Columbia St. Mary's
A Passion for Patient Care

Columbia St. Mary's Medical Staff Bylaws of Columbia St. Mary's Hospital Milwaukee, Columbia St. Mary's Hospital Ozaukee & Sacred Heart Rehabilitation Institute

APPROVALS	
CSM Board of Directors	06.09.04
Draft Revision	03.15.07
CSM Medical Staff Council	04.04.07
CSM Medical Staff	04.19.07
CSM Board of Directors	05.07.07
Draft Revision	11.11.09
CSM Medical Staff Council	12.02.09
CSM Medical Staff	01.20.10
CSM Board of Directors	02.19.10
Draft Revision	02.2011
CSM Medical Staff Council	02.09.11
CSM Medical Staff	04.14.11
CSM Board of Directors	04.19.11
Draft Revision	10.2011
CSM Medical Staff Council	10.12.11
CSM Medical Staff	11.18.11
CSM Board of Directors	12.06.11
Draft Revision	08.2012
CSM Medical Staff Council	08.08.12
CSM Medical Staff	08.30.12
CSM Board of Directors via JQC	09.07.12
Draft Revision	02.2017
CSM Medical Staff Council	02.15.17
CSM Medical Staff	03.01.17
CSM Board of Directors	04.05.17

As Chief of the CSM Medical Staff, I attest to the acceptance and approval of these revised Bylaws, effective April 5, 2017.

Robert D Lyon MD.	04.05.2017
Robert D. Lyon, MD	Date

Table of Contents

PREAMBLE

A. Columbia St. Mary's Hospital Milwaukee, Inc. (CSM Hospital Milwaukee), Columbia St. Mary's Hospital Ozaukee, Inc. (CSM Hospital Ozaukee) and Sacred Heart Rehabilitation Institute, Inc. (Sacred Heart) are three separately licensed hospitals, organized under the laws of the State of Wisconsin, operating within Columbia St. Mary's Inc. (CSM).

B. The physicians, dentists and podiatrists practicing at CSM Hospital Milwaukee, CSM Hospital Ozaukee and Sacred Heart are hereby appointed and organized by the Board of Directors into a single unified medical staff in conformity with these Bylaws, hereinafter collectively referred to as the "CSM Medical Staff" or "Medical Staff."

C. The CSM Medical Staff is organized to promote safety and quality and to improve the quality of care delivered in this institution. Recognizing its responsibility for the overall quality of clinical services provided by its members, the Medical Staff organizes itself for the purpose of self-governance in conformity with these Bylaws. These Bylaws are binding on the Medical Staff and CSM Hospital Milwaukee, CSM Hospital Ozaukee and Sacred Heart.

D. This governing document, and the policies and procedures it implements, will constitute the bylaws directing the Medical Staff and those active members and other providers of CSM Hospital Milwaukee, CSM Hospital Ozaukee and Sacred Heart, and other health care programs owned or operated by CSM Hospital Milwaukee, CSM Hospital Ozaukee and Sacred Heart that require a Medical Staff.

E. The principal functions of the CSM Medical Staff are:

1. Develop and implement policies and procedures governing the Medical Staff and provision of patient care at the Hospitals.

2. Perform all duties required by governmental or private agencies, including The Joint Commission and/or other accreditation agencies, and Medicare Conditions of Participation, as are described as functions of the Medical Staff.

3. Determine clinical privileges for individual professionals and provide oversight as to the quality and scope of clinical practice of those professionals affiliated with the Hospitals.

4. Monitor on an ongoing basis the scope and quality of patient care provided at CSM Hospital Milwaukee, CSM Hospital Ozaukee and Sacred Heart and account for same on a regular basis to the Board of Directors.

5. Ensure that the needs and concerns expressed by members of the Medical Staff who hold current privileges at CSM Hospital Milwaukee, CSM Hospital Ozaukee, and Sacred Heart, regardless of practice or location, are duly considered and addressed.

6. The Medical Staff acknowledges that, in the best interest of patient care, a mutual cooperation shall be maintained between administration, the Board of Directors, and the Medical Staff.

ARTICLE I
DEFINITIONS

A. “Adverse Decision” or “Adverse Action” or “Adverse Recommendation” means any decision, action or recommendation by the Medical Staff Council or Board, including decisions, actions, or recommendations approved by the Board following a recommendation by the Medical Staff Council that, when based on competence or professional conduct, would have the effect of or results in reducing, restricting, suspending, revoking, denying or failing to renew Clinical Privileges or membership of a member of the Medical Staff or an Allied Health Professional, as set forth in these Bylaws and associated Medical Staff policies and procedures.”

B. Allied Health Professional (AHP) refers to a health care provider other than a physician, dentist or podiatrist who is credentialed by the Medical Staff and authorized by the Board of Directors to provide health care services to patients in the Hospitals. While governed by the Medical Staff and Board of Directors, Allied Health Professionals are not members of the Medical Staff.

C. Board of Directors (Board) means the governing board of Columbia St. Mary’s.

D. Board Quality, Safety and Services Committee (BQSS) refers to a standing committee of the Board of Directors whose composition is a least fifty percent (50%) physicians. The BQSS, under the direction of the Board of Directors, reviews and reports on all quality/performance improvement and risk management activities of the corporation and the Hospitals; addresses all issues concerning Medical Staff appointments and clinical privileges; and serves as medical-administrative liaison between the Board of Directors, executive management and the Medical Staff of Columbia St. Mary’s.

E. Caregiver Law – For purposes herein, conviction of a “Caregiver Law” refers to any state or federal felony or misdemeanor pursuant to which the individual is banned from access to patients pursuant to applicable law including under the Wisconsin Caregiver Program found at Wis. Stats. § 50.065 and 146.40.

F. Chief Executive Officer (CEO) (CEO or Designee) refers to the individual appointed by the Board of Directors to act on its behalf in the overall administration of Columbia St. Mary’s and its Hospitals.

G. Chief of Staff refers to the individual who is designated chief administrative officer of the Medical Staff as a whole.

H. Clinical Privileges (Privileges) refers to the permission granted to a Medical Staff member or Allied Health Professional to render specific diagnostic, therapeutic, medical, oral maxillofacial/dental, podiatric or surgical services that may or may not include permission to admit patients.

I. Clinical Service (Service) refers to the clinical specialty or specialties that report as an organized entity to the CSM Medical Staff Council in accordance with the Medical Staff Bylaws, CSM Medical Staff policies and procedures and Medical Staff Division policies and procedures.

J. Columbia St. Mary’s (CSM) is the holding company for the Hospitals.

K. CSM Medical Staff Council (Medical Executive Committee, Medical Staff Council) refers to the committee of elected Division Medical Staff Presidents, Clinical Service Chairs, the

Chief of Staff, and other members that represent and act on behalf of the CSM Medical Staff as a whole.

L. CSM Medical Staff Policies and Procedures (Medical Staff Policies and Procedures) means the policies and procedures adopted by the Medical Staff Council and approved by the Board of Directors under which the Medical Staff as a whole carries out its responsibilities and regulates itself, but only to the extent which they are not in conflict with, preempted by, or superseded by these Bylaws.

M. Days (Calendar Days) mean the calendar days including weekends and holidays. Provided however, if the due date falls upon a weekend or holiday, then the due date shall automatically extend to the first day immediately following that which is not a weekend or holiday.

N. Ethical and Religious Directives for Catholic Health Care Services ("Ethical and Religious Directives") means those Directives as approved, issued and amended from time to time by the United States Conference of Catholic Bishops and implemented by the Roman Catholic Archbishop of Milwaukee.

