ADVOCATE CHRIST MEDICAL CENTER
ADVOCATE CHILDREN'S HOSPITAL-OAK LAWN

MEDICAL STAFF BYLAWS

Approved by the Governing Council on February 18, 2025.[1]
Approved by Medical Executive Committee on January 28, 2025

[1] NIAHO, MS.7, Surveyor Guidance (rev. 18-1).

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DEFINITIONS

“Advanced Practice Clinician” means an individual, other than a Practitioner, who is listed in Section 2.2.1(b), licensed, or certified to render health care services independently or under the supervision of a Medical Staff Member, and who has been granted Privileges by the Hospital to provide direct health care services at the Hospital.

“Adverse Action” means an action or recommended action issued by the MEC or the Governing Council that entitles the affected Medical Staff Member to hearing and appellate review rights as set forth in Section 5.2 of these Bylaws.

“Adverse Action Notice” means a Written Notice informing a Medical Staff Member of an Adverse Action.

“Advocate” or **“Advocate Health Care”** means Advocate Health Care Network.

“Advocate Aurora Health” means Advocate Aurora Health, Inc.

“Advocate Entity” means any facility or entity or operating unit thereof, owned, controlled, or managed by, or under common ownership, control, or management with Advocate Health Care Network.

“Appellate Review Request” means a written request for an appellate review submitted in the manner set forth in these Bylaws by a Medical Staff Member who is entitled to an appellate review under these Bylaws.

“**Applicant**” means a Practitioner who completes and submits an Application for or has been granted the following at the Hospital:

1. Appointment
2. Reappointment
3. Privileges (including initial, renewed, modified, temporary, disaster or emergency Privileges)
4. Modification of Medical Staff Category

“**Application**” means a written request for appointment or reappointment, or Privileges (including initial, renewed, modified, or Temporary Privileges) using the Health Care Professionals Credentialing (or Recredentialing) & Business Data Gathering Form issued by the IDFPR. “Application” in context, also includes any written request for a modification of Medical Staff category.

“Associated Details” means procedural details associated with the basic steps of the processes described in Section 10.1.2 of these Bylaws.

“Bylaws” or “Medical Staff Bylaws” means these Medical Staff bylaws of Advocate Health and Hospitals Corporation, d/b/a, Advocate Christ Medical Center.

"Certificate of Insurance" means a current certificate of insurance evidencing professional malpractice insurance coverage.

"Chief Medical Officer" or **"CMO"** means the individual appointed by Advocate to serve as the senior physician leader responsible for clinical quality and outcomes at the Hospital and assist the Hospital in formulating standards of care, providing strategic direction, and facilitating communication between the Medical Staff and Hospital administration to ensure positive relations.

"Clinical Chairperson" means the Chairperson of a Medical Staff Department.

"**Credentialing Manual**" includes the procedure for credentialing Practitioners and APCs under these Bylaws and Advocate Policy, and also includes the CVO Policy and Procedure Manual.

"**Credentials Verification Organization**" or "**CVO**" means a qualified organization that performs credentials verification services on behalf of the hospital.

"DEA" means the United States Department of Justice Drug Enforcement Agency.

"Delivery Date" means the date upon which any Written Notice is deemed to have been delivered to a Medical Staff Member. The Delivery Date for Written Notices shall be as follows:

Method of Delivery	***Delivery Date***
Personal/Hand Delivery	Date of Delivery
Certified Mail	Date of Delivery, as documented by USPS
Overnight Courier	Date of Delivery, as documented by the overnight courier
Email	Date of Delivery

"Dentist" means an individual who has received a doctorate in dental surgery or a doctorate in dental medicine degree and has a current license to practice dentistry in the State of Illinois.

"Department" means a clinical grouping of Medical Staff Members in accordance with their specialty or major practice interest, as specified in these Bylaws.

"Det Nörske Veritas" or **"DNV"** means an NIAHO standard set forth by Det Nörske Veritas, the Hospital's accreditation agency.

"Ex Officio" means service as a member of a committee or other body by virtue of an office or a position held. Unless otherwise specified in these Bylaws, an Ex Officio member shall serve as a non-voting member.

"Good Standing" means the Medical Staff Member, at the time such standing is determined, has not, at the Hospital or any Advocate Entity: (i) received a suspension or curtailment of their Medical Staff Membership or Privileges for more than thirty (30) consecutive days within the

previous twelve (12) months; (ii) been placed on Probation within the previous twelve (12) months; (iii) entered into a monitoring or some other agreement within the previous twelve (12) months that establishes the terms and conditions of the Medical Staff Member's continued appointment and exercise of Privileges or otherwise restricts the Medical Staff Member's Privileges or right to apply for Medical Staff Membership; (iv) been the subject of an investigation that has not concluded or is the subject of current or pending remedial action; (v) been denied reappointment to the Medical Staff; (vi) withdrawn their application for reappointment to the Medical Staff while under an investigation or subject to pending remedial action; or (vii) voluntarily resigned while under an investigation or subject to pending remedial action.

Notwithstanding the foregoing, a Medical Staff Member is in Good Standing despite the fact that the Medical Staff Member: (i) is subject to ongoing performance evaluation, including, but not limited to, routine proctoring agreements to demonstrate or improve clinical competence or (ii) is the subject of a performance improvement plan, so long as the Medical Staff Member is in compliance with its terms.

"Governing Council" means the Governing Council of the Hospital or any other group of individuals or committee to whom the Board of Directors of Advocate Health and Hospitals Corporation has delegated the responsibility for acting on its behalf in matters regarding oversight of quality care and credentialing of the Medical Staff and Advanced Practice Clinicians, or any other matters applicable to the Medical Staff.

"Hearing Request" means a written request for a hearing submitted in the manner set forth in these Bylaws by a Medical Staff Member who is entitled to a hearing under these Bylaws.

"History and Physical Examination" or "H&P" means a medical history and physical examination that is performed to determine whether any aspect of the patient's overall condition or medical history would affect the planned course of the patient's treatment, such as a medication allergy or a new or existing condition that requires additional interventions to reduce risk to the patient. An H&P must be performed or approved by an individual who has been privileged to do so by the Medical Staff. [2]

"Hospital" means Advocate Health and Hospitals Corporation, d/b/a Advocate Christ Medical Center, located in Oak Lawn, Illinois. The Hospital is a "health care entity" as defined in 42 U.S.C. § 11151(4)(A) and a "hospital" as defined in 42 U.S.C. § 11151(5).

"Hospital President" means the individual appointed by the Governing Council to act on its behalf in the overall management of the Hospital.

"IDFPR" means the Illinois Department of Financial and Professional Regulation.

"Medical Director" means a Physician under contract with the Hospital to assume overall responsibility for a particular service.

[2] 42 C.F.R. § 482.22(c)(5)(i) (Interpretive Guidelines, effective October 17, 2008).

"Medical Executive Committee" or "MEC" means the executive committee of the Medical Staff.

"Medical Staff" means all Practitioners[3] who have been appointed to the Active, Associate, Courtesy, Consulting, Affiliate or Emeritus/Emerita Medical Staff or the Telemedicine Staff by the Governing Council. The Medical Staff is a Professional Review Body and is an integral part of the Hospital (not a separate legal entity).[4]

"Medical Staff Member" means an individual Practitioner who is appointed to the Medical Staff.

"Medical Staff Membership" means appointment to the Active, Associate, Courtesy, Consulting, or Affiliate Medical Staff, or Telemedicine Staff.

"Medical Staff President" means the individual elected by the Medical Staff as its chief administrative officer.

"**Medical Staff Services**" means the Hospital's Medical Staff Office, CVO or TSO, as applicable.

"Medical Staff Year" means the applicable one-year period, beginning on January 1st of each year.

"Modification Request" means a written request for modification of an individual's Medical Staff Category and/or Privileges.

"National Practitioner Data Bank" or **"NPDB"** means the data bank established under the Health Care Quality Improvement Act.

"Oral Surgeon" means a Dentist who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education who possess a current license to practice dentistry in the State of Illinois.

"Patient Encounter" means, for the purpose of determining whether a Medical Staff Member "regularly treats" patients at the Hospital, (a) an inpatient or outpatient admission of a patient during which the Medical Staff Member has direct, in-person contact with the patient; or (b) the performance of a procedure or diagnostic or therapeutic intervention for a Hospital patient.

"Physician" [5] means an appropriately licensed medical doctor (M.D.) or osteopathic physician (D.O.) who possesses a current license to practice medicine in the State of Illinois.

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[3] 77 IAC 250.310(i) (stating that an Active Medical Staff may only include physicians, podiatrists and dentists to perform all the organizational duties of a Medical Staff).
[4] 42 C.F.R. § 482.12(a)(1) (Interpretive Guidelines, effective October 17, 2008).

[5] 77 IAC 250.310(i) (stating that an Active Medical Staff may only include physicians, podiatrists and dentists to perform all the organizational duties of a Medical Staff).

"Podiatrist" means an individual who has received a Doctorate of Podiatric Medicine (DPM) and has a current license to practice podiatry in the State of Illinois.

"Practitioner" means a Physician, Podiatrist, Dentist, or Oral Surgeon.

"Preclusion List" means the CMS Preclusion List and/or the OIG exclusion list.

"Privileges" means permission granted by the Governing Council to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, dental, or podiatry services at the Hospital.

"Probation" is Written Notice that a Medical Staff Member will be subject to remedial action if specified conduct is repeated. The Written Notice of Probation may, but need not, be given as part of an investigation. Probation does not afford the affected Staff Member hearing or appeal rights.

"Professional Review Action" means any action or recommendation of a Professional Review Body which is taken or made in the conduct of Professional Review Activity, which is based on the competence or professional conduct of a health care provider and which affects, or may affect Medical Staff Membership or Privileges.[6]

"Professional Review Activity" means any activity which is undertaken to determine whether (a) a health care provider is eligible for Medical Staff Membership or Privileges; (b) the scope or conditions of such Medical Staff Membership or Privileges; or (c) if such Medical Staff Membership or Privileges should be modified or terminated.[7] Professional Review Activity includes peer review.

"Professional Review Body" means the Governing Council, Medical Staff, MEC, Credentials Committee, peer review committee, any Hearing or Appellate Review Committee, the Practitioner Wellness Committee, any subcommittee or member of the forgoing, and any other committee or entity which, or individual who, conducts or assists the Hospital in the performance of any Professional Review Activity or otherwise participates in a Professional Review Action. Each of the forgoing are a "professional review body" as that term is defined in 42 U.S.C. § 11151(11).

"Section Head" means a member of the Active or Associate Medical Staff who cooperates with the Department Chair of which the Section is component in all of the functions outlined in the Department Chair section of these Bylaws as such functions affect and pertain to the Section.

"Telemedicine Service Organization" or **"TSO"** means a hospital or ambulatory care organization accredited by an agency deemed to meet the CMS Conditions of Participation, and that has contracted with the Hospital to provide telemedicine services through a telemedicine link.

"Written Notice" means a written notice that is delivered to the Medical Staff Member via personal/hand delivery, certified mail, or overnight courier service where delivery can be tracked, to the Medical Staff Member's last known residential or office address. Notwithstanding the

[6] 42 U.S.C. § 11151(9).
[7] 42 U.S.C. § 11151(10).

above, for purposes of Medical Staff meetings, Department meetings, and Medical Staff committee meetings, the term “Written Notice” shall also include notice via email to the Medical Staff Member’s last known email address.

ARTICLE 1. PURPOSE AND RESPONSIBILITIES

1.1 BYLAWS

The purposes of these Bylaws are to: (1) create a system of rights and responsibilities between the organized Medical Staff and the Governing Council, and the organized Medical Staff and its members;[8] (2) describe the organization and structure of the Medical Staff; and (3) establish a mechanism for the organized Medical Staff to carry out its responsibilities and govern the professional activities of its members and other individuals with Privileges.[9]

1.2 ORGANIZED MEDICAL STAFF

The organized Medical Staff is composed of Medical Staff Members.[10] The responsibilities and authority of the organized Medical Staff is delegated from the Governing Council.

1.3 GOVERNING COUNCIL

The purposes and responsibilities of the Governing Council with regard to the Medical Staff are described in these Bylaws and Medical Staff Policies.[11]

1.3.1 Bylaws and Policies.

The Governing Council approves and upholds these Bylaws, Medical Staff Policies, and other Medical Staff rules and regulations; manages quality care; and provides organizational management and planning.[12]

1.3.2 Medical Staff Membership and Privileges.

The Governing Council determines, in accordance with applicable law, which categories of providers are eligible candidates for Medical Staff Membership;[13] appoints Medical Staff Members after considering the recommendations of the MEC;[14] ensures that the criteria for Medical Staff Membership and/or Privileges are in writing and include individual character, competence, training, experience, and judgment;[15] and ensures that under no circumstances is the accordance of Medical Staff Membership or Privileges in the Hospital depend solely upon certification, fellowship, or membership in a specialty body or society.[16]

1.3.3 Communication with the Medical Staff.

The Governing Council: (a) works with Medical Staff leaders to evaluate the Hospital's performance in relation to its mission, vision, and goals; (b) ensures that the Medical Staff is accountable to the Governing Council for the quality of care provided to patients;[17] and

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[8] NIAHO, MS.7 (rev. 18-1).
[9] 42 C.F.R. § 482.12(a)(3) (Interpretive Guidelines, effective October 17, 2008); 42 C.F.R. § 482.22(c) (Interpretive Guidelines, effective October 17, 2008).
[10] 42 C.F.R. § 482.22; NIAHO, MS.1 (rev. 18-1).
[11] 42 C.F.R. § 482.12(a); NIAHO, MS.1 (rev. 18-1)
[12] 42 C.F.R. § 482.12(a)(3-4); NIAHO MS.2. SR.1 (rev. 18-1).
[13] 42 C.F.R. § 482.12(a)(1).
[14] 42 C.F.R. § 482.12(a)(2).
[15] 42 C.F.R. § 482.12(a)(6).
[16] 42 C.F.R. § 482.12(a)(7); NIAHO, MS.11, SR.3 (rev. 18-01).
[17] 42 C.F.R. § 481.12(a)(5); NIAHO, GB.1, SR.1 (rev. 18-01)

(c) provides the organized Medical Staff with the opportunity to participate in Hospital governance, and the opportunity to be represented at Governing Council meetings, by one or more of its members, as selected by the organized Medical Staff.[18]

1.3.4 Consultations with the Medical Staff President.[19]
The Governing Council shall consult directly with the Medical Staff President no less than twice per year to discuss matters related to quality of medical care provided to patients of the Hospital.[20] This requirement may be met through the Medical Staff President's ex officio participation on the Governing Council, provided the Medical Staff President has the opportunity to meet with the Governing Council periodically throughout the calendar year and if necessary to respond to urgent requests of the Medical Staff President to discuss matters related to the quality of medical care provided to Hospital patients.[21]

1.3.5 Delegation of Right to Approve a Hearing Committee.
The Illinois Hospital Licensing Act provides a Governing Council the right to approve the members of any Hearing Committee proposed by Medical Staff leadership.[22] In furtherance of the independence of the Hearing Committee,[23] and because a Medical Staff Member has the right to appeal to the Governing Council any Adverse Action recommended by a Hearing Committee, the Governing Council hereby delegates its right to approve the members of any proposed Hearing Committee to the Hospital President or CMO.[24]

1.4 IMMUNITY AND INDEMNIFICATION

1.4.1 Immunity from Liability.[25]
Because the candid and conscientious evaluation of clinical practice is essential to providing safe health care to the community that the Hospital serves, it is the policy of the State of Illinois to encourage peer review by the Medical Staff. Therefore, any and all Hospital representatives shall have absolute immunity from civil liability for actions performed in good faith in connection with providing, obtaining or reviewing information, and evaluating or making recommendations or decisions, concerning the following: (a) any Professional Review Activity; (b) any Professional Review Action; (c) any Adverse Action, corrective action, remedial action, hearing or appellate review; (e) any ongoing performance evaluation, or other evaluation of patient care services; (f) any utilization review; and (g) other Hospital, departmental or committee activities related to patient care

[18] SYS-001-001, Governing Council Responsibility Policy for AHHC (Advocate).
[19] 42 C.F.R. § 482.12(a)(10) (Interpretive Guidelines, effective Sept. 26, 2014); NIAHO, MS.4, SR.1 (rev. 18-01).
[20] 42 C.F.R. § 482.12(a)(10) (Interpretive Guidelines, effective Sept. 26, 2014); 77 IAC 250.210(f); NIAHO, MS.4, Interpretive Guidelines (rev. 18-01).
[21] 42 C.F.R. § 482.12(a)(10) (Interpretive Guidelines, effective Sept. 26, 2014); 79 Fed. Reg. 27,112 (May 12, 2004); NIAHO MS.4, Interpretive Guidelines (rev. 18-01).
[22] 210 ILCS 85/104(b)(2)(C).
[23] 210 ILCS 85/10.4(b)(2)(C).
[24] 42 U.S.C. § 1112(b)(3)(A)(iii) (Hospital has the right to appoint the hearing panel, provided the members are not in direct competition with the affected Medical Staff Member).
[25] 225 ILCS 60/5; 210 ILCS 85/10.2.

services and professional conduct. For purposes of this Section 1.4.1, the term "Hospital representatives" shall include, without limitation, Medical Staff Members, the Governing Council and its members, the MEC and its members, any and all committees serving as a Professional Review Body on behalf of Hospital, the Practitioner Wellness Committee and its members, the Hospital President, the Medical Staff President and other Medical Staff Officers, employees, agents, and any outside reviewers who provide or evaluate information concerning any Applicant or Medical Staff Member's qualifications, clinical competency, character, mental or emotional stability, health, ethics or any other matter that might have an effect on patient care. In furtherance of the foregoing, each Applicant shall, upon request of the Hospital, execute releases in favor of the Hospital, Hospital representatives and third parties from whom information has been requested by the Hospital or an authorized Hospital representative.

1.4.2 Indemnification.

All Governing Council members, Medical Staff Officers, Clinical Chairpersons, Medical Staff Members and Hospital employees who act for and on behalf of the Hospital in discharging their responsibilities and participating in Professional Review Activities and Professional Review Actions pursuant to these Bylaws, shall be indemnified by Advocate when acting in those capacities, to the fullest extent permitted by law.

ARTICLE 2. MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

2.1 GENERALLY

2.1.1 No Entitlement.
No Applicant shall be entitled to Medical Staff Membership or to the exercise of Privileges at the Hospital merely by virtue of the fact that the Applicant: (a) is licensed to practice medicine, podiatry, or dentistry in this or in any other state; (b) is board certified or a member of any professional organization; or (c) had or currently has such privileges at another hospital.[26] Individuals in administrative positions are subject to the same procedures as all other Applicants for Medical Staff Membership or Privileges.

2.1.2 No Discrimination.
No Applicant who is otherwise qualified shall be denied Medical Staff Membership or Privileges by reason of race, creed, color, national origin, ancestry, religion, sex, sexual orientation, gender identity, marital status, age, disability, military status, or other class protected by law, except as may be permitted by law.

2.1.3 Exercise of Privileges; Certain Restrictions.
Except as provided in Section 2.7, each Medical Staff Member, by virtue of their Medical Staff Membership, shall be entitled to exercise only those Privileges within the scope of their license, certification, education, training, and experience, and as specifically granted to them upon recommendation by the MEC and approval of the Governing Council. Certain Privileges may be subject to specific restrictions.

2.1.4 Admitting and Prescribing Privileges.
The privilege to admit patients to the Hospital shall be specifically delineated. Prescribing privileges shall be limited to the classes of drugs granted to the Applicant by the DEA, Illinois Controlled Substance License, and the Applicant's scope of practice and current competence.

2.1.5 Exclusive Contracts.
The Governing Council may determine, in the interest of quality patient care and as a matter of policy, that certain Hospital facilities, services, and coverages may be provided/used only on an exclusive basis in accordance with written contracts between the Hospital and specific qualified Practitioners or entities. In the grant of an exclusive contract, the contracting entity may waive Article 5 rights on behalf of any Medical Staff Members affiliated with the contracting entity.[27] In the event of any conflict between any such contract and these Bylaws, the contract terms shall prevail.

