performance obtained from other sources, especially from other institutions and health care settings where the Practitioner has exercised Clinical Privileges. The Practitioner has the burden of establishing his/her qualifications and competency in the requested Clinical Privileges. The Clinical Privileges available within a Department and the specific qualifications required for each Privilege shall be recommended by the Department Chair and approved by the MEC and Board.

V.1.3 Limited License Practitioners. For the purpose of administration, dentists and oral surgeons shall be placed in the Department of Surgery, Section of Head and Neck Surgery, Subsection of Dentistry. Podiatrists shall be placed in the Department of Surgery, Section of Orthopedic and Hand Surgery, Subsection of Podiatry. The Chief of the Subsection of Dentistry may be a licensed oral surgeon or dentist, The Chief of the Subsection of Podiatry shall be a

licensed podiatrist. Patients of dentists and podiatrists shall be admitted by an M.D./D.O. who is a Member of the Staff.

V.1.4 Non-Members. Clinical Privileges may be granted to non-Members pursuant to Sections 5.4 and 5.6 and Article VI. Non-Members may not be granted admitting Clinical Privileges, except as otherwise permitted by Sections 5.4 and 5.6. A non-Member may participate in the care of patients, including performance of histories and physicals, only in accordance with the scope of Clinical Privileges granted to the non-Member.

V.2 PRIVILEGE MODIFICATION

V.2.1 Privilege Increase. A Member may request an increase in Clinical Privileges during the term of his/her appointment by submitting a written request in accordance with Medical Staff Policy. Any such request will be processed using substantially the same procedures as for a request for reappointment.

V.2.2 Privilege Decrease. A Member may request a decrease in Clinical Privileges during the term of his/her appointment by written to the Credentials Committee. The Credentials Committee shall promptly notify the MEC and the Board of any Privilege reduction request that it approves.

V.3 FOCUSED PROFESSIONAL PRACTICE EVALUATION

Clinical Privileges granted to initial applicants and additional Clinical Privileges granted in connection with reappointment or a mid-appointment request for additional Clinical Privileges shall be subject to Focused Professional Practice Evaluation as provided in Medical Staff Policy.

V.4 TEMPORARY CLINICAL PRIVILEGES

V.4.1 Procedures. A Practitioner may be granted temporary Clinical Privileges by the CEO, upon the recommendation of the Chief of Staff. Practitioners who hold temporary Clinical Privileges are not Members. Temporary Clinical Privileges shall be granted only (a) when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, competence and judgement to exercise the Clinical Privileges requested, (b) after the Practitioner has provided evidence of professional liability insurance as required by the Board, and (c) after the Practitioner's license has been verified. Temporary Clinical Privileges must be for a specified time period, consistent with the time limits stated in this Section.

V.4.2 Types of Temporary Clinical Privileges. Temporary Clinical Privileges may be granted in the following circumstances:

V.4.2.1 Pendency of Application. If a complete application for Staff appointment (or, in the case of an applicant for APP or House Physician status, a complete application for Clinical Privileges) has been approved by the relevant Department Chair, the applicant may be granted temporary Clinical Privileges in accordance with Section 5.4.1

during the pendency of the application or for up to one hundred twenty (120) days, whichever is shorter. An applicant is eligible for temporary Clinical Privileges under this Section only if the applicant is not/has not been subject to licensure sanction, adverse action on medical staff membership or privileges at another facility, or any other disqualifying criteria specified in Medical Staff Policy.

V.4.2.2 Treatment of Specific Patient(s). Upon the request of a Member, temporary Clinical Privileges may be granted in accordance with Section 5.4.1 to a qualified Practitioner who is not a Member and has not applied for Medical Staff membership when the special skills of that Practitioner would be beneficial to specific Hospital patient(s) who is under the care of the requesting Member and are not readily available from a Member. Such temporary Clinical Privileges automatically terminate when the named patient(s) is discharged from the Hospital.

V.4.2.3 Locum Tenens. Temporary Clinical Privileges may be granted in accordance with Section 5.4.1 to an appropriately licensed Practitioner whose services are needed at the Hospital on a locum tenens basis and who has not applied for Medical Staff membership. Temporary Clinical Privileges may be granted in such circumstances for no more than one hundred twenty (120) consecutive days and a total of no more than one hundred eighty (180) days during any calendar year.

V.4.3 Supervision. Practitioners granted temporary Clinical Privileges shall be subject to the supervision of the Chair of the Department to which assigned and, in the case of a Practitioner who is not a physician, dentist, oral surgeon, or podiatrist, shall be under the supervision of an identified Member. Practitioners granted temporary Clinical Privileges shall comply with these Bylaws and other documents that apply to Members. Temporary Clinical Privileges may be summarily revoked by the CEO, the Chief of Staff or the Department Chair. Denial or termination of temporary Clinical Privileges does not trigger Due Process rights.

V.5 EMERGENCY CLINICAL PRIVILEGES

In case of emergency, any Practitioner who holds Clinical Privileges and any Member is permitted to do everything possible within the scope of his/her license to save the life of the patent or to save the patient from serious harm, regardless of Clinical Privileges or Staff category. For the purpose of this section, an “emergency” is defined as a condition in which serious, permanent harm may result to the patient or in which the life of the patient is in immediate danger, and any delay in administering treatment might add to that danger.

V.6 DISASTER CLINICAL PRIVILEGES

In the event of a disaster requiring activation of the Hospital’s emergency management plan and exceeding the professional resources of the Hospital to meet immediate patient needs, the CEO or designee may grant temporary disaster Clinical Privileges to qualified volunteers in a manner consistent with the Hospital’s emergency management plan.

V.7 EFFECT OF CONTRACTS ON CLINICAL PRIVILEGES

It is recognized that certain clinical activities at the Hospital may be operated under exclusive contracts. The right to provide services within those clinical areas shall be controlled by the specific agreements to which the Hospital is a party. Individuals granted Clinical Privileges pursuant to these Bylaws shall not be deemed to have obtained the right to exercise those Clinical Privileges in a manner contrary to the Hospital's contractual arrangements.

V.8 CONDITIONS TO CLINICAL PRIVILEGES

The provisions of this Section are express conditions to any Practitioner's application for, and exercise of, Clinical Privileges at the Hospital. By applying for Clinical Privileges and/or Medical Staff membership, the Practitioner accepts these conditions with respect to the processing and consideration of his/her application, whether or not membership/C1inical Privileges are granted, and with respect to all activities relating to membership/C1inical Privileges granted.

V.8.1 Release of Liability. The Practitioner absolutely releases the Hospital, the Medical Staff, and any of their representatives, from any liability relative to any communication, recommendation or action, concerning the Practitioner's qualifications or conduct and evaluation thereof, whether in connection with the Practitioner's initial application for Clinical Privileges/Medical Staff membership or any subsequent activities relating to the Practitioner's Clinical Privileges/Medical Staff membership. This release also extends to third parties that furnish information described in this Section, including otherwise privileged or confidential information, to the Medical Staff, the Hospital, or their representatives.

V.8.2 Authorize Communication. The Practitioner authorizes the representatives of the Medical Staff and Hospital to consult with other hospitals, medical associations, licensing boards and other organizations and individuals who may have information bearing on the Practitioner's character, conduct, ethics, physical and mental health, competence and other qualifications (collectively, "Qualifications"), and authorizes said individuals and organizations to provide information to representatives of the Medical Staff and Hospital.

V.8.3 Authorize Document Inspection. The Practitioner consents to representatives of the Medical Staff and Hospital inspecting all records and documents relevant to an evaluation of the Practitioner's Qualifications.

V.8.4 Authorize Release of Information. The Practitioner authorizes representatives of the Hospital and the Medical Staff to provide other hospitals, medical associations, licensing boards, and other organizations and individuals concerned with provider performance and the quality of patient care with any relevant information regarding the Practitioner.

V.8.5 Confidentiality of Professional Practice Review Material. The Practitioner agrees to maintain the confidentiality of all Hospital professional practice review materials.

V.8.6 Health Status. The Practitioner agrees to submit to mental and physical examination and testing (including drug, alcohol and infection screens) by a health professional or at a facility satisfactory to the Medical Executive Committee, Credentials Committee, or Board, if requested in order to determine that the Practitioner's current physical or mental health does not threaten or interfere with his/her ability to practice safely. The results of such examination and testing shall be submitted directly to the body that requested them or the body's designee.

VI. PROVISION OF CARE BY NON-MEMBERS

VI.1 ADVANCED PRACTICE PROFESSIONALS

VI.1.1 Categories of APPs. All APPS shall be described as Category I, Category Il, or Category Ill APPS and the Rules and Regulations shall list which professions meet the qualifications of each category under Illinois law:

VI.1.1.1 "Category I APP" means a licensed independent practitioner, a type of APP who is by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted.

VI.1.1.2 "Category II APP" means an advanced dependent practitioner, a type of APP who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement.

VI.1.1.3 "Category III APP" means a Dependent Practitioner, a type of APP who is permitted by law or the Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted.

VI.1.2 Assignment Supervision and Compliance. Although responsible to the Medical Staff and the Board, Advanced Practice Professionals are not Members of the Medical Staff. Each APP may furnish patient care at the Hospital only within the limits of the Clinical Privileges granted to him/her in accordance with these Bylaws, except as otherwise permitted by Sections 5.4 and 5.6. Each Category II and Category III APP acts under the overall supervision of an identified Supervising Member approved by the Board, acting on the recommendation of the Medical Committee, A Category II or Category III APP shall immediately notify the Chief of Staff in writing if the APP's supervisory arrangement with the Supervising Member ends. A Category Il or Category Ill APP may not be granted Clinical Privileges that exceed those of his/her Supervising Member. The Hospital may grant Clinical Privileges that are less extensive

than the scope of activities an APP is licensed to perform. APPS shall comply with these Bylaws, the Rules, and any Hospital policy intended to govern their activities.

VI.1.3 Qualifications. APPS must possess a license or registration to practice their profession in the state of Illinois, if applicable. Applications for initial, renewed, increased and decreased Clinical Privileges will be processed using the procedures and criteria set forth in Articles IV and V (subject, however, to Due Process in accordance with Article XVII, rather than Article XVI) to the extent applicable to the Practitioner's profession.

VI.1.4 Meeting Attendance. APPs may attend meetings of the Medical Staff and/or their Department at the request of the Department Chair or their Supervising Member and subject to the approval of the individual presiding at the meeting. If so permitted to attend a meeting, APPs may not vote, nor may they otherwise participate unless by the presiding officer.

VI.1.5 Suspension and Termination. An APP's Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Articles XII through XV) in the same manner as a Member of the Medical Staff (subject, however, to Due Process in accordance with Article XVII, rather than Article XVI), as well as in accordance with the terms of any written contract the APP may have with the Hospital and, in the case of a Hospital-employed APP, in accordance with any applicable Hospital policy. If (a) the Supervising Member of a Category II or Category III APP ceases to be a member of the Medical Staff, (b) the supervising arrangement (such as, collaboration agreement or employment) between the APP and the Supervising Member terminates, or (c) the APP ceases to be an employee of the Hospital, if applicable, then the APP's Clinical Privileges shall terminate automatically, without Due Process. The events described in (a) and (b) will not result in automatic termination of the APP's Clinical Privileges if the Board (acting on the MEC's recommendation) immediately approves a substitute Supervising Member.

VI.2 HOUSE PHYSICIANS

VI.2.1 Assignment, Supervision and Compliance. Although responsible to the Medical Staff and the Board, House Physicians are not Members of the Medical Staff. Each House Physician may furnish patient care at the Hospital only within the limits of the Clinical Privileges granted to him in accordance with these Bylaws, except as otherwise permitted by Sections 5.4 and 5.6. Each House Physician acts under the overall supervision of the Chair of the Department or Chief of the Section to which assigned. When participating in the care of a patient admitted to the Hospital, the House Physician shall work under the supervision of the attending Member. House Physicians shall comply with these Bylaws, the Rules, and any Hospital policy intended to govern their activities.

VI.2.2 Qualifications. House Physicians must possess a full license to practice allopathic or osteopathic medicine in the state of Illinois (e.g. not a limited license that restricts practice to activities within the scope of graduate medical education program). Applications for initial and renewed Clinical Privileges will be processed using the procedures and criteria set forth in Articles IV and V, excluding those relating to completion of a residency and Board Certification

and Eligibility. The Board grants or denies Clinical Privileges to prospective House Physicians, upon recommendation of the MEC.

VI.2.3 Meeting Attendance. House Physicians may attend meetings of the Medical Staff and/or their Department at the request of their Department Chair and subject to the approval of the individual presiding at the meeting. If so permitted to attend a meeting, House Physicians may not vote, nor may they otherwise participate unless requested by the presiding officer

VI.2.4 Suspension and Termination. A House Physician's Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Articles XII through XV) in the same manner as a Member of the Medical Staff (subject, however, to Due Process in accordance with Article XVII, rather than Article XVI), as well as in accordance with the terms of any written contract governing the House Physician's services to the Hospital and, in the case of a Hospital-employed House Physician, in accordance with any applicable Hospital policy.

VII. MEDICAL STAFF CATEGORIES

VII.1 CATEGORIES

The Medical Staff shall be divided into the following categories: Active, Courtesy, Consulting, Ambulatory Care, Coverage and Honorary. Each Member shall be assigned to a specific category. All categories, with the respective rights and obligations of each, are summarized in the chart attached as Appendix C to these Bylaws.

VII.2 ACTIVE STAFF

VII.2.1 Qualifications of Active Staff. The Active Staff shall consist of physicians, chiropractors, dentists, oral surgeons, and podiatrists who:

VII.2.1.1 For those Members in a non-Hospital-Based Department, are involved in at least twenty-four (24) Patient Contacts per two-year appointment term; or

VII.2.1.2 For those Members in a Hospital-Based Department, practice a majority of his/her time at the Hospital; or

VII.2.1.3 Have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and Hospital through service on Hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

VII.2.2 Guidelines for Assigning Active Staff:

VII.2.2.1 Unless an Active Staff Member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of classification or of

reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

VII.2.2.2 Any Member who is classified as Attending Staff under the previous Medical Staff Bylaws at the time of adoption of the new Medical Staff Bylaws shall be categorized as Active if the Member meets one of the qualifications in Section 7.2.1. If the Member does not meet one of the qualifications in Section 7.2,1, then the Member shall be classified as either Courtesy or Ambulatory Care Staff based on which qualifications the Member meets.

VII.2.2.3 Thereafter, any Active Staff Member who does not meet one of the qualifications in Section 7.2.1 during his/her two year appointment term, as verified by the Medical Staff Office, shall not be eligible to request Active Staff status at the time of his/her reappointment. Another appropriate staff category will be assisted that best reflects his/her relationship to the Medical Staff and the Hospital (options — Courtesy, Consulting, Ambulatory Care, or Coverage).

VII.2.3 Prerogatives. Each Member of the Active Staff may:

VII.2.3.1 Admit patients without limitation, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;

VII.2.3.2 Vote in all general and special meetings of the Medical Staff and applicable Department and committee meetings;

VII.2.3.3 Hold office, serve as Department Chairs, serve on Medical Staff committees, and serve as chairs of committees; and

VII.2.3.4 Exercise such clinical privileges as are granted to them.

VII.2.4 Responsibilities: Active Staff Members must assume all the responsibilities of membership on the Active Staff, including:

VII.2.4.1 Serving on committees, as requested;

VII.2.4.2 Providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department as may be requested or required by Hospital and/or Medical Staff policies and procedures;

VII.2.4.3 Providing care for unassigned patients;

VII.2.4.4 Participating in the evaluation of new Members of the Medical Staff;

VII.2.4.5 Participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

VII.2.4.6 Accepting inpatient consultations, when requested;

VII.2.4.7 Paying application fees, dues, and assessments; and

VII.2.4.8 Performing assisted duties.

VII.3 COURTESY STAFF

VII.3.1 Qualifications. The Courtesy Staff shall consist of physicians, chiropractors, dentists, oral surgeons, and podiatrists who:

VII.3.1.1 Are in a non-Hospital-Based Department; and

VII.3.1.2 Are involved in more than six (6), but fewer than twenty-four (24), Patient Contacts per two-year appointment term; and

VII.3.1.3 Meet all the same threshold eligibility criteria as other Medical Staff Members, including specifically those relating to availability and response times with respect to the care of their patients; and

VII.3.1.4 Upon request, including but not limited to time of each reappointment, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

VII.3.2 Guidelines for Assigning Courtesy Staff. Unless a Courtesy Staff Member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of classification or of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

VII.3.2.1 Any Member who is classified as Courtesy Staff under the previous Medical Staff Bylaws at the time of adoption of the new Medical Staff Bylaws shall be categorized as Active, Courtesy, or Ambulatory Care based on the number of patient contacts during the previous twelve (12) month period.

VII.3.2.2 Thereafter, any Member who has fewer than six (6) Patient Contacts during his/her two-year appointment term, as by the Medical Staff Office, will

be assigned to another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options — Consulting, Ambulatory Care, or Coverage).

VII.3.2.3 Any Member in a Hospital-Based Department and any Member who has more than twenty-four (24) Patient Contacts during his/her two-year appointment term will be assigned to Active Staff status.

VII.3.3 Prerogatives and Responsibilities. Courtesy Staff Members:

VII.3.3.1 May attend and participate in Medical Staff and Department meetings (without vote);

VII.3.3.2 May not hold office or serve as Department Chairs;

VII.3.3.3 May be invited to serve as Chairs and/or members of committees (with vote);

VII.3.3.4 Are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:

VII.3.3.4.1 Must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician, and

VII.3.3.4.2 Must accept referrals from the Emergency Department for follow-up care of their patients in the Emergency Department, and

VII.3.3.4.3 Will be required to provide specialty coverage if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

VII.3.3.5 Shall cooperate in the professional practice evaluation and performance improvement processes;

VII.3.3.6 Shall exercise such clinical privileges as are granted to them; and

VII.3.3.7 Shall pay application fees, dues, and assessments.

VII.4 CONSULTING STAFF

VII.4.1 Qualifications. The Consulting Staff shall consist of physicians, chiropractors, dentists, oral surgeons, and podiatrists who:

VII.4.1.1 Are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff;

VII.4.1.2 Provide services at the Hospital only at the request of other Members of the Medical Staff;

VII.4.1.3 Were classified as Consulting Staff under the previous Medical Staff Bylaws at the time of adoption of the new Medical Staff Bylaws or apply for such status thereafter; and

VII.4.1.4 At each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

VII.4.2 Prerogatives and Responsibilities. Consulting Staff Members:

VII.4.2.1 May evaluate and treat patients in conjunction with other Members of the Medical Staff;

VII.4.2.2 May not hold office or serve as Department Chairs;

VII.4.2.3 May be invited to serve as Chairs and/or members of committees (with vote);

VII.4.2.4 742.4 May attend meetings of the Medical Staff and applicable Department meetings (without vote);

VII.4.2.5 Are excused from providing specialty coverage for the Emergency Department and providing care for unassiB1ed patients, unless the MEC finds that there are insufficient Active Staff Members in a particular specialty area to perform these responsibilities;

VII.4.2.6 Shall cooperate in the professional practice evaluation and performance improvement processes; and

VII.4.2.7 Shall pay application fees, dues, and assessments.