O. Hospitals mean Columbia St. Mary's Hospital Milwaukee, Inc., Columbia St. Mary's Hospital Ozaukee, Inc. and Sacred Heart Rehabilitation Institute, Inc. and other health care programs owned or operated by CSM Hospital Milwaukee, CSM Hospital Ozaukee and Sacred Heart that require a Medical Staff. Hospital refers to each of them, respectively.

P. Medical Staff (Staff) means the formal organization of all physicians, dentists and podiatrists who are appointed to membership on the Medical Staff of Columbia St. Mary's by the Board of Directors.

Q. Medical Staff Division Policies and Procedures (Division Policies and Procedures) means the Division Medical Staff policies and procedures adopted by the CSM Medical Staff Council and approved by the Board of Directors under which the Division carries out its responsibilities and regulates itself, but only to the extent they are not in conflict with, preempted by, or superseded by these Bylaws and CSM Medical Staff policies and procedures.

R. Medical Staff President (Division President) refers to the individual who is elected Medical Staff officer of the segment of CSM Medical Staff members who hold current privileges at a specific CSM Hospital and Hospital-owned or operated facilities. The Medical Staff President reports to the Chief of Staff.

S. Physician refers to an individual with a MD or DO degree who is licensed to practice medicine.

T. Practitioner refers to a licensed physician, dentist or podiatrist.

U. Vice President Medical Affairs/Chief Medical Officer ("VPMA/CMO") is a physician executive who, under the general direction of the Chief Executive Officer or designee and within the policies and procedures of Columbia St. Mary's, Inc., guides and directs the Hospital functions, systems, processes and activities related to all medical staff activities, CSM quality monitoring and reporting. The VPMA/CMO serves as a liaison for medical-administrative affairs and serves as a member of the Board Quality, Safety and Services Committee (BQSS).

V. Year (Medical Staff Year) shall begin on January 1 of each year.

ARTICLE II
NAME

The name of this single unified medical staff organization shall be the Medical Staff of Columbia St. Mary's, hereafter referred to as the CSM Medical Staff or Medical Staff.

ARTICLE III
MEDICAL STAFF ORGANIZATION

A. The CSM Medical Staff is comprised of all physicians, dentists and podiatrists who are appointed or re-appointed to Medical Staff membership by the Board of Directors, and within the authority of these Bylaws.

B. The CSM Medical Staff is comprised of three (3) Medical Staff Divisions: CSM Hospital Milwaukee, CSM Hospital Ozaukee, and Sacred Heart. Each Division shall operate under these Bylaws and associated CSM Medical Staff policies and procedures and, under their respective Division Medical Staff policies and procedures, but only to the extent they are not in conflict with, preempted by, or superseded by these Bylaws and associated CSM Medical Staff policies and procedures.

C. At the time of initial appointment and with each subsequent reappointment, the practitioner shall designate the Division(s) at which he/she intends to practice. The practitioner's Clinical Service Chair will assign the practitioner to a category of membership at each designated Division in accordance with the criteria set forth in these Bylaws, Medical Staff policies and procedures, and Division policies and procedures. The Clinical Service Chair may also recommend revision of membership category at any time during the practitioner's appointment cycle when a sustained change is noted in the practitioner's clinical activity and Hospital commitment. Such recommendation requires Medical Staff Council and Board approval.

D. The practitioner's assigned category of membership at each designated Medical Staff Division shall determine his/her Hospital Division-specific rights and responsibilities.

E. Practitioners who are assigned to the Active category of Medical Staff membership in one (1) or more Medical Staff Divisions shall be entitled to one (1) vote on matters that call for a vote of the Medical Staff as a whole.

F. The grant of clinical privileges at a designated Hospital Division shall be made by the Board of Directors, after review and recommendation by the CSM Medical Staff, as more specifically described in the Medical Staff policies and procedures.

ARTICLE IV
PURPOSES AND RESPONSIBILITIES

The purpose and responsibilities of this Medical Staff organization are as follows:

A. To account to the Board of Directors for the quality and appropriateness of patient care services, professional and ethical conduct, and teaching and research activities in the Hospital.

B. To maintain a high level of professional performance by all Medical Staff members authorized to practice in the Hospital through the appropriate delineation of clinical privileges and ongoing review and evaluation of each Medical Staff member and Allied Health Professional's performance.

C. Ensure that the needs and concerns expressed by members of the Medical Staff who hold current privileges at CSM Hospital Milwaukee, CSM Hospital Ozaukee, and Sacred Heart, regardless of practice or location, are duly considered and addressed.

D. To provide an organizational structure that allows continuous monitoring and improvement of patient care practices, including ongoing review and evaluation of each Medical Staff member and Allied Health Professional's performance in relation to the delineation of privileges. The Medical Staff shall perform peer review as agents of the Board of Directors in conjunction with Hospital personnel.

E. To provide an appropriate educational setting that will maintain scientific standards and will lead to continuous advancement in professional knowledge and skill.

F. To provide a means whereby issues affecting the Medical Staff and the Hospital may be discussed and considered collaboratively among the Medical Staff, Hospital administration and the Board of Directors.

G. To establish a structure whereby the Medical Staff may evaluate and appoint members; conduct those activities necessary to fulfill its purposes; develop, and recommend to the Board of Directors, appropriate policies and procedures; and pursue corrective action with respect to individual members when indicated.

H. To facilitate Medical Staff support in the development and achievement of the Hospital objectives.

I. To commit to the Columbia St. Mary's Corporate Responsibility – Standards of Conduct and to ensure that Medical Staff members and Allied Health Professionals, as defined in these Bylaws, are aware of and adhere to the Hospital's Standards of Conduct which reflects a high standard of individual and organizational, ethical, and legal business practices.

ARTICLE V
MEMBERSHIP AND PRIVILEGES

SECTION 1. NATURE OF MEMBERSHIP

Membership on the CSM Medical Staff is a privilege that shall be extended only to those practitioners who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the CSM Medical Staff shall confer on the practitioner only such prerogatives as the Board of Directors grants in accordance with these Bylaws.

SECTION 2. QUALIFICATIONS FOR MEMBERSHIP

A. CSM Medical Staff membership shall include physicians, dentists and podiatrists who:

1. Possess, submit and maintain on file at all times current evidence of a valid, unlimited and unrestricted license to practice medicine, dentistry or podiatry in the State of Wisconsin;

2. Possess, submit and maintain on file at all times current evidence of a valid, unrestricted and unlimited Drug Enforcement Agency (DEA) registration certificate, except as when waived by the CSM Medical Staff Council for those members whose practice does not require DEA registration (e.g. pathology).;

3. Possess, submit and maintain on file at all times current evidence of appropriate professional liability insurance with limits that are not less than the minimum amounts determined by Wisconsin Statutes, and in accordance with the individual's area of practice;

4. Are not excluded from participation in any federally funded health care program (i.e. not on the Office of Inspector General's (OIG) list of excluded providers; free of Medicare/Medicaid sanctions);

5. Are not barred from providing direct patient care in the Hospital under–Wisconsin's caregiver misconduct laws;

6. Have completed education and graduate training from a medical or osteopathic school meeting the standards of the Accreditation Council of Graduate Medical Education or the American Osteopathic Association, a dental school meeting the standards of the Council on Dental Education of the American Dental Association, or a school of podiatry meeting the standards of the Council on Education of the American Podiatric Medical Association;

7. Have agreed to submit to proctoring, supervision and/or practice evaluation as deemed necessary by the peer review bodies and the Medical Staff Council

8. Have appropriate and adequate written and verbal communication skills;

9. Have provided evidence of their good reputation, adherence to the ethical code of their respective professions, ability to work competently and cooperatively with others, and to efficiently use resources, to the satisfaction of the Board of Directors;