2.1.6 Duration of Appointment, Reappointment and Privileges.
Initial appointment and reappointment and Privileges shall be granted for a specific period

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[26] 42 C.F.R. § 482.12(a)(7).
[27] 210 ILCS 85/10.4(b)(2)(H).

not to exceed three (3) years upon final approval of the Governing Council.[28]

2.1.7 Ongoing Performance Evaluation of Qualifications and Competence.
Each Applicant's competence to perform Privileges shall be assessed and evaluated on an ongoing basis through the Hospital's ongoing performance evaluation processes (as further described in Medical Staff Policies). In addition, each Applicant must report any changes in the Applicant's qualifications in accordance with Section 2.8.7 of these Bylaws. If at any time, such information indicates that the Applicant is no longer competent to perform any of the Applicant's previously granted Privileges, such Privileges may be modified or terminated by the Governing Council, upon the recommendation of the MEC.[29]

2.2 PROVIDERS ELIGIBLE FOR MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

2.2.1 Eligible Health Care Providers.

(a) The following health care providers are eligible for Medical Staff Membership and/or Privileges:[30]

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Dentists/Oral Surgeons (DDS/DMD)
- Doctors of Podiatric Medicine (DPM)

(b) The following health care providers are eligible for Privileges only:

- Advance Practice Registered Nurses
  - Certified Registered Nurse Anesthetists (CRNA)
  - Nurse Practitioners (NP)
  - Clinical Nurse Specialists (CNS)
  - Certified Nurse Midwives (CNM)
- Physician Assistants (PA)
- Psychologists (Ph.D or Psy.D)
- House Physicians/Moonlighters (MD/DO)
- Surgical First Assistants

2.2.2 Available Privileges.
The Hospital, in consultation with the Medical Staff, shall determine which Privileges it has the space, equipment, personnel, and other necessary resources to support. No Applicant shall be granted Privileges if the Hospital does not have the necessary resources

[28] 42 C.F.R. § 482.22(a)(1); NIAHO, SR.2 (rev.18-01).
[29] NIAHO, MS.3, SR.1 & MS.9 (rev. 18-01).
[30] 42 C.F.R. § 482.12(a)(1) (Interpretive Guidelines, effective October 17, 2008); 42 C.F.R. § 482.22(c)(2) (Interpretive Guidelines, effective October 17, 2008).

to support such Privileges.[31] Lists of the specific Privileges available to each category of provider listed above are maintained by Medical Staff Services.[32]

2.3 QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

Only those Applicants who continuously meet the qualifications, standards and requirements set forth in these Bylaws and associated Medical Staff Policies and Hospital policies (and provide documentation of the same) shall be eligible for Medical Staff Membership and Privileges.[33]

Each Applicant shall have the burden of establishing that they are eligible for Medical Staff Membership and Privileges and it is the sole responsibility of each Applicant to submit all of the information and supporting documentation requested on the forms and in the manner requested. Except as set forth in Section 2.7 (Temporary, Emergency and Disaster Privileges) and Section 3.7 (Emeritus/Emerita Medical Staff), such information and supporting documentation shall include the items listed below.

2.3.1 Current Competence.

Each Applicant must possess the individual character, current competence, training, skills, experience, judgment, background, and health status needed to perform requested Privileges and provide quality patient care.[34]

2.3.2 Complete Application and Fee.

Each Applicant must submit a complete, legible, signed Application and any applicable Application fee (such Application fee shall be established and may be modified by the MEC in consultation with the Medical Staff).

2.3.3 License/Registration.[35]

Each Applicant must: (a) possess a current license to practice their profession in the State of Illinois; (b) provide a list of all current and past licenses and certifications (in any state); and (c) provide an explanation of any current or previous challenges or limitations to, or relinquishments of, current and past licenses and certifications (in any state).[36] Medical Staff Services shall confirm with the IDFPR the status of each Applicant's license/registration and any disciplinary action taken against the Applicant's license/registration before appointment, reappointment, modification of Privileges, and at the time of license expiration.[37]

2.3.4 Board Status, Residency/Training Program, and Board Certification Waiver.

(a) Board Status.[38] Each Applicant must provide, as requested, (a) copies of certificates or letters confirming completion of an approved residency/training program or

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[31] 210 ILCS 85/10.4(b); 77 IAC 250.310(a)(6).
[32] 42 C.F.R. § 482.22(c)(2) (Interpretive Guidelines, effective October 17, 2008).
[33] 42 C.F.R. § 482.22(c)(4); 210 ILCS 85/10.4(b)(1); 77 IAC 250.310(b) & (e); NIAHO, MS.7, SR.1 (rev. 18-01); NIAHO MS.8, SR.1 & SR.2 (rev. 18-01); and NIAHO, MS12, SR.1, SR.5 & Interpretive Guidelines (rev.18-01).
[34] 77 IAC 250.310(e); NIAHO, MS.12, SR.1 (rev. 18-01).
[35] 42 C.F.R. §§ 482.11(c), 482.22(c)(4); NIAHO, SR.1a (rev. 18-01).
[36] IDFPR, Health Care Professionals (Re)Credentialing and Business Data Gathering Form.
[37] 42 C.F.R. §§ 482.11(c), 482.22(c)(4); 77 IAC 250.310(b)(1); NIAHO MS.8, SR.1a (rev. 18-01).
[38] Policy SYS-001-007. Board Certification.

other educational curriculum, as applicable; (b) verifications of certificates or letters from the appropriate specialty board confirming board status (i.e., board eligibility, or board certification), as applicable; and (c) information regarding the Applicant's loss or failure to recertify a board certification, if any.[39]

i. Physicians. A Physician must: (i) have successfully completed (a) a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada or (b) the eligibility requirements of the respective Board of Medical Specialties Board and; (ii) be board certified by a specialty board approved by the American Board of Medical Specialties (ABMS), including primary board certification and specialty certification; equivalent (by training) certification of the AOA; or the Royal College of Physicians and Surgeons of Canada; or be board eligible and receive and maintain board certification in compliance with Advocate Policy.

ii. Podiatrists. A Podiatrist must: (i) have successfully completed a training program accredited by the Council on Podiatric Medical Education; (ii) be board certified by the American Board of Foot and Ankle Surgery (ABFAS); or be board eligible or equivalent status and receive and maintain board certification in the specialty for which privileges are sought in compliance with Advocate Policy.

iii. Dentists. A Dentist must: (i) have successfully completed a training program at a school of dentistry accredited by the Commission on Dental Accreditation (CODA) of the American Dental Association (ADA); and (ii) have successfully completed at least one (1) year of a post-graduate program certified by CODA.

iv. Oral and Maxillofacial Surgeons. An Oral Surgeon must: (i) have successfully completed a post-graduate program residency program accredited by the Commission on Dental Accreditation of the American Dental Association or approved by the MEC; (ii) be board certified by the American Board of Oral and Maxillofacial Surgery; or be board eligible and receive and maintain board certification in compliance with Advocate Policy.

(b) Waiver of Board Certification Requirements.[40] Board certification requirements have been grandfathered for certain Medical Staff Members under Advocate Policy. Also, board certification requirements may be waived for a specific Medical Staff Member or Applicant pursuant to the process set forth in Advocate Policy.

[39] IDFPR, Health Care Professional (Re)Credentialing and Business Data Gathering Form.
[40] Policy SYS-001-007, Board Certification.

2.3.5 Peer Recommendations.

Two (2) peer recommendations are required for all Applicants seeking: (a) initial appointment or Privileges;[41] (b) renewed Privileges if there is insufficient professional practice review data generated by the Hospital to evaluate the Applicant's competence; and (c) modified Privileges if there is insufficient professional practice review data generated by the Hospital to evaluate the Applicant's competence.[42]

2.3.6 Professional Practice Evaluation Data.

Each Applicant must provide or permit access to professional practice evaluation data generated by the Hospital and any other entity that currently privileges the Applicant, if available. The Applicant, in the previous eighteen (18) months, must have (i) treated patients in a hospital or other appropriate setting in which the Applicant's care was subject to evaluation through peer review acceptable to the MEC, or (ii) applied for Medical Staff Membership and Privileges upon completion of a graduate or post-graduate program, as applicable.

2.3.7 No Sanction, Exclusion or Preclusion.[43]

Each Applicant must be eligible for participation in the Medicare and Medicaid programs and shall not (1) currently be on any Preclusion List or otherwise be suspended, excluded, debarred, or ineligible to participate in any health care program funded in whole or in part by the federal or state government; or (2) have been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a health care program funded in whole or in part by the federal or state government after a period of exclusion, suspension, debarment, or ineligibility.

2.3.8 DEA Registration and Illinois Controlled Substance License.

If the Applicant's practice will involve the prescription of controlled substances, then the Applicant must possess a current, unrestricted DEA registration and Illinois Controlled Substance License, which will allow Applicant to prescribe medications for Hospital patients.[44] The Applicant, upon request, must provide a copy of their current DEA registration certificate which should contain a professional practice address, as well as previously successful or currently pending challenges to registration or voluntary or involuntary relinquishment of registration, if any. Medical Staff Services shall confirm each Applicant's DEA registration through primary source verification prior to appointment and reappointment and at time of expiration.

2.3.9 Specified Pre-Conditions.

The Governing Council may precondition appointment, reappointment, or the granting or continued exercise of Privileges upon the Applicant's agreement to comply with certain conditions or restrictions, including but not limited to, the Applicant's agreement to undergo mental or physical examinations, tests or other evaluations the Governing Council

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[41] NIAHO, MS.8, SR.1d (rev. 18-01).

[42] NIAHO, MS.8, SR.2d (rev 18-01); and NIAHO, MS.9, Interpretive Guidelines & Surveyor Guidance (rev. 18-01).

[43] NIAHO, MS.8, SR.1e & 2e (rev. 18-01).

[44] 21 C.F.R. § 1301.12(b)(3). When an Applicant practices in more than one state, they must obtain a separate registration for each state. *See* Fed. Reg., Dec. 1, 2006 (vol. 71, No. 231) pp 69478–69480.

deems appropriate to evaluate or ensure that there is no change in the Applicant's qualifications and ability to exercise Privileges and provide quality care and supervision to Applicant's patients.

2.3.10 Signed Acknowledgement.
The Applicant shall review and sign the acknowledgement, consent and release form before an Application can be deemed complete.

2.3.11 Current and Past Employment, Staff Membership, and Privileges.
Each Applicant must provide contact names and addresses of institutions, organizations and entities with which: (1) the Applicant is currently employed, has staff membership, or holds privileges; (2) the Applicant was employed, had staff membership, or held privileges during the five (5) years prior to the Application date; and (3) any information regarding the voluntary or involuntary termination of the Applicant's employment, staff membership, or limitation, reduction, denial, or loss of clinical privileges at any other institution, organization, or entity.

2. 3.12 For initial Applicants, primary source verification will be performed for:
(1) current staff memberships and privileges (and, if desired, current employment); and (2) previous staff memberships and privileges (and, if desired, previous employment) held by the Applicant during the five (5) years prior to the Application date. Staff membership, privileges and employment held by an initial Applicant prior to the five (5) years preceding the Application date may be verified through primary source verification at the discretion of the Medical Staff. For reappointment Applicants, primary source verification shall only be performed for the Applicant's current staff memberships and Clinical Privileges (and, if desired, employment).

2.3.13 Absence of Criminal Background.
Each initial Applicant must complete a Background Disclosure Form and consent to and cooperate with the performance of a background check, the results of which do not prevent the Hospital from extending Medical Staff Membership or Privileges to the Applicant.[45] Applicants must have a record that is free of convictions and pleas of "guilty" or "no contest" or its equivalent to a felony in any jurisdiction.

2.3.14 National Data Bank Report.[46]
Medical Staff Services will obtain a NPDB report for all initial and reappointment Applicants, and all current Medical Staff Members seeking modified Privileges. Such NPDB report must not contain information which would prevent the Governing Council from extending Medical Staff Membership and Privileges to the Applicant.

[45] 225 ILCS 46 *et. seq.* (Health Care Worker Background Check Act).
[46] NIAHO, MS.8, SR.1e (rev. 18-01).

2.3.15 Health and Immunization Status.[47]
Each Applicant must provide documentation related to the Applicant's health and immunizations in accordance with Advocate Policy.

2.3.16 Certification of Fitness; **Physical and Psychological Examination.**
Each Applicant must attest in writing that they do not have a medical condition, or mental or physical impairment that in any way impairs or limits the Applicant's ability to practice medicine and exercise Applicant's Privileges with reasonable skill and safety.[48] Upon the request of the Credentials Committee, MEC, or Governing Council, each Applicant agrees to undergo mental or physical examinations, tests or other evaluations deemed appropriate to evaluate the Applicant's ability to exercise Privileges. If there is a known medical condition or mental or physical impairment, the Applicant will (i) provide evidence that the medical condition or impairment does not adversely affect the Applicant's ability to exercise Privileges with reasonable skill and safety, and (ii) notify the Credentials Committee, MEC, or Governing Council whether the Applicant requires any accommodations.

2.3.17 Professional Liability Insurance.
Each Applicant must submit a current Certificate of Insurance evidencing professional malpractice insurance coverage with an insurance carrier acceptable to Advocate, or other documentation evidencing such coverage acceptable to Advocate, which has limits not less than those specified by the Advocate Governing Council and must maintain such insurance coverage.

2.3.18 Claims, Lawsuits, Settlements and Judgments.
Each Applicant must provide a listing and description of all claims, settlements, judgments, and lawsuits pending or closed, which have ever been filed against the Applicant, with the exception of personal family law matters. Each Applicant shall provide the following information relating to any claims or actions for damages against the Applicant (pending or closed), regardless of whether there has been a final disposition: (a) the name of liability carrier at the time of the incident giving rise to the claim (and policy number, if available); (b) the docket number; (c) the name, address and age of claimant or plaintiff; (d) the nature and substance of the claim; (e) the date and place at which the claim arose; (f) amounts paid if any and the date and manner of disposition, judgment, settlement, or otherwise; (g) the date and reason for final disposition, if no judgment or settlement; and (h) any additional information requested by Medical Staff Services, the Credentials Committee, Medical Executive Committee, or Governing Council.

[47] NIAHO, IC.1, SR.2 & SR.6 (rev. 18-01); CDC, Recommended Vaccines for Healthcare Workers (2013), *available at* www.cdc.gov/vaccines/adults/rec-vac-hcw.html; Policy, Communicable Disease Surveillance for Credentialed Providers, SYS 001-006.
[48] IDPFR, Health Care Professionals (Re)Credentialing and Business Data Gathering Form, Form E.

2.3.19 Confirmation of Identity.
Each initial Applicant must provide proof of identity as requested by Medical Staff Services.

2.3.20 Continuing Medical Education.[49]
Each Applicant must attest in writing to the completion of acceptable continuing education hours required by the Applicant's licenses and provide additional information upon request.

2.3.21 Alternate Coverage.
Each Applicant must have and maintain appropriate alternate coverage, which must be updated promptly upon changes, and provide all documentation to Medical Staff Services regarding such coverage.

2.3.22 Other Information.
Each Applicant must provide other information requested and deemed by the Clinical Chairperson, Credentials Committee, MEC, or Governing Council to be relevant to the evaluation of the Applicant's ability to exercise Privileges.

2.4 OBTAINING AND SUBMITTING AN APPLICATION

2.4.1 Medical Staff Governing Documents.
Applicants for Medical Staff Membership and/or Privileges are bound by these Bylaws, Rules and Regulations, and Medical Staff Policies.[50]

2.4.2 Obtaining an Application.
Individuals seeking appointment, reappointment, or Privileges (including initial or modified Privileges) must submit an Application.

2.4.3 Applicant's Burden.
Each Applicant shall have the burden of producing complete, accurate and adequate information, and updates thereto, to allow a proper evaluation of and resolve any doubts related to their qualifications. This burden may include completion of a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the MEC or Governing Council, which may also select the examining physician. The Applicant's failure, as determined by the MEC or the Governing Council in its sole discretion, to sustain this burden shall deem the application incomplete.

2.4.4 Effect of Misrepresentation, Misstatement or Omission.
If the MEC determines that the Applicant made a relevant misrepresentation, misstatement, or omission on an Application, the Application may be denied.

[49] NIAHO, MS.10 (rev. 18-01).
[50] 77 IAC 250.310(b); NIAHO, MS.2, SR.3 (rev. 18-01).

2.5 REVIEW AND EVALUATION PROCESS[51]

2.5.1 Generally.

Application for Medical Staff Membership and/or Privileges will be reviewed, as indicated, by Medical Staff Services, the CVO, Clinical Chairperson, Credentials Committee, and MEC as set forth in the Credentialing Manual.

The Applicant has an obligation to appear for any requested interview regarding their Application, or subsequent to appointment or the granting of Privileges, to appear for any requested interviews related to questions regarding the Applicant's qualifications, conduct or competence.

2.5.2 Option to Proxy Credential Telemedicine Staff.[52]

(a) *Options*. Applications to the Telemedicine Staff shall be processed in one of the following ways: (1) the application may be processed in accordance with the standard credentialing and privileging process set forth in these Bylaws; (2) the MEC may rely on credentialing information provided by the TSO in making its recommendation regarding appointment and privileges; or (3) the MEC may rely on the credentialing and privileging decisions of the TSO in making its recommendation regarding appointment and privileges. The MEC may rely on the credentialing information provided by the TSO or the credentialing and privileging decisions of the TSO only if the TSO is subject to an agreement that complies with subsection (b) and applicable regulatory and accreditation requirements. When the MEC relies on the credentialing and privileging decisions of the TSO, an Applicant to the Telemedicine Staff is not required to be evaluated by the Clinical Chairperson under Section 2.5.4 and the Credentials Committee under Section 2.5.5. However, the MEC or the Governing Council may, in its or their sole discretion, require any individual Telemedicine Staff Applicant or all of a TSO's Applicants to be credentialed and privileged in accordance with the standard process set forth in these Bylaws. In addition, any Applicant for the Telemedicine Staff who also wishes to apply for privileges to provide in-person services at the Hospital, shall be credentialed and privileged in accordance with the standard process.

(b) *Telemedicine Services Agreement*.[53] When telemedicine services are furnished at the Hospital pursuant to a written agreement between a Telemedicine Service Organization (TSO) and the Hospital or an entity affiliated with the Hospital, the agreement shall comply with the applicable regulatory and accreditation requirements. If a Telemedicine Staff Applicant is affiliated with and has been granted privileges by a TSO, the Applicant must be in good standing with such TSO and provide written documentation of their current privileges. Telemedicine Staff

[51] NIAHO, MS.2, SR.2 (rev. 18-01).
[52] 42 C.F.R. §§ 482.12(a)(8)–(9), 482.22(a)(3)–(4); 77 IAC 250.310(e)(1)(F); 77 IAC 250.310(f), (g) & (h); NIAHO, GB.3, SR.4 & SR.5 (rev.18-01); NIAHO, MS.20, SR.1, SR.2 & SR. 3 (rev. 18-01).
[53] 42 C.F.R. § 482.12(a)(8)–(9); 42 C.F.R. § 482.22(a)(3)–(4) & (c)(6); NIAHO GB.3, SR.4 & SR.5 (rev. 18-01); NIAHO, MS.20 (rev. 18-01).

Applicants whose telemedicine services at the Hospital are not provided pursuant to a written agreement between a TSO and the Hospital or an entity affiliated with the Hospital shall be credentialed and privileged in accordance with the standard process set forth in these Bylaws.

2.6 NOTIFICATION OF MEDICAL STAFF MEMBERSHIP AND CLINICAL PRIVILEGING DECISIONS

2.6.1 Notification to Applicant.

(a) Favorable Decision. If the Governing Council's decision is favorable to the Applicant, the Hospital President shall notify the Applicant in writing of the final decision of the Governing Council.

(b) Unfavorable Decision. If Governing Council's decision is deemed an Adverse Action, then the Hospital President will provide the Applicant with Written Notice of the Adverse Action, including an explanation of the reasons for the Adverse Action, and advise the Applicant of their hearing rights in accordance with Section 5.3.1.[54]

2.6.2 Communication with Hospital Departments.
Medical Staff Services will ensure that the appropriate Departments and other Hospital patient care areas are informed of the Privileges granted to an Applicant. If there are any revisions or revocations of an Applicant's Privileges, Medical Staff Services also will notify any Advocate Entity where the Applicant has applied for Privileges or has Privileges.[55]

2.7 TEMPORARY, EMERGENCY, AND DISASTER PRIVILEGES

2.7.1 Temporary Privileges; Minimum Criteria for Temporary Privileges.[56]

(a) *Clean Application*. Temporary Privileges may be granted for the purpose of expediting the Application process for the Applicant to become a Medical Staff Member. To be eligible for Temporary Privileges, an Applicant must provide all necessary documents to complete an Application as set forth in Section 2.3 of these Bylaws, with no negative or adverse information contained therein. An Applicant whose license or registration is or has been denied, limited, or challenged in any way or whose staff membership or clinical privileges have been involuntarily terminated, limited, reduced, or denied by the Hospital or any other institution, organization, or entity, is not eligible for Temporary Privileges. If applying for telemedicine Privileges, then a telemedicine services agreement also shall be executed as described in Section 2.3.

(b) *Special Circumstances*. Temporary Privileges may be granted under the Special Circumstances set forth below:

[54] 210 ILCS 85/10.4(b)(2).
[55] 42 C.F.R. § 482.22(a)(2) (Interpretive Guidelines, effective October 17, 2008).
[56] NIAHO, MS.13 (rev. 18-01).

i. The care of a specific patient;

ii. To meet an urgent patient care need for a specified period of time, through locum tenens status; or

iii. To provide specialty or subspecialty care or techniques not represented on the Medical Staff.

(c) *Minimum Criteria for Special Circumstances*. Temporary Privileges may be granted for Special Circumstances if the following criteria are met:

i. Primary verification of license/registration[57];

ii. Primary verification of residency/training program[58];

iii. Demonstration of current competence[59];

iv. Receipt of professional references (including current competence)[60];

v. Receipt of database profiles from the AMA, AOA, NPDB and OIG Medicare/Medicaid Exclusions.[61]

2.7.2 Request for Temporary Privileges

The process for requesting and granting temporary Privileges is set forth in the Credentials Manual.[62]

2.7.3 Emergency Privileges.[63]

In an emergency situation (defined as a circumstance in which immediate action is necessary to prevent serious harm or death), any Medical Staff Member with Privileges may provide any type of patient care, treatment, or services necessary to prevent serious harm or death, regardless of their Staff category or designated Privileges, as long as such care, treatment or services is within the scope of the Medical Staff Member's license.