VII.5 AMBULATORY CARE STAFF

VII.5.1 Qualifications: The Ambulatory Care Staff consists of those physicians, chiropractors, dentists, oral surgeons, and podiatrists who desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital and meet the eligibility criteria set forth in forth in Sections 3.2.1, 3.2.4 and 3.2.5,

VII.5.2 Purpose. The primary purpose of the Ambulatory Care Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff Members for admission and care.

VII.5.3 Prerogatives and Responsibilities. Ambulatory Care Staff Members:

VII.5.3.1 May attend meetings of the Medical Staff and applicable Departments (without vote);

VII.5.3.2 May not hold office or serve as Department Chairs;

VII.5.3.3 Shall generally have no staff committee responsibilities, but may be invited to serve as chairs and/or members of committees (with vote);

VII.5.3.4 May attend educational activities sponsored by the Medical Staff and the Hospital;

VII.5.3.5 May refer patients to Members of the Active Staff for admission and/or care;

VII.5.3.6 Are encouraged to submit their outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

VII.5.3.7 Are also encouraged to communicate directly with Active Staff Members about the care of any patients referred, as well as to visit any such patients and record a courtesy progress note in the medical record containing relevant information from the patients' outpatient care;

VII.5.3.8 May review the medical records and test results (via paper or electronic access) for any patients who are referred;

VII.5.3.9 May perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

VII.5.3.10 May not admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient or outpatient orders (except as set forth in Section 7.5.3.13 below), perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

VII.5.3.11 May actively participate in the professional practice evaluation and performance improvement processes;

VII.5.3.12 Upon request, provide such quality data and other information as may be requested to assist in an appropriate assessment of qualifications for appointment (including, but not limited to, information from another hospital, information from the

individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

VII.5.3.13 May refer patients to the Hospital's diagnostic facilities and order such tests; however, if medical issues arise with such patients while they are receiving the ordered tests, a Member of the Medical Staff with appropriate Clinical Privileges will be consulted to manage the care of the patient (i.e., a hospitalist or the on-call physician); and

VII.5.3.14 Shall pay application fees, dues and assessments.

VII.6 COVERAGE STAFF

VII.6.1 Qualifications. The Coverage Staff shall consist of physicians, chiropractors, dentists, oral surgeons, and podiatrists who:

VII.6.1.1 Desire appointment to the Medical Staff after adoption of the new Medical Staff Bylaws solely for the purpose of being able to provide coverage assistance to Active Staff Members who are members of their group practice or their coverage group;

VII.6.1.2 At each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians); and

VII.6.1.3 Agee that their Medical Staff appointment and Clinical Privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff Member(s) terminates for any reason or they will transfer to another appropriate staff category.

VII.6.2 Prerogatives and Responsibilities. Coverage Staff Members:

VII.6.2.1 When providing coverage assistance for an Active Staff Member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff Member that is being covered (i.e., the Active Staff Member's own patients or unassigned patients who present through the Emergency Department when the Active Staff Member is on call);

VII.6.2.2 Have no independent Medical Staff responsibilities, but are responsible for fulfilling the Active Staff Members' Medical Staff functions and responsibilities, including care for unassigned patients, emergency service care,

consultation, and teaching assignments when providing coverage for members of their group practice or coverage group;

VII.6.2.3 Shall be entitled to attend Medical Staff and Department meetings (without vote);

VII.6.2.4 May not hold office or serve as Department Chairs or committee chairs;

VII.6.2.5 Shall generally have no staff committee responsibilities, but may be assigned to committees (with vote); and

VII.6.2.6 Shall pay applicable fees, dues, and assessments.

VII.7 HONORARY STAFF MEMBERS

VII.7.1 The Honorary Staff shall consist of those Members currently classified as Emeritus Staff and after the new Medical Staff Bylaws are adopted, those practitioners who have retired from the practice of medicine in this Hospital after serving for more than 10 years and who are in good standing.

VII.7.2 Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

VII.7.3 Prerogatives and Responsibilities. Honorary Staff Members:

VII.7.3.1 May not consult, admit, or attend to patients;

VII.7.3.2 May attend Medical Staff and Department meetings when invited to do so (without vote);

VII.7.3.3 May be appointed to committees (with vote);

VII.7.3.4 Are entitled to attend educational programs of the Medical Staff and the Hospital;

VII.7.3.5 May not hold office or serve as Department Chairs or committee chairs; and

VII.7.3.6 Are not required to pay application fees, dues, or assessments.

VIII. DEPARTMENTS DIVISIONS AND SECTIONS

VIII.1 IDENTIFICATION

The Staff shall be divided into Departments, divisions and sections. For identification of current Departments, see the Rules and Regulations.

VIII.2 CREATION

VIII.2.1 An additional Department may be established at the Hospital with the approval of the MEC, the Staff, and the Board of Directors. Request for recognition as an additional Department may be initiated by a majority of the membership of the potential Department or the CEO. Such request must be accompanied by appropriate supportive data and presented to the MEC A minimum of three (3) active physicians are needed to create a new Department.

VIII.2.2 The MEC shall take into consideration the following criteria, among others:

VIII.2.2.1 National trend pertinent to the necessity for such a Department;

VIII.2.2.2 Facilitation of administrative function, quality care of patients, and education by establishment of such a Department;

VIII.2.2.3 Appropriateness of the number and qualifications of staff, volume of patients, and existing facilities for such a Department;

VIII.2.2.4 graduate medical training program in a major field of medicine; and

VIII.2.2.5 Reasonable expectation of permanency,

VIII.3 COMPOSITION

Each Department shall be composed of Staff Members appropriate to the major endeavor of the Department.

VIII.4 DUTIES

Each Department shall:

VIII.4.1 Appointment, Reappointment, Clinical Privileges. Act on appointment and reappointment of the applicants to the membership of the Department and their requested Clinical Privileges, based on the criteria and policies of the Department;

VIII.4.2 Monitoring and Evaluation Monitor and evaluate the appropriateness and the quality of services provided to the patient, education, research, clinical performance of

Practitioners relevant to their Clinical Privileges, and qualifications and credentials of the new applicants;

VIII.4.3 Quality of Care. Establish a systematic and ongoing process to assure that the quality of care meets the standards and criteria for medical practice. These standards and criteria are established in the medical community and accepted by the members of the Department and Staff. These standards and criteria are recommended to the MEC when necessary and they shall be included in the Department policy manual. This process must include discussion of issues, conclusions, recommendation for action and follow-up. The evaluation and monitoring process should include, as applicable, but not limited to the following:

VIII.4.3.1 Jurisdiction for hospitalization of the patient, determination of over-utilization or under-utilization of diagnostic studies and appropriateness of length of stay;

VIII.4.3.2 Documentation of clinical and laboratory evidence supporting the admission and discharge diagnosis, evaluation of si81ificance and appropriateness of all diagnostic modalities;

VIII.4.3.3 Documentation of appropriateness, effectiveness, and side effects of all surgical and medical therapeutic modalities;

VIII.4.3.4 Participation in the evaluation of prophylactic, therapeutic and empiric use of drugs when such evaluation pertains to the endeavors of the Departments. This task may be carried out in conjunction with the Medication and

VIII.4.3.5 Nutrition Committee, appropriate hospital representative and other

VIII.4.3.6 Departments/Divisions/Sections of the Staff;

VIII.4.3.7 Documentation of all complications and morbidity during hospitalization of the patient and establishing an effective mechanism to obtain autopsies for improvement of quality of services;

VIII.4.3.8 Documentation of the stability of the patient’s condition prior to discharge and satisfactory discharge planning;

VIII.4.3.9 Discussion of information received from Divisions/Sections, Infection Control, Health Information, Morbidity-Mortality Review, Transfusion, Tissue and other Committees and Departments of the Staff, as well as other reimbursing or health care agencies;

VIII.4.3.10 Participation in the risk management activities relative to the safety of the patient;

VIII.4.3.11 Consideration of the performance and compliance of the members of the Department with items listed above, prior to recommendation for reappointment; and

VIII.4.3.12 Each Department shall form a Quality Improvement Committee to coordinate and expedite the implementation of items listed above. The members of the Committee shall be appointed by the Chair of the Department to represent a cross-section of the Department and provide an opportunity to all members to participate in the quality improvement program.

VIII.5 MEETINGS

Meetings shall be held by all Department at regular intervals appropriate to the function of the Department and as required by the Bylaws of the Staff and/or regulatory organizations. Members of the Staff who have privileges in any Department shall attend the regular or special meetings of the said Departments as required by the Bylaws. The Chair shall set the agenda. Minutes shall be recorded by a member of the Department chosen by the Chair. The minutes shall include discussion, recommendations, and actions taken, and shall be forwarded to the MEC. The minutes also shall include, when appropriate, the administrative, educational, and quality improvement activities and recommendation of Divisions and Sections of the Department.

VIII.6 CHAIR

Each Department shall function under the direction of a Chair recommended by the MEC and appointed by the Board of Directors for a term of two (2) years following the procedure below.

VIII.6.1 Selection

VIII.6.1.1 The Search Committee shall consist of seven (7) members appointed and elected as follows: the Chief of Staff shall appoint four (4) sitting Department Chairs, and the affected Department shall elect the remaining three (3) members. When appropriate, the chair of the Medical School affiliate department may be invited by the Chief of Staff aner consultation with the CEO/CMO, to serve as a member ex officio without vote. The Search Committee shall interview and assess the candidates for the position of Department Chair on the basis of training, experience, administrative ability, and clinical and professional leadership qualities. The Search Committee shall conduct all sessions as executive sessions. The Search Committee shall make a written recommendation to the MEC. The Search Committee shall recommend no more than two (2) candidates for the position.

VIII.6.1.2 If a vacancy occurs in the Chair of a Department, an Acting Chairman shall be appointed by the Chief Executive Officer or CMO after the appropriate consultation with the membership of the Department. The Search Committee for the Chairman shall be constituted as soon as possible.

VIII.6.1.3 The MEC shall review the recommendation of the Search Committee, and the qualifications of the recommended candidate(s). The IOC shall recommend one (1) candidate, and send its recommendation to the Board for approval. The Board shall review the recommendation of the MEC in consultation with the CEO and CMO, and shall approve or disapprove the recommendation. Only upon approval, the Board shall appoint the recommended candidate to the position of Department Chair. If the Board disapproves the MEC's recommendation, the matter shall be returned to the MEC for further consideration and recommendation.

VIII.6.2 Qualifications. Each Department Char shall be a Member in good standing of the Staff and shall be qualified by training, experience, administrative ability, and clinical and professional leadership qualities necessary for the position. Department Chairs must be certified by an appropriate specialty board or possess comparable competence.

VIII.6.3 Appointment and Reappointment. Appointment and reappointment of the Chair to the membership of the Staff and the granting of Chair's Clinical Privileges shall be through the same process used for all other Members of the Staff. The CMO in consultation with the CEO certifies satisfactory administrative performance for continuation or reappointment to the position of Chair.

VIII.6.4 Duties. The Chair is responsible for the leadership of the Department and for the ongoing and effective operation of the Department. The Chair is responsible for:

VIII.6.4.1 All clinical, academic, and administrative interactions with other clinical departments and the budget process.

VIII.6.4.2 Continuing surveillance of the professional performance of all individuals holding clinical privileges in the Department.

VIII.6.4.3 Recommendations regarding Clinical Privileges for each member of the Department.

VIII.6.4.4 Recommendations to the MEC regarding appropriate disciplinary measures for violations of the Bylaws or Rules.

VIII.6.4.5 Recommendations to the MEC regarding offsite sources for clinical services not provided by the Hospital.

VIII.6.4.6 Maintenance of quality control programs including the continuous assessment and improvement of the quality of care and services provided in the Department.

VIII.6.4.7 Active development and promotion of research activities in the Department.

VIII.6.4.8 Development and implementation of policies and procedures that guide and support the provision of services within the Department.

VIII.6.5 Recall. If a Chair demonstrates gross failure in fulfilling the responsibilities of the position, the membership of the Department may vote in reconsideration of the selection. A vote of two-thirds (2/3) (of the members who have voting privileges) to recall the Chair shall be required to place the issue of recall on the agenda of the next scheduled meeting of the MEC. The results of such a vote, accompanied by the members' justification for such action, shall be forwarded to the MEC and then the Board for appropriate review and affirmation or denial of the recall.

VIII.7 POLICIES

Each Department shall have written policies to enable it to carry out the duties of the Department

VIII.8 DIVISIONS AND SECTIONS

VIII.8.1 Definitions.

VIII.8.1.1 A Division is defined as a discipline of medicine of a specialty which has a certifying board and residency or fellowship program in that particular specialty, operating under the direction of a Chief.

VIII.8.1.2 8.8.1.2A Section is defined as a discipline of medicine of a specialty which has a certifying board in that particular specialty, operating under the direction of a Chief.

VIII.8.2 Identification. For identification of current Divisions and Sections, see Rules and Regulations.

VIII.8.3 Creation. A Division or Section may be established within the various Departments with the approval of the MEC, the Staff and the Board of Directors.

VIII.8.3.1 Request for recognition of an additional Division or Section may be initiated at the request of the Department Chair. Such request must be accompanied by appropriate supportive data and presented to the MEC.

VIII.8.3.2 In the process of approval of a Division/Section, the MEC shall take into consideration the following criteria, among others:

VIII.8.3.2.1 National trend pertinent to the necessity for such a Division/Section;

VIII.8.3.2.2 Facilitation of administrative function, quality care for patients, and education by establishment of such Division/Section; and

VIII.8.3.2.3 Appropriateness of the number and qualifications of staff, volume of patients, and existing facilities for such a Division/Section.

VIII.8.4 Composition. Each Division/Section shall be composed of physicians appropriate to the specialty of the Division/Section.

VIII.8.5 Duties. The provisions of Section 8.6.4, pertaining to the Department also apply to Divisions/Sections, appropriate to the membership and function of Divisions/Sections.

VIII.8.6 Meetings. Meetings shall be held by all Divisions/Sections at regular intervals appropriate to the membership and functions of the Divisions/Sections as required by the Bylaws and/or regulatory organizations. Members of the Division/Section shall attend the regular or special meetings of the Division/Section as required by the Bylaws. Each Department Chair shall determine whether such meetings shall be in lieu of required Departmental meetings. The Chair shall set the agenda. Minutes shall be recorded by a member of the Division/Section chosen by the Chief. The actions and recommendations of the Division/Section shall be forwarded to the Department of which the Division/Section is a component.

VIII.8.7 Chief.

VIII.8.7.1 Each Division/Section shall function under the direction of a Chief, proposed by the Chair of the Department after consultation with the Chief Executive Officer and approved by the MEC and appointed by the Board of Directors.

VIII.8.7.2 The Chief is responsible for quality patient care within the Division/Section and implementation of quality assurance issues described under "Duties of the Division/Section" (Section 8.8.5) in a manner consistent with the Bylaws of the Staff, and the philosophy of Insight Hospital and Medical Center Chicago. The Chief shall ensure the efficient of continuing, graduate, and undergraduate medical education programs. The Chief shall actively encourage and approve research activities within the Division/Section in line with established protocols. The Chief shall demonstrate leadership in academic and clinical endeavors of the Division/Section, and actively encourage members of the Division/Section to perform likewise, in all of these endeavors, the Chief shall provide a positive role model to the Division/Section membership.

VIII.8.8 Policies. Each Division/Section shall have written policies to enable it to carry out the duties of the Division/Section.

IX. OFFICERS

IX.1 GENERAL

The officers of the Staff shall be the Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer. Officers shall be elected at the April meeting of the Staff for a term of two (2) years with the

term beginning on the first of May and running until April 30. No officer shall be elected to succeed himself/herself.

IX.2 CHIEF OF STAFF

IX.2.1 Qualifications. The Chief of Staff shall have been an Active Member of the Staff for at least the past four (4) years.

IX.2.2 Duties and Responsibilities.

IX.2.2.1 The Chief of Staff shall preside at all meetings of the Staff and the MEC, and shall be a member ex officio of all other Committees of the Staff. The attendance of the Chief of Staff at the meetings of the Committees shall be at his/her discretion unless otherwise indicated in the Bylaws.

IX.2.2.2 The Chief of Staff is the liaison between the Staff and the CEO and Board of Directors. The Chief of Staff shall report to the Board of Directors on the performance and maintenance of quality with respect to the delegated responsibility of the Staff to provide medical care.

IX.2.2.3 The Chief of Staff shall be responsible for the enforcement of the Staff Bylaws and Rules and Regulations.

IX.2.2.4 The Chief of Staff shall appoint regular members and Chairs to all standing and special Committees of the Staff except those identified in these Bylaws.

IX.2.2.5 The Chief of Staff may call a meeting at any time of any Committee of the Staff,

IX.2.2.6 The Chief of Staff shall be ultimately responsible for educational activities of the Staff

IX.2.2.7 The Chief of Staff shall be the spokesman for the Staff in its relations with external professional and public groups and organizations.

IX.3 VICE CHIEF OF STAFF

IX.3.1 Qualifications. The Vice Chief of Staff shall have been an Active Staff Member of the Staff for at least the past three (3) years, who automatically will assume the role of Chief of Staff at the next election. Until then, the Vice Chief of Staff assumes all the Chief of Staffs duties during the Chief of Staffs absence.

IX.3.2 Duties and Responsibilities.

IX.3.2.1 The Vice Chief of Staff shall be expected to perform such duties as may be assigned by the Chief of Staff.

IX.3.2.2 The Vice Chief of Staff shall chair meetings as spelled out in Section 9.9.

IX.4 SECRETARY-TREASURER

IX.4.1 Qualifications. The Secretary-Treasurer shall have been an Active Staff Member for at least the past two (2) years.

IX.4.2 Duties and Responsibilities.

IX.4.2.1 The Secretary-Treasurer shall keep accurate and complete minutes of all meetings of the Committees of the Staff.

IX.4.2.2 The Secretary-Treasurer shall call meetings on the order of the Chief of Staff.

IX.4.2.3 The Secretary-Treasurer shall attend to all correspondence, be custodian of the Medical Staff funds, and make an accounting of these funds at the General Meeting of the Staff

IX.4.2.4 9.4,2.4 The Secretary-Treasurer shall dispense any funds in accordance with the Bylaws and Rules and Regulations.

IX.4.2.5 The Secretary-Treasurer shall be responsible for recording minutes of the Staff and the MEC meetings.

IX.4.2.6 The Secretary-Treasurer shall Chair meetings as spelled out in Section 9.9.

IX.5 METHOD OF ELECTION

IX.5.1 Nominations Committee.

IX.5.1.1 Preceding the election of the Staff officers, the Secretary of the Staff shall request the Departments of the Staff to elect, at their October Departmental meetings, members to serve on the Nominations Committee. Two (2) members are to be elected from the Departments of Medicine and Surgery, one (1) each from the remaining clinical Departments. The results of these elections shall be reported to the Secretary of the Staff

IX.5.1.2 The Nominations Committee shall elect at least one (l) candidate for each of the following offices: Vice Chief of Staff and Secretary-Treasurer.

IX.5.1.3 In addition, the Nominations Committee shall select:

IX.5.1.3.1 A representative from the Staff to any committee of the affiliated medical school(s) when so required; and

IX.5.1.3.2 At least six candidates from the Staff as at large delegates to the MEC. These candidates will not be considered officers of the Staff.