10. Have certified that their current health status does not in any way impair their ability to safely exercise the clinical privileges requested or to care for patients. The Board of Directors may precondition appointment, reappointment or the continuing exercise of any or all clinical privileges upon the practitioner undergoing a health examination by a physician acceptable to the Board or upon submission of any other reasonable evidence of current health status that may be requested by the Medical Staff Council or the Board of Directors. The Medical Staff Council may require that a member of the Medical Staff, including an affiliated Medical Staff member, submit to a physical or mental health examination by an appropriate physician at such other times as the Medical Staff Council deems appropriate. A physical or mental condition than can reasonably be accommodated shall not bar the granting of Medical Staff membership or clinical privileges;

11. Have provided evidence of their background, experience, training and demonstrated current competency in his or her specialty for all privileges requested, sufficient to assure, in the judgment of the Board of Directors, that any patient treated by those in the Hospital will be given appropriate, quality medical care;

12. Demonstrate sound judgment as exemplified through satisfactory clinical results;

13. Demonstrate sound character and adherence to the ethics of the profession;

14. Endeavor to obtain and maintain board certification specific to the clinical privileges they seek; Clinical Services may use board certification as one criterion to determine the granting of clinical privileges. The CSM Medical Staff Council may however waive the board certification requirement if the applicant demonstrates qualifications that are essentially equivalent to board certification, as demonstrated through advanced training and/or experience, current competence, and ability to function as teacher and/or mentor. Disputes shall be resolved by the CSM Medical Staff Council.

15. Attest, through a written, signed and dated certification, to:

    a. Their willingness to become familiar with and abide by the Ethical and Religious Directives for Catholic Health Facilities when working in the Hospitals;

    b. Their willingness to become familiar with and abide by the current CSM Medical Staff Bylaws, Medical Staff policies and procedures, Columbia St. Mary's Corporate Responsibility – Columbia St. Mary's Standards of Conduct, the Values, and Hospitals' policies and procedures;

    c. The absence of any physical, mental or behavioral impairment that, with or without reasonable accommodation, interferes with or presents a substantial possibility of interfering with, or that makes difficult the achievement of, compliance with the Qualifications for Membership. As a condition of membership, the applicants may also be required to submit evidence concerning their physical, mental or behavioral condition;

    d. Their willingness and capability to work with and relate to other Medical Staff members, managers, nurses, and other Hospital employees, students and visitors in the cooperative and professional manner that is necessary to maintain an appropriate environment to deliver quality patient care;

    e. Their agreement to provide continuous, appropriate care to their patients in a manner that is consistent with their category of membership and clinical privileges;

    f. Their agreement to meet such other requirements as may be required of members as outlined in the Medical Staff policies and procedures including, but not limited to the requirements associated with the admission, care and discharge of patients (i.e. physical examination and medical history).

16. Maintain a valid, active and secure electronic address capable of communicating in an acceptable manner with the medical staff services office (e.g. email) in order to receive official medical staff communications.

B. No practitioner shall be entitled to membership on the Medical Staff or to clinical privileges solely upon certification, fellowship, or membership in a specialty body or society, or as a result of previous membership on this or any other Medical Staff, or an administrative position with or employment by the Hospital.

C. Applicants and members of this Medical Staff who provide professional services in any Hospital within the CSM system must meet all additional qualifications for clinical privileges required by policies of the Medical Staff Division in which they intend to provide professional services; but only to the extent that such requirements are not in conflict with, preempted by, or superseded by provisions of these Bylaws and CSM Medical Staff policies and procedures.

SECTION 3. NONDISCRIMINATION

Eligibility for Medical Staff membership or clinical privileges shall not include any consideration of sex, age, disability, sexual orientation, race, creed, color, national origin, or any other bases protected by law.

SECTION 4. CREDENTIALING AND PRIVILEGING

A. Initial appointments and re-appointments to the Medical Staff, including medical staff membership, membership category, and the determination whether to grant, deny, continue, revise, discontinue, limit or revoke specified privileges, shall be made by the Board of Directors after review and recommendation by the Medical Staff and, in accordance with these Bylaws and associated Medical Staff policies and procedures. In those instances where the Medical Staff has failed to make a recommendation six (6) calendar months after receipt of a complete application, the Board of Directors may act independently after reviewing reliable evidence with respect to the applicant's professional and ethical qualifications.

B. All requests for applications for appointment to the medical staff and requests for clinical privileges will be forwarded to the CSM Central Credentials. Upon receipt of the request, Central Credentials will provide the applicant with an application package, which will include a complete set or overview of the Medical Staff Bylaws or a reference to an electronic source for this information. This package will enumerate the eligibility requirements for medical staff membership, privileges, and performance expectations for individuals granted medical staff privileges and/or membership.

C. If an applicant does not meet the Board's membership or privileging criteria as identified in these Bylaws and Medical Staff policies and procedures, his/her application will not be processed and he or she will not be entitled to a fair hearing or any rights or due process provided under the Medical Staff Bylaws.

D. Each applicant accepted to membership on the Medical Staff shall be appointed for a period of up to two (2) years and assigned to a category of membership based upon the criteria identified in these Bylaws and associated CSM Medical Staff policies and procedures. Upon the expiration of the initial two (2) year appointment, unless there is reason not to do so, the term shall be extended as necessary so that the reappointment is handled in accordance with the standard reappointment procedures of the Medical Staff as more specifically described in Medical Staff policies and procedures.

E. Each application for a Medical Staff appointment shall be signed by the applicant and shall contain a specific acknowledgement of the obligation to:

    1. Provide continuous appropriate care to patients;

    2. Pledge that he/she will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services;

    3. Abide by the Medical Staff Bylaws and the policies and procedures of the Medical Staff and the Hospital;

    4. Abide by the Ethical and Religious Directives for Catholic Health Care Services as promulgated by the National Conference of Catholic Bishops;

    5. Release the Hospital and its agents and employees from any and all liability arising from actions taken in good faith in connection with the investigation and evaluation of the applicant's credentials;

6. Release all third parties who provide information in good faith to the Hospital, its employees and agents in connection with such investigation and evaluation from any liability;

7. Consent to and direct the sharing of health care services review information among the Hospitals and its related and affiliated institutions; and

8. Comply with the Standards of Conduct established under the Hospital Corporate Compliance Program.

F. The credentialing and privileging process, as outlined in associated Medical Staff policies and procedures, shall involve a series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical staff and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant's licensure, education, training, current competence, and physical ability to discharge patient care responsibilities shall be established. Before a requested privilege is granted, it shall be determined whether sufficient space, equipment, staffing and financial resources are in place or are available to support the requested privilege.

G. Credentialing shall involve the collection, verification, and assessment of information regarding three critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s).

1. The license verification process shall be conducted prior to the granting of initial privileges, re-privileging, and at the time of each practitioner's professional license expiration, as outlined in associated Medical Staff policies and procedures.

2. The verification of an applicant's education and relevant training shall be obtained from the original source, whenever feasible, as outlined in associated Medical Staff policies and procedures. When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source.

3. Experience, ability, and current competence in performing the requested privilege(s) shall be verified by peers knowledgeable about the applicant's professional performance. This process shall include an assessment for proficiency in the following six (6) areas: patient care; medical/clinical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice, as outlined in associated Medical Staff policies and procedures.

H. The CSM Medical Staff shall establish and maintain a privileging process as outlined in associated Medical Staff policies and procedures.

1. The criteria for granting a new privilege(s) to a practitioner with a record of competent professional performance at CSM shall include information from the practitioner's professional practice evaluation data that are collected and assessed on an on-going basis.

2. If the practitioner does not have a record of competent professional performance at CSM, current data shall be collected during a time-limited period of privilege-specific professional performance monitoring conducted at CSM.