2.7.4 Disaster Privileges.[64]

Disaster Privileges may be granted to volunteer Practitioners only when the Hospital Disaster Plan has been activated in response to a disaster and the Hospital is unable to meet immediate patient needs.[65] Such disaster Privileges may only be granted by the Hospital President or the Medical Staff President) at their discretion on a case-by-case basis upon presentation of any of the following:

(a) A current picture hospital identification card;

[57] NIAHO, MS.13, SR.3c (rev. 18-01).
[58] NIAHO, MS.13, SR.3a (rev. 18-01).
[59] NIAHO, MS.13, SR.3b (rev. 18-01).
[60] NIAHO, MS.13, SR.3d (rev. 18-01).
[61] NIAHO, MS.13, SR.3e (rev. 18-01).
[62] NIAHO, MS.13, SR.1 (rev. 18-01).
[63] 210 ILCS 85/10.4(a) (stating that "individuals granted privileges who provide care in an emergency situation, in good faith and without direct compensation, shall not, as a result of their acts or omissions, except for acts or omissions involving willful and wanton misconduct…, on the part of the person, be liable for civil damages").
[64] NIAHO, MS.13, SR.4 (rev. 18-01).
[65] 77 IAC 250.310(b)(18); NIAHO, MS.14, SR.4 (rev.18-01).

(b) A current license to practice (which will be verified through primary source verification as set forth below) and a valid picture identification card issued by a Federal State or regulatory agency;

(c) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or an Illinois Medical Emergency Response Team (IMERT);

(d) Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (authority having been granted by a Federal, state, or municipal entity); or

(e) Presentation by a current Hospital employee or Medical Staff Member with personal knowledge regarding the Practitioner's identity.

Primary source verification of license will begin as soon as the immediate situation is under control and will be completed within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital. In the event that primary source verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances, it will be completed as soon as possible and the reasons for the delay as well as the attempts made to complete the verification will be documented. Medical Staff Services will maintain a Practitioner file with appropriate documents and signatures.

2.7.5 Monitoring and Review-Emergency and Disaster Privileges.
Individuals exercising emergency or disaster Privileges shall act under the supervision and observation of the Clinical Chairperson of the Department to which they are assigned.[66] The Medical Staff President or the Hospital President may impose special requirements in order to monitor and assess the quality of care rendered by the Practitioner exercising emergency or disaster Privileges.

2.7.6 Termination of Emergency and Disaster Privileges.
Emergency and disaster Privileges shall automatically terminate at the end of the specific period for which they were granted. In addition, emergency and disaster Privileges shall be immediately terminated by the Hospital President upon notice of any failure by the Practitioner to comply with any special requirements. The Hospital President may at any time, upon the recommendation of the Medical Staff President, terminate a Practitioner's emergency or disaster Privileges, effective upon the discharge of the Practitioner's patient(s) from the Hospital. However, if the life or health of such patient(s) would be endangered by continued treatment by the Practitioner, any person authorized to impose a summary suspension in accordance with Section 4.2.1 of these Bylaws may terminate the Practitioner's emergency or disaster Privileges, effective immediately. The Medical Staff President shall assign a Medical Staff Member to assume responsibility for the care of such terminated Practitioner's patient(s) until discharge from the Hospital. The wishes of the

[66] 77 IAC 250.310(b)(18)(iii) (stating that the bylaws require a mechanism to manage individuals who receive disaster privileges).

patient(s) shall be considered where feasible in selection of an alternate Medical Staff Member.

2.7.7 No Hearing and Appellate Review Rights.
An individual who has been granted emergency or disaster Privileges shall not be entitled to the hearing and appellate review rights afforded by these Bylaws as the result of their inability to obtain emergency or disaster Privileges or the termination thereof.

2.7.8 Organ and Tissue Procurement.
Medical personnel who enter the Hospital to obtain organs and tissues for transplant from a deceased donor in accordance with the Illinois Hospital Licensing Act are not required to be privileged.[67]

2.8 ONGOING OBLIGATIONS OF MEDICAL STAFF MEMBERS

Each Medical Staff Member signifies their agreement that acceptance of and continued compliance with the ongoing obligations set forth below are express conditions of the Medical Staff's and Governing Council's consideration of Medical Staff Member's Application for appointment, reappointment, or Privileges, continued Medical Staff Membership and the exercise of Privileges.[68]

2.8.1 Maintain Qualifications.
The Medical Staff Member agrees to maintain all necessary qualifications for Medical Staff Membership and Privileges as set forth in Section 2.3 of these Bylaws.

2.8.2 Ongoing Performance Evaluation.
The Medical Staff Member agrees to comply with all ongoing performance evaluation processes and requirements imposed at any time by the MEC, including, without limitation, any performance improvement plan, proctoring requirement, monitoring requirement, or other condition imposed on the Medical Staff Member to demonstrate current clinical competence. The Medical Staff Member further agrees to review Hospital, Department, Medical Staff and Advocate Aurora Health communications and be responsible for staying current regarding the content of those communications.

2.8.3 Duty to Appear
The Medical Staff Member is required to participate in ongoing performance evaluations and any Professional Review Activity, as requested by Medical Staff leadership. In addition, the Medical Staff member has an obligation to appear for any requested interview related to questions regarding the Medical Staff Member's qualification, conduct or competence.

2.8.4 Provide Continuous and Competent Care.
The Medical Staff Member shall provide or arrange for continuous care to their patients at the professional level of quality and efficiency established by the Medical Staff and

[67] 77 IAC 250.310(b)(1); 755 ILCS 50.
[68] NIAHO, MS.2, SR.3 (rev. 18-01).

Hospital and seek consultations for their patients consistent with Section 10.5 of these Bylaws.[69]

2.8.5 Compliance with Ethical Guidelines.

The Medical Staff Member agrees to abide by the Principles of Medical Ethics of the American Medical Association, the American Podiatric Medical Association, Inc., the American Osteopathic Association, the Code of Ethics of the American Dental Association, or other applicable ethical principles or codes for professional association of the Practitioner, including any ethics opinions issued by such professional associations, as if the same were appended to and made a part of these Bylaws.

2.8.6 Compliance with Bylaws, Policies, and Laws/Regulations.

As a condition of Medical Staff Membership, each Medical Staff Member agrees to strictly abide by: (a) these Bylaws, Medical Staff Policies, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff, the Hospital, and Advocate, including but not limited to Section 2.8.17 of these Bylaws and Advocate's EMTALA policy;[70] and (b) all applicable laws and regulations, DNV Standards, and professional review regulations, standards and principles applicable to the Medical Staff Member's professional practice.

2.8.7 Mandatory Self-Disclosure.

Each Applicant and Medical Staff Member agrees to notify the Medical Staff President in writing promptly after they become aware (in no event later than the end of the next business day) of any of the following:

(a) Any circumstance or condition which would affect or result in a change in status of any of the Applicant's qualifications for Medical Staff Membership or Privileges as set forth in these Bylaws;

(b) Any investigation, disciplinary action, Adverse Action, restriction, or change related to the Applicant's professional practice by any entity (including but not limited to the Applicant's employer, other hospitals, health plans, and agencies);

(c) Applicant's receipt of notice that an adverse professional review action report or medical malpractice payment report has been filed with the NPDB;

(d) Changes to the Applicant's participation in any health plan;

(e) Dishonorable discharge from any branch of the US Armed Forces, including any reserve component;

[69] 77 IAC 250.310(b)(7); NIAHO, MS.18 (rev. 18-01). *See also* 77 IAC 250.320(a) (stating that "[a]ll persons admitted to the hospital shall be under the professional care of a member of the medical staff"). However, "[p]atients admitted by a podiatrist or a dentist shall be under the care of both the admitting medical staff member and a physician who is also a medical staff member. The podiatrist or the dentist shall be responsible for all care within the limits of the Privileges granted to them; [and] the physician shall be responsible for all aspects of general medical care." *Id.*

[70] Policy SYS-002-010. Emergency Treatment at Advocate Hospitals.

(f) If the Applicant is admitted for, seeks, or is undergoing treatment for alcohol or substance abuse or a behavioral health problem. "Substance abuse" shall include but not be limited to, use or ingestion of illegal drugs, or use or ingestion of prescription medications not prescribed or not being taken as prescribed in the ordinary course of treatment of injury or disease. "Behavioral health problem" shall mean any condition or disease of a psychiatric or psychological nature which, in the opinion of a qualified psychiatrist, may adversely affect the Applicant's ability to care for patients or practice their profession in accordance with the applicable prevailing standard of care;

(g) Changes in residency;

(h) Any pending charge (including arrest, charge, arraignment, or indictment) or conviction (including "no contest" pleas and matters where sufficient facts of guilt were pled or found), whether for a felony, misdemeanor, or ordinance against the Applicant. Minor traffic offenses need not be reported under this Section. A charge of Driving Under the Influence is not a "minor traffic offense" and must be reported;

(i) The investigation of allegations or a finding by any government or regulatory agency, that the Applicant committed any act, offense or omission related to the abuse or neglect of any person, or misappropriation (improperly taking or using) of the property of a patient or other person; and

(j) An occurrence or knowledge of any new or updated information that is pertinent to any question on Applicant's Application form that is material to any professional qualification or credential.

2.8.8 Perform Administrative and Medical Staff Duties.
Medical Staff Members agree to perform such Medical Staff, Department, Committee, and Hospital functions for which they are responsible based upon appointment, election, assignment, or otherwise, including as appropriate, participating in quality improvement and other monitoring activities, serving on Medical staff committees, and providing on-call coverage for emergency care services within their clinical specialty, as required by the Medical Staff.[71]

2.8.9 Cooperate with Hospital.
The Medical Staff Member agrees to cooperate in good faith with the Hospital and Advocate Aurora Health:

(a) in matters involving its fiscal responsibilities and policies, including matters relating to payment or reimbursement by governmental and third-party payers.

(b) in the defense of any matter for which the Medical Staff Member and the Hospital may be found jointly and severally liable. The Medical Staff Member shall not

[71] *See* 77 IAC 250.310(i)(1) (setting forth the minimum duties of active medical staff members).

serve as a retained expert witness and take an adverse position against Advocate Aurora Health in any matter where an Advocate Aurora Health entity is a party.

(c) with any investigation or inquiry of the Medical Staff or Hospital, including peer review, remedial actions, loss prevention investigations, and other similar investigations and inquiries.

2.8.10 Participate in Quality Improvement and Other Initiatives.[72]
A Medical Staff Member has a duty to participate in peer review, ongoing performance evaluation, quality assessment, performance improvement, risk management, case management/resource management, initiatives to promote the appropriate utilization of Hospital resources, and other Hospital review and improvement initiatives as requested. In addition, the Medical Staff Member agrees to maintain the confidentiality of all peer review information, quality assessment and performance improvement data, and other information related to professional review activities.

2.8.11 Exhaustion of Remedies.
The Medical Staff Member agrees that if an Adverse Action is taken or recommended, they will exhaust the remedies afforded by these Bylaws before resorting to legal action.

2.8.12 Submission of Medical Staff Member Dues.
All Medical Staff Members with the exception of Emeritus/Emerita Medical Staff Members agree to timely pay annual Medical Staff Member dues.

2.8.13 Assessment of Competence.
The Medical Staff Member agrees to use the Hospital to provide clinical care in a manner and frequency that permits the Governing Council, through assessment by appropriate Medical Staff committees, Clinical Chairpersons, and others, to evaluate the Medical Staff Member's current clinical competence.

2.8.14 Unanticipated Outcome Disclosure to Patients.
The Medical Staff Member agrees to disclose unanticipated medical outcomes to the Hospital, patients, and others in accordance with applicable policies.

2.8.15 Medical Staff Member Identification.
The Medical Staff Member agrees to accurately identify themselves and any other individual providing treatment, care, or services.

2.8.16 Appropriate Delegation of Responsibility for Diagnosis.
The Medical Staff Member agrees that when delegating responsibility for diagnoses or care of Hospital patients, to do so only to a Medical Staff Member or other individual adequately qualified, supervised, or credentialed by the Medical Staff with appropriate Privileges to undertake the responsibility.

[72] NIAHO, MS.9 & Interpretive Guidelines (rev. 18-01).

2.8.17 EMTALA Compliance.

(a) Responsibility of On Call Practitioners: Medical Staff Members shall participate on the Emergency Department on-call list as determined by each Department. When an on-call Medical Staff Member is contacted by an Emergency Room Practitioner, the Medical Staff Member must respond within the time set forth by policy and, if requested by the Emergency Room Practitioner, must respond in person to personally examine the patient. This response may include completion of the medical screening or provision of stabilizing treatment. Failure to respond in a timely manner may result in Remedial Action under these Bylaws. If a Medical Staff Member fails or refuses to respond resulting in the need to transfer a patient to another facility, the name and address of the Practitioner will be included in the patient record forwarded to the receiving Hospital, as required by law.

(b) Medical Screening Examinations: Medical Screening Examinations ("MSE") of patients shall be performed as follows:

(i) Patients who come to the Emergency Department shall receive a MSE by qualified medical personnel (QMP). A QMP is an emergency room Practitioner, on-call Practitioner, obstetrician, house Practitioner, or, if granted appropriate Privileges, resident Physician, APRN (including a Certified Nurse Midwife) or PA.

(ii) Pregnant patients and postpartum patients within 6 weeks of delivery may be seen in the Obstetric Emergency Department.. A pregnant patient with a non-pregnancy related medical need may be seen in the Emergency Department.

2.8.18 HIPAA Compliance.

Medical Staff Members shall protect the confidentiality and security of all patient information in compliance with federal and state law and Hospital policies and procedures.

2.8.19 Compliance with the Universal Protocol for Procedural Safety Policy, Including Red Rule.

Medical Staff Members shall comply with the Universal Protocol for Procedural Safety Policy, and any red rule policies and procedures established by the Hospital.

2.9 LEAVE OF ABSENCE; VOLUNTARY RESIGNATION

2.9.1 Leave of Absence.

The review and approval process for granting a leave of absence and reinstatement procedure shall be set forth in the Credentialing Procedures Manual.

(a) Request for Leave. A Medical Staff Member may obtain a leave of absence from the Medical Staff, as applicable, for a period not to exceed one (1) year by

submitting a written request with the reason to the MEC. A leave shall be granted only if approved by the MEC and the Governing Council. The MEC and Governing Council may, in their discretion, extend a Medical Staff Member's leave of absence for a period not to exceed one (1) additional year.

(b) Reinstatement. At least sixty (60) days before a leave of absence ends, the Medical Staff Member must request reinstatement of Medical Staff Membership and Privileges by submitting a written request to the Medical Staff President. The written request shall include an attestation that no changes have occurred in the Practitioner's qualifications for Medical Staff Membership or Privileges, or if a change has occurred, a detailed description of such change. The Practitioner shall provide any additional information requested. Reinstatement shall be granted only if approved by the MEC and Governing Council.

(c) Failure to Request a Return. Failure of a Medical Staff Member to request reinstatement shall constitute a voluntary resignation from the Medical Staff, as applicable, and shall not entitle the Medical Staff Member to hearing or appellate review rights.

2.9.2 Voluntary Resignation

Resignations from the Medical Staff must be submitted in writing to Medical Staff Services and must state the date the resignation becomes effective. The Medical Staff Member's Clinical Chairperson, the Hospital President, the MEC, and the Governing Council shall be informed of all resignations. A Medical Staff Member who voluntarily resigns may not submit a new Application for Medical Staff Membership for at least one (1) year from their resignation date. In unusual circumstances, exceptions may be granted by the MEC.

2.9.3 Reapplication Following Voluntary Resignation.

A Practitioner who seeks to reapply for Medical Staff Membership or Privileges following voluntary resignation must complete an initial Application, meet all of the requirements for initial appointment and Privileges, and pay any applicable Application fee.

ARTICLE 3. MEDICAL STAFF CATEGORIES

3.1 GENERALLY[73]

3.1.1 Medical Staff Member Categories Generally.

Each Medical Staff Member shall be appointed to one of the following Medical Staff categories[74]:

- Active
- Associate
- Courtesy
- Consulting
- Affiliate
- Emeritus/Emerita
- Telemedicine

3.1.2 Individuals with Privileges Only.

Each of the following Practitioners or APCs shall be granted Privileges by the Governing Council but may not be appointed as a Medical Staff Member. [75]:

- Telemedicine Staff
- Advanced Practice Clinicians
- House Physicians/Moonlighters

3.2 ACTIVE MEDICAL STAFF[76]

3.2.1 Composition.

The Active Medical Staff shall consist of Medical Staff Members who:

(a) have completed at least one (1) year of Associate Medical Staff Membership

(b) have an office within the primary or secondary service area of the Hospital to provide continuous care to patients;

(c) assume all the functions and responsibilities of appointment to the Active Medical Staff; and

(d) regularly treat patients at the Hospital. "Regularly treat" means the Active Medical

[73] NIAHO, MS.7, SR.3 (rev. 18-01).

[74] 42 C.F.R.§ 482.277 (stating that the medical staff bylaws must include a statement of the duties and privileges of each category of the medical staff); *see also* 77 IAC 250.310(j). The medical staff may include other categories of the Medical Staff, provided that the other categories do not modify the duties and responsibilities of the Active Medical Staff.

[75] 77 IAC 250.310(i) (stating that an Active Medical Staff may only include physicians, podiatrists and dentists to perform all the organizational duties of a Medical Staff).

[76] 77 IAC 250.310(b)(2). Active and Consulting categories are required in Illinois.

Staff Member has more than ten (10) Patient Encounters during the most recent three (3) year reappointment period.

3.2.2 Rights and Obligations.[77]

(a) Active Medical Staff Members shall be:

i. eligible to apply for Privileges (including the privilege to admit, perform procedures, or write orders);
ii. required to attend Medical Staff and Department meetings;
iii. eligible to vote at Medical Staff and Department meetings;
iv. eligible to serve in a voting capacity on and as chairperson of one or more Medical Staff committees;
v. eligible to hold Medical Staff office; and
vi. eligible to serve as a Clinical Chairperson.

(b) As may be required by the MEC or the Governing Council, Active Medical Staff Members must actively participate in recognized functions of Medical Staff appointment, including but not limited to, participating in quality improvement, peer review and other monitoring activities, serving on Medical Staff committees, and discharging other functions as may be required from time to time.

(c) Active Medical Staff Members must participate in emergency department back-up call and other specialty coverage programs in accordance with Medical Staff Policies or as requested by the MEC. At the discretion of the Clinical Chairperson of the applicable Department, Active Medical Staff Members who have attained the age of sixty-five (65) years may be released from the obligation and responsibility of providing emergency department back-up call service.

3.3 ASSOCIATE MEDICAL STAFF

3.3.1 Composition.

The Associate Medical Staff shall consist of Medical Staff Members who are:

(a) new to the Medical Staff and being considered for advancement to the Active Medical Staff;

(b) have an office within the primary or secondary service area of the Hospital to provide continuous care to patients;

(c) assume all the functions and responsibilities of appointment to the Associate Medical Staff.

Associate Medical Staff Members may be advanced to the Active Medical Staff after one (1) year or may serve an additional period(s) on the Associate Medical Staff upon recommendation of the Clinical Chairperson of the applicable Department. Associate Medical Staff Members shall be observed by the appropriate Clinical Chairperson to assess

[77] NIAHO, MS.7 Surveyor Guidance (rev. 18-01).

clinical and professional performance and eligibility for advancement to another Medical Staff category.

3.3.2 Rights and Obligations.[78]

(a) Associate Medical Staff Members shall be:

i. eligible to apply for Privileges (including the privilege to admit, perform procedures, or write orders);

ii. eligible and encouraged to attend Medical Staff meetings in a non-voting capacity;

iii. required to attend Medical Staff meetings in a non-voting capacity, if their presence is requested by the Medical Staff President;

iv. eligible and encouraged to attend Department meetings in a non-voting capacity;

v. eligible to serve on Medical Staff committees in a voting capacity only if the MEC determines that such Medical Staff Member has expertise that is not otherwise available;

vi. eligible to serve as a Medical Staff committee chairperson only if the MEC determines that such Medical Staff Member has expertise that is not otherwise available; and

vii. eligible to serve as a Clinical Chairperson only if the MEC determines that such Medical Staff Member has expertise that is not otherwise available.

(b) As may be required by the MEC or the Governing Council, Associate Medical Staff Members must actively participate in recognized functions of Medical Staff appointment, including but not limited to, participating in quality improvement, peer review and other monitoring activities, serving on Medical Staff committees, and discharging other functions as may be required from time to time.

(c) Associate Medical Staff Members must participate in emergency department back-up call and other specialty coverage programs in accordance with Medical Staff Policies or as requested by the MEC. At the discretion of the Clinical Chairperson of the applicable Department, Associate Medical Staff Members who have attained the age of sixty-five (65) years may be released from the obligation and responsibility of providing emergency department back-up call service.

3.4 COURTESY MEDICAL STAFF

3.4.1 Composition.

The Courtesy Medical Staff shall consist of Medical Staff Members who:

(a) Do not regularly admit or care for patients at the Hospital but provide unique clinical expertise not otherwise available to Hospital patients, and/or represent or

[78] NIAHO, MS.7 Surveyor Guidance (rev. 18-01).

provide back-up to a scarce medical specialty as determined by the MEC.

(b) Assume all the functions and responsibilities of appointment to the Courtesy Medical Staff.

3.4.2 Rights and Obligations.[79]

(a) Courtesy Medical Staff Members shall be eligible to:

i. apply for Privileges (including the Privilege to perform procedures, or write orders);

ii. attend Medical Staff and Department meetings in a non-voting capacity;

iii. serve on Medical Staff committees in a non-voting capacity; and

iv. serve on Medical Staff committees in a voting capacity only if the MEC determines that such Medical Staff Member has expertise that is not otherwise available.