IX.5.1.4 No member of the Nominations Committee shall be nominated for any of the above-mentioned offices by the Nominations Committee, but his/her name may be placed in nomination via the petition route.

IX.5.1.5 All selections shall be presented to the January meeting of the Staff.

IX.5.1.6 If, at any time, a vacancy occurs among the previously-nominated candidates, replacement candidates must be nominated by the Nominations Committee prior to additional nominations by petition being announced.

IX.5.2 Nomination by Petition. At the January meeting of the Staff, immediately after the slate announcement by the Nominations Committee, the Chief of Staff shall announce to the membership the prerogative of nominating by petition bearing at least ten (10) signatures of voting Staff Members. These petitions shall be received by the Chief of Staff at least two (2) weeks prior to the March meeting of the Staff, at which meeting the total slate (those of the Nominations Committee and the petitions) shall be announced. There will be no vocal floor nominations.

IX.5.3 Electoral Procedure

IX.5.3.1 The election of officers and representatives-at-large shall be by written ballot in the odd-numbered years. The names of all candidates shall appear on the printed ballot. There shall be an individual ballot for each office. A majority of ballots cast for each office shall be required for election to that elected office.

IX.5.3.2 Members with voting privileges may vote at any time during the fourteen (14) days preceding 10:00 a.m. on the first Thursday in April in the election year. The ballots may be obtained, at 10:00 a.m. on Thursday, fourteen (14) days prior to the election, from the Medical Staff Office. Such ballots are to be marked and deposited before 11:00 a.m. on the referenced first Thursday in April, into a locked ballot box to be provided in the Medical Staff Office. The key to the locked box shall be in the possession of the incumbent Chief of Staff.

IX.5.3.3 The Chief of Staff shall appoint counters to tally the ballots. The counters shall tally the ballots at 11:00 a.m. on the first Thursday in April of the election year, with the results to be announced the same day.

IX.5.3.4 If a majority is not obtained on the first ballot, a second ballot between the two (2) candidates with the highest number of votes shall be held at the regularly scheduled meeting of the Staff.

IX.5.3.5 In the event of a tie vote in the second election, a special meeting of the Staff shall be held within thirty (30) days to elect one (1) of the two (2) candidates to fill the office in question. None of the elections is valid unless a quorum of the Staff is present and voting.

IX.6 RECALL

IX.6.1 Grounds. If, after election to office, the elected official demonstrates gross failure in fulfilling the responsibilities of office, the MEC shall reconsider the situation at its next meeting.

IX.6.2 Request for Resignation. The MEC, after consideration of the situation, may request the resignation of any member of the MEC. Such request shall not be filed in the membership file of that individual, nor shall it have any reflection upon the competence of the member in the practice of medicine, nor shall it affect the future participation of this individual in Staff activities.

IX.7 VACANCIES

IX.7.1 Chief of Staff. In the case of death, permanent disability, or resignation of the Chief of Staff, the Vice Chief of Staff shall assume the office of the Chief of Staff for the unexpired term in addition to his/her elected term. If the Vice Chief of Staff has been appointed by the MEC, at the next regular election a Chief of Staff and a Vice Chief of Staff shall be nominated and elected as outlined in the Article of the Bylaws. In the case of absence of the Chief of Staff, the Vice Chief of Staff shall temporarily assume the office of Chief of Staff

IX.7.2 Vice Chief of Staff. If a vacancy occurs in the office of Vice Chief of Staff, the MEC, at its next meeting, shall elect from the six (6) at-large representatives to the MEC, a successor to fill the unexpired term until the next election, at which time a Chief of Staff and a Vice Chief of Staff shall be nominated and elected as outlined in the Article IX of the Bylaws.

IX.7.3 Other Offices. If a vacancy occurs in any of the positions held by the representatives elected at-large to the MEC, a special election shall be held at the next meeting of the Staff to fill this office. If a vacancy occurs in any other elected office of the Staff, a successor to fill the unexpired terms shall be elected by the MEC at its next meeting from among the six (6) at-large representatives to the MEC.

IX.7.4 Simultaneous Vacancies. If a vacancy occurs simultaneously in the offices of Chief of Staff and Vice Chief of Staff, the MEC, at a special meeting called by the Secretary-Treasurer of the Staff, shall elect from among the six (6) at-large representatives to the

MEC, two (2) successors to fill the unexpired term until the next election, at which time a Chief of Staff and a Vice Chief of Staff shall be nominated and elected as outlined in the Bylaws.

IX.8 IMMEDIATE PAST CHIEF OF STAFF

The duties of the Immediate Past Chief of Staff shall be advisory in nature, but will include the chairing of meetings, if necessary, as spelled out in Section 9.9. The Immediate Past Chief of Staff (or equivalent title) is a member of the MEC.

IX.9 CHAIRMANSHIP SEQUENCE

In the event of the absence of the appropriate officer to chair the General Meeting of the Staff, the MEC, the following sequence of replacement chairs shall be utilized:

IX.9.1 Vice Chief of Staff

IX.9.2 Secretary-Treasurer

IX.9.3 Immediate Past Chief of Staff

X. COMMITTEES

X.1 COMMITTEE MEMBERSHIP

X.1.1 Whereas it is necessary for the effective functioning of the Medical Staff that it have appointed Committees to handle broad-based Staff problems and where Staff policy will originate; whereas these Committee responsibilities should not be borne by only a few; and whereas it is the of every Active Staff to participate in Committees; therefore, the Chief of Staff shall take these items into consideration in the appointment of members to the Staff Committees in order to insure appropriate participation of Active Staff Members in the various Committees.

X.1.2 Members of all medical-administrative Committees shall be appointed jointly by the Chief of Staff and the Chief Executive Officer. The Chief of Staff shall appoint to other Committees members appropriate to the function of the Committee and appropriate to the membership of the Departments.

X.2 MEDICAL EXECUTIVE COMMITTEE

X.2.1 Composition. The MEC shall consist of the Chief of Staff, Immediate Past Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer of the Staff; six members (6) from the Active Staff elected at large pursuant to Section 9.5.1.3.2 and the Chairs of the clinical Departments of the Staff. The Chief Executive shall be an Ex Officio member with vote. The Chief Operating Officer, Vice President of Patient Care Services, and CMO shall be Ex Officio members without vote.

X.2.2 Chair. The Chief of Staff shall preside at the meetings of the MEC.

X.2.3 Duties. The duties of the MEC, through regular attendance, shall be:

X.2.3.1 To represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Bylaws;

X.2.3.2 To fulfill the Staffs accountability to the Board of Directors of Insight Hospital and Medical Center Chicago for the care rendered to patients;

X.2.3.3 To ensure that the Staff is kept abreast of the accreditation program and informed of the accreditation status of Insight Hospital and Medical Center Chicago;

X.2.3.4 To take all reasonable steps to insure professional ethical conduct and competent clinical performance on the part of all Practitioner including initiation of and/or participation in corrective or review measures when warranted;

X.2.3.510.2.3.5 To receive and act upon Department and committee reports;

X.2.3.6 To coordinate the activities and general policies of the various Departments, and to implement policies for the Staff not otherwise the responsibility of the Departments;

X.2.3.7 To provide liaison between Staff and Chief Executive Officer and the Board of Directors;

X.2.3.8 To recommend action to the Chief Executive Officer on matters of a medical-administrative nature and to make recommendations on Hospital management matters (e.g., budgeting and planning) to the Board of Directors through the Chief Executive Officer; and

X.2.3.9 To be accountable for the quality of all medical education and research.

X.2.4 Meetings. The MEC shall meet at least ten (10) times per year. Additional meetings may be called by the Chief of Staff.

X.2.5 Minutes. The Secretary-Treasurer shall be responsible for keeping the minutes of the MEC proceedings. The Secretary-Treasurer shall provide to the Members of the Staff all minutes of the MEC meetings at least one (1) week prior to the next general meeting of the Staff.

X.3 BYLAWS COMMITTEE

X.3.1 Composition. The Chief of Staff shall appoint members from the clinical Departments of the Staff appropriate to the function of the Committee and appropriate to the membership of the Departments. There may be one (1) administrative representative appointed by the Chief Executive Officer.

X.3.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall appoint one (1) of the members as chair.

X.3.3 Duties. The Bylaws Committee shall review annually the Bylaws and Rules and Regulations and Policies of the Staff and shall recommend appropriate revisions or additions in order to foster quality care to patients and to maintain the highest professional conduct. The Bylaws Committee shall interpret current Bylaws and Rules and Regulations and Policies when requested to do so.

X.3.4 Meetings. Meetings of the Bylaws Committee shall be held as specified in the Rules and Regulations. Additional meetings may be called by the Chief of Staff or by the chair of the Bylaws Committee.

X.3.5 Minutes. Minutes shall be recorded by a member of the Committee chosen by the chair. Minutes shall be forwarded to the MEC.

X.4 CANCER COMMITTEE

X.4.1 Compositions. The members shall be appointed jointly by the Chief of Staff and the Chief Executive Officer. Appointments shall include at least one (1) member from each clinical Department, and administrative representatives as required by the Commission on Cancer of the American College of Surgeons.

X.4.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall name one (1) of the members as chair.

X.4.3 Duties.

X.4.3.1 The Cancer Committee shall be responsible for directing the cancer programs at Insight Hospital and Medical Center Chicago. It will recommend regulations, directives, and policies with respect to furnishing services to cancer patients. It will implement the requirements of the Commission on Cancer of the American College of Surgeons, particularly with respect to the Tumor Registry. It will recommend and advise regarding needs and requirements necessary to maintain approved cancer programs. It will supervise the of the Tumor Board, Tumor Registry, and tumor clinics.

X.4.3.2 Information concerning specific practice patterns of individual physicians will be submitted in writing to the appropriate Division or Section Chief, or to the Chair of the Department, who will utilize this information at the time of reappointment,

X.4.4 Meetings. Meetings of the Cancer Committee shall be held as specified in the Rules and Regulations. Additional meetings may be called by the Chief of Staff.

X.4.5 Minutes. Minutes shall be recorded by a member of the Committee chosen by the chair, and shall be forwarded to the MEC.

X.5 CREDENTIALS COMMITTEE

X.5.1 Composition. The Chief of Staff shall appoint members from the clinical Departments of the Staff proportionate to the membership of the Departments.

X.5.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall name one (1) of the members as chair.

X.5.3 Duties.

X.5.3.1 The Credentials Committee shall investigate the credentials of all new applicants for Staff membership and APPS applying for Clinical Privileges (including the candidates for administrative positions). The Committee will make recommendations in conformity with Articles IV and V of the Bylaws.

X.5.3.2 The Credentials Committee shall also review the reappointment applications of Members of the Staff as well as APPs in the same manner as provided in Articles IV and V of the Bylaws. The Credentials Committee shall investigate the credentials of all Members being considered for classification change and make recommendations regarding the classification change.

X.5.3.3 The Credentials Committee shall acquire from the National Data Bank information regarding any applicant for appointment, and for any applicant for reappointment when deemed necessary by the Credentials Committee.

X.5.4 Meetings. Meetings of the Credentials Committee shall be held as specified in the Rules and Regulations. Additional meetings may be called by the Chief of Staff or the chair of the Credentials Committee.

X.5.5 Minutes. Minutes shall be recorded by a member chosen by the chair of the Credentials Committee. Minutes shall be forwarded to the MEC.

X.6 PROTECTION CONTROL COMMITTEE

X.6.1 Composition. Members shall be appointed jointly by the Chief of Staff and the Chief Executive Officer. Appointments shall include at least one (1) member from each clinical Department, and administrative representation as indicated.

X.6.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall name one (1) of the members as chair.

X.6.3 Duties. The Infection Control Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual hospital infections;

the promotion of preventive and corrective programs designed to minimize infection hazards; the supervision of infection control in all phases of hospital activities, i.e., operating rooms, special care units, sterilization procedures, isolation procedures, inhalation equipment, personnel culturing, and disposal of infectious material.

X.6.4 Meetings. Meetings of the Infection Control Committee shall be held as specified in the Rules and Regulations. Additional meetings may be called by the Chief of Staff or the chair of the Infection Control Committee.

X.6.5 Minutes. Minutes shall be recorded by a member of the Committee chosen by the chair, and shall be forwarded to the MEC.

X.7 HEALTH INFORMATION MANAGEMENT COMMITTEE

X.7.1 Composition. The members shall be appointed jointly by the Chief of Staff and the Chief Executive Officer. Appointments shall include one (1) member from each of the clinical Departments, and administrative representation as indicated.

X.7.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall name one (1) of the members as chair of the Health Information Management Committee.

X.7.3 Duties. The Health Information Management Committee shall be responsible for assuring that all medical records meet high standards. Information concerning specific practice patterns of individual Practitioners will be submitted in writing to the appropriate Division or Section Chief, or Chair of the Department, who will utilize this information at the time of reappointment.

X.7.4 Meetings. Meetings of the Health Information Management Committee shall be held as specified in the Rules and Regulations. Additional meetings may be called by the Chief of Staff or the chair.

X.7.5 Minutes. Minutes will be recorded by a member of the Committee chosen by the chair. Minutes shall be forwarded to the Quality Improvement Committee.

X.8 PHARMACY & THERAPEUTICS COMMITTEE

X.8.1 Composition. Members shall be appointed jointly by the Chief of Staff and the Chief Executive Officer. Appointments shall include at least one (l) member from each clinical Department, and administrative representatives as indicated.

X.8.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall name one (1) of the members as chair of the Pharmacy & Therapeutics Committee.

X.8.3 Duties. The Pharmacy & Therapeutics Committee shall be responsible for the following:

X.8.3.1 The addition or deletion of drugs and nutritional agents from formulary;

X.8.3.2 Review of non-formulary requests of drugs;

X.8.3.3 Formulation of policies and procedure for safe use of medication;

X.8.3.4 Development of drug utilization evaluations;

X.8.3.5 Review of adverse drug reactions; and

X.8.3.6 Review of investigational drug protocols,

X.8.4 Meetings. Meetings of the Pharmacy & Therapeutics Committee shall be held as specified in the Rules and Regulations. Additional meetings may be called by the Chief of Staff or the chair.

X.8.5 Minutes. Minutes will be recorded by a member of the Committee chosen by the chair. Minutes shall be forwarded to the Quality Improvement Committee.

X.9 PHYSICIAN WELLNESS AND ASSISTANCE COMMITTEE

X.9.1 Composition. The Chief of Staff shall appoint from the Staff three (3) members for staggered terms up to three (3) years. The members appointed shall possess knowledge, expertise, and recognition by their peers appropriate to the function of the Committee.

X.9.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall appoint one (1) of the members as chair of the Physician Wellness and Assistance Committee.

X.9.3 Duties. The duties of the Physician Wellness and Assistance Committee shall be as follows:

X.9.3.1 The Committee shall assist and act as advocate for any Practitioner having physical and/or emotional problems which interfere with his/her performance to such an extent that harm may result to the Practitioner, members of his/her family, patients, Members of the Staff, and/or the Hospital. This Committee is NOT a disciplinary committee.

X.9.3.2 The Committee shall be a delegated body within Insight Hospital and Medical Center Chicago to evaluate the concerns it receives through its chair. The chair shall be responsible for receiving and transmitting all substantial concerns to the Committee. Any Practitioner in need of assistance may seek the assistance of this Committee voluntarily.

X.9.3.3 In any concerns reviewed by the Committee, the Practitioner will be advised of the particular concern about to be reviewed, and the early deliberations must be carried out with great discretion and sensitivity. If the concern received by the

Committee finally is to be justified, appropriate members of the Committee, directed by the chair of the Committee, shall contact the individual in need of assistance to establish the initiation of a voluntary diagnostic and therapeutic program.

X.9.3.4 The Committee shall assist the Practitioner in need of assistance to secure appropriate professional resources for diagnostic, therapeutic and rehabilitative purposes. A systematic report on the status, purpose and prognosis of the individual in need of assistance shall be sought by the Committee from the facility (facilities) or person(s) who have assumed the responsibility for the assistance of the Practitioner. After successful rehabilitation of the Practitioner, the Committee shall assist the Practitioner in the reinstatement of possibly curtailed privileges and the resumption of professional responsibilities leading to an active practice and the resumption of a healthy life. In the event a Practitioner in need of assistance refuses or fails to continue treatment to successful rehabilitation, the Committee shall make an appropriate recommendation to the MEC. The Committee shall establish an educational process to increase the awareness of the Staff in identifying and assisting any Practitioner possibly in need of help.

X.9.4 Meetings. Meetings of the Professional Assistance Committee shall be held as specified in the Rules and Regulations. Additional meetings may be called by the chair.

X.9.5 Minutes. Minutes shall be forwarded to the MEC and shall be as brief as possible, relating to actions taken by the Committee and protecf.ng the confidentiality of all proceedings. Confidentiality is imperative; no identifying data shall be included.

X.10 QUALITY & SAFETY COMMITTEE

X.10.1 Composition. The Chief of Staff shall appoint members from the clinical Departments appropriate to the function of the Committee, and appropriate to the membership of the Departments. There shall be one (1) administrative representative appointed by the Chief Executive Officer, the Director of Quality and Patient Safety, and appropriate representatives from Patient Care Services.

X.10.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall name one (1) of the members as chair,

X.10.3 Duties.

X.10.3.1 To ensure quality care in a cost effective manner;

X.10.3.2 To assure that the quality of care meets the standards and criteria as established in the medical community;

X.10.3.3 To establish a systematic and ongoing process, indicating and assuring that the quality of services exists. This process must include discussion of issues,

conclusions, recommendations for actions, and follow-up. The evaluation and monitoring processes should include, as applicable, but not be limited to the following:

X.10.3.3.1 Documentation of clinical and laboratory evidence supporting the admission and discharge diagnoses, evaluation of significance and appropriateness of all diagnostic modalities;

X.10.3.3.2 Documentation of appropriateness, effectiveness, and side effects of all and medical therapeutic modalities;

X.10.3.3.3 Participation in the evaluation of prophylactic, therapeutic, and empiric use of drugs. This task may be carried out in conjunction with the Pharmacy & Therapeutics Committee, appropriate hospital representatives, and other Departments/Divisions/Sections of the Staff (see Policies of Drug Utilization);

X.10.3.3.4 Documentation of all complications and morbidities during hospitalization of the patient, and establishing an effective mechanism to obtain autopsy for improvement of quality of service;

X.10.3.3.5 Documentation of stability of the patient's condition prior to discharge, and satisfactory discharge planning;

X.10.3.3.6 Integration of the outcome and recommendations of quality improvement activities of all Departments and Committees of the Staff, and discussion of the data received from reimbursing organizations or other health care agencies regarding quality care and utilization; and

X.10.3.3.7 Recommendation to the MEC of the Standards and Criteria pertinent to the practice of medicine in order to improve quality of service, when necessary and required by the quality and patient safety program.

X.10.3.4 Meetings. Meetings of the Quality & Safety Committee shall be held as specified in the Rules and Regulations. Additional meetings may be called by the Chief of Staff or the chair.

X.10.3.5 Minutes. Minutes shall be recorded by a member of the Committee chosen by the chair. Minutes shall be forwarded to the MEC.