SECTION 5. <u>FOCUSED PROFESSIONAL PRACTICE REVIEW (FPPE)</u>

A. A period of Focused Professional Practice Review (FPPE) shall be implemented when privileges are initially granted, when new privileges are granted to any currently privileged practitioner, and in response to concerns regarding the provision of safe, high quality patient care. Triggering events for such evaluation may consist of single incidents or evidence of a clinical practice trend. FPPE is a routine step of peer review – it is not Corrective Action, as described in Article XV of these Bylaws. FPPE shall be implemented in accordance with these Bylaws and associated CSM Medical Staff policies and procedures.

B. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of the Practitioner's current clinical competence, practice behavior and ability to perform the requested privilege.

C. Information for FPPE includes, as appropriate, chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient, as further outlined in associated Medical Staff policies and procedures.

SECTION 6. ONGOING PROFESSIONAL PRACTICE REVIEW (OPPE)

A. Ongoing Professional Practice Evaluation (OPPE) is the routine ongoing monitoring and evaluation of current competency for those members of the Medical Staff who currently hold clinical privileges. OPPE data may be obtained from a variety of sources including, for example, individual case review, aggregate performance measures such as rate, rule, or review indicators, as well as referrals for adverse events. OPPE is a routine step of peer review – it is not Corrective Action, as described in Article XV of these Bylaws. OPPE shall be implemented in accordance with these Bylaws and associated Medical Staff policies and procedures.

B. Relevant information obtained from the OPPE process shall be integrated into Medical Staff performance improvement activities. Such information shall help determine whether existing privileges should be maintained, revised, or revoked.

C. The Clinical Service Chair may recommend revision of membership category at any time during the practitioner's appointment cycle when a sustained change is noted in the practitioner's clinical activity and Hospital commitment. (i.e. The Clinical Service Chair may recommend "Membership Only" when the practitioner demonstrates a sustained pattern/trend of no clinical activity.) Such recommendation requires Medical Staff Council and Board approval.

SECTION 7. TEMPORARY PRIVILEGES

A. The CEO or designee, acting on behalf of the Board of Directors and based on the recommendation of the Chief of Staff or designee, may grant temporary clinical privileges to a qualified practitioner who fulfills the criteria set forth below.

B. The circumstances for which the granting of temporary privileges is acceptable include the following:

1. To fulfill an important patient care, treatment, and/or services need (Article V, Section 7, D).

2. When a new applicant with a complete application that raises no concerns is awaiting review and approval of the medical staff executive committee (e.g. Medical Staff Council) and governing body (Article V, Section 7, E).

C. Temporary privileges may be granted to the following:

1. Qualified Physicians, Dentists, Podiatrists and Independent Allied Health Professionals who request temporary privileges to render care to a single patient or to render care to patients while awaiting a formal appointment decision from the Medical Staff Council and the Board of Directors. For Physicians, this includes the privilege to admit patients in accordance with the directives set forth in the Medical Staff Bylaws and Policies; and,

2. Dependent Allied Health Professionals who request temporary privileges to assist their sponsoring Physician(s) in rendering care to a single patient or to render care to patients while awaiting a formal appointment decision from the Medical Staff Council and the Board of Directors.

D. Temporary Privileges to fulfill an important patient care, treatment, and/or services need.

1. Temporary privileges can only be granted on a case by case basis when there is an important patient need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved.

2. Temporary privileges may be granted by the CEO or designee upon recommendation of the Division Medical Staff president (or designee). On weekends and evenings, privileges may be granted verbally by the Administrator-on-call based upon subsequent receipt of documentation by Central Credentials.

3. When temporary privileges are granted to meet an important patient care need, current licensure and current competence will be verified by Central Credentials. Temporary clinical privileges for the visiting practitioner will be granted on a per case basis, not to exceed four (4) cases/episodes in a one-year period.

E. Temporary Privileges for an applicant whose file is pending review/approval of the Medical Staff Council and governing body.

F. Temporary privileges may be granted to a new applicant with a complete application that raises no concerns and is awaiting review and approval of the CSM Medical Staff Council and governing body.

G. Temporary privileges may be granted only if the applicant:

1. Has no current or previously successful challenge to licensure or registration;

2. Has not been subject to involuntary termination of medical staff membership at another organization; and

3. Has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

4. Temporary privileges for the “practitioner with application pending” will be granted for ninety (90) days or until such time that the Hospital Board formally acts upon the request for clinical privileges, not to exceed one hundred twenty (120) days.

H. General Conditions for Temporary Privileges.

1. If granted temporary privileges, the practitioner shall act under the supervision of the Clinical Service chairperson to which the practitioner has been assigned and shall ensure that the chairperson, or the chairperson’s designee, is kept closely informed as to his/her activities within the Hospital.

2. Temporary privileges may be terminated at any time by the Hospital CEO or designee or the Chief of Staff or designee or The Chief of Staff or designee shall assign a member of the Medical Staff to assume the responsibility for the care of such practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff Member. A practitioner currently holding temporary privileges or one whose temporary privileges have been terminated shall not be entitled to the procedural rights in accordance with the Bylaws.

SECTION 8. EMERGENCY PRIVILEGES

In case of an emergency, any Medical Staff member or Allied Health Professional, to the degree permitted by his/her license, regardless of his/her Medical Staff Status or lack thereof, shall be permitted to do everything possible to care for the patient, using every facility in the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Medical Staff member or Allied Health Professional must request the privileges necessary to continue to treat the patient. Should the Medical Staff member or Allied Health Professional not desire to request such privileges, the patient shall be assigned to an appropriate Medical Staff member. For purposes of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of the patient is in immediate danger, and in which any delay in administering treatment would increase that danger.

SECTION 9. DISASTER PRIVILEGES

A. Disaster privileges may be granted when the emergency management plan has been activated and the hospital is unable to handle the immediate patient needs. The CEO or designee, CSM Chief of Staff or a Medical Staff President (or their designees) may grant Disaster privileges in response to a disaster, to providers of known competence, qualifications and quality, who hold medical staff membership and clinical privileges at another facility accredited by The Joint Commission or at a Medicare certified hospital. These credentials will be verified as soon as possible utilizing the Wisconsin Disaster Credentialing (WDC) website or contacting the Emergency Operations Center (EOC), both of which are operated under the auspices of the Wisconsin Hospital Emergency Preparedness Plan (WHEPP).

B. If the disaster is such that communication with the WDC website or EOC is not possible, the CEO or designee, CSM Chief of Staff or a Medical Staff President (or their designees) may grant disaster privileges upon presentation of any of the following:

   A valid, government-issued photo ID issued by a state or federal agency (e.g., driver's license or passport); and

   At least one (1) of the following:

   1. A current hospital photo ID card that clearly identifies professional designation;
   2. A current license to practice (primary source verified);
   3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);
   4. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity);
   5. Identification by current hospital or medical staff members(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during the disaster.

C. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time that the volunteer practitioner presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible; there then must be documentation of the following:

1. why primary source verification could not be performed in the required time frame;
2. evidence of a demonstrated ability to continue to provide adequate care, treatment and services; and
3. an attempt to rectify the situation as soon as possible.

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

D. Those granted disaster privileges must practice under the direction of an existing member of the medical staff. Disaster privileges will terminate once the disaster situation subsides.

E. The grant of disaster privileges will be communicated to key departments via the process outlined in the Medical Staff policy. Credentialing files containing copies of verifications and other supporting documentation will be maintained for all providers who are granted disaster privileges.

F. Any individual identified in the hospital's disaster plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

SECTION 10. TELEMEDICINE PRIVILEGES

All licensed independent practitioners who are responsible for a patient's care, treatment, and services via a telemedicine link at any hospital in the CSM system must be credentialed and privileged to do so at CSM Hospitals through the CSM Medical Staff credentialing process.