(b) Courtesy Medical Staff Members shall **not** be eligible to:

i. serve as a Clinical Chairperson; or

ii. hold Medical Staff office.

(c) At the request of the MEC/Department, Courtesy Medical Staff Members shall participate in emergency department back-up call under exigent circumstances including, but not limited to, gaps in coverage caused by the lack of a particular specialty on the Active or Associate Medical Staff.

3.5 CONSULTING MEDICAL STAFF[80]

3.5.1 Composition.

The Consulting Medical Staff shall consist of Medical Staff Members who:

(a) Represent a recognized specialty with board certification consistent with Advocate policy, who have been granted Privileges to provide consultations for Hospital patients as requested by a treating Practitioner; and

(b) Do not have admitting Privileges and cannot act as a patient's attending.

3.5.2 Rights and Obligations.

(a) Consulting Medical Staff Members are eligible to attend Medical Staff, Department, or Medical Staff committee meetings in a non-voting capacity.

(b) Consulting Medical Staff Members shall **not** be eligible to:

i. serve on Medical Staff committees;
ii. hold Medical Staff office;
iii. serve as a Clinical Chairperson; or

[79] NIAHO, MS.7 Surveyor Guidance (rev. 18-01).
[80] 77 IAC 250.310 (b)(2).

iv. participate in emergency department back-up call.

3.6 AFFILIATE MEDICAL STAFF

3.6.1 Composition.
The Affiliate Medical Staff shall consist of Practitioners who represent a recognized specialty with board certification consistent with Advocate policy but who do not wish to provide care for their patients within the Hospital.

3.6.2 Rights and Obligations.[81]
(a) Affiliate Medical Staff Members may:

i. Refer their patient to a Medical Staff Member for care within the Hospital and follow their patient while admitted;
ii. Review the medical record of their patients referred to the Hospital and communicate with the attending Practitioner, Consulting Medical Staff, and Hospital staff concerning such patients. This authorization does not include documenting in the medical record, performing procedures, or ordering tests, consultations, drugs or therapies or examination of patients; and
iii. Attend Medical Staff, Department, or Medical Staff committee meetings in a non-voting capacity.

(b) Affiliate Medical Staff Members shall **not** be eligible to:

i. Admit patients or be granted Privileges to provide patient care in the Hospital;
ii. Serve on Medical Staff committees;
iii. Hold Medical Staff office;
iv. Serve as a Clinical Chairperson; or
v. Participate in emergency department back-up call.

3.7 EMERITUS/EMERITA MEDICAL STAFF

3.7.1 Composition.
The Emeritus/Emerita Medical Staff shall consist of Practitioners who have retired from medical practice and are recognized by the MEC for their positive contributions to the health and medical sciences, as well as their contributions to the Hospital or Advocate Aurora Health. Emeritus/Emerita Medical Staff Members must complete the appropriate Application as requested by Medical Staff Services and be approved at the sole discretion MEC. Emeritus/Emerita Medical Staff shall be in good standing when moved to Emeritus/Emerita status and shall have served on the Medical Staff for 10 years. The MEC may approve granting Emeritus/Emerita status to a Medical Staff Member with less than 10 years' service under special circumstances.

3.7.2 Rights and Obligations.[82]
(a) Emeritus/Emerita Medical Staff Members shall **not** be eligible for Privileges.

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[81] NIAHO, MS.7 Surveyor Guidance (rev. 18-01).
[82] NIAHO, MS.7 Surveyor Guidance (rev. 18-01).

(b) Emeritus/Emerita Medical Staff Members are not entitled to the procedures and rights set forth in Article 5 of these Bylaws.

Emeritus/Emerita Medical Staff Members shall be eligible to attend Medical Staff, Department, and Medical Staff committee meetings in a non-voting capacity with the approval of the Medical Staff. When attending meetings and Hospital functions in person, Emeritus/Emerita Medical Staff Members shall adhere to infectious disease protocols.

3.8 TELEMEDICINE STAFF

3.8.1 Composition.
The Telemedicine Staff shall consist of Practitioners who:

(a) have been granted telemedicine Privileges as their only Privileges at the Hospital;

(b) provide contracted medical services within the Practitioner's area of expertise through a telemedicine link from a remote location; and

(c) assume all the functions and responsibilities of the Telemedicine Staff.

3.8.2 Rights and Obligations. Telemedicine Staff shall be eligible to exercise their telemedicine Privileges only.

3.9 ADVANCED PRACTICE CLINICIANS

3.9.1 Composition.
Advanced Practice Clinicians granted privileges hereunder shall be eligible to provide patient care services in the Hospital. The Medical Staff shall have oversight of Advanced Practice Clinicians who hold Privileges[83] and ensure that all individuals with Privileges provide services only within the scope of Privileges granted. Advanced Practice Clinicians are not members of the Medical Staff.

3.9.2 Rights and Obligations.

Advanced Practice Clinicians shall:

(a) be credentialed through medical staff processes;

(b) be granted delineated clinical Privileges;[84]

(c) be afforded rights of a limited review of an adverse action as set forth in the system policy: *Advanced Practice Clinician and Psychologist Credentialing Corrective Action and Adverse Action Review Plan*;

(d) be monitored through the Credentialing Corrective Action and Adverse Action Review Plan set forth in the system policy;

[83] 77 IAC 250.320(b).
[84] 77 IAC 250.320(b).

(e) be subject to renewal of Privileges and evaluation as defined by Hospital through medical staff processes;

(f) be subject to all current regulatory standards relevant to the APC with delineated clinical Privileges; and

(g) abide by the system policy: *Advanced Practice Clinician and Psychologists Credentialing, Corrective Action and Adverse Action Review Plan*.

Amendments to Advocate policy: *Credentialing, Corrective Action and Adverse Action Review Plan*, shall be effective upon approval of the MEC.

3.10 HOUSE PHYSICIANS/MOONLIGHTERS

3.10.1 Composition.

The Medical Staff shall have oversight of House Physicians/Moonlighters who hold Privileges[85] and ensure that all individuals with Privileges provide services only within the scope of Privileges granted. House Physicians/Moonlighters shall:

(a) be credentialed through medical staff processes;

(b) be granted delineated clinical privileges;[86]

(c) be monitored through the Hospital's credentialing and related policies;

(d) be subject to renewal of privileges and evaluation as defined by Hospital through medical staff processes;

(e) be subject to all current regulatory standards relevant to the House Physician/Moonlighter with delineated clinical privileges;

(f) shall not be entitled to any procedural rights granted to Medical Staff Members pursuant to these Bylaws, including without limitation, hearing, or appeal rights.

3.10.2 Rights and Obligations.

House Physicians/Moonlighters granted privileges to perform regular professional medical duties in the hospital must:

(a) Have an unrestricted license to practice medicine in Illinois

(b) Have professional liability insurance in the amount otherwise required of members of the medical staff, which specifically covers activities of a House Physician.

[85] 77 IAC 250.320(b).
[86] 77 IAC 250.320(b).

(c) Be under contract with the Medical Center to perform services.

(d) The privileges shall automatically cease at the end of the contract term.

(e) The House Physician/Moonlighter shall not be granted membership on the medical staff and is not required to pay dues.

(f) The House Physician/Moonlighter may apply for medical staff membership and clinical privileges whenever eligible.

ARTICLE 4. REMEDIAL ACTIONS

4.1 PROCESS FOR REMEDIAL ACTION[87]

4.1.1 Applicability.
These provisions of Article 4 shall apply to all Medical Staff Members in Active, Associate, Courtesy, and Consulting categories.

4.1.2 Request for Review: General Provisions.

(a) Request for Review. A request for review of a concern/complaint or the initiation of remedial action regarding actions, behaviors, or quality of care concerns of a Medical Staff Member ("Request for Review") shall be reviewed, and an investigation initiated, as set forth herein whenever there is reason to believe that a Medical Staff Member's acts, omissions, demeanor, conduct, or professional performance is, or is reasonably likely to be:

i. Detrimental to patient safety or the delivery of quality care;
ii. Disruptive to the operations of the Hospital, the Medical Staff, or a Department;
iii. Below the professional standards of care;
iv. A violation of professional ethical standards of the American Medical, Osteopathic, Dental or Podiatric Associations;
v. Contrary to these Bylaws, Medical Staff Policies, the policies of Advocate or the Hospital, the Rules and Regulations of the Medical Staff or the Medical Staff Member's Department, or applicable laws, regulations, or accreditation standards; or
vi. Unprofessional conduct or inappropriate behavior.

(b) Basis for Request. A Request for Review must be based on a reasonable belief that the professional review action is in furtherance of quality health care[88] and supported by reference to the specific acts or omissions which constitute the grounds for the request.

(c) Submission of Request for Review. All Requests for Review must be submitted in writing to the Hospital President, Medical Staff President, the CMO, a Department Chair, a member of the MEC, officer of the Medical Staff, and/or the Governing Council.

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[87] NIAHO, MS.7, SR.4 & MS.14 (rev. 18-01).
[88] 42 U.S.C. § 11112(a)(1).

(d) Written Notice to Medical Staff Member. The Medical Staff President shall provide the affected Medical Staff Member with a Written Notice of the Request for Review. The Written Notice shall advise the Medical Staff Member:

i. of the Request for Review and the basis therefor; and
ii. that they may request a preliminary interview with the MEC, and such request must be made within fifteen (15) days of receipt of the Written Notice.

4.1.3 Preliminary Interview with Medical Staff Member.
The preliminary interview with the MEC, if requested, shall not constitute a hearing under these Bylaws and no legal counsel shall be present. A summary of the preliminary interview shall be documented in the minutes.

4.1.4 Medical Executive Committee Review and Action.
Following the MEC's review of the Request for Review, the preliminary interview, peer review, and any other information reviewed by the MEC, the MEC may take one or more of the following actions:

i. Reject or modify the Request for Review;
ii. Issue a documented verbal warning; warning letter or formal letter of reprimand;
iii. Issue a period of Probation;
iv. Require retrospective case reviews or specific education/additional training;
v. Impose a term of monitoring;
vi. Require prior consultation, but without prior approval;
vii. Require prior consultation and approval with or without supervision or monitoring;
viii. Recommend reduction, limitation, modification, suspension or revocation of Privileges;
ix. Recommend that an existing summary suspension of Privileges be terminated, modified or sustained;
x. Recommend that the Medical Staff Membership be revoked; or
xi. Any other action which may be appropriate under the circumstances.

4.1.5 Practitioner Referrals Pursuant to the Practitioner Wellness Policy.
If the MEC believes that a Medical Staff Member may be impaired such that the Medical Staff Member's professional performance or conduct is adversely affected by age, loss of motor or cognitive skills, or physical or mental health disorders or illness, such as chemical dependency, the MEC may refer the Medical Staff Member to a Practitioner Wellness Committee as set forth in the Advocate or Hospital Practitioner Wellness Policy.

4.1.6 Written Notice of Adverse Action.
The Hospital President shall provide Written Notice to the Medical Staff Member of the Adverse Action and their right to request a hearing (if any), as set forth in Article 5 of these Bylaws.

4.1.7 Communication with Hospital Departments.

When an Adverse Action affects a Medical Staff Member's Privileges, the Medical Staff Services office will communicate with the appropriate Departments and patient care areas to ensure that no cases or procedures are scheduled if restricted by the Adverse Action.[89]

4.1.8 Enforcement and Alternate Coverage.

The Medical Staff President shall enforce all remedial actions with the assistance of the Hospital President, the CMO, and the applicable Clinical Chairperson(s). If a Medical Staff Member is suspended, the Medical Staff Member shall appoint alternate coverage. In the event the Medical Staff Member fails to arrange alternate coverage, the Medical Staff President shall appoint alternate coverage, which may be the Medical Staff Member's back-up coverage. The wishes of the patient shall be considered in the selection. The Medical Staff Member shall confer with the alternate Practitioner to ensure continuous quality care.

4.1.9 Notice to Advocate Entities.

When the MEC issues a Notice of a Remedial Action, the Medical Staff President shall notify the Advocate Entities where the Medical Staff Member is on staff, employed, or has applied for Medical Staff membership or employment.

4.1.10 Adverse Action at an Advocate Entity

Final actions of the Governing Council at an Advocate Entity shall be applied to the Staff Member's Membership or Privileges at this Hospital. The hearing rights provided by the Advocate Entity initiating the Adverse Action shall satisfy the Medical Staff Member's hearing rights under these Bylaws. No additional hearing rights under Article 5 shall be afforded.

4.2 SUMMARY SUSPENSION[90]

4.2.1 Authority and Indications.

The Medical Staff President, the Medical Staff President-elect, the Hospital President, the MEC, and the CMO shall have the authority to summarily suspend all or any portion of the Privileges of a Medical Staff Member whose conduct or continued practice at the Hospital presents an immediate danger to the public, including patients, visitors, and Hospital employees and staff.[91] A summary suspension may not be imposed unless, at the time of imposition and Summary Suspension Review, if requested pursuant to Section 4.2.3, there is documentation or other reliable information that an immediate danger exists.[92]

4.2.2 Verbal and Written Notice of Summary Suspension.

The Hospital President or CMO shall provide the Medical Staff Member with verbal notice of the summary suspension, which shall take effect immediately and continue until the

[89] 42 C.F.R. § 482.22(a)(2) (Interpretive Guidelines, effective October 17, 2008).
[90] 210 ILCS 85/10.4(b)(2)(C); 77 IAC 250.310(e)(2)(B)(i); NIAHO, MS.7, SR.4 & MS.12, SR.7 (rev. 18-01).
[91] 210 ILCS 85/10.4(b)(2)(C)(i).
[92] 210 ILCS 85/10.4(b)(2)(C)(i).

Governing Council takes final action. Verbal notice shall be followed by a written Adverse Action Notice, which shall comply with Sections 5.3.1 and 5.3.2.

4.2.3 Summary Suspension Review.[93]
A Medical Staff Member whose Privileges have been summarily suspended may request a Summary Suspension Review by the MEC as set forth in Section 5.3.2(a). A Summary Suspension Review is not a hearing under Article 5 but is a review of the summary suspension to determine if it was reasonable and prudent under the circumstances and to recommend whether the summary suspension should be affirmed, lifted, expunged, or modified.[94]. If the MEC recommends that the summary suspension be lifted, expunged, or modified, this recommendation must be reviewed and considered by the Governing Council on an expedited basis.[95] All documents and reliable information upon which the summary suspension was based must be made available at the Summary Suspension Review[96] and minutes shall be taken.

4.2.4 Notice to Advocate Entities.
When a Medical Staff Member is summarily suspended, the Medical Staff President shall notify the Advocate Entities where the Medical Staff Member is on staff, employed, or has applied for Medical Staff Membership or employment.[97]

4.3 AUTOMATIC SUSPENSION AND TERMINATION[98]

A Medical Staff Member's Membership or Privileges shall automatically be suspended or terminated as set forth herein.

4.3.1 Limitations on License to Practice.[99]

(a) Revocation. If a Medical Staff Member's Illinois license is revoked, then the Medical Staff Member's Membership and Privileges shall be immediately and automatically terminated.

(b) Suspension. If a Medical Staff Member's Illinois license is suspended, the Medical Staff Member's Privileges shall be automatically suspended effective upon and for the term of the license suspension.

(c) Limitation or Restriction. If a Medical Staff Member's Illinois license is limited or restricted, those Privileges that are within the scope of the limitation or restriction shall be limited or restricted automatically, effective upon and for the term of the limitation or restriction.

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[93] 210 ILCS 85/10.4(b)(2)(C)(i).
[94] 210 ILCS 85/10.4(b)(2)(C)(i).
[95] 210 ILCS 85/10.4(b)(2)(C)(i).
[96] 210 ILCS 85/10.4(b)(2)(C)(i).
[97] *See also* Section 4.1.9 of these Bylaws.
[98] NIAHO, MS.12, SR.6, SR.7 & SR.8 (rev. 18-01).
[99] NIAHO, MS.12, SR.6a (rev. 18-01).

(d) Expiration. If a Medical Staff Member's Illinois license expires, and is not timely renewed, the Medical Staff Member's Membership and Privileges shall be immediately and automatically suspended as of the effective date of such expiration until the Medical Staff Member submits proof of a current license. If the Medical Staff Member fails to show proof of a current license within ninety (90) days after the expiration of their license, the MEC shall recommend to the Governing Council termination of the Medical Staff Member's Membership and Privileges.

(e) No Hearing Rights. No hearing rights under Article 5 of these Bylaws shall be afforded to any Medical Staff Member whose Membership or Privileges are limited, suspended or terminated due to limitation, suspension, revocation, or other loss of the Medical Staff Member's Illinois license.[100]

4.3.2 Limitation on DEA Certification or Illinois Controlled Substance License.[101]

(a) If a Medical Staff Member's DEA certification or Illinois controlled substance license is revoked, suspended, or voluntarily relinquished the Medical Staff Member's Privileges shall automatically be suspended effective until such time as Medical Staff Member regains their certification or Illinois controlled substance license.

(b) If a Medical Staff Member's DEA certification or Illinois controlled substance license is restricted, limited, or placed on probation the Medical Staff Member's right to prescribe medications covered by the certification or license shall at least be restricted or limited, automatically effective upon and for the term of the restriction or limitation.

(c) If a Medical Staff Member's DEA certification or Illinois controlled substance license expires and is not timely renewed, the Medical Staff Member's Privileges to prescribe medications covered by such certification or license shall be automatically suspended, as of the effective date of such expiration, until they provide proof of the renewed certification or license. If the Medical Staff Member fails to show proof of a current certification or license within ninety (90) days after the expiration, the MEC shall recommend to the Governing Council termination of Medical Staff Membership and Privileges.

4.3.3 Written Notice of Automatic Suspension or Termination.

The Hospital President shall provide Written Notice to the Medical Staff Member of the Automatic Suspension or Termination.

4.4 ADMINISTRATIVE SUSPENSION[102]

A Medical Staff Member's Membership or Privileges shall be administratively suspended as set forth herein. In the event of an Administrative Suspension under this Section, the Hospital

[100] 210 ILCS 85/10.4(b)(2)(C)(i).
[101] NIAHO, MS.12, SR.6b (rev. 18-01).
[102] 210 ILCS 85/10.4(b)(2)(C)(i).

President shall provide Written Notice to the Medical Staff Member of the Administrative Suspension and their right to request a hearing (if any), as set forth in Article 5, including Section 5.3.2(b), of these Bylaws.

4.4.1 Exclusion from Health Care Program.[103]

If a Medical Staff Member is excluded from participation in Medicare, Medicaid or any health care program funded in whole or in part by the federal or state government, the Medical Staff Member's Membership and/or Privileges shall be subject to an administrative suspension immediately and for the duration of the exclusion. If the Medical Staff Member's exclusion is not revoked within ninety (90) days after the effective date of the administrative suspension, the MEC may recommend to the Governing Council that the Medical Staff Membership and Privileges be terminated.

4.4.2 Failure to Maintain Professional Liability Insurance.[104]

If a Medical Staff Member fails to maintain the amount of professional liability insurance required or fails to submit a Certificate of Insurance or other documentation evidencing such coverage acceptable to Advocate as required under these Bylaws or as otherwise requested, the Medical Staff Member's Staff Membership and Privileges shall be immediately administratively suspended until the Medical Staff Member submits a Certificate of Insurance evidencing the required insurance. If the Medical Staff Member fails to provide a Certificate of Insurance or other documentation evidencing such coverage acceptable to Advocate within thirty (30) days after the termination or expiration of the prior insurance policy, the MEC may recommend to the Governing Council termination of Medical Staff Membership and Privileges.

4.4.3 Failure to Complete Medical Records.[105]

(a) Delinquency Notice / Opportunity to Cure. If a Medical Staff Member fails to complete medical records in compliance with Advocate Aurora Health policy[106], the Department of Health Information Management shall send a Written Notice of delinquency ("Delinquency Notice").

(b) If the Medical Staff Member fails to correct the medical record deficiencies consistent with Hospital policy after the Delinquency Notice, without a justifiable cause as determined by the MEC, the Medical Staff Member may be administratively suspended until the medical records are completed. The Medical Staff President or CMO shall send an Adverse Action Notice to the suspended Medical Staff Member. The Adverse Action Notice shall inform the Medical Staff Member that:

[103] NIAHO, MS.12, SR.7 (rev. 18-01).
[104] NIAHO, MS.12, SR.6c (rev. 18-01).
[105] NIAHO, MS.12, SR.6d (rev. 18-01).
[106] Timeliness of Provider Documentation in Hospital Setting

i. The Medical Staff Member's Privileges have been administratively suspended and shall remain suspended until the medical record(s) are complete; and

ii. If the Medical Staff Member fails to correct the medical record deficiencies within forty-five (45) days after the date of the Adverse Action Notice or if the Medical Staff Member has three (3) administrative suspensions for failure to complete medical records within a twelve (12) month period, the MEC may recommend to the Governing Council that Medical Staff Membership and Privileges be terminated.

4.4.4 Failure to Pay Dues.

If a Medical Staff Member fails to pay required dues within thirty (30) days following Written Notice of the delinquency, the Medical Staff Member's Membership and Privileges, shall be administratively suspended and shall remain so suspended until the Medical Staff Member pays the delinquent dues. If the Medical Staff Member has not paid such dues within thirty (30) days after the effective date of the administrative suspension, the MEC may recommend to the Governing Council that the Medical Staff Membership and Privileges be terminated.