X.11 TRANSFUSION COMMITTEE

X.11.1 Composition. The Chief of Staff shall appoint members from the clinical Departments of the Staff appropriate to the function of the Committee and appropriate to the membership of the Departments. Appointments shall include one (1) ex officio member from the Department of Nursing.

X.11.2 Chair. The Chief of Staff, aner consultation with the Chief Executive Officer, shall name one (1) of the members as chair.

X.11.3 Duties.

X.11.3.1 The Transfusion Committee shall review the use of blood products as they affect the quality of patient care, including the availability of quality blood products, and justification for usage as discovered in case review, and documentation of any untoward events in such administration. The Transfusion Committee shall be responsible for development and proposal of policies and procedures relative to the distribution, handling, utilization, and administration of blood.

X.11.3.2 10.11.3.2 Information concerning specific practice patterns of individual physicians will be submitted in writing to the appropriate Division or Section Chief, or Chair of the Department if there is no Division of Section Chief, who will utilize this information at the time of reappointment.

X.11.4 Meetings. Meetings of the Transfusion Committee shall be held at least quarterly. Additional meetings may be called by the Chief of Staff or the chair.

X.11.5 Minutes. Minutes shall be recorded by a member of the Committee chosen by the chair. Minutes shall be forwarded to the Quality Improvement Committee.

X.12 CRITICAL CARE QUALITY IMPROVEMENT COMMITTEE

X.12.1 Composition. The members shall be appointed jointly by the Chief of Staff and the Chief Executive Officer. Appointments shall include: Medical Staff -- Medical Directors of ICU, CCU, Telemetry; Chair, Department of Emergency Medicine; Administrative Staff-President of Patient Care Services, Nursing Director of Critical Care Services, Unit Managers of ICU, CCU, Telemetry, Cardiac Cath Lab and Emergency Medicine, Director of Respiratory Care Services. Additional members or consultants may be requested by the Chair as appropriate as need arises to meet the goals and objectives of the committee.

X.12.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall name one of the members as chair.

X.12.3 Duties. Evaluate practice patterns and identify areas for performance improvement in all critical care areas. Critical care areas include intensive care unit (ICU), coronary care unit (CCU), telemetry unit, cardiac catheterization lab and emergency department (ED). Set performance improvement goals and priorities for all critical care areas. Review and monitor results of performance improvement initiatives in all critical care areas. Review equipment needs for all critical care areas and determine product standards. Monitor and evaluate the performance of cardiopulmonary resuscitation (CPR) and other code blue calls throughout the hospital, including adequacy of equipment, organization and personnel, adherence to guidelines and outcomes.

X.12.4 Meetings. Meetings will be held no less than quarterly. Additional meetings will be called as needed by the Chair or the Chief of Staff of the Medical Staff

X.12.5 Minutes. Minutes shall be recorded by a member of the committee chosen by the chair. The Chair will make regular reports to the Quality Improvement Committee (QIC) as determined by the QIC reporting schedule.

X.13 CME/LIBRARY COMMITTEE

X.13.1 Composition. The CME/Library Committee shall consist of at least three Medical Staff members broadly representative of the clinical Departments and other Hospital and Administrative representatives as necessary.

X.13.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall name one of the members as chair.

X.13.3 Duties. The CME/Library Committee shall (a) organize a program to provide educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public and the profession; (b) maintain documentation of physician participation in continuing education programs within the Hospital; and (c) oversee the professional library service.

X.13.4 Meetings. Meetings will be held no less than quarterly. Additional meetings will be called as needed by the chair or the Chief of Staff of the Medical Staff .

X.13.5 Minutes. Minutes shall be recorded by a member of the committee chosen by the chair. The Chair will make regular reports to the MEC.

X.14 PROFESSIONAL PRACTICE EVALUATION COMMITTEE ("PPEC")

X.14.1 Composition. The PPEC shall consist of the following:

X.14.1.1 Voting Members:

X.14.1.1.1 Immediate Past Chief of Staff of the Medical Staff;

X.14.1.1.2 One other Past Chief of Staff of the Medical Staff; and

X.14.1.1.3 Physician advisors.

X.14.1.2 Non-Voting Members:

X.14.1.2.1 CMO;

X.14.1.2.2 CQO;

X.14.1.2.3 Chief Medical Informatics Officer; and

X.14.1.2.4 PPE Support Staff representatives.

X.14.1.3 Before any PPEC member begins serving, the member must understand the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on professional practice evaluation, with the nature of the training to be identified by the MEC or the PPEC.

X.14.1.4 To the fullest extent possible, PPEC members shall serve staggered, multiple-year terms, so that the Committee always includes experienced members. Appointed members may be reappointed for additional terms.

X.14.1.5 Other Medical Staff members or Hospital personnel may be invited to attend a particular PPEC meeting (as guests, without vote) in order to assist the PPEC in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and shall be bound by the same confidentiality requirements as the standing members of the committee.

X.14.2 Chair. The Chief of Staff, after consultation with the Chief Executive Officer, shall name one of the voting members as Chair

X.14.3 Duties. The PPEC shall perform the following functions:

X.14.3.1 Oversee the implementation of the Professional Practice Evaluation policy ("PPE Policy") and ensure that all components of the process receive appropriate training and support;

X.14.3.2 Review and approve OPPE quality data elements that are identified by Departments;

X.14.3.3 Review and approve the specialty-specific quality indicators identified by the Departments that will trigger the professional practice evaluation/peer review process;

X.14.3.4 Review, approve, and/or assist in the development of patient care protocols and guidelines that are recommended by Departments, specialties, or others;

X.14.3.5 Identify those variances from the Rules or protocols which do not require physician review, but for which an informational letter may be sent to the Practitioner involved in the case;

X.14.3.6 Review cases referred to it as outlined in the PPE Policy;

X.14.3.7 Develop, when appropriate, performance improvement plans for Practitioners, as described in the PPE Policy;

X.14.3.8 Monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved;

X.14.3.9 Periodically review the effectiveness of the PPE Policy and recommend revisions as may be necessary; and

X.14.3.10 Perform any additional functions as may be requested by the MEC or the Board.

X.14.4 Meetings. Meetings will be held no less than quarterly. Additional meetings will be called as needed by the chair or the Chief of Staff of the Medical Staff.

X.14.5 Minutes. Minutes shall be recorded by a member of the committee chosen by the chair. The chair will make regular reports to the MEC and Quality Improvement Committee.

X.15 JOINT CONFERENCE COMMITTEE

The Joint Conference Committee is a Medical Staff-Hospital body that may be convened as needed to address specific issues related to the Hospital, including conflicts between the Medical Staff and Chief Executive Officer or the Medical Staff and the Board. A Joint Conference shall be composed of equal representation from the Board and the Medical Staff. The Medical Staff shall be represented by the Chief of Staff and additional members designated by the MEC.

XI. GENERAL MEETINGS OF THE MEDICAL STAFF

XI.1 REGULAR MEETINGS

General staff meetings should be held semi-annually or as needed, as specified in the Rules and Regulations.

XI.2 SPECIAL MEETINGS

Special meetings of the Staff may be called at any time by the Chief of Staff. A special meeting also may be called at the direction of the NOC or at the request of five (5) Members of the Staff. Such request must be in writing, shall be signed by persons requesting the meeting, and shall be addressed to the Chief of Staff. The Chief of Staff then shall set an appropriate date for the special meeting. The date set shall be within thirty (30) days after receiving the request.

No business shall be transacted at a special meeting except that stated in the notice calling the meeting.

XI.3 ATTENDANCE AT MEETINGS

All Members of the Staff shall be expected to attend meetings of the Staff as provided in the Bylaws and Rules and Regulations,

XI.4 LOCATION

All meetings of the Staff shall be held at Insight Hospital and Medical Center Chicago.

XI.5 QUORUM

For any regular or special meeting of the Medical Staff, twenty (20) voting staff Members must be present in order to establish a quorum. The exception to this general rule is when amendments to these Medical Staff Bylaws or the related Bylaws Documents will be discussed, in which case at least 10% of the entire voting staff must be present in order to establish a quorum.

XI.6 VOTING

No voting shall take place at any regular or special meeting of the Medical Staff. Issues shall be discussed and deliberated at such meetings, but voting on all issues shall take place by written or electronic means. Specifically, the voting Members of the Medical Staff shall be presented with matters requiring a vote by mail, facsimile, e-mail, website, hand-delivery, telephone, or other technology approved by the Chief of Staff. Votes shall be returned to the Chief of Staff via the Medical Staff Office by the method designated in the notice. The question raised shall be determined in the affirmative and shall be binding if a quorum is achieved (as defined above in Section 11.5) and the majority of the responses returned has so indicated.

XI.7 AGENDA

XI.7.1 General Meetings. Guidelines for agenda of the general meetings of the Staff shall be as follows:

XI.7.1.1 Call to order;

XI.7.1.2 Approval of the minutes of the last regular or business meeting, and of any special meetings held since the last business or regular meeting;

XI.7.1.3 Approval of the agenda;

XI.7.1.4 Approval of the actions and minutes of all meetings of the MEC since the last regular or business meeting;

XI.7.1.5 Report of the Chief Executive Officer of Insight Hospital and Medical Center Chicago;

XI.7.1.6 Report of the Chief of Staff;

XI.7.1.7 Reports of Chairs of Departments, Chiefs of Sections/Divisions, Chairs of the Committees;

XI.7.1.8 Unfinished business;

XI.7.1.9 New business;

XI.7.1.10 Announcements and communications;

XI.7.1.11 Setting of date for the next meeting; and

XI.7.1.12 Adjournment.

XI.7.2 Special Meetings. Guidelines for the agenda of a special meeting shall be:

XI.7.2.1 Call to order;

XI.7.2.2 Reading of the Notice calling the meeting;

XI.7.2.3 Transaction of business for which the meeting was called; and

XI.7.2.4 Adjournment.

XI.7.3 Department. Division, and Section Meetings. Guidelines for agenda of the meetings of the Departments/Divisions/Sections and Committees of the Staff:

XI.7.3.1 Call to order;

XI.7.3.2 Approval of the minutes of the last regular or business meeting and of any special meetings held since the last business or regular meeting;

XI.7.3.3 Approval of the agenda;

XI.7.3.4 Quality Improvement Committee and other reports;

XI.7.3.5 Unfinished business;

XI.7.3.6 New business;

XI.7.3.7 Announcements and communications;

XI.7.3.8 Setting of date for the next meeting; and

XI.7.3.9 Adjournment.

XII. CORRECTIVE ACTION

XII.1 GROUNDS FOR REQUEST

Any Officer of the Medical Staff, the Chair of any Department, the Chief Medical Officer, the Chief Executive Officer, or the Board of Directors may request corrective action with respect to a Practitioner with Clinical Privileges based on reasonable grounds including, but not limited to, any of the following:

XII.1.1 It appears the Practitioner no longer possesses the qualifications for Medical Staff membership or for the Clinical Privileges held.

XII.1.2 Personal activity or professional conduct that is, or is likely to be, detrimental to patient safety or to delivery of patient care, or disruptive to Hospital operations.

XII.1.3 Unethical professional practice in or outside of the Hospital.

XII.1.4 Conduct that constitutes sexual harassment or morally offensive conduct toward any Medical Staff Member, Practitioner who holds Clinical Privileges, Hospital personnel, patient, or Hospital visitor.

XII.1.5 Violation of these Bylaws or the Rules.

XII.1.6 Conduct that indicates unwillingness or inability to work harmoniously with Medical Staff Members, other Practitioners who hold Clinical Privileges, Hospital personnel, or patients.

XII.2 FORM OF REQUEST

All requests for corrective action shall be in writing, submitted to the Medical Executive Committee, and supported by reference to the specific activity or conduct that constitutes the grounds for the request. If a member of the Medical Executive Committee is the subject of a request for corrective action, that Practitioner shall not participate in MEC discussions or action relating to the request. Complaints regarding a Practitioner that are lodged by anyone other than the individuals listed in Section 12.1 shall be directed to the Chair of the Department to which the Practitioner is assigned.

XII.3 NOTICE OF REQUEST

The Chief Executive Officer shall be notified in writing of all requests for corrective action received by the Medical Executive Committee and shall be kept fully informed of all action taken in conjunction therewith.

XII.4 INVESTIGATION

The Medical Executive Committee may designate an Individual or an ad hoc committee (from among its members or not) to investigate the grounds for a request for corrective action, if deemed necessary or appropriate by the Medical Executive Committee. The designated person or committee shall promptly investigate the matter (which may, but is not required to, include an interview with the affected Practitioner) and, within 30 days after receipt of the assignment, shall forward a written report of its/his/her findings to the Medical Executive Committee. If the affected Practitioner is interviewed, the interview shall be informal; such an interview does not constitute a hearing and therefore none of the procedural rules relating to hearings (including presence of an attorney) shall apply.

XII.5 OPTIONAL MEDICAL EXECUTIVE COMMITTEE INTERVIEW OF PRACTITIONER

At any point after it receives a corrective action request, the Medical Executive Committee may, but is not required, to interview the affected Practitioner. As described in Section 12.4, any such interview does not constitute a hearing.

XII.6 MEDICAL EXECUTIVE COMMITTEE'S ACTION ON REQUEST

As soon as practical after receiving the corrective action request or (if an investigation was performed) after receipt of the investigating party's report, the Medical Executive Committee shall act on the request. The Medical Executive Committee's response to a corrective action request may include, without limitation:

XII.6.1 Reject the request for corrective action.

XII.6.2 Issue a written warning that future corrective action will be taken if the affected Practitioner's behavior does not conform to the standards stated in the warning.

XII.6.3 Issue a written reprimand stating the MEC's disapproval of the affected Practitioner's behavior, and directing that the behavior cease immediately.

XII.6.4 Require proctoring or consultation (if the affected Practitioner is not required to obtain consent of the consultant or proctor before the Practitioner may provide patient care).

XII.6.5 Require education to improve the affected Practitioner's knowledge, skills or ability in clinical subjects or in non-clinical subjects (such as anger management), that does not affect current Clinical Privileges.

XII.6.6 Require a health assessment of the affected Practitioner by a health professional or at a facility selected by the Medical Executive Committee and under such conditions (including reports to the MEC or its designee) as the Committee may establish, and/or require the affected Practitioner to undergo appropriate treatment.

XII.6.7 Recommend to the Board of Directors:

XII.6.7.1 Reduction, limitation, suspension, or revocation of Clinical

XII.6.7.2 Privileges;

XII.6.7.3 Suspension or revocation of Staff appointment;

XII.6.7.4 Any other form of discipline that materially limits the Practitioner's right to provide direct patient care as previously authorized (such as proctoring or consultation in which consent of the proctor or consultant is required before patient care may be provided).

XII.7 REPORT TO THE BOARD

XII.7.1 All Medical Executive Committee actions relating to a corrective action request shall be reported promptly to the Board.

XII.7.2 If the Medical Executive Committee recommends any of the actions specified in Section 12.6,7, the Board will not act on the recommendation until the affected Practitioner has either waived or completed a hearing. The Board may then adopt, modify, or reject the Medical Executive Committee's recommendation.

XII.7.3 In addition to considering and acting upon recommendations of the Medical Executive Committee regarding corrective action, the Board may, at any time, respond to a corrective action request by imposing corrective action against the Practitioner, subject to the Practitioner's right, if applicable, to Due Process.

XII.8 MONITORING PRACTITIONER'S COMPLIANCE

If the Medical Executive Committee's or the Board's response to a corrective action request entails proctoring, consultation, continuing education or other remedies that require subsequent evaluation to determine the affected Practitioner's compliance, competence, or improvement, the Medical Executive Committee or Board, as applicable, shall designate an individual to monitor the affected Practitioner's compliance and to report to the Medical Executive Committee or Board regarding the Practitioner's progress or the lack of progress, until the matter is resolved.

XIII. SUMMARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

XIII.1 IMPOSITION

The following individuals and bodies have the authority to suspend or summarily all or any portion of the Clinical Privileges of a Practitioner whenever they determine failure to take immediate action may result in an imminent danger to the mental or physical health or safety of any individual: (a) any two of the following individuals: the CEO, the Chief of Staff and appropriate Chair, or their designees, respectively, (b) the Medical Executive Committee, or (c)

the Executive Committee of the Board of Directors. Summary suspension is effective immediately upon imposition. The Chief Executive Officer shall promptly notify the suspended Practitioner of the suspension by Special Notice.

XIII.2 MEDICAL EXECUTIVE COMMITTEE REVIEW

Within ten (10) days after the affected Practitioner receives notice of the summary suspension, the Practitioner may make a written request to the Chief of Staff that the Medical Executive Committee review the suspension. If the suspended Practitioner makes a timely request, the Medical Executive Committee will review the suspension within ten (10) days from receipt of the Practitioner's request. If the affected Practitioner does not make a timely request, the Medical Executive Committee shall review the suspension at its next regular meeting. The Medical Executive Committee's review of the suspension shall be an informal proceeding and shall not be deemed a hearing and therefore none of the procedural rules relating to hearings (including presence of an attorney) shall apply. The suspended Practitioner will be invited to present his/her point of view to the Medical Executive Committee at the meeting for in this Section. The Medical Executive Committee may recommend modification, continuation or termination of the summary suspension and shall recommend the future status of the Practitioner's Medical Staff membership/Clinical Privileges (for example, reinstate after suspension of a specified duration, or terminate Medical Staff membership/Clinical Privileges).

XIII.3 FAVORABLE RECOMMENDATION

XIII.3.1 If the Medical Executive Committee, acting pursuant to Section 13.2, recommends termination of the suspension and a disposition of the matter that does not trigger Due Process, the suspension is terminated, unless the suspension was imposed by the Executive Committee of the Board, in which case Section 13.3.2 applies.

XIII.3.2 In the case of suspensions imposed by the Executive Committee of the Board, the Medical Executive Committee's recommendation to terminate the suspension and to take no action that triggers that Due Process shall be transmitted immediately, together with all supporting documentation, to the Board. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Board.

XIII.4 UNFAVORABLE RECOMMENDATION

If the Medical Executive Committee, acting pursuant to Section 13.2, recommends continuation of the suspension and/or a disposition of the matter that triggers Due Process, the Practitioner shall be to Due Process. The terms of the summary suspension shall remain in effect pending a final decision by the Board regarding the suspension and the future status of the Practitioner's Medical Staff membership/Clinical Privileges.

XIII.5 CARE OF PATIENTS

Immediately upon imposition of a summary suspension, the CEO or Chief of Staff shall have authority to provide for alternative medical coverage for patents of the suspended Practitioner at

the Hospital during the period of suspension. The wishes of the patients shall be considered, as feasible, in the selection of an alternative Practitioner.

XIV. INVESTIGATIVE SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

XIV.1 IMPOSITION

The following individuals and bodies have the authority to suspend or restrict all or any portion of the Clinical Privileges of a Practitioner for up to fourteen (14) days pursuant to this Article XIV: (a) any two of the following individuals: Chief of Staff, the Chair of the Department in which the holds Clinical Privileges, the Chief Executive Officer, and the Chief Medical Officer, (b) the Medical Executive Committee, or (c) the Executive Committee of the Board of Directors. An investigative suspension may be imposed if authorized individual(s) or a body listed in this Section conclude that grounds may exist for imposing summary suspension under Article XIII, but additional time and investigation is needed to determine the relevant facts (for example, to reconcile conflicting accounts of a key event), or to obtain access to the expertise needed to determine whether summary suspension is warranted. An investigative suspension is effective immediately upon imposition. The Chief Executive Officer shall promptly notify the suspended Practitioner of the suspension by Special Notice.