SECTION 11. MEDICAL HISTORY AND PHYSICAL EXAMINATION

A. A medical history and physical examination will be completed and documented for each patient no more than thirty (30) days before or within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. It is the responsibility of the attending physician to complete or delegate the completion of an admission history and physical examination. The operating surgeon/physician shall assume responsibility for completing or delegating the completion of a surgical history and physical examination. If the admission history and physical examination is written/dictated by someone other than a physician member of the CSM Medical Staff, it must be authenticated by a physician member of the CSM Medical Staff or by a practitioner with current privileges to perform a comprehensive history and physical examination at CSM.

B. When the medical history and physical examination are completed within thirty (30) days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) hours after admission or registration, but prior to a surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician member of the CSM Medical Staff or by a practitioner with current privileges to perform a comprehensive history and physical.

SECTION 12. AUTOPSIES

The medical staff should attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest. The mechanism for documenting permission to perform an autopsy is defined by Hospital policy.

ARTICLE VI
MEDICAL STAFF DUES

Annual Medical Staff dues shall be governed by the most recent action taken by the Medical Staff Council as more specifically described in the Medical Staff policies and procedures. Invoices for dues will be distributed to Medical Staff members and Allied Health Professionals during the first quarter of the calendar year. Failure to pay dues by the last day of May shall constitute a resignation from the Medical Staff and shall not be subject to any procedural rights set forth in these Bylaws.

ARTICLE VII
CATEGORIES OF THE MEDICAL STAFF

A. The Medical Staff shall be divided into the following categories with the majority of each category being physicians: Active, Courtesy, Membership-Only, Volunteer, and Honorary.

B. At appointment and with each subsequent reappointment, or whenever sustained change is noted in the practitioner's level of commitment and activity, the appropriate Clinical Service Chair (or designee) shall recommend that the practitioner's membership category be evaluated and when indicated, adjusted to reflect his/her current commitment/activity at each Medical Staff Division at which he/she intends to practice. Such recommendation shall reflect the criteria set forth in these Bylaws and requires Medical Staff Council and Board approval.

SECTION 1. ACTIVE MEDICAL STAFF

A. The Active Medical Staff shall consist of those Practitioners who:

1. Are professionally qualified and regularly admit, attend, or consult on patients at the Hospital or Hospital-owned/operated facilities (defined as ten (10) or more episodes of patient care/services over the previous two- (2) year period), or;
2. Regularly refer patients to the Hospital for treatment and/or services on an ongoing basis and are willing and able to devote their time to the interest of the Hospital.

B. Active members are expected to fulfill the functions and responsibilities of the Active Medical Staff including, but not necessarily limited to, emergency consultation and care when indicated, participation at designated meetings of the Hospital or Medical Staff, timely completion of mandatory training as assigned by the Hospital or Medical Staff, active participation in the Hospital's continuing medical education program and/or post graduate medical education activities, and ongoing participation in CSM patient care quality improvement programs, including OPPE and FPPE.

C. In addition to Article VII, Section 1, A and B above, Active members at Sacred Heart must also attain acceptable qualifications in physiatry according to current national standards, or otherwise be qualified by virtue of training and experience to provide rehabilitation and medical management, and support charity care as assigned by the Medical Director.

D. Appointees to the Active Staff may:

1. Admit patients subject to these Bylaws and to applicable Medical Staff policies and procedures;

2. Exercise clinical privileges as recommended by the CSM Medical Staff Council and approved by the Board of Directors;

3. Vote on all matters presented by or to the Medical Staff, unless otherwise specified elsewhere in these Bylaws;

4. Serve as a member of any committee unless otherwise specified elsewhere in these Bylaws; and

5. Hold office, serve as Clinical Service chair, and serve as chair of any committee, unless otherwise specified elsewhere in these Bylaws.

SECTION 3. COURTESY MEDICAL STAFF

A. The Courtesy Medical Staff shall consist of practitioners who are not willing or able to devote their time to the interest of the Hospital, but are essential in providing occasional care to patients at the Hospital, Hospital-owned or operated facilities, or Hospital-sponsored free clinics. The services may include patient consultation and/or coverage for members of the Active or Courtesy Medical Staff.

B. The Courtesy Medical Staff must provide evidence of active membership at another hospital where there is documented participation in a patient care quality improvement program and evidence of good standing at the hospital.

C. The Courtesy Medical Staff must participate and cooperate with the Hospital's Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) in accordance with the applicable Medical Staff policies and procedures. This may include obtaining OPPE and FPPE information from other hospitals to ensure that the Medical Staff has sufficient information to conduct OPPE and FPPE.

D. Appointees to the Courtesy Staff may:

1. Admit patients subject to these Bylaws and to applicable Medical Staff policies;

2. Exercise clinical privileges as recommended by the CSM Medical Staff Council and approved by the Board of Directors.

E. Appointees to the Courtesy staff may not:

1. Vote on all matters presented by or to the Medical Staff at Clinical Service meetings subject to these Bylaws and to applicable Medical Staff policies;

2. Hold office, including the positions of Clinical Service chair;

3. Vote for Medical Staff officers, including Clinical Service chairs;

4. Serve as voting members of CSM Medical Staff or Division-specific committees, unless so waived by the Medical Staff Council;

5. Serve as committee chair for CSM Medical Staff or Division-specific committees, unless so waived by the Medical Staff Council.

SECTION 4. VOLUNTEER MEDICAL STAFF

A. Volunteer Medical Staff shall consist of those practitioners who require Medical Staff membership and privileges in order to volunteer their services at Hospital-sponsored free clinics.

B. Appointees to the Volunteer staff may:

1. Exercise such clinical privileges as are granted by the Board of Directors upon recommendation of the CSM Medical Staff Council. These privileges are only to be exercised at the designated Hospital-sponsored free clinic(s).

C. Appointees to the Volunteer staff may not:

1. Admit patients;

2. Vote on all matters presented by or to the Medical Staff at Clinical Service meetings subject to these Bylaws and to applicable Medical Staff policies;

3. Hold office, including the positions of Clinical Service chair;

4. Vote for Medical Staff officers, including Clinical Service chairs;

5. Serve as voting members of CSM Medical Staff or Division-specific committees, unless so waived by the Medical Staff Council;

6. Serve as committee chair for CSM Medical Staff or Division-specific committees, unless so waived by the Medical Staff Council and approved by the Board of Directors.

SECTION 5. MEMBERSHIP ONLY MEDICAL STAFF

A. Membership Only Medical Staff shall consist of those practitioners who require Medical Staff membership in order to participate in insurance plans or those practitioners who do not meet the criteria for the Active, Courtesy, Volunteer or Honorary Medical Staff Categories, but wish to maintain membership.

B. Practitioners assigned to the category of Membership Only shall not be assigned to a specific Clinical Service. Review and recommendation of the credentials for Membership Only practitioners will be completed by the Chair of the Credentials Committee or designee.

C. Appointees to the Membership Only staff may not:

1. Admit patients;

2. Exercise clinical privileges;

3. Vote on all matters presented by or to the Medical Staff at Clinical Service meetings subject to these Bylaws and to applicable Medical Staff policies;

4. Serve as voting members of committees subject to these Bylaws and to applicable Medical Staff policies;

5. Hold office, including the positions of Clinical Service chair;

6. Vote for Medical Staff officers, including Clinical Service chairs; nor

7. Serve as committee chair for CSM Medical Staff or Division-specific committees.

SECTION 6. HONORARY MEDICAL STAFF

A. The Honorary Medical Staff shall consist of practitioners who were formerly members of the Active staff of the Hospital, who have made significant contributions to the Hospital, but are no longer in active practice. They are honored by the Medical Staff for their outstanding professional reputation and exceptional service to the Hospital.