4.4.5 Conviction of a Serious Crime.

If a Medical Staff Member is (a) convicted of a "Disqualifying Offense" as such term is defined in Section 25 of the Illinois Health Care Worker Background Check Act ("HCWBCA"), or any successor statute, and the Medical Staff Member has not received a waiver pursuant to Section 40 of the HCWBCA, or any successor regulation thereto[107]; or (b) is convicted of, or pleads "guilty" or "no contest" or its equivalent to a felony in any jurisdiction, the Medical Staff Member's Membership and Privileges shall be administratively suspended effective on the date of such conviction or plea.

4.4.6 Failure to Comply with Health and Immunization Policies.

If a Medical Staff Member fails to comply with the Advocate Policies regarding required immunizations, vaccines, and testing by the due date determined by Hospital, the Medical Staff Member shall be administratively suspended until the Medical Staff Member complies.[108] If the Medical Staff Member has not complied with the Advocate Policies within ninety (90) days of the effective date of the administrative suspension, the MEC may recommend to the Governing Council that the Medical Staff Membership and Privileges be terminated. A Medical Staff Member who is not in compliance with Advocate Policies is not eligible to apply for reappointment.[109]

[107] 225 ILCS 46; 225 ILCS 46/25; 225 ILCS 46/40.

[108] SYS-001-006, Communicable Disease Surveillance for Credentialed Providers; Associate and Physician Immunization, SYS-017-040; Communicable Disease Exposure, SYS-014-015; Influenza and Pneumococcal Immunizations, SYS 017-030; Bloodborne Pathogens SYS-014-017; and any other applicable health or immunization policy that may be passed by the system and required for Advocate health care providers.

4.4.7 Failure to Satisfy an Appearance Requirement.
If a Medical Staff Member fails to satisfy an appearance required under Section 2.8.3 (ongoing performance evaluation), without good cause as determined by the MEC, the Medical Staff Member shall be administratively suspended until such time as the Medical Staff Member appears. If the Medical Staff Member has not complied with the appearance requirement within ninety (90) days of the effective date of the administrative suspension, the MEC may recommend to the Governing Council that the Medical Staff Membership and Privileges be terminated.

4.4.8 Failure to Comply with Ongoing Performance Evaluation.[110]
If a Medical Staff Member fails to comply with any ongoing performance evaluation processes or requirements imposed by the MEC, including any performance improvement plan, proctoring requirement, or monitoring requirement, the Medical Staff Member's Privileges to admit patients and perform procedures shall be administratively suspended. The suspension shall remain in effect until the Medical Staff Member complies. If the Medical Staff Member has not complied with the ongoing performance evaluation performance evaluation processes or requirements within ninety (90) days of the effective date of the administrative suspension, the MEC may recommend to the Governing Council that the Medical Staff Membership and Privileges be terminated.

4.4.9 Failure to Complete Required Training.
If a Medical Staff Member fails to complete training required by the MEC or AAH within the specified timeframe, the Medical Staff Member shall be administratively suspended until such time as the Medical Staff Member completes the required training. If the Medical Staff Member fails to complete the required training within thirty (30) days of the effective date of the administrative suspension, the MEC may recommend to the Governing Council that the Medical Staff Membership and Privileges be terminated.

4.4.10 Failure to Make Mandatory Self-Disclosure.
If the MEC determines that (i) a Medical Staff Member fails to make a Mandatory Disclosure required by Section 2.8.7 and (ii) either the Medical Staff Member knowingly intended to withhold such information or should have known disclosure was required, the Medical Staff Member shall be administratively suspended. If the Medical Staff Member fails to make a full disclosure to the satisfaction of the MEC and Hospital Administration within thirty (30) days of the effective date of the administrative suspension, the MEC may recommend to the Governing Council that the Medical Staff Membership and Privileges be terminated.

[110] NIAHO, MS.9 (rev. 18-01).

4.4.11 Failure to Comply with Universal Protocol for Procedural Safety Policy.[111], [112]
If a Medical Staff Member fails to comply with AAH's Universal Protocol for Procedural Safety Policy, or other such AAH policy, that requires a Time Out prior to a surgical or invasive procedure, the Medical Staff Members' Membership and/or Privileges may be administratively suspended consistent with current policy applicable to all health care providers, and if the facts and circumstances warrant it, the MEC may recommend remedial action up to and including termination of Medical Staff Membership and Privileges. The Administrative Suspension provisions of this Section do not prevent imposition of a Summary Suspension pursuant to Section 4.2.

4.4.12 Failure to Comply with HIPAA Privacy or Security Policies.
If a Medical Staff Member fails to comply with the Advocate or Hospital policies governing the access, use or disclosure of patient information, then the Medical Staff Member may be administratively suspended pursuant to these Bylaws and Advocate or Hospital policy. Nothing shall prevent the MEC, if the facts and circumstances warrant, from taking additional remedial action, pursuant to Section 4.1. Such action could include the MEC recommending a suspension for a period of thirty-one (31) days or more, or other remedial action up to and including termination of Medical Staff Membership and/or Privileges.

4.4.13 Failure to Provide Required Information to Maintain Membership and Privileges.
If a Medical Staff Member fails to provide, or timely update within 30 days upon a change, required information set forth in Article 2.3 of these Bylaws, then the Medical Staff Member may be administratively suspended pursuant to these Bylaws and Advocate or Hospital policy. Such suspension shall remain in place until the MEC and Hospital Administration are satisfied that the information provided meets the requirements set forth in Article 2.3. If the Medical Staff Member fails to provide the requested information to the satisfaction of the MEC and Hospital Administration within thirty (30) days of the effective date of the administrative suspension, the MEC may recommend to the Governing Council that the Medical Staff Membership and Privileges be terminated.

[111] Universal Protocol for Procedural Safety Policy
[112] 210 ILCS 85/10.4(b)(2)(C)(ii).

ARTICLE 5. HEARING AND APPELLATE REVIEW PROCEDURE

5.1 GENERAL PROVISIONS

5.1.1 Purpose.
The hearing and appellate review processes described herein are designed to ensure that: (1) Adverse Actions are issued or imposed in the furtherance of quality health care after full consideration and reconsideration of all quality and safety issues; and (2) a Medical Staff Member who is subject to an Adverse Action has a fair opportunity to appeal such action.[113]

5.1.2 Applicability.
For purposes of this Article 5, the term Medical Staff Member includes Practitioners within Active, Associate, Consulting, and Courtesy categories as well as an Applicant to such categories.

5.1.3 Consistency of Action by Hospital and Advocate Entities
Through the Application process, all Medical Staff Members have been provided notice and consented to sharing of credentialing and peer review information throughout Advocate as part of an integrated health system. To ensure that consistent quality care is provided to our patients regardless of where they seek care within Advocate, all Advocate Entities shall apply Consistency of Action as set forth in this Section when appointing Medical Staff Membership, granting Privileges, or implementing Rehabilitative Action or any suspension. No Medical Staff Member is entitled to more than one hearing and one appellate review on any matter which shall have been the subject of an Adverse Action. To ensure Consistency of Action, the following automatic actions shall apply:

(a) If a Medical Staff Member's appointment or Privileges are automatically suspended as a result of an administrative suspension or automatically *terminated*, in whole or in part, at an Advocate Entity, then the Medical Staff Member's appointment or Privileges at this Hospital shall automatically and immediately become subject to the same action without recourse to the provisions set forth in this Article 5.

(b) If a Medical Staff Member's appointment or Privileges are summarily suspended, such summary suspension or agreement shall automatically and equally apply to the Medical Staff Member's appointment or Privileges at this Hospital and shall remain in effect until such time as the Advocate Entity renders a final decision or otherwise terminates the process.

(c) If a Medical Staff Member's appointment or Privileges are limited, suspended or terminated at an Advocate Entity, in whole or in part, based on professional conduct or clinical competency concerns, then the Medical Staff Member's appointment or Privileges at this Hospital shall become subject to the same decision without

[113] 42 U.S.C. § 11112(a)(1)–(2); 210 ILCS 85/10.4(b)(2); NIAHO, MS.7, SR4 (rev.18-01).

recourse to provisions set forth in Article 5, *unless otherwise provided in the final decision at the Advocate Entity*.

(d) If a Medical Staff Member withdraws an application for appointment, re-appointment, and/or Privileges at an Advocate Entity while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such application withdrawal shall automatically and equally apply to an application for appointment and/or Privileges at this Hospital without recourse to the procedural rights set forth in these Bylaws and the provisions set forth in this Article 5.

5.1.4 Substantial Compliance.
Except as set forth in Section 5.1.5, technical or immaterial deviations from the procedures set forth in this Article 5 shall not be grounds for invalidating the action taken.

5.1.5 Construction of Time Periods; Waiver.
(a) Unless a time period is specifically required by law, failure to strictly comply with a time limit specified in this Article 5 shall not be deemed to invalidate an action.

(b) A Medical Staff Member may waive any time limits specified in this Article 5 in writing. Where these Bylaws specifically provide that a right of a Medical Staff Member shall be waived as a result of the failure to act within a specified time period, such provisions shall be strictly applied.

5.1.6 Exhaustion of Remedies.
A Medical Staff Member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

5.2 GROUNDS FOR A HEARING OR APPELLATE REVIEW

5.2.1 Adverse Actions.
Except as otherwise specified in Sections 4.3.1 and 4.3.2,[114] any one or more of the following, if recommended or issued by the MEC, shall be deemed an Adverse Action, and shall constitute grounds to request a hearing or appellate review:

(a) Denial of initial Medical Staff appointment[115];

[114] 210 ILCS 85/10.4(b)(2); 210 ILCS 85/10.4(c)(ii).
[115] U.S.C. §§ 1111-1112. The Health Care Quality Improvement Act ("HCQIA") requires hospitals to engage in professional review activities and take "professional review actions" in furtherance of quality of care; but for the hospital and members of its medical staff to have immunity from liability for these actions, the affected practitioner must have adequate notice and hearing rights. *See id.*; *see also* 45 C.F.R. § 60.3 (defining a "professional review action as "any recommendation or action of a [hospital] taken in the course of a professional review activity based on the professional competence or professional conduct of a [practitioner] which affects or could affect adversely the health or welfare of a patient [] and which adversely affects or may adversely affect the clinical privileges or membership . . .."). The National Practitioner Guidebook further clarifies this right to a hearing for initial

(b) Denial of Medical Staff reappointment;

(c) Revocation of Medical Staff Membership

(d) Refusal to reinstate a Medical Staff Member following an approved leave of absence, provided the Medical Staff Member submitted a written request for reinstatement in compliance with Section 2.9 of these Bylaws unless the Medical Staff Member fails to maintain qualifications for Privileges as set forth in these Bylaws;

(e) Involuntary change or denial of a requested change in Medical Staff category, if such involuntary change or denial results in the denial, reduction, or termination of Privileges;

(f) Denial of Medical Staff Member's requested Privileges;

(g) Involuntary reduction or suspension of Medical Staff Member's Privileges;

(h) Termination of Medical Staff Member's Privileges; or

(i) Imposition of a mandatory monitoring, supervision, proctoring, review or consultation requirement if: (i) the Medical Staff Member cannot exercise one or more Privilege(s) without the prior approval of the monitor, supervisor, proctor, reviewer or consultant or without the monitor, supervisor, proctor, reviewer or consultant being present and observing the Medical Staff Member, or (ii) the monitoring, supervision, proctoring, review or consultation is not imposed as part of the ongoing performance evaluation process for newly granted Privileges.

5.2.2 Actions Which Do Not Entitle the Medical Staff Member to Hearing/Appellate Review Rights.

The following shall not be deemed Adverse Actions and shall not constitute grounds for a hearing or appellate review rights (unless the action is reportable to the NPDB):

(a) Any automatic suspension under Section 4.3.1[116] of these Bylaws.

(b) An Administrative Suspension for actions of the Medical Staff Member at an Advocate Entity (Section 4.4.10).

(c) The revocation of Medical Staff Membership or Medical Staff Member's Privileges in accordance with Section 2.1.5 of these Bylaws, unless specifically provided to the contrary in a contract.

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applicants who are denied membership or privileges, stating that "[d]enials or restrictions of clinical privileges for more than 30 days that result from professional review actions relating to the practitioner's professional competence or professional conduct that adversely affects or could adversely affect, the health or welfare of a patient must be reported to the NPDB. **This includes denials of initial applications for clinical privileges**." NPDB Guidebook (Oct. 2018), pp. E-35, E-43 (emphasis added). If an initial applicant withdraws their application prior to an Adverse Decision or if an application is not processed because the applicant does not meet the qualifications for membership or Privileges, then they would not have a right to a hearing under these Bylaws (and the withdrawal or non-processing of the application is not reported to the NPDB). *Id.* E-35, E-36.

[116] 210 ILCS 85/10.4(b)(2)(C)(i).

(d) Involuntary change or denial of a requested change in Medical Staff category, if such involuntary change or denial does not result in the denial, reduction, or termination of Privileges.

(e) The denial, suspension or revocation of emergency Privileges or disaster Privileges or temporary Privileges not granted for the purpose of expediting the Application process for the Applicant to become a Medical Staff Member.

(f) Failure to process an incomplete Application.

(g) Monitoring, supervision, proctoring, review, or consultation conducted as part of the ongoing performance evaluation process for newly granted Privileges, including, without limitation, routine assignment of a proctor to a recently appointed Medical Staff Member, or to a Medical Staff Member with newly granted Privileges.

(h) The imposition of monitoring, supervision, proctoring, review, or consultation requirements, where prior approval of the monitor/supervisor/proctor/reviewer/consultant is not required before the provision of medical care by the Medical Staff Member.

(i) A recommendation that a Medical Staff Member obtain retraining, additional training, or continuing education.

(j) Letters of warning.

(k) Appointment, reappointment, or Privileges which are granted for a period of less than three (3) years.

(l) Failure to place a Medical Staff Member on any on-call or interpretation roster, or removal of any Medical Staff Member from any such roster.

(m) Denial or revocation of membership on the Emeritus/Emerita Medical Staff.

(n) The removal of a Medical Staff Member from any medico-administrative position, including but not limited to a Medical Staff Officer or Clinical Chairperson.

(o) Denial of additional time to submit an Application for reappointment/renewal.

(p) The refusal to recommend or approve a waiver of board certification requirements.

(q) Loss of Good Standing classification, provided that the reason for such re-classification is not itself an Adverse Action under Section 5.2.1.

(r) Failure to reinstate a Medical Staff Member after a Leave of Absence when the Medical Staff Member failed to request reinstatement in accordance with these Bylaws.

5.3 PRE-HEARING PROCESS[117]

5.3.1 Adverse Action Notice; General Requirements.[118]

The Medical Staff President promptly shall provide an Adverse Action Notice to the Medical Staff Member which includes:

(a) The general facts which formed the basis for the Adverse Action[119];

(b) An explanation of the reasons for the Adverse Action, including any reason based on the quality of medical care or any other basis, including economic factors[120];

(c) The right to request a hearing to review the Adverse Action before a Hearing Committee[121] by submitting a written hearing request ("Hearing Request") to the Medical Staff President by the deadline set forth in the Adverse Action Notice, which shall be the applicable time limit set forth in Section 5.3.3, following the Delivery Date of the Adverse Action Notice;

(d) A statement that failure to submit a Hearing Request by the deadline set forth in the Adverse Action Notice, or to personally appear at the scheduled hearing without good cause, shall constitute a waiver of the Medical Staff Member's right to the hearing and subsequent appellate review;[122]

(e) A statement that the Medical Staff Member has the right to be represented at the hearing by another Medical Staff Member or legal counsel[123];

(f) The right to inspect all pertinent, non-privileged information in the Hospital's possession on which the Adverse Action was based[124];

(g) The right to call, examine and cross-examine witnesses, and present evidence deemed relevant by the Hearing Committee Chairperson, regardless of its admissibility in a court of law[125];

(h) The right to submit written statements: (i) before the hearing; and (ii) in lieu of closing arguments, at the close of the hearing[126];

(i) A statement that a record of the hearing will be made, and that the Medical Staff Member may receive a copy of the hearing record upon payment directly to the court reporter for the preparation thereof[127]; and

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[117] NIAHO, MS.12, SR.8 (rev. 18-01); 210 ILCS 85/10.4(b)(2).
[118] 42 U.S.C. § 11112(b)(1)(A)–(B); 210 ILCS 85/10.4(b)(2).
[119] 42 U.S.C. § 11112(b)(1)(A).
[120] 210 ILCS 85/10.4(b)(2)(A)-(B); *see also* 77 IAC 250.310 (defining *economic factor* as "any information or reasons for decisions unrelated to quality of care or professional competency").
[121] 210 ILCS 85/10.4(b)(2)(C).
[122] 42 U.S.C. § 11112(b)(3)(B).
[123] 42 U.S.C. § 11112(b)(3)(C)(i); 210 ILCS 85/10.4(b)(2)(E-5).
[124] 210 ILCS 85/10.4(b)(2)(D).
[125] 42 U.S.C. § 11112(b)(3)(C)(iii)-(iv); 210 ILCS 85/10.4(b)(2)(E).
[126] 42 U.S.C. § 11112(b)(3)(C)(v).
[127] 42 U.S.C. § 11112(b)(3)(C)(ii).

(j) A statement that the Medical Staff Member will receive a copy of the Hearing Report upon completion of the hearing, which shall include the Hearing Committee's findings concerning each basis and its recommendations.[128]

5.3.2 Adverse Action Notice; Additional Requirements.

(a) *Summary Suspensions*. For Summary Suspension hearings, the Adverse Action Notice also shall include:

i. The right to request a Summary Suspension Review by the MEC (or committee thereof) as soon as possible, but in no less than five (5) business days, for the purpose of recommending whether the Summary Suspension should be affirmed, lifted, expunged, or modified.[129] The written request shall be made within twenty-four (24) hours to the Medical Staff President or CMO, and such request must be received within twenty-four (24) hours, which may be made via e-mail. If not received by the deadline, then the Medical Staff Member forfeits their right for such review.

ii. A statement that the scope of a Summary Suspension Review pursuant to Section 4.2.3 is limited to a determination of whether the summary suspension was reasonable and prudent under the circumstances; it is not a hearing. The Medical Staff Member will be invited to attend, along with the individual who imposed the summary suspension. Neither the Medical Staff Member nor the MEC shall be permitted to have legal counsel present at this review.

iii. A statement that all actual documentation or other reliable information which formed the basis for the summary suspension will be provided to the Medical Staff Member before the Summary Suspension Review.[130]

iv. A statement regarding the right to have the summary suspension hearing commence within fifteen (15) days of the effective date of the summary suspension and completed without delay unless otherwise agreed to by the Medical Staff Member.[131]

(b) *Automatic or Administrative Suspensions or Denial of an Initial Application*.

i. In the event of an automatic or administrative suspension where hearing rights are available, the Adverse Action Notice also shall advise the Medical Staff Member that the automatic or administrative suspension hearing shall commence within fifteen (15) days of the Delivery Date of the Adverse Action Notice and completed without delay unless otherwise agreed to by the Medical Staff Member.[132]

[128] 42 U.S.C. § 11112(b)(3)(D)(i); 210 ILCS 85/10.4(b(2)(C).
[129] 210 ILCS 85/10.4(b)(2)(C)(i).
[130] 210 ILCS 85/10.4(b)(2)(C)(i).
[131] 210 ILCS 85/10.4(b)(2)(C)(i).
[132] 210 ILCS 85/10.4(b)(2)(C)(i).

ii. In the event of a denial of an Initial Application, the Adverse Action Notice also shall advise the Applicant that the hearing shall not commence less than thirty (30) days or more than sixty (60) days from the Date of Delivery of the Written Notice,[133] unless otherwise waived by the Applicant.

(c) *Exclusive Contracts*. In the event that the Hospital closes a department or unit of the Hospital to an exclusive contract, the Adverse Action Notice shall provide the Medical Staff Member with at least sixty (60) days prior notice of the effective date of closure. If a hearing is requested, it shall be held and a Hearing Report provided to the Medical Staff Member, the MEC and the Governing Council within thirty (30) days of the Hearing Request.[134]

5.3.3 Hearing Request—Deadlines to Request a Hearing.
A Medical Staff Member who is entitled to a hearing under these Bylaws shall have until the deadline set forth in the Adverse Action Notice following the Delivery Date of the Adverse Action Notice to submit a Hearing Request in writing to the Medical Staff President.[135] The Adverse Action Notice shall contain the deadline to request a hearing:

(a) For remedial action: thirty (30) days;[136]
(b) For summary suspension: five (5) days;[137]
(c) For automatic or administrative suspension: five (5) days;[138]
(d) For Adverse Actions resulting from exclusive contracts or denial of an initial application: fourteen (14) days;[139] and
(e) For Adverse Actions on applications for reappointment or additional Privileges: thirty (30) days.[140]

5.3.4 Failure to Request Hearing.
The Medical Staff Member's failure to timely submit a Hearing Request shall be deemed a waiver of the Medical Staff Member's right to a hearing, and to any appellate review by the Governing Council. If summary suspension or administrative suspension was *imposed* by the MEC, it shall remain effective pending the Governing Council's action. If an Adverse Action was *recommended* by the MEC, it shall not become effective until the Governing Council takes action on the matter in accordance with Section 5.6.1.

[133] 42 U.S.C. § 11112(b)(2)(A).
[134] 210 ILCS 85/10.4(b)(2)(C)(iii).
[135] 42 U.S.C. § 11112(b)(1)(B)(i)–(ii).
[136] 42 U.S.C. § 11112(b).
[137] *See* 210 ILCS 85/10.4(b)(2)(C)(i) (stating that any requested hearing must be commenced within fifteen 15 days).
[138] *See* 210 ILCS 85/10.4(b)(2)(C)(ii) (stating that any requested hearing must be commenced within fifteen 15 days); 210 ILCS 85/10.4(b)(2)(C)(i) (stating that no hearing is necessary where a Medical Staff Member's license to practice has been suspended or revoked).
[139] 210 ILCS 85/10.4(b)(2)(C)(iii).
[140] 42 U.S.C. § 11112(b).