XIV.2 INTERIM NATURE

An investigative suspension is a professional renew activity, but does not constitute disciplinary action or a determination regarding the affected Practitioner's competence. An investigative suspension ends (a) 14 days after it is imposed or (b) when lifted by the individual(s) or body that imposed it, whichever occurs first.

XIV.3 CARE OF PATIENTS

Immediately upon imposition of an investigative suspension, the CEO or Chief of Staff shall have authority to provide for alternative medical coverage for patients of the suspended Practitioner at the Hospital during the period of suspension. The wishes of the patients shall be considered, as feasible, in the selection of an alternative Practitioner.

XV. AUTOMATIC SUSPENSION/TERMINATION OF CLINICAL PRIVILEGES/MEMBERSHIP

If a Practitioner's Medical Staff membership or Clinical Privileges are automatically suspended or terminated, the Medical Staff Office shall the Practitioner of the suspension or termination in writing, after notifying the Chief of Staff The following events shall result in automatic suspension or termination of a Practitioner's Medical Staff membership or Clinical Privileges, as specified, without right to Due Process:

XV.1 PROFESSIONAL LICENSE

A Practitioner whose license to practice a health profession in the State of Illinois is suspended, restricted or lapsed shall automatically be suspended from practicing in the Hospital. If a Practitioner's health profession license in the State of Illinois is revoked or otherwise terminated, or is suspended, restricted or lapsed for more than thirty (30) consecutive days, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

XV.2 15.2 DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION OR STATE CONTROLLED SUBSTANCES LICENSE

A Practitioner whose DEA registration or Illinois controlled substances license is revoked, suspended, restricted or lapsed shall automatically be divested of the right to prescribe medications covered by such registration license. As soon as practical after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA registration or controlled substances license was revoked, suspended, restricted or lapsed. The Medical Executive Committee shall then take such further action, if any, pursuant to Article XII or XIII, as the Medical Executive Committee determines appropriate.

XV.3 MEDICAL RECORDS

In accordance with the Rules, an automatic suspension of a Practitioner's Clinical Privileges shall be imposed for failure to complete medical records within the periods prescribed in the Rules.

XV.4 MALPRACTICE INSURANCE

A Practitioner who fails to provide the Hospital with adequate evidence of the professional liability insurance required by the Board of Directors shall be automatically suspended from practicing in the Hospital. If the Practitioner fails to provide the Hospital with adequate evidence of the required insurance within ninety (90) days after being suspended, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

XV.5 FEDERAL PROGRAM EXCLUSION

Exclusion of a Practitioner from a federal health care program shall cause an automatic termination of the Practitioner's Medical Staff membership and Clinical Privileges. (The terms of this Section do not apply to a decision by a Practitioner not to participate in federal health care program(s).)

XV.6 DUES

If a Medical Staff Member fails to pay Medical Staff dues within ninety (90) days after the due date, the Member's Clinical Privileges shall be suspended automatically until dues are paid in full. If a Member fails to pay Medical Staff dues for more than one hundred eighty (180) days

after the due date, the Member's Medical Staff membership and Clinical Privileges shall terminate automatically.

XV.7 LEAVE OF ABSENCE

Failure to submit a timely request for reinstatement from a leave of absence or failure to provide a summary of activities during a leave of absence or other information requested or required will result in automatic termination of Medical Staff membership and Clinical Privileges as provided in Section 3.6.

XV.8 REAPPOINTMENT

A Practitioner who fails to file a timely application for reappointment to the Medical Staff or renewal of Clinical Privileges shall automatically cease to be a Medical Staff Member and cease to hold Clinical Privileges upon expiration of the Practitioner's term of appointment.

XV.9 ADVANCED PRACTICE PROFESSIONALS

The Clinical Privileges of an APP are subject to automatic termination as provided in Section 6.1.5.

XV.10 HEALTH EVALUATION

A Practitioner who fails to submit to a physical or mental health evaluation within thirty (30) days of a written request therefor by the Board based on evidence of need for the evaluation supplied to the Board by the Medical Executive Committee, shall be automatically suspended from practicing at the Hospital until the evaluation occurs. If the Practitioner fails to submit to the evaluation and furnish the Hospital with the results thereof within ninety (90) days after being suspended, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

XV.11 COMMUNICABLE DISEASE TEST RESULTS

A Practitioner who fails to provide satisfactory evidence of communicable disease test results as required by Hospital policy, within thirty (30) days of request therefor, shall be automatically suspended from practicing at the Hospital until such documentation is furnished. If the Practitioner fails to provide the Hospital with satisfactory evidence of test results within ninety (90) days after being suspended, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

XV.12 REPORTS OF ADVERSE EVENTS

Within fifteen (15) days after any of the following events occurs with respect to a Practitioner, that Practitioner shall report the matter in writing to the Chief of Staff: (a) the Practitioner is convicted of (or pleads guilty or no contest to) a felony, (b) disciplinary action is imposed on the Practitioner by a licensed health facility, or (c) the Practitioner resigns or limits clinical

privileges at a licensed health facility while under investigation or in order to avoid an investigation or proceedings. A Practitioner's Medical Staff membership and Clinical Privileges shall be suspended automatically if the Medical Executive Committee or Board determines that the Practitioner failed to make a report that is required by this Section. If summary suspension is not imposed within fifteen (15) days after an automatic suspension is imposed pursuant to this Section 15.12, the automatic suspension shall expire at the end of that 15-day period.

XV.13 VACCINATION/IMMUNITY

A Practitioner who fails to comply with Hospital policy regarding proof of immunity/vaccination, shall be automatically suspended from practicing at the Hospital until the Practitioner complies with that policy. If the Practitioner fails to comply with the policy within ninety (90) days after being suspended, the Practitioner's Medical Staff membership and Clinical Privileges shall terminate automatically.

XVI. HEARING AND APPELLATE REVIEW PROCESS - MEDICAL STAFF MEMBERS AND APPLICANTS

XVI.1 DUE PROCESS

The Due Process rights of Staff Members and of applicants for Medical Staff membership are governed by this Article XVI.

XVI.2 RIGHT TO A HEARING

XVI.2.1 Appealable Matters. The affected Practitioner will be entitled to a hearing if (a) the Medical Executive Committee recommends any of the following actions or (b) the Board of Directors decides to take any of the following actions (and the Board's action was not preceded by a recommendation by the Medical Executive Committee to take one of the following actions):

XVI.2.1.1 Denial of Medical Staff membership;

XVI.2.1.2 Denial of Medical Staff reappointment;

XVI.2.1.3 Denial of requested initial or renewed Clinical Privileges;

XVI.2.1.4 Denial of requested increased Clinical Privileges;

XVI.2.1.5 Suspension or revocation of Medical Staff membership;

XVI.2.1.6 Reduction, limitation, suspension or revocation of Clinical Privileges;

XVI.2.1.7 Denial of a timely complete request for reinstatement from a leave of absence; or

XVI.2.1.8 Other material limitation of the right to provide direct patient care as previously authorized (such as requiring proctoring or consultation, if the affected Practitioner is required to obtain consent of the proctor or consultant before patient care may be provided).

XVI.2.2 Non-Appealable Matters. The affected Practitioner will not be to a hearing as a result of a recommendation or action that is not listed in Section 16.2. l, including the following matters:

XVI.2.2.1 Voluntary resignation of Clinical Privilege(s) or Medical Staff membership, including expiration and failure to file timely application for reappointment/renewal of Clinical Privileges;

XVI.2.2.2 Issuance of a warning or a letter of reprimand;

XVI.2.2.3 Imposition of a consultation or proctoring requirement, if the affected Practitioner is not required to obtain consent of the consultant/proctor before patient care may be provided;

XVI.2.2.4 Imposition of an investigative suspension or restriction of Clinical Privileges pursuant to Article XIV of these Bylaws;

XVI.2.2.5 Imposition of automatic suspension or termination pursuant to Article XV of these Bylaws;

XVI.2.2.6 Denial of a request for, or termination of, temporary Clinical Privileges;

XVI.2.2.7 Denial of a request for, or imposition of conditions or limitations on, a leave of absence;

XVI.2.2.8 Mandated education that does not affect current Clinical Privileges;

XVI.2.2.9 Any action or recommendation (including those listed in Section 162.1) based upon (a) the Practitioner's failure to meet the written minimum objective criteria for the Clinical Privileges or Medical Staff status at issue, or (b) closure or limitation of a Department, division, section or service by action of the Board, including the award of an exclusive contract;

XVI.2.2.10 Requiring a health assessment, report and/or treatment, as described in Section 5.8.6 or 12.6.6; or

XVI.2.2.11 Appointment or reappointment or the granting of Clinical Privileges for a period less than twenty-four (24) months.

XVI.3 PRE-HEARING PHASE

XVI.3.1 Notice of Hearing Rights. The Chief Executive Officer shall notify the Practitioner by Special Notice of a recommendation or action that entitles the Practitioner to a hearing.

XVI.3.2 Contents of Notice. The notice referred to in Section 16.3,1 shall state the following:

XVI.3.2.1 The adverse recommendation or action;

XVI.3.2.2 The reason(s) for the adverse recommendation or action;

XVI.3.2.3 The Practitioner's right to request a hearing;

XVI.3.2.4 A summary of the Practitioner's hearing rights; and

XVI.3.2.5 A time limit of thirty (30) days from the date of the Practitioner's receipt of the notice within which the Practitioner may submit a written request for a hearing to the Chief Executive Officer,

XVI.3.3 Request for Hearing. The Practitioner's request for a hearing shall state whether the Practitioner will be represented at the hearing by either a Member of the Medical Staff or an attorney. A Practitioner who is subject to a summary suspension or whose term of appointment is likely to expire during Due Process, may request an early hearing as described in Section 16.3.5.1.

XVI.3.4 Waiver. If the Chief Executive Officer does not receive a written request for a hearing from the Practitioner within the 30-day deadline, the Practitioner waives all right to such a hearing and appellate review.

XVI.3.5 Notice of Scheduled Hearing: Witness Lists.

XVI.3.5.1 Within sixty (60) days after receipt of a timely request for a hearing, the Chief Executive Officer shall notify the Appellant by Special Notice of the date, time and place of the hearing. Best efforts will be made to issue this notice of a scheduled hearing in fewer than sixty (60) days if the Appellant requested an early hearing pursuant to Section 16.3.3.

XVI.3.5.2 The notice of the hearing shall be delivered at least thirty (30) days in advance of the scheduled hearing date (unless this time limit is mutually waived) and shall include a list of the witnesses, if any, expected to at the hearing on behalf of the Hospital; the Hospital shall supplement the list with a written list of the names of additional witnesses as they are determined.

XVI.3.5.3 Not less than fourteen (14) days before the hearing, the Appellant shall furnish to the Chief Executive Office a list of the names of the individuals expected to at the hearing on behalf of the Appellant; the Appellant shall supplement the list with a list of the names of additional witnesses as they are determined.

XVI.3.5.4 Any witless who was not identified in to the other party at least seven (7) days before the date of testimony may testify only if the presiding officer determines there was good cause for not furnishing earlier notice.

XVI.3.6 Composition and Appointment of Hearing Committee.

XVI.3.6.1 When a hearing is triggered by an adverse recommendation of the Medical Executive Committee, the Chief of Staff and the Chief Executive Officer, acting on behalf of the Hospital, shall jointly appoint a hearing committee of not fewer than three (3) Members of the Medical Staff. One of the members shall be designated as chair.

XVI.3.6.2 When a hearing is triggered by an adverse decision of the Board of Directors, the Board Chair shall appoint a hearing committee of not fewer than three (3) Members of the Medical Staff. One of the members shall be designated as chair.

XVI.3.6.3 No member of a Hearing Committee may be in direct economic competition with the Appellant or be a professional or business associate or family member of the Appellant.

XVI.3.7 Hearing Officer. The individuals who appoint the hearing committee may, with the concurrence of the Chief Executive Officer, appoint a hearing officer, who may not be legal counsel to the Hospital, to preside at the hearing. The hearing officer may not act as a prosecuting officer, or as an advocate for the Board of Directors, the Medical Executive Committee or the Appellant. The hearing officer will, at the request of the hearing committee, participate in the deliberations of the hearing committee, serve as a legal advisor to it, and assist in drafting the hearing committee's report, but shall not be entitled to vote. If a hearing officer is not appointed, the chair of the hearing committee shall preside.

XVI.3.8 Pre-Hearing Conference. Prior to or at the beginning of any hearing the presiding officer may, in his/her discretion, require the representatives of the parties to participate in a conference to consider:

XVI.3.8.1 The framing and simplification of issues to be presented at the hearing;

XVI.3.8.2 Admission of facts or documents that will avoid unnecessary hearing testimony and proof;

XVI.3.8.3 Limitation by the presiding officer of the number of witnesses to be called by the parties in order to reduce repetitive or irrelevant testimony; and

XVI.3.8.4 Such other matters as the presiding officer determines may aid in the expeditious disposition of the matters before the hearing committee.

The pre-hearing conference may be held by phone. The presiding officer may submit a summary of the decisions reached at the conference to the hearing committee and such summary will be used to control the subsequent course of the hearing.

XVI.3.9 Documents. The Appellant shall be entitled, upon request, to access to the information on which the Medical Executive Committee or Board, as applicable, relied in making the adverse recommendation or action that is the subject of the hearing, provided the Appellant and Appellant's attorney, if any, shall agree in writing to preserve the confidentiality of any professional practice review materials to which they are given access. There are no other discovery rights.

XVI.4 HEARING PHASE

XVI.4.1 Preliminary Rules.

XVI.4.1.1 At least a majority of the members of the hearing committee shall be present when the hearing takes place.

XVI.4.1.2 An accurate record of the hearing shall be kept by means of a court reporter or an electronic recording unit, as selected by the hearing committee. Upon request, the Appellant shall be entitled to a copy of the hearing record upon payment of any reasonable charge for preparation thereof.

XVI.4.1.3 Postponement of a hearing beyond the time set forth in these Bylaws may be granted by the hearing committee, but only for a good reason, and in the sole discretion of the hearing committee.

XVI.4.2 Presence of Appellant. The personal presence of the Appellant shall be required. An Appellant who fails, without good cause, to appear at a hearing waives his/her rights to a hearing and to appellate review.

XVI.4.3 Representation.

XVI.4.3.1 If the hearing is triggered by an adverse recommendation of the Medical Executive Committee, the Chief of Staff shall appoint a Medical Staff Member and/or an attorney to represent the Medical Executive Committee at the hearing.

XVI.4.3.2 If the hearing is triggered by an adverse decision of the Board of Directors, the Board Chair shall appoint one of its members and/or an attorney to represent the Board of Directors at the hearing.

XVI.4.3.3 The Appellant shall be entitled to be represented at the hearing by a of the Medical Staff or an attorney, if the Appellant stated his/her intent to be so represented in the request for a hearing.

XVI.4.4 Conduct of Hearing.

XVI.4.4.1 The presiding officer shall preside over the hearing, determine the order of procedure during the hearing, determine what evidence is admissible, ensure that all participants in the hearing have a reasonable opportunity to present oral and documentary evidence, rule on any issues that arise, set deadlines for the submission of briefs or other documentation, maintain decorum, ensure that all parties present their positions without delay, and ensure that no party abuses its privileges under this Article. The presiding officer may limit the number of witnesses and/or duration of testimony, especially character witnesses or evidence that is repetitive.

XVI.4.4.2 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make the evidence inadmissible over objection in a civil or criminal action.

XVI.4.4.3 The parties to the hearing shall have the following rights:

XVI.4.4.3.1 To call and examine witnesses; however, neither party has the authority to compel witnesses to appear;

XVI.4.4.3.2 To introduce written evidence;

XVI.4.4.3.3 To cross-examine a on any relevant matter; and

XVI.4.4.3.4 To challenge any and to rebut any evidence.

XVI.4.4.4 If the Appellant does not otherwise testify, the Appellant may be called and examined as if under cross-examination.

XVI.4.4.5 Upon the request of either of the parties, the presiding officer shall order that oral evidence be taken only on oath or affirmation administered by any person designated by the presiding officer and entitled to notarize documents in the State of Illinois.

XVI.4.4.6 Members of the hearing committee may question witnesses. Witnesses may volunteer information that the hearing committee determines to be relevant, even if not elicited by a specific question posed by the hearing committee or by a party.

XVI.4.4.7 Each party shall present any objections to procedures to the presiding officer as soon as possible, so that they may be timely addressed.

XVI.4.4.8 The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its action. The Appellant shall have the burden of proving that there was no reasonable basis for the adverse recommendation/action.

XVI.4.4.9 Each party may, at the close of the hearing, submit a statement concerning any relevant issues of procedure or of fact, and such statements shall become part of the hearing record. The hearing committee may require such statements to be filed within a specified time after the close of the hearing and may limit the length thereof.

XVI.4.5 Recess of Hearing. The hearing committee may, at its discretion, recess the hearing and reconvene the same for the convenience of the participants, or for the purpose of obtaining new or additional evidence or consultation.

XVI.5 POST-HEARING PHASE

XVI.5.1 Decision of Hearing Committee.

XVI.5.1.1 The hearing committee shall deliberate outside the presence of the parties to the hearing. No member of the hearing committee may vote by proxy. Within thirty (30) days after the later of (a) the closing of the hearing or (b) the deadline for filing post-hearing statements, if applicable, the hearing committee shall make a written report containing its recommendations and the basis therefor, and shall forward the report, together with the complete hearing record and all written evidence and exhibits, to the body whose action triggered the hearing (either the Medical Executive Committee or the Board of Directors). The Chief Executive Officer shall send a copy of the hearing committee's report to the Appellant by Special Notice.

XVI.5.1.2 The hearing committee's report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or adverse decision of the Board of Directors.

XVI.5.1.3 At its next regularly scheduled meeting after receiving the hearing committee's report, the Medical Executive Committee or the Board of Directors, whichever initiated the hearing, shall affirm, or reverse its original recommendation/action.

XVI.5.2 Notice of Post-Hearing Recommendation.

XVI.5.2.1 Medical Executive Committee-Initiated Hearing. Within seven (7) days after the Medical Executive Committee makes its post-hearing recommendation, the Chief Executive Officer shall forward the recommendation, together with all

supporting documentation, to the Board of Directors for its decision and shall send a copy of the post-hearing recommendation to the Appellant by Special Notice.

XVI.5.2.1.1 At its next regularly scheduled meeting, the Board of Directors shall elect one of the following options:

XVI.5.2.1.1.1 Concur with favorable Medical Executive Committee recommendation; the Board of Directors' decision is final.

XVI.5.2.1.1.2 Overrule unfavorable Medical Executive Committee recommendation; the Board of Directors' decision is

XVI.5.2.1.1.3 Overrule favorable Medical Executive Committee recommendation; Appellant has the right to request an appellate review.