B. Honorary Staff Membership is a lifetime appointment when recommended by the Medical Staff Council and approved by the Board, and is not subject to credentialing and privileging requirements as identified in these Bylaws and applicable Medical Staff policies and procedures. Should questions of ethical or professional misconduct arise, Honorary Status may be rescinded by a majority vote of the Medical Staff Council, pending Board approval. Such action shall constitute a resignation from the Medical Staff and shall not be subject to any procedural rights set forth in these Bylaws.

C. Appointees to the Honorary Staff may:

1. Serve as voting members of committees subject to these Bylaws and to applicable Medical Staff policies; and

2. Upon invitation, attend all appropriate Medical Staff functions and events.

D. Appointees to the Honorary Staff may not:

1. Admit patients;

2. Hold clinical privileges;

3. Hold office, including the positions of Clinical Service chair;

4. Vote on matters in the Medical Staff organization, with the exception of Article VII, Section 6, C-1;

5. Serve as committee chair for CSM Medical Staff or Division-specific committees, unless so waived by the Medical Staff Council and approved by the Board of Directors.

C. Honorary Medical Staff members are not required to attend Medical Staff meetings, Clinical Service meetings, or committee meetings.

SECTION 7. ALLIED HEALTH PROFESSIONALS

A. Allied Health Professionals (AHPs) are not members of the Medical Staff however their activities are governed by the Medical Staff organization. Therefore, in accordance with these Bylaws and associated Medical Staff policies and procedures, the Medical Staff shall review the credentials, qualifications and competency of Allied Health Professionals and forward recommendations to the Board of Directors for final approval. Allied Health Professionals shall be divided into three (3) categories: Independent, Advanced Practice, and Dependent as described in these Bylaws and Medical Staff policies and procedures.

B. Independent Allied Health Professionals: Independent AHPs are permitted by law to practice within the scope of their certification/licensure in accordance with their delineated clinical privileges as recommended by the Medical Staff and authorized by the Board of Directors, and in accordance with these Bylaws and associated Medical Staff policies and procedures.

C. Advanced Practice Allied Health Professionals: Advanced Practice AHPs are permitted by law to practice within the scope of their certification/licensure in accordance with their delineated clinical privileges as recommended by the Medical Staff and authorized by the Board of Directors, and in accordance with these Bylaws and associated Medical Staff policies and procedures. Furthermore, Advanced Practice AHPs shall practice via a collaborative practice agreement or set of supervisory guidelines with a physician.

D. Dependent Allied Health Professionals: Dependent AHPs are permitted by law to practice within the scope of their certification/licensure under the sponsorship/supervision of a Medical Staff member who holds current privileges at the Hospitals, and within the parameters of their respective job description which has been approved by the Medical Staff and Board of Directors. Dependent AHPs shall practice in accordance with these Bylaws and associated Medical Staff policies and procedures.

E. A decision by the Medical Staff Council or the Board of Directors not to grant the requested privileges or scope of practice to an Allied Health Professional or to suspend, to terminate, or to discontinue such privileges or scope of practice shall entitle the affected individual to the procedural rights as described in Medical Staff policies and procedures.

ARTICLE VIII
OFFICERS

SECTION 1. OFFICER OF THE MEDICAL STAFF AS A WHOLE

A. Officer

The highest designated position of the Medical Staff is the Chief of Staff.

B. Qualifications

The Chief of Staff must have been an Active member of the Medical Staff for at least five (5) years. Further, he/she must have served in a Medical Staff leadership capacity or served on Medical Staff committees. The Chief of Staff must be an Active member of the Medical Staff in good standing at the time of nomination and election and must remain an Active member in good standing during his/her term of office.

C. Election

The Medical Staff Council shall meet as a Nominating Committee during the latter part of the even year to nominate one (1) or two (2) candidates for Chief of Staff. Election for the Chief of Staff will take place at a regularly scheduled meeting of the Medical Staff Council during the last quarter of the even year. The Chief of Staff shall be elected by a majority vote of the voting members of the Medical Staff Council.

D. Term of Office

The Chief of Staff shall serve a two (2) year term beginning on January 1 of the odd year or the day after Board approval if the Board has not approved the newly elected Chief of Staff prior to January 1. The Chief of Staff is restricted to three (3) consecutive terms in office.

E. Vacancy

In the case of temporary absence, incapacitation or resignation of the elected Chief of Staff, the Chief Executive Officer or designee shall appoint a current Medical Staff President to serve as Chief of Staff for the remainder of the term, contingent upon the approval of the CSM Board of Directors. Should the current Medical Staff Presidents decline to fill the vacancy, the Chief Executive Officer or designee, in collaboration with the Medical Staff Council shall appoint a qualified Active Staff member for the remainder of the term, contingent upon the approval of the CSM Board of Directors.

F. Removal From Office

A Chief of Staff may be removed from office with or without cause by the CSM Board of Directors upon receipt of a recommendation of a two-thirds (2/3) majority of the Medical Staff Council, excluding the Chief of Staff as a voting member, or by petition of ten percent (10%) of the Active members of the Medical Staff and a subsequent two-thirds (2/3) affirmative vote by ballot of the Active Medical Staff members. Permissible bases for removal from office include, without limitation, failure to meet the qualifications for office, and failure to perform the duties of the office.

G. Duties

The Chief of Staff shall:

1. Serve as the Medical Staff's advocate and representative to the Board of Directors and Hospital Administration;

2. Evaluate the effectiveness of the hospital's credentialing, privileging, and quality processes and report results to the Board of Directors, Medical Staff Council, and administration;

3. Act in coordination and cooperation with the Division officers and the Chief Executive Officer or designee regarding matters of mutual concern that impact the Medical Staff as a whole;

2. Serve as a member of all Medical Staff committees that serve the Medical Staff as a whole;

3. Be responsible for the enforcement of Medical Staff Bylaws and pertinent Medical Staff policies and procedures for implementation of sanctions where they are indicated, and for compliance with the procedural requirements under the Medical Staff Bylaws when corrective action is requested against a Medical Staff member.

4. Call, preside at, and be responsible for the agenda of all meetings of the general Medical Staff;

5. Call, preside at, and be responsible for the agenda of all meetings of the Medical Staff Council;

6. Appoint Medical Staff members to serve as chair of Medical Staff committees when such committees serve the Medical Staff as a whole.

7. Act as a spokesperson for the Medical Staff as a whole in its external professional and public relations.

SECTION 2. DIVISION OFFICERS

A. Officers

Each of the three (3) Medical Staff Divisions will elect a Medical Staff President to represent the needs and concerns of the Medical Staff members who hold current privileges in the Division. These positions shall include:

1. Medical Staff President, CSM Hospital Milwaukee
2. Medical Staff President, CSM Hospital Ozaukee
3. Medical Staff President, Sacred Heart

B. Qualifications

Division officers must be Active Medical Staff members in their respective Division at the time of nomination and election, and must remain Active and in good standing during their term of office. Furthermore, each Medical Staff President must regularly contribute to the care of patients at the Hospital (or clinic/ambulatory center owned by that Hospital) that he/she represents.

C. Election of Officers

1. During the latter half of the even year, notice shall be sent to the Active Medical Staff in each Division informing them of the upcoming election for Medical Staff President of their Division, and inviting qualified candidates to self-nominate. If more than three (3) qualified candidates self-nominate, runoff elections will be held until no more than three (3) candidates remain for each office. A final slate of candidates must be identified at least ten (10) days in advance of the election.

2. Eligible Active Staff in each Division will be notified of the electronic balloting process no later than December 1 of the even year. In the event that only one candidate is running for any office, balloting will not be held for that office.