5.3.5 Hearing Committee.[141]
The Hearing Committee has independent authority to recommend action to the Governing Council.[142]

(a) *Appointment*. Except as set forth in Section 5.3.10, and subject to the approval of the Hospital President or CMO,[143] the Medical Staff President shall designate five (5) active Medical Staff Members to the Hearing Committee. The Medical Staff President shall designate a Hearing Committee member to serve as the Hearing Committee Chairperson.

(b) *Managing Potential Conflicts of Interest*. Excluded from participation on the Hearing Committee are Medical Staff Members who (i) are in direct economic competition with the Medical Staff Member; (ii) were involved in initiating the complaint or served on any Peer Review Committee that considered the Adverse Action or were involved in the investigation of the matter; (iii) have a close personal or business relationship with the Medical Staff Member; and/or (iv) serve on the Governing Council of the Hospital. Knowledge of the matter shall not preclude a Medical Staff Member from serving on the Hearing Committee provided they can objectively participate in the hearing. Employment of a Medical Staff Member by Advocate shall not preclude appointment to a Hearing Committee, provided that they do not practice in the same specialty as the Medical Staff Member. A reasonable effort will be made to appoint a Hearing Committee member with the same specialty as the Medical Staff Member but may not be possible and is not required.

5.3.6 Scheduling of Hearing; Postponement[144]

(a) After receipt of a Hearing Request, the MEC shall schedule and arrange for the hearing as soon as reasonably possible, with the goal of providing the Medical Staff Member Written Notice of the scheduled hearing within fifteen (15) days. The hearing shall not commence less than thirty (30) days or more than sixty (60) days from the Date of Delivery of the Written Notice,[145] unless otherwise waived by the Medical Staff Member. For summary or administrative suspension hearings, the hearing shall begin within fifteen (15) days from the effective date of such suspension unless otherwise waived by the Medical Staff Member.[146]

(b) The hearing will be scheduled in good faith, with an effort to accommodate the schedules of the parties, Hearing Committee members and witnesses. The Hearing Committee Chairperson has the sole discretion to approve or disapprove any rescheduling requests of the Medical Staff Member. In the event that the Medical Staff Member requests to (re)schedule the hearing in order to accommodate the Medical Staff Member or their legal counsel or witnesses for a date occurring

[141] 42 U.S.C. § 11112(b)(3)(A)(iii); 210 ILCS 85/10.4(b)(2)(C).
[142] 210 ILCS 85/10.4(b)(2)(C).
[143] 42 U.S.C. § 11112(b)(3)(A)(iii); see also Section 1.3.5 of these Bylaws.
[144] 42 U.S.C. § 11112(b)(2)(A).
[145] 42 U.S.C. § 11112(b)(2)(A).
[146] 210 ILCS 85/10.4(b)(2)(C)(i).

beyond the time limits set forth in subsection (a), then the Medical Staff Member shall be deemed to have waived the time limits set forth therein.

5.3.7 Written Notice of Hearing.[147]

The Hospital President shall provide Written Notice of the hearing ("Hearing Notice") to the affected Medical Staff Member, with a copy to the MEC. This Hearing Notice should be provided as soon as possible but no later than fifteen (15) days before the hearing (or in the case of a summary, automatic or administrative suspension, as soon as possible before the hearing). The Hearing Notice shall inform the Medical Staff Member:

(a) Of the time, place, and date of the hearing[148];

(b) The names and specialties of the Hearing Committee members and the Hearing Committee Chairperson;

(c) Of the right to be represented at the hearing by another Medical Staff Member, legal counsel, or any other individual chosen by the Medical Staff Member[149];

(d) Of the right to call, examine and cross-examine witnesses, and present evidence deemed relevant by the Hearing Committee Chairperson, regardless of its admissibility in court[150];

(e) That before the hearing, the parties shall cooperate in good faith to exchange in writing the following and any changes thereto:

i. The name and contact information for legal counsel (or other Medical Staff Member representative), if any;

ii. copies of written materials that the parties intend to present at the hearing, which should be exchanged at least ten (10) days before the hearing or as otherwise agreed by the parties (and in the case of a summary suspension or administrative suspension, at least three (3) days before the hearing); and

iii. a list of witnesses that may be called to testify on a party's behalf and their profession/specialty, noting whether each witness is a fact witness, character witness or expert witness, and include the curriculum vitae for any expert witness. This information should be exchanged at least ten (10) days before the hearing or as otherwise agreed by the parties (and in the case of a summary suspension or administrative suspension, at least three (3) days before the hearing);

(f) Of the right to submit written statements before the hearing, and in lieu of closing arguments, at the close of the hearing.[151] Any written statements also must be shared with the other party;

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[147] 42 U.S.C. § 11112(b)(2)(A)–(B).
[148] 42 U.S.C. § 11112(b)(2)(A).
[149] 42 U.S.C. § 11112(b)(3)(C)(i); 210 ILCS 85/10.4(b)(2) (E-5).
[150] 42 U.S.C. § 11112(b)(3)(C)(iii) -(iv); 210 ILCS 85/10.4(b)(2)(E).
[151] 42 U.S.C. § 11112(b)(3)(C)(v).

(g) That failure to personally appear at the scheduled hearing without good cause, shall constitute a waiver of the right to the hearing and subsequent appellate review[152];

(h) That a record of the hearing will be made, and that the Medical Staff Member may receive a copy of the hearing record upon payment directly to the court reporter for the preparation thereof[153]; and

(i) That the Medical Staff Member will receive a copy of the Hearing Report, which shall include the Hearing Committee's findings concerning each basis for the Adverse Action and its recommendations.[154]

5.3.8 Representation.

(a)The affected Medical Staff Member may request a Medical Staff Member, legal counsel, or any other individual to represent him/her at the hearing[155] and any pre-hearing conferences that may be held by the Hearing Committee Chairperson. The MEC, when its action has prompted the hearing, shall appoint one (1) of its members to represent it at the hearing. Either the MEC representative or legal counsel shall present facts in support of the Adverse Action and examine witnesses. If the Medical Staff Member will be represented by legal counsel at the hearing and did not provide the contact information for their legal counsel in the Hearing Request, then the Medical Staff Member shall inform the Hospital President as soon as possible before the hearing.

(b) The affected Medical Staff Member, the MEC representative, and the Hearing Committee are entitled to the advice of legal counsel both before and during the hearing and on appeal.

5.3.9 Access to Information and Witnesses.

(a) The Medical Staff Member has a right to inspect all pertinent, non-privileged information in the Hospital's possession on which the Adverse Action was based,[156] including but not limited to the names of any patients and patient medical records, applicable committee minutes, analyses, reports and communications before the hearing. Records of other Medical Staff Members, as well as the medical records of patients who were not involved in the matter, shall not be made available to the affected Medical Staff Member.

(b) Neither the Medical Staff Member, their legal counsel, nor any other individual on behalf of the Medical Staff Member, shall contact an Advocate employee while the employee is working to discuss anything related to the subject matter of the hearing, but shall work with the MEC's legal counsel to determine if such employees are available to testify at the hearing.

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[152] 42 U.S.C. § 11112(b)(3)(C)(iii) -(iv); 210 ILCS 85/10.4(b)(2)(E).
[153] 42 U.S.C. § 11112(b)(3)(C)(ii).
[154] 42 U.S.C. § 11112(b)(3)(D)(i); 210 ILCS 85/10.4(b(2)(C).
[155] 42 U.S.C. § 11112(b)(3)(C)(i); 210 ILCS 85/10.4(E-5).
[156] 210 ILCS 85/10.4(b)(2)(d).

(c) Before the hearing, the parties shall cooperate in good faith to exchange in writing lists of expected witnesses and provide copies of documentary evidence that may be presented at the hearing and any changes to the witness list or documentary evidence. If the change does not provide the Medical Staff Member adequate notice to prepare a defense before the scheduled hearing, then the Hearing Committee Chairperson may elect to reschedule the hearing.[157] However, the grounds for an Adverse Action arising out of a summary or administrative suspension shall not be modified.[158]

5.3.10 Hearing Procedures for Administrative Suspensions and Denials of Initial Applications.

An Administrative Suspension entitles the affected Medical Staff Member/initial Applicant to a hearing under these Bylaws. Except as set forth below, the pre-hearing procedures for an Administrative Suspension or a denial of an initial application shall follow the pre-hearing procedures for summary suspensions:

(a) No Summary Suspension Review will be provided by the MEC.

(b) The CMO and two (2) members of the MEC shall comprise the Hearing Committee. The Medical Staff President shall appoint the MEC members to the Hearing Committee and appoint the Chairperson.

(c) The parties may be represented by legal counsel, but only the parties shall present evidence or question witnesses. Legal counsel's role shall be limited to consultation with the parties.

(d) The Hearing Committee will determine relevance of testimony and evidence.

(e) The Hearing Record shall be reflected in minutes, with deliberations occurring in executive session outside the presence of the parties.

(f) For Administrative Suspensions, the decision of the Hearing Committee does not afford a right to appellate review by the Governing Council unless the decision results in termination from the Medical Staff or a limitation or a suspension of Privileges of 31 days or more.

(g) For initial Applicants, the decision of the Hearing Committee does not afford a right to appellate review by the Governing Council.

[157] 42 U.S.C. §11112(b)(1)(A)(ii) (stating that a physician must have adequate notice of the reasons for a proposed Adverse Action).
[158] 210 ILCS 85/10.4(b)(2)(C)(i).

5.4 HEARING PROCEDURE[159]

5.4.1 Role of the Hearing Committee Chairperson.
The Hearing Committee Chairperson shall preside over the hearing to: (a) determine the order of procedure; (b) assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence, (c) maintain decorum, and (d) make all rulings on questions of procedure and evidence.

The Hearing Committee Chairperson may hold a pre-hearing conference with the participants to clarify the scope of the hearing, its length, witnesses to be called and other procedural matters, and also may recommend the use of experts or consultants to be called by the Hearing Committee.

5.4.2 Personal Presence Required.
The Medical Staff Member must be personally present at the hearing. A Medical Staff Member who fails without good cause to appear and participate at a hearing shall be deemed to have waived their hearing and appellate review rights under these Bylaws.[160]

If a pre-hearing conference is held, then the parties or their legal counsel must be present. If a party or legal counsel fails without good cause to participate in a pre-hearing conference, then such party waives the right to object to the matters decided therein.

5.4.3 Submission of Written Statements.

(a) The parties may submit written statements concerning any issue of procedure or of fact, and such written statements shall become a part of the hearing record. The written statement shall be submitted to the Hearing Committee Chairperson and shared with the other party, at least two (2) days before the scheduled hearing.

(b) In lieu of oral closing arguments, the parties may submit written statements to the Hearing Committee for consideration before deliberating,[161] and such statements shall become part of the hearing record.

(c) If the MEC obtained an external consultant to conduct Peer Review in the matter and provide a report, then the affected Medical Staff Member and the applicable Peer Review Committee, have a right to provide a written response within thirty (30) days. Any written response(s) by the Medical Staff Member or applicable Peer Review Committee shall be considered by the Hearing Committee and become part of the Hearing Record.[162]

[159] 42 U.S.C. § 11112(b)(3); NIAHO, MS.12, EP.8 & Interpretive Guidelines (rev.18-01).
[160] 42 U.S.C. § 11112(b)(3)(B).
[161] 42 U.S.C. § 11112(b)(3)(C)(v).
[162] 210 ILCS 85/10.4(b)(2)(C-5) (noting also that the Governing Council must review all written response(s) to an external consultant's report before making a final decision that affects the Medical Staff Member's appointment or Privileges).

5.4.4 Hearing Record.
An accurate record of the hearing must be kept. The mechanism by which the hearing is recorded shall be established by the Hearing Committee Chairperson and may be through the use of a court reporter, electronic recording unit, detailed transcription, or by the taking of adequate minutes. If the Medical Staff Member requests a transcript of the hearing, they shall bear the cost.[163]

5.4.5 Evidence; Witnesses.
The parties each shall have the right to: (i) call and examine witnesses,[164] (ii) introduce written evidence, (iii) cross-examine any witness on any relevant matter, (iv) rebut any witness, and (v) rebut any evidence.[165] The Hearing Committee Chairperson may require that oral evidence be taken under oath. If the Medical Staff Member does not testify on their behalf, they may be called and examined as if under cross-examination.

The hearing does not need to be conducted according to courtroom procedure relating to the examination of witnesses or admission of evidence. Any relevant evidence may be considered, regardless of admissibility in court.[166] Either party shall have the opportunity to request a scientific or technical matter be officially noticed or refute the notice of matters of evidence. The Hearing Chairperson shall notify the parties of these matters and they shall be noted in the record.

5.4.6 Burden of Proof.
The MEC representative has the burden to present sufficient evidence to support that the Adverse Action was implemented/recommended in furtherance of quality health care after a reasonable effort to obtain the facts of the matter.[167] Thereafter, the Medical Staff Member has the burden to show that it is more likely than not[168] that the charges or grounds for the Adverse Action lack substantial factual basis, or that the MEC's actions were either arbitrary, capricious, or unreasonable.

5.4.7 Recess; Deliberations; Conclusion of the Hearing.

(a) The Hearing Committee may, in its sole discretion and without Written Notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining additional evidence or consultation.

(b) Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The Hearing Committee may then, reconvene with or without its counsel, conduct its deliberation outside the presence of both the affected Medical Staff Member and the MEC representative. Upon the conclusion of these deliberations, the hearing shall be declared "Closed". No record of deliberations shall be made.

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[163] 42 U.S.C. § 11112(b)(3)(C)(ii).
[164] 210 ILCS 85/10.4(E).
[165] 42 U.S.C. § 11112(b)(3)(C);
[166] 42 U.S.C. § 11112(b)(3)(C)(iv).
[167] 42 U.S.C. § 11112(a)(1)-(2); 210 ILCS 85/10.4(b)(2)(F).
[168] 42 U.S.C. § 11112(a)(4) (presumption is rebutted by a preponderance of the evidence).

(c) A majority of Hearing Committee members must be present during the hearing; however, a Hearing Committee member who misses any portion of the hearing may only participate in deliberations and vote on the matter if they review the hearing record/transcript for the time missed.

5.4.8 Hearing Report.[169]

Within ten business (10) days after the hearing is Closed, the Hearing Committee shall issue a written Hearing Report, which shall include (a) the Hearing Committee's findings of fact, its recommendations, including affirmation, modification, or rejection of the original Adverse Action and the Hearing Committee's basis therefor; and (b) notice of the parties' rights to appellate review by the Governing Council as set forth in Section 5.4.9. The Hearing Report may include the Hearing Committee's official notice of any generally accepted technical or scientific matter relating to the issues presented at the hearing.

5.4.9 Written Notice of Right to Appeal to the Governing Council[170]

The Hearing Report shall include Written Notice of each parties' right to appeal the Hearing Committee's recommendation, which shall provide at a minimum the following:

(a) The right to request within ten (10) days in writing to the Hospital President, an appellate review of the Hearing Committee's recommendation by the Governing Council, consistent with the requirements of Section 5.5.1 ("Appellate Review Request");

(b) If an appellate review is requested, each party may submit a written statement to the Governing Council within fifteen (15) days of the Delivery Date of the Appellate Review Request;

(c) Inform the parties that the appellate review shall be held only on the record upon which the Adverse Action is based, including the Hearing Report, and if provided by the parties, their written statements; and

(d) State that a party's failure to submit an Appellate Review Request within the specified time shall constitute a waiver of a party's right to appellate review, and the Hearing Report will be forwarded to the Governing Council for a final decision.

5.4.10 Distribution of the Hearing Report.

The Hearing Committee shall send the Hearing Report to the parties, with an informational copy to the Hospital President and the Governing Council Chairperson, via secured e-mail. If the parties are represented by legal counsel, the report shall be forwarded to legal counsel via secured e-mail.

5.4.11 Hearing Committee's Recommendation.

Any Summary Suspension or Administrative Suspension that was *imposed* by the MEC before the Medical Staff Member's exercise of their hearing rights shall remain in effect until the Governing Council takes a final action on the matter. If an Adverse Action is *recommended* by the MEC or the Hearing Panel, then such recommendation shall not

[169] 210 ILCS 85/10.4(b)(2)(F).
[170] 42 U.S.C. § 11112(b)(1)(A)–(B).

become effective until the Governing Council takes a final action on the matter in accordance with Section 5.6.1.

5.5 APPELLATE REVIEW PROCESS[171]

5.5.1 Appellate Review Request.
An Appellate Review Request must be in writing, addressed to the Hospital President with a copy to the other party. The appealing party shall have ten (10) days following the Delivery Date of the Hearing Report to request appellate review. The Appellate Review Request must set forth the party's disagreement with Hearing Committee's findings of fact, conclusions or procedural matters and the reasons for such party's disagreement.

5.5.2 Failure to Request an Appellate Review.
A party's failure to timely submit an Appellate Review Request shall be deemed a waiver of the party's right to appellate review by the Governing Council. If no appeal is requested, then the Governing Council will make its final decision and the Medical Staff Member shall be notified as set forth in Section 5.6.1.

5.5.3 Appointment of Appellate Review Committee.
The Governing Council shall appoint (a) an Appellate Review Committee, which shall consist of not less than three (3) Governing Council members, none of whom have been members of any committee which previously made a recommendation on the matter; and (b) one Governing Council member to act as the Appellate Review Committee Chairperson.

5.5.4 Scheduling the Appellate Review.
As soon as reasonably practicable, but no sooner than twenty (20) days after receipt of an Appellate Review Request,[172] the Appellate Review Committee shall conduct the appellate review and make a final decision in the matter.

5.5.5 Conducting an Appellate Review; Standard of Review.
The appellate review is limited to the record of the hearing prepared pursuant to Section 5.4.4, documentary evidence presented by the parties for the hearing, the hearing report, the Appellate Review Request, and if provided, each party's written statements provided pursuant to Section 5.4.9. The standard of an appellate review is limited to a determination of whether:

(a) The proceedings were conducted in substantial compliance with these Bylaws and without procedural irregularities that materially prejudiced the Medical Staff Member;[173] and

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[171] NIAHO, MS.12, SR.8 (rev. 18-01).
[172] The Medical Staff Member has 15 days to submit a written statement, and then this permits at least 5 days to forward to Governing Council for review before appellate review.
[173] 42 U.S.C. § 11112(a)(3).

(b) The recommendation of the Hearing Committee is based on a reasonable effort to obtain the facts, is taken in furtherance of the quality of care, is supported by the record, [174] and is not arbitrary or capricious.

5.5.6 Recess; Deliberations.
The Appellate Review Committee may, in its sole discretion and without Written Notice to the parties, recess the appellate review and reconvene at a later date for the convenience of its members. Upon conclusion of the review of the written evidence, the appellate review shall be adjourned (the "Adjournment Date"). Within ten (10) days after the Adjournment Date, the Appellate Review Committee shall complete its deliberations. The Appellate Review Committee may: (a) conduct its deliberations outside the presence of the Medical Staff Member for whom the hearing was convened at a time convenient to itself; and (b) consider any pertinent information that was made available to the Medical Staff Member prior to or during the hearing and appellate review process.

5.5.7 Appellate Review Committee Report.
Within fifteen (15) days after the Adjournment Date, the Appellate Review Committee shall issue a written Appellate Review Committee Report, which (a) shall include the Appellate Review Committee's recommendations, including confirmation, modification, or rejection of the original Adverse Action and the basis therefore, and (b) may include the Appellate Review Committee's official notice of any generally accepted technical or scientific matter relating to the issues under consideration at the appellate review and of any facts which may be judicially noticed by the courts of this state. The Appellate Review Committee shall: (a) submit such Appellate Review Committee Report, the appellate review and hearing record, and all other documentation, to the Governing Council; and (b) deliver a copy of the Appellate Review Committee Report to the Medical Staff Member through the Appellate Review Committee Chairperson via Written Notice as set forth within these Bylaws.

5.6 FINAL DECISION OF THE GOVERNING COUNCIL

5.6.1 Final Decision.
Within fifteen (15) business days of its receipt of the Hearing Committee Report (if no appeal is requested), or the Appellate Review Committee Report and the other documentation described in Section 5.5.7 of these Bylaws, the Governing Council shall make a final decision in the matter and shall send notice thereof to the Medical Executive Committee and the applicable Hospital President(s). The Appellate Review Committee Chairperson (or their designee) shall provide the Medical Staff Member and the MEC Written Notice of its final decision, which shall include the basis for its final decision.[175] The final decision shall be effective immediately for all final decisions resulting from a

[174] 42 U.S.C. § 11112(a)(1)-(2).
[175] 42 U.S.C. § 11112(b)(3)(D)(ii); 210 ILCS 85/10.4(b)(2)(F-5).

summary suspension. To permit an appropriate and orderly transition of care of the Medical Staff Member's patients, all other final decisions shall be effective fifteen (15) days from the Delivery Date.[176]

5.6.2 Communication with Hospital Departments and Advocate Entities.
The Hospital President will ensure that the appropriate Departments, applicable Hospital patient care areas, and applicable Advocate Entities, are informed of any scheduled suspension, revision or revocation of a Medical Staff Member's Privileges.[177]

5.6.3 Limitation on Re-applying for Medical Staff Membership or Privileges.
In the event that a Final Decision is made which terminates a Medical Staff membership, the Practitioner cannot re-apply for membership or privileges for two (2) years after the Final Decision and, if applicable, the conclusion of any litigation and appeals sought by the Practitioner in court.