XVI.5.2.1.1.4 Concur with unfavorable Medical Executive Committee recommendation (including a Board decision to impose a form of discipline listed in Section 16.2.1 different from that recommended by the Medical Executive Committee); Appellant has the right to request an appellate review.

XVI.5.2.1.2 The Chief Executive Officer shall promptly notify the Appellant by Special Notice of the Board of Director's decision and, if applicable, the Appellant's right to request an appellate review.

XVI.5.2.2 Board of Directors-Initiated Hearing.

XVI.5.2.2.1 When the Board of Directors' post-hearing decision is favorable to the Appellant, the Board of Directors' decision is final. The Chief Executive Officer shall promptly notify the Appellant of the favorable decision by Special Notice,

XVI.5.2.2.2 When the Board of Directors' post-hearing decision is unfavorable to the Appellant, the Chief Executive Officer shall promptly the Appellant by Special Notice of the adverse decision and the Appellant's right to request an Appellate Review.

XVI.5.2.3 16.5.2.3 "Favorable/Unfavorable." For purposes of this Section 16.5.2, a recommendation or action is "unfavorable" if it entails any of the appealable matters listed in Section 16.2.1, and is "favorable" if it does not entail any of the appealable matters listed in Section 16.2.1.

XVI.6 APPELLATE REVIEW

XVI.6.1 Appeal to the Board of Directors.

XVI.6.1.1 An Appellant who is entitled to an appellate review shall have fifteen (15) days following receipt of the Special Notice sent pursuant to Section 16.5.2.1 or 16.5.2.2 in which to submit a written request for appellate review to the Chief Executive Officer by means of Special Notice. To be complete, the request must be accompanied by a written statement of the reasons for the Appellant's contention that there is no reasonable basis for the adverse recommendation/action that is the subject of the appellate review. The written request shall not be deemed to be complete unless it includes such a written statement. If the Appellant wishes to make an oral statement to the appellate review committee, the Appellant's request for appellate review must include a request to make an oral statement.

XVI.6.1.2 If the Chief Executive Officer does not receive a complete written request for appellate review from the Appellant within the 15-day deadline, the Appellant waives the right to appellate review and the adverse recommendation or decision shall remain in effect.

XVI.6.1.3 Within fifteen (15) days after receipt of a complete written request for an appellate review, the Board of Directors shall schedule a date, time and place for the appellate review and notify the Appellant of same via Special Notice. The appellate review shall be held within sixty (60) days after the date the Appellant's request for appellate review is received. The Appellant shall have the burden of proving that there was no reasonable basis for the adverse recommendation/action that is the subject of the appellate review.

XVI.6.1.4 The appellate review shall be conducted by an ad hoc committee of the Board of Directors, composed of not fewer than three (3) of its members.

XVI.6.1.5 Prior to the appellate review the Medical Executive Committee or Board, as applicable, may submit to the appellate review committee and the Appellant a written statement in support of its recommendation/action,

XVI.6.1.6 The appellate review committee, in its discretion, will determine whether oral statements will be allowed and, if so, the maximum duration of statements. If the Appellant requested an opportunity to make an oral statement and the appellate review committee elects to permit oral statements, the Appellant or the Appellant's attorney shall be permitted to speak against the adverse decision and the Appellant and the Appellant's attorney shall answer questions from members of the appellate review committee. The Board may also be represented by one of its members and/or an attorney to present its position and answer questions from any member of the appellate review committee.

XVI.6.1.7 New or additional matters not raised during the original hearing or in the hearing committee report may be introduced at the appellate review only if the evidence is relevant and could not have been presented at the hearing. The appellate review committee shall, in its sole discretion, determine whether such new matters will be accepted.

XVI.6.1.8 Within twenty (20) days after the conclusion of the appellate review, the appellate review committee shall make a written recommendation to the Board of Directors.

XVI.6.2 Final Decision by the Board of Directors. At its next regularly scheduled meeting after receipt of the appellate review committee's recommendation, the Board of Directors shall consider the appellate review committee's recommendation and make its final decision in the matter and shall send notice of its final decision to the Appellant by Special Notice and to the Medical Executive Committee.

XVI.6.3 Right to One Hearing and Appeal Only. No Practitioner shall be entitled to more than one hearing and one appellate review on any matter that may be the subject of a hearing/appeal, without regard to whether such matter is the subject of a recommendation or an action of the Medical Executive Committee or the Board of Directors, or a combination of recommendations or actions of such bodies.

XVII. HEARING AND APPELLATE REVIEW PROCESS ADVANCED PRACTICE PROFESSIONALS AND APP APPLICANTS

XVII.1DUE PROCESS

The Due Process rights of Advanced Practice Professionals and of applicants for APP status are governed by this Article XVII, subject to the terms of any written contract the APP may have with the Hospital and, in the case of Hospital-employed APP, any applicable Hospital policy.

XVII.2RIGHT TO A HEARING

XVII.2.1 Appealable Matters. The affected Practitioner will be entitled to a hearing if (a) the Medical Executive Committee recommends any of the following actions or (b) the Board of Directors decides to take any of the following actions (and the Board's action was not preceded by a recommendation by the Medical Executive Committee to take one of the following actions), but only if the recommendation or action is based on reason(s) directly related to the quality of patient care:

XVII.2.1.1 Denial of requested initial or renewed Clinical Privileges;

XVII.2.1.2 Denial of requested increased Clinical Privileges;

XVII.2.1.3 Reduction, limitation, suspension or revocation of Clinical Privileges;

XVII.2.1.4 Denial of request for reinstatement from a leave of absence; or

XVII.2.1.5 Other material limitation of the right to provide direct patient care as previously authorized (such as requiring proctoring or consultation, if the affected Practitioner is required to obtain consent of the proctor or consultant before patient care may be provided).

XVII.2.2 Non-Appealable Matters. The affected Practitioner will not be entitled to a hearing as a result of a recommendation or action that is not listed in Section 17.2.1, including the following matters:

XVII.2.2.1 Voluntary resignation of Clinical Privilege(s) including expiration and failure to file timely application for renewal of Clinical Privileges;

XVII.2.2.2 Issuance of a written warning or a letter of reprimand;

XVII.2.2.3 Imposition of a consultation or proctoring requirement, if the affected Practitioner is not required to obtain consent of the consultant/proctor before patient care may be provided;

XVII.2.2.4 Imposition of an investigative suspension or restriction of Clinical Privileges pursuant to Article XIV of these Bylaws;

XVII.2.2.5 Imposition of automatic suspension or termination pursuant to Article XV of these Bylaws;

XVII.2.2.6 Denial of a request for, or termination of, temporary Clinical Privileges;

XVII.2.2.7 Denial of a for, or imposition of conditions or limitations on, a leave of absence;

XVII.2.2.8 Mandated education, that does not affect current Clinical Privileges;

XVII.2.2.9 Any action or recommendation (including those listed in Section 17.2.1) that is not based on reason(s) directly related to quality of patient care;

XVII.2.2.10 Any action or recommendation (including those listed in Section 17.2.1) based on the Practitioner's failure to meet the written minimum objective criteria for the Clinical Privileges at issue;

XVII.2.2.11 Requiring a health assessment, report and/or treatment, as described in Section 5.8.6 or 12.6.6; and

XVII.2.2.12 Granting Clinical Privileges for a period less than twenty-four (24) months.

XVII.3PRE-HEARING PHASE

XVII.3.1 Notice of Hearing Rights.

XVII.3.1.1 The Chief Executive Officer shall notify the Practitioner by Special Notice of a recommendation or action that entitles the Practitioner to a hearing.

XVII.3.1.2 The notice referred to in Section 17.3.1.1 shall state the following:

XVII.3.1.2.1 The adverse recommendation or action.

XVII.3.1.2.2 The reason(s) for the adverse recommendation or action.

XVII.3.1.2.3 The Practitioner's right to request a hearing.

XVII.3.1.2.4 A summary of the Practitioner's hearing rights.

XVII.3.1.2.5 A time limit of fifteen (15) days from the date of the Practitioner's receipt of the notice within which the Practitioner may submit a written request for a hearing to the Chief Executive Officer. A Practitioner who is subject to a summary suspension or whose term of appointment is likely to expire during Due Process, may request an early hearing as described in Section 17.3.2.1.

XVII.3.1.3 If the Chief Executive Officer does not receive a written request for a hearing from the Practitioner within the 15-day deadline, the Practitioner waives all right to such a hearing and appellate review.

XVII.3.2 Notice of Scheduled Hearing.

XVII.3.2.1 Within thirty (30) days after receipt of a timely request for a hearing, the Chief Executive Officer shall notify the Appellant by Special Notice of the date, time and place of the hearing. Best efforts will be made to issue this notice of a scheduled hearing in fewer than thirty (30) days if the Appellant requested an early hearing pursuant to Section 17.3.12.5.

XVII.3.2.2 The notice of the hearing shall be delivered at least fifteen (15) days in advance of the scheduled hearing date (unless this time limit is mutually waived).

XVII.3.3 Composition and Appointment of Hearing Committee.

XVII.3.3.1 When a hearing is triggered by an adverse recommendation of the Medical Executive Committee, the Chief of Staff, acting on behalf of the Hospital, shall appoint a hearing committee of not fewer than two (2) members. One of the members shall be desiB1ated as chair and shall preside at the hearing.

XVII.3.3.2 When a hearing is triggered by an adverse decision of the Board of Directors, the Board Chair shall appoint a hearing committee of not fewer than two (2) members. One of the members shall be designated as chair and shall preside at the hearing.

XVII.3.3.3 No member of a hearing committee may be in direct economic competition with the Appellant or be a professional or business associate or family member of the Appellant.

XVII.3.4 Documents. The Appellant shall be entitled, upon request, to access to the information on which the Medical Executive Committee or Board, as applicable, relied in making the adverse recommendation or action that is the subject of the hearing, provided the Appellant shall agree in to preserve the confidentiality of any professional practice review materials to which the Appellant is given access. There are no other discovery rights.

XVII.4HEARING PHASE

XVII.4.1 Postponement. Postponement of a hearing beyond the set forth in these Bylaws may be by the hearing committee, but only for a good reason, and in the sole discretion of the hearing committee.

XVII.4.2 Hearing Participants.

XVII.4.2.1 The personal presence of the Appellant shall be required. An Appellant who fails, without good cause, to appear at a hearing shall waive his/her rights to a hearing and to appellate review.

XVII.4.2.2 Attorneys will not attend the hearing.

XVII.4.3 Conduct of Hearing.

XVII.4.3.1 At the hearing, the hearing committee will provide the Appellant with an opportunity to respond orally to the reason(s) for the adverse recommendation or action and the hearing committee may question the Appellant. The Appellant may also submit written evidence to the hearing committee. Unless the hearing committee, within its discretion, agrees to an exception, only the Appellant will attend and present his/her views to the hearing committee.

XVII.4.3.2 The hearing committee may limit the duration of the hearing and the length of written evidence submitted to it. The hearing may be conducted informally and rules of evidence will not apply.

XVII.4.4 Recess of Hearing. The hearing committee may, at its discretion, recess the hearing and reconvene the same.

XVII.5POST-HEARING PHASE

XVII.5.1 Decision of Hearing Committee.

XVII.5.1.1 The hearing Committee shall deliberate outside the presence of the Appellant. Within thirty (30) days after the hearing, the hearing committee shall state in writing its recommendations and the basis therefor, and shall forward its statement to the body whose action triggered the hearing (either the Medical Executive Committee or the Board of Directors). The Chief Executive Officer shall send a copy of the hearing committee's statement to the Appellant.

XVII.5.1.2 The hearing committee may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or adverse decision of the Board of Directors.

XVII.5.1.3 At its next regularly scheduled meeting after receiving the hearing committee's written statement, the Medical Executive Committee or the Board of Directors, whichever initiated the hearing, shall affirm, modify or reverse its original recommendation/action.

XVII.5.2 Notice of Post-Hearing Recommendation.

XVII.5.2.1 Medical Executive Committee-Initiated Hearing. Within seven (7) days after the Medical Executive Committee makes its post-hearing recommendation, the Chief Executive Officer shall forward the recommendation, together with all supporting documentation, to the Board of Directors for its decision and shall send a copy of the post-hearing recommendation to the Appellant.

XVII.5.2.1.1 At its next regularly scheduled meeting, the Board of Directors shall elect one of the following options:

XVII.5.2.1.1.1 Concur with favorable Medical Executive Committee recommendation; the Board of Directors' decision is final.

XVII.5.2.1.1.2 Overrule unfavorable Medical Executive Committee recommendation; the Board of Directors' decision is final.

XVII.5.2.1.1.3 Overrule favorable Medical Executive Committee recommendation; Appellant has the right to request an Appellate Review.

XVII.5.2.1.1.4 Concur with unfavorable Medical Executive Committee recommendation (including a Board decision to impose a form of discipline listed in Section 17.2.1 different from that recommended by the Medical Executive Committee); Appellant has the right to request an Appellate Review.

XVII.5.2.1.2 The Chief Executive Officer shall promptly notify the Appellant by Special Notice of the Board of Director's decision and, if applicable, the Appellant's right to request an appellate review.

XVII.5.2.2 Board of Directors-Initiated Hearing. The Board of Directors' post-hearing decision is final. The Chief Executive Officer shall promptly notify the Appellant of the Board's decision.

XVII.5.2.3 "Favorable/Unfavorable." For purposes of this Section 17.5.2, a recommendation or action is "unfavorable" if it entails any of the appealable matters listed in Section 17.2.1, and is "favorable" if it does not entail any of the appealable matters listed in Section 17.2.1.

XVII.6APPELLATE REVIEW

XVII.6.1 Appeal to the of Directors.

XVII.6.1.1 An Appellant who is entitled to an appellate review shall have fifteen (15) days following receipt of the Special Notice sent pursuant to Section 17.5.2.1.2 in which to submit to the Chief Executive Officer by means of Special Notice a written statement of the reasons for the Appellant's contention that there was no reasonable basis for the adverse recommendation/action that is the subject of the appellate review. An Appellant who requests appellate review shall have the burden of proving that there was no reasonable basis for the adverse recommendation/action that is the subject of the appellate review.

XVII.6.1.2 If the Chief Executive Officer does not receive such a written statement from the Appellant within the 15-day deadline, the Appellant waives the right to appellate review and the adverse recommendation or decision shall remain in effect.

17.6.2 Final Decision by the Board of Directors. At its next regularly scheduled meeting after receipt of a timely appellate review statement pursuant to Section 17.6.1, the Board of Directors shall review the Appellant's written statement and, if requested, a written statement from the Medical Executive Committee or Chief of Staff, and make its final decision in the matter and shall send notice of its final decision to the Appellant by Special Notice and to the Medical Executive Committee.

XVII.6.2 Right to One Hearing and Appeal Only. No Practitioner shall be entitled to more than one hearing and one appellate review on any matter that may be the subject of a hearing/appeal, without regard to whether such matter is the subject of a recommendation or an action of the Medical Executive Committee or the Board of Directors, or a combination of recommendations or actions of such bodies.

XVIII. IMMUNITY CONFIDENTIALITY AND RELEASES

XVIII.1 IMMUNITY

The Hospital and the Staff and any such representatives acting within the scope of duties exercised as a representative of the Hospital or Staff, and any third party participating with, assisting or providing services to the Hospital or Staff or any such representative, shall not be liable to a Practitioner for damages or other relief for any actions, omissions, communications, decisions, opinions, statements, disclosure, recommendations or any other conduct, provided that such representative or third party acts in good faith. The Hospital and the Staff and any such representative acting within the scope of duties exercised as a representative of the Hospital or Staff, and any third party, shall not be liable to a Practitioner for damages or other relief by reason of providing information to a representative of the Hospital or Staff or to any other health care entity or organization of health professionals concerning a Practitioner who is, or has been, an applicant to or Member of the Staff, or an applicant for, or who did or does exercise, Clinical Privileges, provided that the Hospital, Staff, such representative, or such third party acts in good faith.

XVIII.2 CONFIDENTIALITY

All communications, information, interviews, reports, records, statements, documents, memoranda or other data with respect to a Practitioner submitted, collected, or prepared by the Hospital or Staff or any such representative, any other health care entity, organization or medical staff, or third party, used for the purpose of evaluating and improving quality of care, reducing morbidity and mortality, medical research, or granting, limiting, or revoking Clinical Privileges, shall, to the fullest extent permitted by law, be privileged and confidential. Such data shall not be disseminated to anyone other than the Hospital or Staff or such representative, nor be used in any way except as provided in these Bylaws or except as otherwise required by law. This information shall not become part of any particular patient's records. Any person providing information to, participating in or present during any such activity described above or in Section .3 herein shall be bound by the confidentiality provisions in these Bylaws, unless otherwise required by law. Breach of such confidentiality provisions may be grounds for corrective action.

XVIII.3 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided in these Bylaws shall apply to all acts, communications, interviews, reports, records, statements, documents, recommendations, findings, evaluations, opinions, conclusions, or disclosures performed or made in connection with the activities of this Hospital or Staff or any other health care entity, organization, or

medical staff, including otherwise privileged or confidential information, relating, but not limited to:

XVIII.3.1 Applications for appointment, reappointment, or Clinical Privileges;

XVIII.3.2 Periodic appraisals undertaken for reappointment or for increase or decrease in Clinical Privileges;

XVIII.3.3 Corrective action, including summary suspension or restriction of privileges;

XVIII.3.4 Hearings and appellate reviews;

XVIII.3.5 Quality improvement and improvement activities;

XVIII.3.6 Utilization reviews;

XVIII.3.7 Any other Hospital, Staff, Departmental, Section, Service, or Committee activities related to monitoring and maintaining quality patient care and appropriate professional competence and conduct;

XVIII.3.8 Matters of inquiry concerning professional qualifications, credentials, clinical competence, character, physical and mental health status, ethics or behavior; and

XVIII.3.9 Any other matter that might directly or indirectly have an effect on professional competence or conduct, on patient care or on the orderly operation of the Hospital or any other health care entity.

XVIII.4 RELEASES

In furtherance of the foregoing, each applicant to or member of the Staff shall execute releases, including an agreement to release and waive liability, in favor of the individuals, entities, and organizations specified in these Bylaws in accordance with the express provisions and general intent of this Article. Execution of such releases is not a prerequisite to the effectiveness of this Article.

XVIII.5 CUMULATIVE EFFECT

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

XIX. AMENDMENTS

XIX.1 NO UNILATERAL AMENDMENT

Neither the MEC, the Medical Staff, nor the Board shall unilaterally amend these Bylaws.

XIX.2 COMPLIANCE WITH FEDERAL AND STATE LAW

Amendments to these Bylaws that are in compliance with state and federal law and accreditation standards may be proposed by the Bylaws Committee, the MEC, or by a petition signed by at least twenty (20) voting members of the Medical Staff

XIX.3 PROCESS

XIX.3.1 All proposed amendments to these Bylaws shall be reviewed by the Bylaws Committee which shall report on the amendments to the MEC. The only exception is for amendments that are necessary only to comply with state or federal law or accreditation standards which the MEC may act upon without prior review by the Bylaws Committee. In this exceptional circumstance, amendments may be acted upon by the NEC with the assent of the Chair of the Bylaws Committee. Amendments shall also be reviewed by the MEC prior to a vote by the Medical Staff The MEC may, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose; however, voting on the amendments shall not occur at such meetings.