3. In the event of a tie, the current Division Medical Staff President will cast a vote to break the tie and determine who shall serve as Medical Staff President. In the event of a tie and the Division Medical staff President is a candidate, the Chief of Staff will cast a vote to break the tie.

D. Term of Office

All officers shall serve a two (2) year term beginning on January 1 of the odd year (or the day after Board approval if the Board has not approved the officers' election prior to January 1). Elected officers are restricted to three (3) consecutive terms in the same office, unless so waived by the CSM Medical Staff Council and approved by the Board of Directors.

E. Vacancies

In the event of a vacancy in the office of Medical Staff President, the Chief of Staff shall appoint a qualified Active Medical Staff member to serve the remainder of the term with the approval of the Medical Staff Council. Vacancies in the office of Immediate Past President will not be filled.

F. Removal from Office

The Division Medical Staff President may be removed from office with or without cause by the CSM Board of Directors upon receipt of a recommendation of a two-thirds (2/3) majority of the Medical Staff Council, excluding the officer as a voting member, or by petition of ten percent (10%) of the Active members of the Division and a subsequent two-thirds (2/3) affirmative vote by ballot of the Active Medical Staff members in the Division. Permissible bases for removal from office include, without limitation, failure to meet the qualifications for office, and failure to perform the duties of the office.

G. Duties

The duties of the Medical Staff Presidents are to support the mission of the Medical Staff which includes: credentialing and privileging, quality assessment and improvement, governance functions, administration of duties, and effective communication. Furthermore, the Medical Staff Presidents have a unique obligation to ensure that the needs and concerns expressed by members of the Medical Staff who hold privileges at their respective Hospital are given due consideration. The Medical Staff Presidents may call regular or special meetings to address the needs or concerns of Medical Staff members who hold privileges at their respective Hospital, and shall report on such matters at the Medical Staff Council meetings.

1. Act in coordination and cooperation with the Chief of Staff and the Chief Executive Officer or designee regarding Hospital-level matters of mutual concern.

2. Call, preside at, and be responsible for the agenda of all regular and special meetings of their respective Medical Staff Division.

3. Be responsible for the enforcement of the Bylaws, Medical Staff policies, and Hospital-based policies and procedures.

4. Act in coordination and cooperation with the Chief of Staff for implementation of sanctions where indicated, and for compliance with the procedural requirements under the Medical Staff Bylaws when corrective action is requested against a Medical Staff member.

5. Appoint Chairs and Medical Staff members of all Hospital-based Medical Staff Committees, except as otherwise provided in the Bylaws or Division policies.

6. Represent the Hospital-based views, needs, and grievances of the Medical Staff to the Chief of Staff, and Chief Executive Officer or designee.

7. Report to the CSM Medical Staff Council on the performance of quality assessment and improvement activities of the Medical Staff.

8. Monitor and support the educational requirements of the Medical Staff.

SECTION 3. DISCLOSURE OF CONFLICTS

Medical Staff officers and Medical Staff Council (Medical Executive Committee) members shall disclose in writing to the Medical Staff, prior to the date of election or appointment, any personal, professional, or financial affiliations or relationships which could foreseeably result in a conflict of interest with their activities on behalf of or responsibilities of the Medical Staff.

ARTICLE IX
COMMITTEES

A. There shall be such standing and special committees of the Medical Staff as are necessary to perform the functions required by these Bylaws. Except as otherwise provided in these Bylaws, whenever the committee is Medical Staff Division-specific, the Medical Staff President of that Medical Staff Division shall appoint the committee chair and members, in collaboration with the Chief Executive Officer or designee. Whenever the committee serves the Medical Staff as a whole, the Chief of Staff shall appoint the committee chair and members, in collaboration with the Chief Executive Officer or designee.

B. The members present at any duly noted regular or special committee meeting shall constitute a quorum for all purposes. Voting at Medical Staff committee meetings shall be limited to those members in attendance and, the action of the majority of the members present at a meeting shall be the action of the Medical Staff. Each voting member of the committee shall be entitled to one (1) vote, even if such person holds more than one (1) position entitled to membership on the committee. In exigent circumstances, the committee chair may act on behalf of the committee and must report such actions at the next committee meeting for approval. The Medical Staff Presidents, Chief Executive Officer or designee and Vice President of Medical Affairs/Chief Medical Officer or their respective designees shall be voting members of all committees unless otherwise stated in these Bylaws and associated Medical Staff policies and procedures.

C. All standing committees shall prepare a record of attendance at their meetings and maintain a record of recommendations. Records of special meetings need only be maintained when consideration of a recommendation is requested. All standing committees, not specifically identified in these Bylaws, shall be described in Medical Staff policies and procedures.

SECTION 1. MEDICAL STAFF COUNCIL (CSM MEDICAL EXECUTIVE COMMITTEE)

A. Composition

1. The voting members of the Medical Staff Council shall be Active, physician members of the Medical Staff.

2. The following shall serve as voting members of the Medical Staff Council:

    a. Chief of Staff;

    b. Three (3) Medical Staff Presidents;

    c. Clinical Service Chairs;

    d. Medical Director, Inpatient Medicine Program

3. The following shall serve as non-voting members of the Medical Staff Council:

    a. Medical Director, Family Medicine Residency Program;

    b. Chief Executive Officer or designee;

    c. Vice President of Medical Affairs/Chief Medical Officer; and

d. Vice President of Patient Care Services.

B. Duties

The duties of the Medical Staff Council shall be to:

1. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

2. Receive, review and resolve significant discrepancies or disputes related to membership, credentialing and privileging;

3. Oversee the process for Corrective Action and Fair Hearing/Appellate Review in accordance with the procedures set forth in Articles XV and XVI of these Bylaws;

4. Oversee the process for Corrective Action when a summary suspension has been served in accordance with the procedures set forth in Article XV of these Bylaws;

5. Serve as the Bylaws Committee and perform a review of the Medical Staff Bylaws and associated Medical Staff Policies and Procedures in a reasonable, timely, and responsible manner, so as to have Bylaws of generally recognized quality, to provide a basis for acceptance by accrediting agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review;

6. Receive and act upon committee reports/recommendations;

7. Develop, implement and enforce policies of the CSM Medical Staff and of the ~~two~~ Divisions;

8. Provide liaison between the Chief Executive Officer or designee and the Board of Directors through the BQSS;

9. Recommend action to the Chief Executive Officer or designee on matters of medical administrative nature;

10. Establish committees of the CSM Medical Staff and of the Divisions as are necessary to carry out its purpose;

11. Make recommendations on Hospital management matters to the Board of Directors through the BQSS;

12. Fulfill the Medical Staff's accountability to the Board of Directors for the quality of medical care rendered to patients;

13. Review the Credentials Committee's recommendations regarding the performance and clinical competence of Medical Staff members with clinical privileges, and as a result of such reviews, make recommendations to the Board of Directors through the BQSS of appointments, reappointments, and renewal of clinical privileges;

14. Promote ethical conduct and competent clinical performance on the part of all members of the Medical Staff;

15. Be responsible to the BQSS and the Board of Directors for the implementation of the Hospital quality improvement plan as it affects the Medical Staff;

16. Consider and recommend amendments to the policies of the CSM Medical Staff as necessary for the proper conduct of its work; and

17. Act on behalf of the Medical Staff in the intervals between Medical Staff meetings.

B. Confidentiality, Protection and Immunity

From time to time, the Medical Staff Council may need to address certain issues which may fulfill the criteria for "Health Services Review" which is defined in Wis. Stats. 146.37 and 146.38 as "the review or evaluation of services of health care providers in order to improve the quality of health care, to avoid improper utilization of health care provider services, or to determine the reasonable charges for such services." In this circumstance, the Chair of the Medical Staff Council shall adjourn the routine meeting and reconvene as a special meeting to include only the members of the Medical Staff Council as identified above in Article IX Section1-A-2 and 1-A-3 (Composition), and those ad hoc members whose participation serves a role that is integral to the topic at hand. Special meetings of the Medical Staff Council shall adhere to the pertinent guidelines set forth in CSM Medical Staff Policy 1158 entitled, "Peer Review: Medical Staff and Allied Health Professionals" and shall be protected under Wis. Stats. 146.37 and 146.38.