[176] 210 ILCS 85/10.4(b)(2)(G) (requiring that the effective date of an Adverse Action based on economic reasons can be no less than 15 days from the Governing Council's decision and as otherwise set forth in the bylaws for others).
[177] 42 C.F.R. § 482.22(a)(2) (Interpretive Guidelines, effective October 17, 2008).

ARTICLE 6. MEDICAL EXECUTIVE COMMITTEE

6.1 COMPOSITION

6.1.1 Voting Members.
A majority of MEC members must be Practitioners.[178] MEC members listed below serve Ex Officio with vote. A MEC member may be removed from the MEC by removing their from the office/service identified below.

(a) Medical Staff President (The Medical Staff President shall serve as the MEC Chairperson)

(b) Medical Staff President Elect

(c) Secretary-Treasurer

(d) Immediate Past President

(e) Clinical Department Chairperson(s) as determined by the MEC

(f) One or more Staff Members at Large, without vote, as determined by the MEC.

In the event a Chair is unable to attend, the Vice Chair, or other designee, may attend

6.1.2 Nonvoting Members.
The following individuals shall be invited to attend MEC meetings, but are not eligible to vote at such meetings:

(a) Hospital President

(b) Chief Medical Officer(s)

(c) Chief Nurse Executive[179]

(d) Chairperson, Medical Education Committee

(e) Chief Operating Officer

(f) Invited Guests and Observers.

The Medical Staff President may at their discretion invite other people to attend the MEC meetings.

[178] 42 C.F.R. § 482.22(b)(2); NIAHO MS.5, SR.1 (rev. 18-1).
[179] NIAHO, MS.5, SR.2 (rev. 18-1).

6.2 DUTIES AND RESPONSIBILITIES

The MEC is authorized to represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.[180] The authority delegated to the MEC may be limited or removed by the Medical Staff by amending these Bylaws in accordance with Section 10.1.[181] The duties and responsibilities of the MEC shall be to:

(a) Coordinate the activities and general policies of the Departments;

(b) Receive, review and act upon Department and Medical Staff committee reports;

(c) Develop, implement, approve, and monitor Medical Staff policies not otherwise the responsibility of the Departments;

(d) Provide liaison among the Medical Staff, the Hospital Executive Team, and the Governing Council;

(e) Make recommendations to the Hospital Executive Team on matters of a medico-administrative nature;

(f) Make recommendations to the Governing Council or the Hospital Executive Team on matters concerning the management of the Hospital;

(g) Fulfill the Medical Staff's accountability to the Governing Council for the medical care rendered to patients in the Hospital and participation in quality improvement and peer review activities;

(h) Ensure that the Medical Staff actively participates in the Hospital's accreditation programs and assists the Hospital in maintaining its accreditation status;

(i) Review and act on the credentials of all Applicants and make recommendations to the Governing Council for staff appointment, assignments to Departments and delineation of Privileges;

(j) Review periodically all information available regarding the performance and clinical competence of Medical Staff Members and other individuals with Privileges, and as a result of such reviews, make recommendations to the Governing Council for reappointments and renewal of or changes in Privileges;

(k) Take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Medical Staff Members, including the initiation of or participation in Medical Staff corrective or review measures when warranted;

(l) Report at each general Medical Staff meeting;

(m) Review and support infection prevention activities;

(n) Review, recommend, and support Hospital sponsored educational activities that are relevant to the Medical Staff. and

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[180] NIAHO, MS.5 (rev. 18-01).

[181] NIAHO, MS.7, SR.2 (rev. 18-01).

(o) Consult with the Hospital when the Hospital makes a decision to close Medical Staff Membership in any portion or entire department or unit.[182]

6.3 MEDICAL EXECUTIVE COMMITTEE MEETINGS

6.3.1 Scheduling and Notice.

(a) Regular Meetings. The MEC shall meet as often as necessary, but in no event less than ten times per year, to fulfill its duties and responsibilities.

(b) Special Meetings. The Medical Staff President, Hospital President or Chief Medical Officer may call a special meeting of the MEC at any time.

(c) Notice. Medical Staff Services shall send Written Notice of each regular and special MEC meeting to all MEC members.

6.3.2 Quorum and Voting Requirements.

A quorum shall consist of at least 50% of the MEC's voting members. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless these Medical Staff Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.

6.3.3 Attendance Requirements.

(a) *Minimum Attendance*. MEC members are expected to attend at least 70% of its scheduled meetings, including Special Meetings.

(b) *Attendance by Audio or Visual Telecommunication*. MEC members may participate in MEC meetings via audio or visual telecommunication whereby all participants can simultaneously hear each other.

6.3.4 Minutes.

Minutes of each regular and special MEC meeting shall be maintained and shall include a record of attendance and the vote taken on each action.[183]

6.3.5 Discussion of Remedial Actions and Other Sensitive Matters.

When a remedial action or sensitive matter is discussed, invited guests and those with potential or actual conflicts may be excused during the discussion and any voting on such matter. Those persons being excused that have information to provide concerning the matter may do so prior to being excused.

[182] 210 ILCS 85/10.4(c).
[183] 77 IAC 250.310(b)(5).

ARTICLE 7. ORGANIZED MEDICAL STAFF

7.1 DUTIES AND RESPONSIBILITIES

The purposes and responsibilities of the organized Medical Staff are as follows:

7.1.1 Administration and Enforcement of Bylaws and Medical Staff Policies.
The Medical Staff develops, adopts, reviews, amends, monitors and enforces these Bylaws, Rules & Regulations, and Medical Staff Policies for the proper functioning of the Medical Staff.[184]

7.1.2 Accountability to the Governing Council.
The Medical Staff is accountable to the Governing Council for the quality of medical care provided to Hospital's patients.[185]

7.1.3 Recommendations for Medical Staff Membership and Privileges.[186]
The Medical Staff: (i) develops criteria for Medical Staff Membership and Privileges designed to assure the Medical Staff and the Governing Council that patients will receive quality care, treatment, and services; (ii) evaluates and recommends individuals for Medical Staff Membership and Privileges; and monitors and evaluates the ethical and professional practice of individuals with Medical Staff Membership and/or Privileges in order to make recommendations regarding same.

7.1.4 Quality Assurance and Performance Improvement.
The Medical Staff engages in and collaborates with the Hospital in activities related to quality assurance, performance improvement, patient safety, patient satisfaction, risk management, case management, utilization review, resource management and peer review, consistent with current federal and state regulations, and accreditation requirements, including but not limited to the following:[187]

(a) Establishes, maintains, and monitors patient care standards and ensures that all Hospital patients receive care that is commensurate with applicable standards of care and available community resources[188];

(b) Monitors the quality of care, treatment and services provided by individuals with Privileges, consistent with current federal and state regulations and accreditation requirements;

(c) Measures, assesses, and improves processes that primarily depend on the activities of individuals credentialed and privileged through the Medical Staff process;[189]

(d) Pursues remedial actions with respect to Medical Staff Member's with Privileges

[184] 42 C.F.R. § 482.22(c) (Interpretive Guidelines, effective October 17, 2008); 77 IAC 250.310(i)(2); NIAHO, MS.1 (rev. 18-01).
[185] 42 C.F.R. § 482.12(a)(5) (Interpretive Guidelines, effective October 17, 2008); NIAHO, MS.1 (rev. 18-01).
[186] 77 IAC 250.310(b)(1); NIAHO, MS.8 (rev. 18-01).
[187] 42 C.F.R. § 482.22(b)(1); 42 C.F.R. § 482.22(c)(3); NIAHO, MS.9 (rev. 18-01).
[188] 77 IAC 250.310(b)(11); NIAHO, MS.9 SR.1, SR.2, SR.3, SR.9 & SR.10 (rev. 18-01).
[189] NIAHO, MS.6 SR.6 (rev. 18-01); NIAHO MS.9 (rev. 18-01).

when warranted;

(e) Communicates findings, conclusions, recommendations, and actions to improve performance to the MEC and the Governing Council[190];

(f) Assists the Hospital in identifying community health needs and establishing services or programs to meet such needs and other institutional goals; and

(g) Coordinates the care, treatment and services provided by individuals with Privileges with those provided by the Hospital's nursing, technical, and administrative staff.

7.1.5 Continuing Education.
The organized Medical Staff provides continuing education opportunities to promote best practices, encourages continuous advancement in professional knowledge, and complements quality assessment/improvement activities.

7.1.6 Compliance with Laws, Regulations, and Accreditation Standards.
The organized Medical Staff assists the Hospital in reviewing and maintaining Hospital accreditation and ensuring compliance with applicable accreditation standards and federal, state, and local laws and regulations.[191]

7.1.7 Conflict Management.
The organized Medical Staff implements a process to manage any conflicts that arise between the Medical Staff and the MEC.

7.2 MEDICAL STAFF OFFICERS

7.2.1 Medical Staff Officers.[192]
The officers of the Medical Staff shall be:

(a) Medical Staff President
(b) Medical Staff President-elect
(c) Secretary-Treasurer
(d) Immediate Past President

7.2.2 Duties and Responsibilities.

(a) Medical Staff President. The Medical Staff President shall serve as the organized Medical Staff's chief administrative officer and will fulfill those duties specified in Medical Staff Policies, and shall:

i. act on behalf of the Medical Staff, and present the views, policies, needs and grievances of the Medical Staff to the Governing Council, the Hospital President, and CMO;

[190] NIAHO, MS.6 SR.7 (rev. 18-01).
[191] 42 C.F.R. § 482.11(a).
[192] 77 IAC 250.310(b)(3).

ii. act in coordination and cooperation with the Hospital President in all matters of mutual concern within the Hospital;

iii. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff and MEC meetings;

iv. serve as a voting member of the MEC;

v. have the right to attend any Medical Staff committee;
attend at least 70% of meetings of committees
which the President chairs or serves on as a member;

vi. enforce these Bylaws, Medical Staff Policies, and applicable system and Hospital policies;

vii. implement Adverse Decisions; and ensure compliance with procedural safeguards where Remedial Action has been requested for a Medical Staff Member;

viii. in consultation with the Medical Staff Officers, appoint Medical Staff committee chairpersons to all Medical Staff committees except the MEC and in consultation with the respective committee chairperson, appoint committee members;

ix. communicate Governing Council policies to the Medical Staff and provide required reports to the Governing Council;

x. upon request of Hospital, represent the Medical Staff in its external professional and public relations; and

xi. perform such other duties that ordinarily pertain to the office.

(b) Medical Staff President-elect. The Medical Staff President-elect shall:

i. be a voting member of the MEC;

(k) attend at least 70% of meetings of committees which the President-elect chairs or serves on as a member;

i. in the absence of the Medical Staff President, assume the duties of the Medical Staff President;

ii. automatically succeed the Medical Staff President upon the expiration of the Medical Staff President's term or when the Medical Staff President is unable to serve for any reason; and

iii. perform such other duties as ordinarily pertain to the office.

(c) Secretary/Treasurer. The Secretary/Treasurer shall:

i. be a voting member of the MEC;
ii. ensure attendance is taken at all MEC meetings and minutes are maintained;
iii. be responsible for all fiscal affairs of the Medical Staff;
attend at least 70% of meetings of committees which the Secretary/Treasurer chairs or serves on as a member;

iv. automatically succeed the President-elect upon the expiration of the President-elect's term or when the President-elect fails to serve for any reason; and
v. perform such other duties as ordinarily pertain to such office.

(d) Immediate Past President

i. attends Governing Council as a non-voting member
ii. Perform such other duties as ordinarily pertain to such office.

7.2.3 Qualifications; Nomination; Election, Term.[193]

(a) Qualifications.

i. At the time of nomination and election, and throughout their term of office, a Medical Staff Officer must:
- Be an Active Medical Staff Member in Good Standing;
- Constructively participate in Medical Staff affairs, including active participation in quality and/or peer review activities and on Medical Staff committee(s).

ii. Medical Staff Officers may not:
- Serve as a medical staff officer, department chairperson (except as an endowed department chairperson as part of a graduate medical education program), MEC member, or member of a Governing Council or board, of any non-Advocate hospital or ambulatory surgery center that provides health care services in competition with the Hospital;
- Serve as a department chairperson at any Advocate hospital; or
- Have an ownership interest in any non-Advocate hospital or ambulatory surgery center that provides health care services in competition with the Hospital.

(b) Nomination. Medical Staff Officer nominees shall be set forth by a Nominating Committee. The Nominating Committee shall consist of at least two or more of the following individuals: the Medical Staff President, the Medical Staff President-elect, and two to three Active Medical Staff Members.

[193] 77 IAC 250.310(i)(2).

(c) Election. Medical Staff Officers shall be elected every other year at the annual meeting of the Medical Staff (or via electronic voting if applicable), subject to the approval of the Governing Council.[194] Only Active Medical Staff Members shall be eligible to vote. Election by the Medical Staff for each office shall require a majority vote of the total votes cast. The election ballots may be cast by paper ballots, electronic voting, fax, or other technology.

(d) Term. All Medical Staff Officers shall serve for a two (2) year term unless removed from office or a successor is elected. A Medical Staff Officer may not serve a third consecutive term in the same office unless two-thirds (2/3) of the Active Medical Staff present at a regular or special meeting of the Medical Staff at which the question is considered vote to approve such a third consecutive term, and such third consecutive term is approved by the Governing Council. Such third consecutive term shall become effective when approved by the Governing Council. Medical Staff Officers shall take office on the first day of the Medical Staff year.

7.2.4 Vacancies in Office.
Vacancies in office during a Medical Staff Officer's two (2) year term, except for the Medical Staff President, shall be filled by the MEC, after consultation with the Hospital President. The individual filling the vacancy shall serve out the remaining term. If there is a vacancy in the office of the Medical Staff President, the Medical Staff President-elect shall serve out the remaining term.

7.2.5 Resignation.
Any Medical Staff Officer may resign at any time by giving Written Notice to the MEC.

7.2.6 Removal from Office.
(a) Automatic Removal**.** The MEC shall automatically remove from office any Medical Staff Officer upon verification of the Medical Staff Officer's:

i. revocation of license to practice in the State of Illinois;

ii. revocation or denial of Active Medical Staff Membership, or

iii. who is subject to Summary Suspension pursuant to Article 4.2. There shall be no right of appellate review or hearing in connection with removal from a Medical Staff Officer position.

(b) Discretionary Removal. A Medical Staff Officer may be removed from office in following circumstances:

i. Membership or Privileges are suspended (other than a Summary Suspension pursuant to (a) above), pending the outcome of the hearing and appellate review procedures provided in these Bylaws;

ii. A written request to consider removal signed by at least one-quarter (1/4) of the Active Medical Staff Members (where such request includes a statement of specific concerns); or

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[194] NIAHO GB.1 SR.1(c).

iii. The MEC determines that the Medical Staff Officer is unable to discharge the duties of the office.

(c) Removal Procedure.

i. *MEC Meeting*. A meeting of the MEC shall be called as soon as practicable to consider the removal of the Medical Staff Officer. A quorum of the MEC must be present for action on the matter. The Medical Staff Officer shall have no vote on their removal and may be excluded from the meeting except as provided in (ii) below.

ii. *Appearance*. The Medical Staff Officer shall be permitted to make an appearance at the MEC meeting before the MEC votes on the matter.

iii. *Vote*. A Medical Staff Officer may be removed by an affirmative vote of two-thirds (2/3) of the MEC members present at a meeting. The Medical Staff Officer may not participate or be present for the vote.

iv. *Notification*. The Medical Staff President (or Medical Staff President-elect if the Medical Staff President is the subject of the vote) shall provide the Medical Staff Officer written notification of the MEC's decision.

v. *Hearing and Appeal Rights.* There shall be no right of appellate review or hearing in connection with removal from office.

7.3 MEDICAL STAFF MEETINGS

7.3.1 Purpose.
The purposes of Medical Staff meetings are to report on the activities of the Medical Staff, education, Hospital updates, provide Practitioner input, and to conduct other business on the agenda.[195]

7.3.2 Scheduling and Written Notice.

(a) Regular Meetings. The Medical Staff shall meet as determined by the MEC, but no less than once every year. Written Notice stating the time and place of each regular Medical Staff meeting and shall be sent to each member of the Medical Staff to the email address on file with the Medical Staff Office at least five (5) days before the date of the meeting. The attendance of a Medical Staff Member at a meeting shall constitute a waiver of Written Notice.

(b) Special Meetings. The Medical Staff President may call a special meeting of the Medical Staff at any time. Written Notice stating the time, place and purposes of each special Medical Staff meeting shall be sent to each member of the Medical Staff to the email address on file with the Medical Staff Office at least forty-eight (48) hours before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the Written Notice of such special meeting.

[195] 77 IAC 250.310(b)(5).

The attendance of a Medical Staff Member at a meeting shall constitute a waiver of Written Notice of such meeting.

The Medical Staff President shall be required to call a special meeting within twenty (20) days after receipt of:

i. a written request signed by not less than ten percent (10%) of the members of the Active Medical Staff which states the purpose of such special meeting; or

ii. a written MEC resolution which states the purpose of a special meeting.

7.3.3 Attendance.

(a) *Requirements*. Medical Staff Members are encouraged to attend Medical Staff meetings. Meeting attendance will not be used in evaluating members at the time of reappointment; however, it is expected that members of the Medical Staff will make every effort to attend Medical Staff meetings.

(b) *Attendance by Audio or Visual Telecommunication*. Medical Staff Members may participate in Medical Staff meetings via audio or visual telecommunication whereby all participants can simultaneously hear each other.

(c) *Attendance by Hospital Leadership*. The Hospital President may attend any meeting of the Medical Staff.

7.3.4 Quorum and Voting Requirements.

For Medical Staff meetings, a quorum shall consist of Active Medical Staff Members present and voting. Action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless these Medical Staff Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.

7.3.5 Minutes.

Written minutes of each Medical Staff meeting shall be prepared, including attendance, and maintained in a permanent file.[196] Copies shall be submitted to the MEC.

[196] 77 IAC 250.310(b)(5).

ARTICLE 8. CLINICAL DEPARTMENTS

8.1 ORGANIZATION OF DEPARTMENTS AND SECTIONS

8.1.1 Organization.
Each Department shall be organized as a separate part of the Medical Staff and shall have a Clinical Chairperson who is: (a) elected by the Active Medical Staff Members of the applicable Department, or a role appointed by Hospital Administration with department input; and (b) has the authority, duties and responsibilities as specified in Section 8.3 of these Bylaws. A Clinical Chairperson may establish Sections within their Department. Clinical departments are established by the MEC and approved by Governing Council.

8.2 ASSIGNMENT TO DEPARTMENTS

The MEC will, after consideration of the recommendations of the Clinical Chairperson of the appropriate Department(s) and Credentials Committee, recommend Department assignments for each Medical Staff Member in accordance with the Medical Staff Member's qualifications. Each Staff Member shall be assigned to one Department but may be granted Privileges in other specialties. The exercise of Privileges or the performance of specified services within any Department shall be subject to the policies of that Department and the authority of that Department's Clinical Chairperson.

8.3 CLINICAL CHAIRPERSONS

8.3.1 Qualifications, Nomination; Election; Appointment; Term.[197]

(a) Qualifications. At the time of nomination and election or appointment, and through their term of office, a Clinical Chairperson must:

i. Be an Active Medical Staff Member in Good Standing, or, if the MEC determines that such Medical Staff Member has qualifications that are not otherwise available, an Associate Medical Staff Member in Good Standing;

ii. Be and remain Board Certified in their specialty in compliance with policy;

iii. Constructively participate in Medical Staff affairs, including active participation in quality and/or peer review activities and on Medical Staff committee(s).

(b) No Conflict of Interest. A Clinical Chairperson may not:

i. Serve as a medical staff officer, department chairperson (except as an endowed department chairperson as part of a graduate medical education program), MEC member, or member of a Governing Council or board, of any non-Advocate hospital or ambulatory surgery center that provides health care services in competition with the Hospital; or

[197] 77 IAC 250.310(i)(2).

ii. Have an ownership interest in any non-Advocate hospital or ambulatory surgery center that provides health care services in competition with the Hospital.

(c) Nomination. For elected Clinical Chair roles, the Active Medical Staff Members of each Department shall nominate candidates for the position of Clinical Chairperson of the Department.

Election. The Clinical Chairperson of each Department shall be elected by a majority vote of all Active Medical Staff Members of the respective Department in the election year for such Department's Clinical Chairperson. In the event no nominee receives a majority vote, the nominee receiving the fewest votes shall be eliminated and successive run-off elections shall be held until one (1) nominee receives a majority of the votes cast. The results of the election shall be announced at the next Medical Staff meeting. The election mechanisms that may be considered for utilization include paper ballots and electronic voting.

8.3.2 Appointed Chairperson

Where the scope and responsibilities of a chair role are such that an appointed chair is needed, a search committee may be formed which will be broad-based and include representation from the Medical Staff as appointed by the Medical Staff President with the concurrence of the Medical Executive Committee, Hospital President and CMO. The search committee should also include representation from Hospital Administration. The committee's recommendation and report shall be presented to the Hospital President and CMO for consideration and approval.

8.3.3 Term.

Each Clinical Chairperson shall serve a two (2) year term unless removed from office or a successor is appointed by the applicable Department.