XIX.3.2 The MEC shall present all proposed amendments to these Bylaws to the voting staff by written ballot or e-mail to be returned to the Chief of Staff in care of the Medical Staff Office by the date by the MEC. Along with the proposed amendments, the MEC shall provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least fifty percent (50%) of the Active Staff, and (ii) the amendment must receive a majority of the votes cast.

XIX.4 TECHNICAL AMENDMENTS

The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.

XIX.5 BOARD APPROVAL

XIX.5.1 All amendments shall be effective only after approval by the Board.

XIX.5.2 If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of

further communicating the Board's rationale for its contemplated action Staff to discuss rationale for the will be scheduled by the within two weeks after receipt of a request.

XX. POLICIES. RULES AND REGULATIONS

XX.1 ADOPTION

The Staff shall adopt such Rules and Regulations and Medical Staff Policies as may be necessary for the proper conduct of its work.

XX.2 ROLE OF MEC

The MEC may propose adoption, amendment or repeal of Medical Staff Policies and Rules and Regulations consistent with these Bylaws, as it may from time to time deem advisable for the proper conduct of the Medical Staff, effective upon Board approval.

XX.3 NO UNILATERAL AMENDMENT

Neither the MEC, the Medical Staff, nor the Board may unilaterally amend Medical Staff Policies or the Rules and Regulations.

XX.4 CONFLICT MANAGEMENT

If members of the Medical Staff object to a Medical Staff Policy or Rule and Regulation or to an amendment or repeal thereof adopted by the MEC, or if the MEC objects to a Medical Staff Policy or Rule and Regulation or an amendment or repeal thereof proposed by the Medical Staff, the objecting party may pursue its rights to call a special meeting of the Medical Staff as described in Section 11.2.

XX.5 PRESENT RULES

XX.5.1 The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

XX.5.2 Any Medical Staff Policy or Rule and Regulation initiated by the MEC and approved by the Board shall be communicated by the MEC to the Medical Staff via regular channels of communication.

XX.5.3 Nothing here is intended to abrogate or conflict with the Articles of Incorporation and Bylaws of Insight Chicago, Inc.

XXI. ADOPTION OF BYLAWS AND RULES AND REGULATIONS AND POLICIES

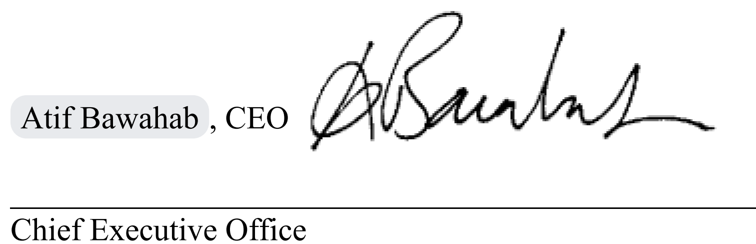
These Bylaws, together with the Rules and Regulations and Policies may be adopted at any meeting of the presently active Staff. They shall replace any previous Bylaws and Rules and Regulations, and shall become effective when adopted by the Staff and approved by the Board of Directors.

Presented by the Bylaws Committee
These amendments are necessary to comply with accreditation (HFAP) standards. The bylaws are adopted as of June 1, 2021.

Adopted by the Medical Staff

/s/ Naveed Mallick______________________________ ___________
Chief of Staff

Approved by the Board of Directors of Insight Chicago, Inc.; Insight Hospital and Medical Center Chicago.



____ ___12/9/2021__
Chief Executive Office Date

APPENDIX A
HISTORY AND PHYSICAL EXAMINATIONS

(1) General Documentation Requirements

(a) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(b) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;
- social history, including any abuse or neglect;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnosis;
- data reviewed;
- assessments, including problem list;
- plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.
- If for a surgical procedure requiring sedation, a specific assessment of the airway and documentation of ASA (American Society of Anesthesiologists) risk status.

(c) In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(2) H&Ps Performed Prior to Admission

(a) Any history and physical performed more than 30 days prior to an admission or registration does not meet this requirement.

(b) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/refraction or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

(c) The update of the history and physical examination shall be based upon an examination of the patient and must reflect (i) any changes in the patient's condition since the date of the original history and physical that might be for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

(3) Cancellations, Delays, and Emergency Situations

(a) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operative suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the attending physician states in that an emergency situation exists.

(b) In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

(4) Short Stay Documentation Requirements

For ambulatory or same day procedures, a Short Stay History and Physical Form, approved by the MEC, may be utilized. These forms shall document, at a minimum, the patient's chief complaint or reason for the procedure, relevant history of the present illness or injury, current clinical condition, general appearance, vital signs, airway assessment and an assessment of the heart and lungs.

(5) Prenatal Records

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before

admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

APPENDIX B
CREDENTIALS VERIFICATION

Applications shall be available only to eligible individuals in accordance with criteria established by the Board and individual's ability to meet any preliminary requisites necessary for consideration for eligibility as determined by the individual's responses in the pre-application form.

Applications must be returned with a non-refundable filing fee in accordance with Section V (K) of the Staff Rules and Regulations within thirty (30) days of receipt of application, or the application will be deemed withdrawn. Application for initial appointment to the Staff shall be presented in writing on the prescribed form which has been approved by the Board after consultation with the MEC and shall be addressed to the CMO. Application signifies that Applicant has been given, and has read, a copy of these Bylaws (which shall be available at the Hospital for such purposes), and agrees to be bound by the terms therein, and agrees to fully abide by the provisions set forth in Article XVIII of these Bylaws which outline the effect of application.

Applicant shall have the responsibility to provide adequate information for proper evaluation of competence, character, ethics and other qualifications, and for resolving any reasonable doubts about such qualifications. At a minimum, Applicant shall be required to furnish copies of the following, as applicable:

a. All items in the application form filled in, and the application and dated by Applicant. Unless changed, the information and documents provided in response to the pre-application form will be incorporated and attached to the application. The application form shall be sent with a statement advising the Applicant that if the information and/or documents provided in response to the pre-application have changed, the Applicant should provide updated information/documents; otherwise the preapplication information/ documents are automatically incorporated into and attached to the application without need of further production.

b. All related forms fully answered, signed and dated by Applicant.

c. Professional school diploma.

d. Documentation of internship, residencies, fellowships and Board certification.

e. Current Illinois Medical License, practitioner license or certifications, if same exists in applicable field.

f. Current federal and state narcotic license, if applicable.

g. Evidence of malpractice insurance in compliance with required coverage levels.

h. Current photograph.

i. Listing of delineated privileges at institution(s) where Applicant currently has privileges.

j. Letters, if appropriate, from the directors of Applicant's internship, residency and/or fellowship and other training programs, supporting Applicant's qualifications.

k. Letters from individuals with same or equivalent degree who have had experience m observing and working with Applicant and who can provide adequate references pertaining to Applicant's professional performance and character during the one (1) year immediately preceding the application to the Staff.

l. Information as to whether Applicant's membership status and/or clinical privileges have ever been revoked, suspended, reduced or not renewed at another hospital or institution; and whether membership in local, state or national professional societies or license to practice any profession in any state has ever been suspended or terminated; and whether any adverse action has ever been taken on Applicant's National Practitioner Identifier.

m. Information regarding any malpractice claim or settlement, any adverse actions by state or federal authorities, or any pending litigation involving Applicant.

n. Information as to whether Applicant's narcotic license has ever been revoked, suspended or restricted.

o. Information regarding Professional Review Organization sanctions, actions or reviews with respect to Applicant.

p. Information regarding Applicant's mental and physical health status, which may include, upon discretion of the MEC or the Board, a medical certificate regarding Applicant from a physician whom Applicant selects from a list of physicians provided by the MEC. Such certificate shall be limited to Applicant's ability to perform requested clinical privileges and required Staff functions without endangering the patients' or Applicant's safety.

q. Applicant's acknowledgment of agreement to provide continuous care and supervision of patients, to accept committee assignments, and to cooperate with the quality improvement process and educational programs of the Hospital,

APPENDIX C
MEDICAL STAFF CATEGORIES SUMMARY

	Active	Courtesy	Consulting	Ambulatory Care	Coverage	Monotary
Basic Requirements						
Number of Patient Contacts/2-year	> 24	> 6 & < 24	NA	NA	NA	NA
Rights						
Admit	Y	> 6 & < 24	Y	N	P	N
Exercise clinical privileges	Y	Y	Y	N	P	N
May attend meetings	Y	Y	Y	Y	Y	Y
Voting privileges	Y	P	P	P	P	P
Hold office	Y	N	N	N	N	N
Responsibilities						
Serve on committees	Y	Y	Y	Y	Y	Y
Emergency call coverage	Y	F/U	N	F/U	P	N
Meeting requirements	Y	N	N	N	N	N
Dues	Y	Y	Y	Y	Y	N
Comply w/ guidelines	Y	Y	Y	Y	Y	N
OPPVFPPE	Y	Y	Y	N	Y	N
Electronic Medical Record Access	Y	Y	Y	Y	Y	N

Y = Yes
N = No
NA = Not Applicable

P = Partial (with respect to voting, the individual may only vote at committee meetings for the committee(s) to which the individual has been appointed)

F/U = Follow-up care

RULES AND REGULATIONS

AND

POLICIES

OF THE

MEDICAL STAFF

INSIGHT HOSPITAL AND MEDICAL CENTER
CHICAGO, ILLINOIS

JUNE 2021

RULES AND REGULATIONS

TABLE OF CONTENTS

I. APPROVED DEPARTMENTS, DIVISIONS, AND SECTIONS

A. Medical Staff 1

II. ADMISSIONS

A. Admitting Privileges 3

B. Co-Admission 3

C. Acceptable Admissions 3

D. Provisional Diagnosis 3

E. Admitting Policies

1. Admitting Department 3

2. Route of Admission 3

3. Information 3

F. Outpatient Medical/Radiological/Surgical Interventions 3

III. HOSPITAL STAY

A. Complete Record 4

B. Dental Patients' Records 4

C. History and Physical Examination 5

D. Initial Visits 6

E. Frequency of Service 6

F. Coverage While Away 6

G. Hospital Employed Members of the Medical Staff

1. Termination 10

H. Limited License Practitioners

1. Non-Member Limited License Practitioner 10

2. Podiatrist Limited License Practitioner 10

I. Emergencies 11

J. Rules of Procedure 11

K. Meetings

1. General Staff Meeting

a. Time 12

b. Attendance 12

c. Quorum 12

d. Majority Vote 12

L. Filing Fee 13

G. Termination of Physician's Services 6

H. Orders 7

1. Admitting Orders 7

2. Written/Verbal Orders 7

3. Respiratory Therapy Orders 7

I. Consultations

1. Method 7

2. Indications 7

J. Radioactive Therapy

1. Radiation Therapy 8

2. Radio-isotope Therapy 8

K. Surgical First Assistant 8

L. Signature Stamps 8

IV. DISCHARGE

A. Discharge Orders 8

V. MEDICAL ADMINISTRATIVE

A. Disclaimer Statement 8

B. Need for New Members 8

C. Dues

1. Collection 8

2. Payment 9

3. Amount 9

4. Billing 9

5. Delinquency 9

6. Expenditures 9

7. Bonding 9

D. Leave of Absence

1. Process 9

2. Duration 10

3. Termination of Leave 10

4. Dues and Voting Privileges 10

E. Resignation

1. Request by Member 10

I. APPROVED DEPARTMENTS, DIVISIONS AND SECTIONS

A. Medical Staff

1. Department of Emergency Medicine

2. Department of Family Medicine

3. Department of Medicine

a. Divisions of

(1) Physical Medicine

b. Sections of

(1) Dermatology

(2) Endocrinology

(3) Gastroenterology

(4) Geriatrics

(5) Hematology/Oncology

(6) Infectious Diseases

(7) Internal Medicine

(8) Nephrology

(9) Neurology

(10) Pulmonary Medicine

(11) Rheumatology

4. Department of Obstetrics and Gynecology

a. Sections of

(1) Maternal/Fetal Medicine

(2) Gynecologic Endocrinology and Infertility

(3) Gynecologic Oncology

5. Department of Ophthalmology

6. Department of Pathology

   a. Section of Biologic Sciences

7. Department of Pediatrics

   a. Sections of

      (1) Pediatric Allergies/Immunology

      (2) Developmental Pediatrics

      (3) Endocrinology

      (4) Genetics

      (5) Hematology

      (6) Infectious Diseases

      (7) Neonatology

      (8) Pediatric Neurology

      (9) Primary Care

8. Department of Psychiatry

9. Department of Radiology

   a. Sections of

      (1) Diagnostic Radiology

      (2) Therapeutic Radiology

10. Department of Surgery

   a. Sections of

      (1) Thoracic Surgery

      (2) General Surgery

      (3) Neurological Surgery

(4) Orthopedic and Hand Surgery

(a) Subsection of Podiatry

(5) Head and Neck Surgery

(a) Subsection of Dentistry

(6) Minimally Invasive Surgery

(7) Anesthesiology

11. Department of Cardiovascular Medicine

a. Sections of

(1) Cardiology

(2) Cardiac Surgery

II. ADMISSIONS

A. Admitting Privileges

Patients will be admitted to Insight Hospital and Medical Center Chicago only by physicians who have been granted admitting privileges from the Board of Directors.

B. Co-Admission

No patient shall be admitted or co-admitted to the service of any physician without consent of the physician.

C. Acceptable Admissions

The Hospital shall admit patients suffering from alt types of diseases with the exception of patients having diseases which may be restricted from the admission to the general hospital by specific rules and regulations of the Board of Health.

D. Provisional Diagnosis

No patient shall be admitted without at least a provisional diagnosis in the record. Physicians admitting patients shall make every effort to provide at or prior to the time of admission, such information as may be necessary for the protection of other patients from harm or danger from any cause whatsoever, or the protection of the patient from self harm.

E. Admitting Policies

1. Admitting Department

   The Admitting Department is responsible for facilitating the entry of patients into the hospital and coordinating patients' placement.

2. Route of Admission

   a. Admitting Department

   b. Emergency Department

   c. Direct admission to the Critical Care Units at the request of the physician

   d. Direct admission of obstetrical patients

e. Direct admission of patients transferred from other hospitals by prearrangement.

3. Information Required by Admitting Department

The following information must be provided to the Admitting Department prior to or at the time of admission by the attending physician:

a. Name and date of birth of patient, telephone number where the patient can be reached, both at home and at work;

b. Admission diagnosis;

c. Date of surgical or medical procedure when applicable;

d. The name of consultant and co-attending physician when applicable; and Preadmission tests desired.

4. Procedure for Elective Medical and Surgica Admission

a. The attending physician shall call the Surgery Department or Medical/Surgical/Radiological laboratories to schedule the patients for intended surgical, medical or radiological interventions. The Admitting Office shall be notified to assure that there is no conflict between the time of admission and procedure to be performed.

b. The attending physician shall make every attempt to make arrangements for a •consultant (if any) to see the patient prior to admission, but not sooner than ten days.

5. Pre-Admission Tests

Pre-admission testing should be done with sufficient time to allow review by the attending physician and consultants where appropriate.

F. Outpatient Medical/Radiological Surgical Interventions

The RULES AND REGULATIONS pertinent to inpatient medical/radiological/surgical interventions are also applicable to outpatient medical/radiological/surgical interventions.

Policies pertinent to history, physical examination, consultation, progress notes, preoperative, operative, postoperative management, the use of local or general anesthesia, monitoring of various perimeters must be defined by the

Department/Division/Section responsible for patients' care in the operating suite and medical/radiological/surgical laboratories.

IV. HOSPITAL STAY

A. Complete Record

The completion of a medical record for each patient is the responsibility of the physician(s) participating in the patient's care, as indicated in the medical record forms. The record shall include identification of data; preadmission provisional diagnosis or reason(s) for hospitalization; history of present illness; personal history; family history; physical examination, special reports such as consultations, clinical, laboratory, x-rays and others; medical and surgical treatment; discharge summary, including diagnosis and condition on discharge, follow-up plans, medications, diet, and activity on dismissal or autopsy when available. All significant data should have date, signature, and be legible. The medical chart, including the summary shall be completed within thirty days of dismissal. To facilitate the continuum of patient care, a written post-operative note and dictated operative report shall be prepared immediately for procedure(s) performed in the surgical suite or various laboratories (including gastrointestinal, cardiology and radiology) at Insight Hospital and Medical Center Chicago.

The privileges of the physician who fails to complete medical records within 30 days of discharge may be administratively suspended.

B. Dental Patients' Records

All dental patients shall have history and physical examination recorded by a designated resident physician of Insight Hospital and Medical Center Chicago.

C. History and Physical Examination

General Documentation Requirements

A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

The scope of the medical history and physical examination will include, as pertinent:

Patient identification

Chief complaint

History of present illness

Review of systems

Personal medical history, including medications and allergies

Family medical history

Social history, including any abuse or neglect

Physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses Data reviewed

Assessments, including problem list

Plan of treatment, and

If applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which wilt be documented in the plan of treatment.

If for a surgical procedure requiring sedation, a specific assessment of the airway and documentation of ASA (American Society of Anesthesiologists) risk status.

In the case of a pediatrics patient, the history and physical examination report must also include:

Developmental age

Length or height

Weight

Head circumference (if appropriate)

Immunization status

H&Ps Performed Prior to Admission

Any history and physical performed more than 30 days prior to an admission or registration does not meet this requirement.

If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

The update of the history and physical examination shall be based upon an examination of the patient and must reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or state that there have been no changes in the patient's condition.

<u>Cancellations, Delays and Situations</u>

When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operative suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an attending physician states in writing that an emergency situation exists.

In an emergency situation, when there is no time to record either a complete or a Short Stay history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum an assessment of the patients heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete history and physical examination.

<u>Short Stay Documentation Requirements</u>

For ambulatory or same day procedures, a Short Stay History & Physical Form approved by the MEC, may be utilized. These forms shall document, at a minimum, the patient's chief complaint or reason for the procedure, relevant history of the present illness or injury, current clinical condition, general appearance, vital signs, airway assessment and an assessment of the heart and lungs.

<u>Prenatal Records</u>

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the Hospital before admission. An interval admission note must be

written that includes pertinent additions to the history and any subsequent changes in the physical findings.

D. Initial Visits

The attending physician or another attending physician designee shall see the patient as soon as possible after notification of the admission, but within the first twenty-four hours.

E. Frequency of Service

The attending physician, or another attending physician designee, shall provide documented service (generally daily) as appropriate to the patient's needs. All notes should be dated and signed.

F. Coverage While Away

A member of the Medical Staff who is unable to care for his/her patients in the hospital for any reason must name another appropriately qualified staff member to carry out all duties necessary for the proper care of the patient. The physician must clearly communicate the temporary transfer and the covering physician must accept the responsibility to cover the physician requesting the coverage. If such an assignment is not made, the administration of the hospital shall request the chief of the section/division or chairman of the department as appropriate to assign to the patient any member(s) of the attending staff considered necessary to ensure proper and adequate care of the patient.

G. Termination of Physician's Services

When a patient wishes to terminate the services of a member of the Staff, and engage the services of another member of the Staff, a request in writing will be made by the patient or his legal representative on a prescribed form to the Administrator (who will communicate with the chairman of the department, or the chief of the division or section). It must be acknowledged by the current physician, accepted by the new physician involved, and by the Administrator of the hospital who shall report the date and time of this transfer to the record room. The current physician or dentist may make a notation of the occurrence in the clinical record if he/she desires.

H. Orders

1. Admitting Orders

(See Article "I.E, 'Preadmission", RULES AND REGULATIONS)

2. Written/Verbal Orders

All orders shall be in writing and signed by a physician or his resident designee. Verbal, telephone and facsimile orders should be given and signed in accordance with Insight Hospital and Medical Center Chicago Information Management's current policies and procedures.

3. Respiratory Therapy Orders

Orders for respiratory therapy, when no duration of days is indicated, shall be discontinued after forty-eight hours unless the order is renewed.

I. Consultations

1. Method

a. All consultations shall be requested by the attending physician or the attending physician designee. All requests shall be understandably communicated to the consultant.

b. Consultations should be performed in a timely manner in keeping with the acuity and severity of the clinical condition. In general, it is expected that an initial consultation will be performed by the attending physician consultant within 24 hours of notification documented by a dated and signed consultation note.

c. A consulting physician should make recommendations regarding treatment to the referring physician. The consultant should not assume direct management of the clinical situation(s) unless directed to do so by the referring physician. Appropriate follow-up should be consistent with the patient's needs and the referring physician's direction. There should be chart documentation of termination of consultation services.

2. Indications

a. When the diagnosis is obscure or the treatment is doubtful, and it appears that the quality of service may be enhanced.

b. When the patient or family requests;

c. When the treatment demands technique or expertise that the referring physician may not have.

d. When there are medical-legal consideration; or

e. When complications arise, the patient is high risk, and therapy or recovery is prolonged beyond the anticipated norms.

J. Radioactive Therapy

1. Radiation Therapy

All patients receiving radium and x-ray therapy must have the procedures done in conjunction with and under the direction of the Director of Radiation Therapy.

2. Radio-isotope Therapy

Radio-isotope therapy may be used only under the supervision of a member who has such privileges.

K. Surgical First Assistant

The first surgical assistant in surgical cases shall be an appropriately licensed and credentialed professional.

L. Signature Stamps

The use of rubber stamps for signature on the various reports in patients' medical records is not acceptable; however, members of the Medical Staff may authorize their name to be mechanically affixed to reports which they have dictated through use of their private PIN (Personal Identification Number).

IV. DISCHARGE

A. Discharge Orders

Patients shall be discharged only upon written orders of the attending physician or his designee. In the event of a serious disaster, the Chairman of the Disaster Committee or his designee may discharge patients as needed.

V. MEDICAL ADMINISTRATIVE

A. Disclaimer Statement

Protocols and other guidelines will carry the following disclaimer statement:

"Protocols and other guidelines published and circulated in Staff and hospital manuals are intended to provide general standards for patient care and do not require an attending or resident physician to strictly

adhere to them, nor do they limit or supersede the physician's clinical judgment."

B. Need for New Members

Every Section, Division or Department shall at regular intervals evaluate the adequacy of its membership and determine the need for new members to provide services to all hospitalized patients as well as to all educational programs at Insight Hospital and Medical Center Chicago.

c. Dues

1. Collection

Dues will be collected annually by the Secretary-Treasurer to cover the approved expenses of the Medical Staff.

2. Payment

Dues shall be paid by all members, unless specified otherwise in the BYLAWS.

3. Amount

The amount of dues to be assessed from time to time will be reviewed by the Medical Staff prior to the initiation of Staff reappointments.

4. Billing

Billing for dues will be done on an annual basis.

5. Delinquency

In December of each year, every eligible member of the Medical Staff shall receive notice for payment of annual dues. If, after thirty days, such dues have not been paid, the physician shall receive a second notice informing that there with be ten percent penalty on the unpaid dues, which must be paid in addition to the regular dues amount. If, within thirty days of the mailing of the second notice, the member still is delinquent in payment of dues, his privileges will be suspended by the Chief Executive Officer upon the recommendation of the Chief of Staff... Failure to pay annual dues constitutes voluntary resignation from staff membership.

6. Expenditures

The decision for major expenditures of the Staff fund will be made by the members of the Medical Staff in regular and/or special meetings of the

Staff. Officers of the Medical Staff (Chief of Staff, Vice Chief of Staff, and Secretary-Treasurer) may expend prudent amounts of money for the day to day expenses of the Staff, such as, for instance, courtesies for members of the Staff, their immediate families, and notable exceptions.

7. Bonding

The officers will be bonded at an appropriate amount with the Medical Staff covering the expenses.

D. Leave of Absence

1. Process

Leave of absence, when requested by a member of the Medical Staff shall be communicated via the chief of section/division to the chair of the department, who shall forward the request to the Chief of Staff, the Medical Executive Committee and the Board of Directors for approval. The request shall include coverage arrangements.

2. Dues, Voting, Clinical and Admitting Privileges

During a leave of absence, the member of the Medical Staff shall not be responsible for dues payment or meeting attendance. Voting rights, admitting and Clinical privileges will be suspended for the duration of the leave.

3. Communications

All routine communications with a Staff member will cease during leave of absence unless the member has requested otherwise.

4. Duration

Leaves of absence shall not exceed one year duration; however, a leave of Absence may be extended for an additional year, if requested and approved.

5. Termination of Leave

At the end of the initial term of a leave of absence, the individual will be notified that the leave and the Staff appointment have expired, and the extension of the leave of absence or reappointment to the active staff will be entertained upon the written request of the member, and that failure to request extension of the leave of absence or reappointment to the Medical

Staff within thirty days after mailing of such notice will be deemed to constitute a resignation by such member from the Medical Staff.

E. Resignation

1. Request by Member

A request for resignation from the Staff shall be in writing, and communicated via the chief of section/division to the chairman of the department, who shall communicate it to the Medical Executive Committee and the Board of Directors for acceptance.

F. Hospital Employed Members of the Medical Staff

1. Termination

Any member of the Medical Staff whose services are engaged by the Hospital and who receives compensation therefor from the Hospital, shall not have his Medical Staff privileges terminated without the same due process provisions as are provided for any other member of the Medical Staff unless otherwise stated in the employment contract entered into between the Hospital and such member.

G. Limited License Practitioners

1. Privileges for Non-Member
Limited License Practitioner

Clinical privileges for non-member limited license practitioners must be delineated in writing by the administrative departments in which these individuals are active, after being accepted by the appropriate clinical Department, Division, or Section, and after consultation with the appropriate disciplines, in accordance with the licensing laws of the State of Illinois. Privileges given to such limited license practitioners are to be reviewed and updated bi-annually.

2. Podiatrist Member
Limited License Practitioner

A podiatrist member limited license practitioner may see and treat hospital patients as an agent of an attending physician. The invitation to the podiatrist and his notes shall be recorded on a consultation form. The privileges granted to the podiatrist will be determined and recorded on a privilege card by the Chief of the Section of Orthopedics and the Chairman of the Department of Surgery.

H. Emergencies

1 . In the case of an emergency, all RULES AND REGULATIONS are suspended and any available physician can be expected to do all in his/her power to save the life of a patient, including the calling of such consultation as may be immediately available. For the purposes of this section, an emergency is defined as a condition in which the life of the individual is in immediate danger, and in which any delay in administration of treatment would add danger.

2. Medical Staff Disaster Assignments

All staff physicians shall accept assignments or posts, whether in the hospital or auxiliary hospitals or in public mobile casualty stations, as requested and it is their responsibility to report to their assigned stations when called.

3. A patient's condition upon discharge from the Emergency Room must be recorded in the Emergency Room record.

4. Should any difference of opinion occur between the emergency medicine physician and the attending physician pertinent to the admission of a patient to the hospital, and the emergency medicine physician deems it necessary to hospitalize, but the attending physician of the patient does not concur, the attending physician shall examine the patient in the Emergency Room, and his recommendation will be considered final.

5. If any individual presents to the Emergency Department and/or a request is made on the individual's behalf for examination or treatment for a medical condition, a qualified medical professional shall provide an appropriate medical screening examination within their capabilities, including ancillary services routinely avail to this Emergency Department, to determine whether or not an emergency medical condition exists.

Obstetrical patients who are over 20 weeks gestation may be seen in the Labor and Delivery Department. An initial screening by a physician or a qualified professional Designee (R.N., midwife or physician assistant) will be performed in accordance with guidelines established by the Chair of the Department of Obstetrics & Gynecology and the Chief of the Section of Maternal/Fetal Medicine.

I. Rules of Procedure

1. ROBERTS RULES OF ORDER shall be adhered to at all meetings of the Medical Staff, or at any committee thereof.

2. All meetings of the Medical Staff, including general, department, committee and Division/Section meetings shall be conducted according to ROBERTS RULES OF ORDER.

3. In the event of conflict between the Medical Staff-Faculty BYLAWS and the Medical staff, RULES AND REGULATIONS, the BYLAWS shall take preference.

J. Meetings

1. General Staff Meeting

a. Time

General staff meetings should be held semi-annually, or such other time as may be determined by the Chief of Staff with the approval of the Medical Staff.

b. Attendance

Unless otherwise indicated in the BYLAWS, if a member shall, without valid excuse, fail to attend fifty percent (50%) of both the general meetings of the Medical Staff and the departmental meetings during the member's current two-year appointment to the Staff, such failure will be reviewed by the Credentials Committee and forwarded to the Medical Executive Committee for final action. Where a valid excuse is presented by the member, the minutes of the meeting shall reflect both nonattendance of such member and that a valid excuse has been tendered and accepted by the Chairperson.

c. Quorum

(a) For any regular or special meeting of the Medical Staff, twenty (20) voting staff members must be present in order to establish a quorum. The exception to this general rule is when amendments to these Medical Staff Bylaws or the related Bylaws Documents will be discussed, in which case at least 10% of the entire voting staff must be present in order to establish quorum.

(b) At the Committees' meetings of the Medical Staff and Medical Administrative Committees, except for committees under (d), the required quorum shall be three members including the chairman.

(c) At Medical-Administrative committees, the quorum additionally shall require the presence of at least one physician.

(d) The following committees will meet at regular intervals:

1. Credentials Committee

2. Medical Executive Committee

3. Institutional Review Board

4. Quality & Safety Committee

d. The following committees will meet at appropriate intervals:

1. Bylaws Committee

2. Physician Wellness Committee

d. Majority Vote

More than fifty percent of the votes cast by the voting members at the

POLICIES

Table of Contents

POLICIES

A.	Approval of Policies	1
B.	Autopsy Policy	1
C.	Policy for Approval of Parenteral Administration of Medications by Nurses	1
D.	Pharmacy Services	2
E.	Policy for Emergency Medicine Procedure Re: Inability to Contact Attending Physician	3
F.	Policy for Emergency Room Patients with Acute Abdomens	4
G.	Telephone Orders for Tests on Specimens Submitted to Pathology	4
H.	Tissue Policy	4

meeting of the Medical Staff, department-division or section, and committees at which a quorum is present shall constitute majority vote.

K. Filing Fee

Each applicant requesting from Insight Hospital and Medical Center Chicago an application for membership on the Medical Staff should submit, along with the completed application, a non-refundable filing fee to cover the processing of the application, whether or not the applicant is accepted. The amount of such filing fee shall be determined from time to time by the Medical Executive Committee.

A. Approval of Policies

Policies of Departments, Divisions, and Sections of the Medical Staff, and hospital services (Dietary, Nursing, etc.) when pertinent to the responsibilities of the Medical Staff and patient care, shall be approved by the Medical Executive Committee, the General Staff, and the Board of Directors and be appended to these POLICIES.

The Policies shall be reviewed periodically and updated, and the date of approval is to be recorded in the Policies.

B. Autopsy Policy

An autopsy permit shall be completed in all cases of death and shall become part of a permanent record whether or not the autopsy is consented to by an authorized person. This form must be signed by the person seeking to obtain the consent. No autopsy shall be performed until the consent form has been filled out in conformance with the laws of the State of Illinois. All autopsies shall be performed by the hospital pathologist, or by the physician to whom he has delegated the duty. Each member of the Medical Staff is expected to aid in securing autopsies. The attending physician should make every effort to cooperate with funeral directors in signing the death certificate promptly in line with the laws of the State of Illinois.

The attending physician, or his designee (resident), after consultation with the attending physician, following the announcement of the death of a patient, must request a consent for autopsy from appropriate members of the patient's family unless unusual circumstances render this request inadvisable.

C. Policy for Approval of Parenteral Administration of Medications by Nurses

Members of the appropriate division/section of the Medical Staff, after in-depth discussion and consultation with the Director of the Division of Nursing and the Director of Pharmacy, will make recommendations to the appropriate department of the Medical Staff for approval. The Director of Pharmacy shall confer with the Pharmacy and Therapeutics Committee prior to the final recommendation.

This recommendation shall include:

1. Geographic location for administration of I.V. medications;

2. Necessity for monitoring during administration;

3, Name and quantity of drug if quantity should be limited;

4. Method of I.V. administration (e.g., bolus vs. infusion); and

5. New routes of administering drugs.

Members of the division/section, Division of Nursing, or the Pharmacy and Therapeutics Committee may initiate recommendations for approval.

D. Pharmacy Services

1. The Director of Pharmacy Services shall be responsible for all activities of the Pharmacy Department and implementation of all Federal, State, and local law requirements.

2. Drugs shall be FDA approved and shall meet the current bio-equivalency standards.

3. The Formulary shall be a list of those drugs which have been approved through the established Pharmacy and Therapeutics Procedure (See R&R V.K.B.). It shall be a continually revised compilation of pharmaceuticals which reflects the current judgment of the Pharmacy and Therapeutics Committee with consultation of the appropriate Medical Staff Department/Division/Section. It serves as a guide in prescribing, administering, and dispensing of drugs.

4. All Schedule Il and Ill controlled substances used as analgesics must be reordered every seventy-two hours.

   All other Schedule Il controlled substances must be reordered in ten days.

   All other controlled substances - Schedule Ill to V, must be reordered every ten days.

   Antibiotics must be reviewed every seventy-two hours and reordered every five days.

   Intermittent parenteral anticoagulants and parenteral gluco-corticoids must be reviewed every twenty-four hours and ordered every five days.

   Patients on oral gluco-corticoid maintenance must be reviewed every seven days. Tapering doses must be evaluated every twenty-four hours and reordered every five days.

   Oral anti-coagulants must be reordered daily or ordered for a specific number of doses.

All parenteral H2 antagonists must be reviewed every seventy-two hours and reordered every five days.

Continuous intravenous fluids with or without additional medications must be ordered daily.

5. All medications are to be discontinued at midnight prior to the administration of any general or spinal anesthetic unless the physician specifically requests otherwise. Following the completion of an operative procedure, all orders for medications are to be rewritten specifically by the physician, or physician's designee, and service responsible for the procedure.

6. Only those abbreviations on a list published by the Pharmacy and Therapeutics Committee, and approved by the General Staff (available in the Pharmacy) may be used in writing orders for medications.

7. Investigational drugs will be used only under the direct supervision of the principal investigator or his designee, and according to the Policies and Procedures of the Institutional Review Board for the Protection of Human Subjects. (Institutional Review Board of Insight Hospital and Medical Center Chicago).

8. Request for Addition to Formulary
Any member of the Medical Staff may request the addition of a drug to be placed on the Formulary. He/She must receive the approval of the members of the Division/Section of which he/she is a member, and the approval of the members of the Department. After approval of such request by members of the Division/Section and Department, the request form (Appendix 3) shall be completed by the requesting member and forwarded by the Chairman of the Department to the Secretary or Chairman of the Pharmacy and Therapeutics Committee. This form shall be signed by the Chief of Division/Section and the Chairman of the Department, to signify approval of the request.

If members of the Pharmacy and Therapeutics Committee do not concur with such a request, the minutes reflecting their decision and the reasons therefor shall be forwarded to the Medical Executive Committee for final resolution.

9. Request for Use of Non-Formulary Medication

a. Any member of the Medical Staff may request a non-Formulary medication for use on his/her patient. The member must complete and sign the appropriate request form (Appendix 4).

b. This form shall be delivered to the pharmacy prior to attempts to obtain the drug. Upon receipt of the completed form, the pharmacy shall obtain the medication through routine channels. Drugs requested during the week will be obtained within one day; drugs requested over a weekend will be obtained within a minimum of two days.

c. If an attending physician deems it necessary to use a non-Formulary medication as an absolute necessity, or for an emergency, his verbal authorization to a pharmacist will suffice for the pharmacy to obtain that medication by the most expedient means possible. The attending physician then will return a completed copy of the "Request for use of Non-Formulary Medication" form to the pharmacy within forty-eight hours of the authorization.

10. Drug Experience Report

The form for drug experience reporting (Appendix 5) must be completed by members of the Medical Staff-Faculty for documentation and tabulation of adverse experiences. The attending physician must review and approve this form prior to its submission. This form shall be sent to the Secretary of the Pharmacy and Therapeutics Committee.

The definition of a drug experience is an adverse reaction defined as any pathologic condition precipitated by administration of a drug. This would include both idiosyncratic and hypersensitivity reactions as well as extensions of other expected pharmacologic action of the drug.

E. Policy for Emergency Medicine Procedure Re: Inability to Contact Attending Physician

1. Upon deciding that an Emergency Medicine patient requires admission, the Emergency Medicine attending physician will contact the patient's private attending physician, or for unassigned patients, the appropriate attending physician on call.

2. Should the patient's private attending physician be unavailable after a reasonable period of time spent attempting to reach him/her, the physician's preference card will be referred to, and his/her alternate (back-up in the same specialty) will be contacted. Should this physician also be unavailable, the chairman of the appropriate department will be contacted.

3. Should an attending on call for the Emergency Room be unavailable, after a reasonable amount of time spent attempting to reach him/her, the

alternate wilt be contacted. Should the alternate also be unavailable, the second on-call physician (on call for the following day) should be called. If this physician also is unavailable, the chairman of the appropriate department will be contacted.

4. Should the department chairman be unavailable, the Chief of Staff will be contacted.

5. The Chairman of the Department of Emergency Medicine is to be notified prior to going to the department chairman.

F. Policy for Emergency Room Patients with Acute Abdomens

1. Patients with G.I. bleeding of an undetermined nature, who arrive at the Emergency Room and have no attending physician, shall be referred to members of the Department of Medicine on-call as listed in the schedule; and

2. Patients with abdominal pain of an undetermined nature, who arrive at the Emergency Room and have no attending physician, shall be referred to the surgeon on-call as listed in the schedule.

G. Telephone Orders for Tests on Specimens Submitted to Pathology

No work shall be performed by the Department of Pathology on telephoned orders until a requisition has been received, including orders for additional tests on specimens provided earlier, and that the person calling is so informed.

H. Tissue Policy

All tissues, including foreign bodies, removed at an operation shall be sent to the hospital pathologist. Exceptions may be mandated by Departmental Policy. The pathologist shall make such recommendations as she/he may consider necessary to arrive at a pathological diagnosis. He/She shall record his/her findings and sign the report. The surgeon, or his designee, shall complete the tissue requisition form, including pertinent clinical data.