8.3.4 Duties and Responsibilities.

Each Clinical Chairperson is responsible for implementation, review, and evaluation activities to improve the quality, efficiency and consistency of patient care provided in the Department. Each Clinical Chairperson shall:

(a) Serve as Chairperson of the Department meetings while providing leadership and guidance to the Medical Staff.

(b) Be a voting member of the MEC.

(c) Establish, when appropriate, sections within the Department, and appoint Section Leaders, subject to approval by the MEC.

(d) Enforce Hospital policies, these Bylaws, and Medical Staff Policies.

(e) Establish guidelines for the granting of Privileges and the performance of specified services.

(f) Recommend or provide continuing education programs based upon best practices and areas identified by review activities.

(g) Maintain oversight of the professional performance of all Department members.

(h) Oversee and support the performance, service and conduct expectations, address identified issues with the support of Hospital administration, and involve MEC as appropriate.

(i) Recommend criteria for Privileges within the Department.

(j) Make recommendations regarding appointment or reappointment Medical Staff Membership and Privileges for Department members.

(k) Develop and implement policies and procedures to guide and support the provision of care, treatment, and services.

(l) Oversee the quality improvement activities of the Department.

(m) Be responsible for the orientation and continuing education of Department members.

(n) Make recommendations for space, resources, and budgetary planning as needed by the Department.

(o) Be responsible for arranging and securing appropriate Departmental emergency service on-call coverage in accordance with the needs of the Hospital.

(p) Monitor adherence to Hospital, Medical Staff and Department policies and procedures and requirements for alternate coverage and for consultations.

(q) Submit written reports as requested by the MEC.

(r) Promulgate Department policies addressing administrative and clinical procedures specific to the Department to be effective upon approval by the MEC. The Medical Staff President of the Medical Staff delegates authority to Clinical Chairpersons to sign appropriate policies as required.

(s) Conduct Department meetings and establish committees as are necessary for the purpose of fulfilling the functions described herein.

(t) Fulfill duties as otherwise assigned.

8.3.5 Vacancies in Clinical Chairperson.
Vacancies in a Clinical Chairperson position shall be filled by the Medical Staff President, or designee, in consultation with the Hospital President and CMO. The individual filling the vacancy shall serve out the remaining term.

8.3.6 Resignation of Clinical Chairperson.
Any Clinical Chairperson may resign at any time by giving Written Notice to the MEC.

8.3.7 Removal of Clinical Chairperson.

(a) Automatic Removal**.** The MEC shall automatically remove any Clinical Chairperson from their position upon verification of their : (i) revocation of license

to practice in the State of Illinois; (ii) revocation or denial of Active Medical Staff Membership; or (iii)who is subject to Summary Suspension pursuant to Article 4.2. There shall be no right of appellate review or hearing in connection with removal from a Clinical Chairperson position.

(b) Discretionary Removal. A Clinical Chairperson may be removed from their position in following circumstances:

i. Membership or Privileges are suspended (other than a Summary Suspension), pending the outcome of the hearing and appellate review procedures provided in these Bylaws;

ii. A written request to consider removal signed by at least one-quarter (1/4) of the Active Medical Staff Members (where such request includes a statement of specific concerns); or

iii. The MEC determines that the Clinical Chairperson is unable to discharge the duties of the position.

(c) Removal Procedure.

i. *MEC Meeting*. A meeting of the MEC shall be called as soon as practicable to consider the removal of the Clinical Chairperson. A quorum of the MEC must be present for action on the matter. The Clinical Chairperson shall have no vote on their removal and may be excluded from the meeting except as provided in (ii) below.

ii. *Appearance*. The Clinical Chairperson shall be permitted to make an appearance at the MEC meeting before the MEC votes on the matter.

iii. *Vote*. A Clinical Chairperson may be removed by an affirmative vote of two-thirds (2/3) of the MEC members present at a meeting. The Clinical Chairperson may not participate or be present for the vote.

iv. *Notification*. The Medical Staff President shall provide the Clinical Chairperson written notification of the MEC's decision.

v. *Hearing and Appeal Rights.* There shall be no right of appellate review or hearing in connection with removal from the position.

8.4 DEPARTMENT MEETINGS

8.4.1 Scheduling and Written Notice.

(a) Regular Meetings. Each Department may set the time for holding the Department's regular meetings. Department meetings shall be held as often as deemed necessary or desirable. Written Notice stating the time, place and purposes of each regular Department meeting shall be sent to each member of the Department to the email address on file with the Medical Staff Office at least five (5) days before the date of the meeting. The attendance of a Department member at a meeting shall constitute a waiver of Written Notice.

(b) Special Meetings**.** The Clinical Chairperson or the Medical Staff President may call a special meeting of the Department at any time. Written Notice stating the time, place and purposes of each special Department meeting shall be sent to each member of the Department to the email address on file with the Medical Staff Office at least forty-eight (48) hours before the date of the meeting. No business shall be transacted at any special meeting, except as stated in the Written Notice. The attendance of a Department member at a meeting shall constitute a waiver of Written Notice.

8.4.2 Attendance Requirements.

(a) *Attendance*. Department members are expected to attend their scheduled meetings, including Special Meetings.

(b) *Attendance by Audio or Visual Telecommunication*. Department members may participate in Department meetings via audio or visual telecommunication whereby all participants can simultaneously hear each other when available.

(c) *Attendance by Medical Staff and Hospital Leadership*. The Medical Staff President, Hospital President and/or CMO may attend any Department meeting.

8.4.3 Quorum and Voting.

For Department meetings, a quorum shall consist of those present and voting. Action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action, unless these Medical Staff Bylaws or any law, ordinance, or governmental rule or regulation requires a greater number of affirmative votes.

8.4.4 Minutes.

Written minutes of each Department meeting, including attendance, shall be prepared, and maintained.[198] Copies shall be submitted to the MEC.

[198] 77 IAC 250.310(b)(5).

ARTICLE 9. MEDICAL STAFF COMMITTEES

9.1 FORMATION, COMPOSITION, AND DISSOLUTION

The MEC may, without amendment of these Bylaws establish or dissolve Medical Staff committees.[199]

9.2 DUTIES AND RESPONSIBILITIES

The MEC shall, without amendment of these Bylaws, describe the duties, responsibilities, and Associated Details of each standing Medical Staff committee.[200] Medical Staff committees shall report to the MEC.

9.3 MEDICAL STAFF COMMITTEE MEETINGS

9.3.1 Scheduling and Written Notice.

(a) Regular Meetings. Each Medical Staff committee may set the time for holding the committee's regular meetings.

(b) Special Meetings**.** A special meeting of a Medical Staff committee may be called at any time by or at the request of the chairperson of that committee, or by the Medical Staff President.

(c) Written Notice**.** Written Notice stating the place, day, and hour of any special meeting or of any regular meeting of a Medical Staff committee that is not held pursuant to the regular schedule shall be delivered to each committee member not less than two (2) business days before the time of such meeting. The attendance of a member at a meeting shall constitute a waiver of Written Notice of such meeting.

9.3.2 Participation by Hospital President and CMO.

The Hospital President and/or the CMO may attend any Medical Staff committee meeting.

9.3.3 Minutes.

Minutes of each regular and special Medical Staff committee meeting shall be prepared, maintained, and include attendance.[201] The minutes shall be approved by the Chair of the committee and submitted to the MEC.[202]

9.3.4 Quorum and Voting Requirements.

[199] *See* Article X, Section 10.1.2 of these Bylaws, "Associated Details." All committees, other than the MEC, can be set forth in a Medical Staff Committee Manual or Medical Staff Policies rather than the Bylaws. Medical Staff Committees required by DNV & Illinois Admin Code: P&T/Medication Management; Infection control; utilization review; Blood Use, Patient Care Evaluation/Quality Management; medical records. DNV also requires Tissue Review.

[200] *See* Article X, Section 10.1.2 of these Bylaws.

[201] NIAHO, MS.6, Surveyor Guidance (rev. 18-01) (advising surveyors to review medical staff committee meeting minutes, data and other documentation to ensure medical staff involvement in organizational activities).

[202] NIAHO, MS.6, Surveyor Guidance (rev. 18-01).

The quorum and voting requirements for each Medical Staff committee shall be set forth in Medical Staff Policies and committee charters.

ARTICLE 10. MEDICAL STAFF BYLAWS AND POLICIES

10.1 BYLAWS

10.1.1 Adoption of Bylaws. [203]

These Bylaws have been developed by the organized Medical Staff, shall be adopted at any regular or special meeting of the Active Medical Staff, and shall become effective when approved by the Governing Council.

10.1.2 Required Processes: Basic Steps and Associated Details.

These Bylaws contain the basic steps of medical staff governance required to be in the Bylaws by CMS, the DNV, or other accrediting entity, and Illinois law.[204] Associated Details may be placed in these Bylaws, a Medical Staff procedure manual, a Medical Staff Policy, or an Advocate or Hospital Policy approved by the Hospital's MEC.[205]

10.1.3 Periodic Review of Bylaws.[206]

These Bylaws shall be reviewed periodically, but no less frequently than biennially by the MEC or other committee appointed by the Medical Staff President for such purpose ("Bylaws Committee").

10.1.4 Amendment of Bylaws.

Neither the Medical Staff nor the Governing Council may unilaterally amend these Bylaws. All amendments to these Bylaws must be approved by both the Medical Staff and the Governing Council.[207] The MEC will ensure that approved amendments are communicated to the Medical Staff.

(a) Amendments Proposed by a Medical Staff Member, Committee or Department. Any Medical Staff Member, Medical Staff committee, or Section/Department, may submit a proposed amendment to these Bylaws to the Medical Staff President. The Medical Staff President shall determine whether to forward the proposed amendment to the MEC or the Bylaws Committee (if one has been appointed) for its review and comment; and (ii) shall submit the proposed amendment to the Medical Staff at the next regular Medical Staff meeting, at a special Medical Staff meeting called for such purpose, or using electronic voting via computer, fax, or other technology. For a vote taken at a Medical Staff meeting, an amendment shall require a majority vote of the actual votes taken by the Active Medical Staff Members present at the time the vote is taken. If electronic voting is taken, an amendment shall require a majority vote of the actual votes taken by the Active Medical Staff Members voting according to the prescribed time frame provided in the voting instructions. An amendment approved by the Medical Staff shall be forwarded to the Governing Council for its approval and shall become effective if

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[203] 42 C.F.R. § 482.22(c); 77 IAC 250.310(e); NIAHO, MS.7, SR.2 (rev. 18-01).
[204] 210 ILCS 85/10.4; 77 IAC 250.310(b); NIAHO, MS.7 (rev. 18-01).
[205] NIAHO, MS.7, SR.2 (rev. 18-01) (stating that changes to only the medical staff bylaws and rules & regulations require approval of the medical staff and Governing Council).
[206] NIAHO, MS.7 does not specify specific time frame or address periodic review. We recommend flexibility in this provision.
[207] 77 IAC 250.310(b); NIAHO, MS.1 & MS.7, SR.2 (rev. 18-01).

and when it is approved by the Governing Council.[208]

(b) Amendments Proposed by the Governing Council. Amendments proposed by the Governing Council shall be submitted to the Medical Staff President. The Medical Staff President shall submit the proposed amendment to the Medical Staff at the next regular Medical Staff meeting, at a special Medical Staff meeting called for such purpose, or using electronic voting via computer, fax, or other technology. For a vote taken at a Medical Staff meeting, an amendment proposed by the Governing Council shall require a majority vote of the actual votes taken by Active Medical Staff Members present at the time of the vote is taken. If electronic voting is taken, an amendment shall require a majority vote of the actual votes taken by the Active Medical Staff Members voting according to the prescribed time frame provided in the voting instructions. An amendment approved by the Medical Staff shall be returned to the Governing Council for its final approval and shall become effective if and when it is approved by the Governing Council.

(c) Amendment to Comply with Law or Regulations. The professional conduct of Medical Staff Members shall at all times be governed by applicable state and federal statutes and regulations. In the event the provisions of these Bylaws are not consistent with applicable state or federal law or regulation, the MEC may approve an amendment to such documents, without vote by the Medical Staff. Such amendment must be approved by the Governing Council before taking effect.[209] In such a circumstance, the MEC will notify the Medical Staff of the amendment. In the event of conflict between state and/or federal law and these bylaws, state and/or federal law shall apply.

10.1.5 Technical Modifications of Bylaws.
Modifications that do not materially change any Bylaw provision, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, or correction of statutory, regulatory, or accreditation standard citations contained in a footnote reference, shall not be considered an amendment of the Bylaws and shall not require approval as described above.

10.2 MEDICAL STAFF RULES, REGULATIONS, AND POLICIES

10.2.1 Adoption or Amendment of Medical Staff Rules, Regulations and Policies.

(a) Generally. The MEC may adopt or amend Medical Staff Rules, Regulations and Policies as may be necessary to implement more specifically the general principles found within these Bylaws and guide and support the provision of care, treatment, and services at the Hospital, subject to the approval of the Governing Council.[210] Medical Staff Rules, Regulations and Policies must be consistent with these Bylaws, Hospital policies, and applicable statutes and regulations. The MEC will

[208] 77 IAC 250.310(b); NIAHO, MS.1 & MS.7, SR.2 (rev. 18-01).
[209] NIAHO, MS.7, SR.1 (rev. 18-01).
[210] NIAHO, MS.7, SR.2 (rev. 18-01).

ensure that all approved Rules, Regulations, and Policies are communicated to the Medical Staff.

(b) Adoption Process. Any Medical Staff Member, Medical Staff committee (including the MEC), or Department, may submit a proposal to adopt a Medical Staff Rule, Regulation or Policy to the Medical Staff President. The Medical Staff President shall submit the proposed Rule, Regulation or Policy to the MEC for approval at the next regular MEC meeting, or at a special MEC meeting called for such purpose. A Medical Staff Rule, Regulation or Policy must be approved by a majority vote of the MEC.[211]

10.2.2 Technical Modifications of Medical Staff Rules, Regulations or Policies. Modifications that do not materially change any provision contained in a Medical Staff Rule, Regulation or Policy, such as reorganization, reformatting, renumbering, correction of grammatical, spelling, or punctuation errors, or correction of statutory, regulatory, or accreditation standard citations contained in a footnote reference, shall not be considered an amendment of the Medical Staff Rule, Regulation or Policy, and shall not require approval as described above.

10.3 DEPARTMENTAL POLICIES

Each Department may develop and propose amendments to policies intended to guide and support the provision of care, treatment, and services in such Department, or govern the administration of such Department. Such policies or proposed amendments must: (1) be consistent with these Bylaws, Medical Staff Rules, Regulations and Policies, and applicable Hospital policies; and (2) be approved by the MEC. If the MEC declines to approve a Department policy or proposed amendment recommended by the relevant Clinical Chairperson, the MEC shall provide a written explanation of its action to the Clinical Chairperson.

10.4 HISTORY AND PHYSICAL EXAMINATIONS[212]

Physicians, Oral Surgeons, Dentists, Podiatrists, Advanced Registered Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists and Certified Nurse Midwives may perform a medical history and physical examination (H&P). An H&P must be performed and documented no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but in all cases before a high-risk procedure, surgery or a procedure requiring anesthesia services.[213] If the H&P is performed within thirty (30) days before the patient's admission or registration, a Physician, Oral Surgeon, Podiatrist, Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetists or Certified Nurse Midwife must complete and document an updated examination of the patient, including any changes in the patient's condition, within twenty four (24) hours after the patient's admission or registration, but in all cases before surgery or a procedure requiring anesthesia services.[214] Patients admitted directly by a Dentist or a Podiatrist (who have not been co-admitted by another Medical Staff Member) may have their

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211 NIAHO, MS.7 SR.1 & SR.2 (rev. 18-01).

212 NIAHO, MS.17 (rev. 18-01).

213 42 C.F.R. § 482.22(c)(5)(i) (Interpretive Guidelines, effective October 17, 2008, providing that H & P documentation requirements must be included in the Medical Staff Bylaws).

214 42 C.F.R. § 482.22(c)(5)(ii) (Interpretive Guidelines, effective October 17, 2008, providing that H & P documentation requirements must be included in the Medical Staff Bylaws).

H&Ps performed by the admitting Dentist or Podiatrist, provided the Dentist or Podiatrist has been approved to perform H&Ps by the Governing Council and the H&Ps are directly related or incident to the dental or podiatrist service, procedure or surgery.[215] Please refer to Medical Staff Policies for more information regarding H&P documentation requirements.

10.5 CONSULTATION REQUIREMENTS[216]

Each Medical Staff Member shall: (a) provide or arrange for continuous care to their patients at the professional level of quality and efficiency established by the Medical Staff and Hospital[217]; (b) delegate in their absence the responsibility for diagnosis and care of their patients to a qualified Practitioner who possesses the Privileges necessary to assume care of such patients; and (c) seek consultation with another Practitioner who possesses appropriate Privileges in any case when the clinical needs of the patient exceed the Privileges of the Medical Staff Member.[218] Circumstances requiring consultation or management by another qualified Medical Staff Member are, but are not limited to the following:

(a) Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life-threatening illness.

(b) Unexpected complications arise which are outside level of competence of the Medical Staff Member.

(c) Specialized treatment or procedures are contemplated which are outside the Medical Staff Member's level of competence.

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[215] 77 IAC 250.320(a).

[216] NIAHO MS.18 (rev. 18-01).

[217] 77 IAC 250.320(a) (stating that "[a]ll persons admitted to the hospital shall be under the professional care of a member of the medical staff"). However, "[p]atients admitted by a podiatrist or a dentist shall be under the care of both the admitting medical staff member and a physician who is also a medical staff member. The podiatrist or the dentist shall be responsible for all care within the limits of the Privileges granted to them; [and] the physician shall be responsible for all aspects of general medical care." *Id.*

[218] 77 IAC 250.310(b)(7); NIAHO, MS.18 (rev. 18-01).

ARTICLE 11. MISCELLANEOUS

11.1 COMPLIANCE WITH LAWS AND REGULATIONS

11.1.1 Conflict Between the Bylaws and Changes in Law.

Any act or omission that may be considered inconsistent with the provisions set forth in these Bylaws or Medical Staff Policies, but which was undertaken in order to comply with applicable federal or state statutes or regulations, shall not be considered in violation of these Bylaws or Medical Staff Policies. In the event these Bylaws or Medical Staff Policies are inconsistent with such statutes or regulations, the MEC shall initiate in a timely manner the applicable amendment process. In the event of a conflict between these Bylaws and applicable federal or state statutes or regulations, applicable federal or state statutes or regulations shall apply.

11.1.2 Closure of Hospital.

In the event that the Hospital closes, all Medical Staff credentialing files shall be maintained.[219]

11.2 GOVERNING LAW

The validity, construction, and enforcement of these Bylaws shall be construed and enforced solely in accordance with the laws of the State of Illinois. The parties agree that jurisdiction and venue for any dispute shall be in DuPage County, Illinois and no party or person may object to personal jurisdiction in, or venue of such courts or assert that such courts are not a convenient forum. Both parties waive trial by jury in any action hereunder.

11.3 ELECTRONIC RECORD KEEPING

Whenever these Bylaws call for maintenance of written records, such records may be recorded or maintained in an electronic format.

11.4 HEADINGS AND ANNOTATIONS

The captions, headings and annotations used in these Bylaws are for convenience only and are not intended to limit or otherwise define the scope of effects of any provisions of these Bylaws.

11.5 IDENTIFICATION

Although the masculine gender and singular are generally used throughout these Bylaws and associated policies for simplicity, words which import one gender may be applied to any gender and words which import the singular or plural may be applied to the plural or the singular, all as a sensible construction of the language so requires.

11.6 COUNTING OF DAYS

In any instance in which the counting of days is required in these Bylaws in connection with the giving of a Written Notice or for any other purpose, the day of the event shall not count, but the

[219] 77 IAC 250.310(b)(16).

day upon which the notice is given shall count. Except for Summary Suspensions whereby the Practitioner has not waived a deadline, any case where the date on which some action is to be taken, Written Notice given or period expired occurs on a holiday, a Saturday or a Sunday, such action shall be taken, such Written Notice given, or such period extended to the next succeeding Monday, Tuesday, Wednesday, Thursday, or Friday which is not a holiday. For the purposes of this Section, the term "holiday" shall mean such days as are commonly recognized as holidays by the U.S. Federal Government.

11.7 SEVERABILITY

In the event that any provision of these Bylaws shall be determined to be invalid, illegal, or unenforceable, the validity, enforceability of the remaining provisions shall not in any way be affected or impaired by such a determination.

11.8 TERM USE

Use of Delegee or Designee. Wherever an individual is authorized under these Bylaws to perform a duty by virtue of their position, then this duty may be delegated to another appropriate Hospital executive or administrator, medical staff officer or clinical chairperson as appropriate.

11.9 SUBSTANTIAL COMPLIANCE

The Illinois Hospital Licensing Act and related regulations provide minimum requirements for Medical Staff appointment and/or clinical privileges determinations and corrective action for existing Medical Staff Members. These Bylaws are intended, in part, to create a framework to comply with those statutory obligations. To the extent the Medical Staff and Governing Council act consistent with statutory obligations, and except for the time frames for a Medical Staff Member to request a hearing or appellate review, strict compliance by the Medical Staff or Governing Council with the procedures and timelines set forth in the Bylaws is not required. Further, these Bylaws are not intended to create contractual rights between the Hospital and its Medical Staff Members. Accordingly, these Bylaws shall not be interpreted as or construed to give Medical Staff Members any claim for breach of contract, or other legal claim, for failing to act in strict compliance with these Bylaws.