C. Meetings

The Medical Staff Council shall meet at least four (4) times per year on a quarterly basis, or more often as needed to perform its assigned functions.

D. Quorum and Voting

1. The majority of voting members at any duly noted regular or special committee meeting of the Medical Staff Council shall constitute a quorum for all purposes.

2. All matters shall be determined by the Medical Staff Council based upon a simple majority vote at a regular or special meeting.

3. Each voting member present at any duly noted regular or special committee meeting is entitled to one (1) vote. Voting shall be cast in person or via telephone only if the member joins the meeting via teleconference call.

E. Removal of Member(s)

1. If a member of the Medical Staff Council is removed from his/her respective office, it is grounds for removal from the Medical Staff Council.

2. A Division physician representative may be removed from the Medical Staff Council with or without cause by the CSM Board of Directors upon receipt a two-thirds (2/3) majority of the Medical Staff Council, excluding the representative as a voting member. Permissible bases for removal from office include, without limitation, failure to meet the qualification for office, and failure to perform the duties of the office.

ARTICLE X
MEETINGS OF THE MEDICAL STAFF

A. Meetings of the Medical Staff as a Whole

1. Regular meetings of the Medical Staff as a whole shall be held as needed. The Chief of Staff shall preside at these meetings and report on matters on behalf of the Medical Staff Council. Each Medical Staff President shall report on matters on behalf of his/her respective Medical Staff Division.

2. The Chief of Staff or a majority of the Medical Staff Council, may call a special meeting of the Medical Staff at any time. The Chief of Staff shall call a special meeting of the Medical Staff within thirty (30) days after receipt of a written request signed by not fewer than twenty-five (25) members of the Active Medical Staff stating the purpose for such meeting. The Chief of Staff shall designate the time and place of any special meeting. No business shall be transacted at any special meeting except as stated in the notice calling that meeting.

3. Electronic notice stating the location, date and time of any regular or special meeting of the Medical Staff shall be communicated to the Medical Staff not less than ten (10) calendar days before the date of such meeting. No amendment to these Bylaws or other material change in Medical Staff governance shall be acted upon at any regular or special meeting unless the notice calling the meeting so stipulated.

4. The Active Medical Staff members present at any duly noticed regular or special meeting of the Medical Staff shall constitute a quorum for purposes of amendments of these Bylaws and for all other actions. The action of a majority of the members present at a meeting shall be the action of the Medical Staff. Only Medical Staff members who are assigned to an Active category of membership in at least one Medical Staff Division may vote on matters presented at such meetings but all members of the Medical Staff and ex officio members may have a voice in the deliberations.

5. Minutes of each regular or special meeting of the Medical Staff shall be documented, and shall include a record of attendance of members, and the action taken on each item of business.

B. Meetings of the Medical Staff Divisions

1. Regular or special meetings of the Medical Staff Divisions shall be held as needed. The Division Medical Staff President will preside at Division Medical Staff meetings to address the needs or concerns of Medical Staff members who hold privileges at the Hospital, or to report on matters unique to the Hospital. Matters which impact the entire Medical Staff shall be presented at the regular or special meetings of the Medical Staff as a whole.

2. The Division Medical Staff President or a majority of the Medical Staff Members who hold current privileges in the Division may call a special meeting of the Division Medical Staff at any time. The Division Medical Staff President shall call a special meeting of the Division Medical Staff within thirty (30) days after receipt of a written request signed by not fewer than twenty-five (25) members of the Active Medical Staff who hold current privileges in the Division, stating the purpose for such meeting. The Division Medical Staff President shall designate the time and place of any special meeting. No business shall be transacted at any special meeting except as stated in the notice calling that meeting. In the event a Division has less than twenty-five (25) Active members, the Division Medical Staff President shall call a special meeting after receipt of a written request signed by not fewer than fifty percent (50%) of the Active Medical Staff who hold current privileges in the Division, stating the purpose for such meeting.

3. Electronic notice stating the location, date and time of any regular or special meeting of the Medical Staff shall be communicated to the Medical Staff not less than ten (10) calendar days before the date of such meeting.

4. The Active Medical Staff members present at any duly noticed regular or special meeting of the Medical Staff Division shall constitute a quorum for purposes of voting on matters which pertain only to Medical Staff Division. The action of a majority of the voting members present at a meeting shall be the action of the Medical Staff Division. Only Medical Staff members who are assigned to an Active category of membership may vote on matters presented at such meetings but all members of the Medical Staff and ex officio members may have a voice in the deliberations.

5. Minutes of each regular or special meeting of the Medical Staff Division shall be documented, and shall include a record of attendance of members, and the action taken on each item of business.

C. Methodology to Opt-out of the Unified Medical Staff

The methodology to opt-out of the unified Medical Staff is described in Article XX of these Bylaws.

ARTICLE XI
CLINICAL SERVICES

The Hospital Divisions shall be organized into Clinical Services based upon the needs of the respective Divisions. Clinical Service designations, service meetings and officers shall be described in Medical Staff policies and procedures.

ARTICLE XII
IMMUNITY FROM LIABILITY

A. The following shall be express conditions to any individual's application or reapplication for, or exercise of, clinical privileges or medical staff membership:

B. Any act, communication, report, recommendation or disclosure, with respect to any individual, performed or made in good faith and without malice and made at the request of an authorized representative of this or any other health care facility for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

C. Such privileges shall extend to members of the medical staff, hospital personnel and the Board of Directors, the Chief Executive Officer or designee and designated representatives and to third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purposes of this section, the term "third parties" means both individuals and organizations who have supplied information to or received information from an authorized representative of the hospital (including the Board of Directors or the Medical Staff) and includes but is not limited to individuals, health care facilities, governmental agencies, peer review organizations and any other person or entity with relevant information.

D. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

E. Such immunity shall apply to all acts, communications, reports, or disclosures performed or made in connection with this or any other health care institution's activities related to, but not limited to:

1. Applications for appointment or clinical privileges;
2. Monitoring of members of the provisional staff or of any other practitioner or paramedical affiliate under the monitoring protocol established by the medical staff;
3. Periodic reappraisals for reappointment or clinical privileges;
4. Corrective action, including suspension;
5. Hearings and appellate reviews;
6. Medical care evaluations;
7. Utilization reviews;
8. Profiles and profile analysis;
9. Malpractice loss prevention; and
10. Other hospital, service or committee activities related to quality patient care and interprofessional conduct.

F. The acts, communications, reports, recommendations, and disclosures referred to in this section may relate to an individual's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

G. Each individual who exercises clinical privileges or performs any service that is monitored under the monitoring protocols established under these Bylaws, as a condition of exercising the clinical privileges or performing the service, shall indemnify and hold harmless all members of the Medical Staff and the Board of Directors, the Chief Executive Officer or designee and their designated representatives from any liability arising from or out of the services performed by the individual being monitored, including but not limited to claims of malpractice, negligent supervision, and any other basis. The exercise of clinical privileges or performance of any service that is monitored constitutes the individual's acceptance of the terms of this indemnification agreement.

H. To reaffirm the immunity intended by this section, each individual shall, upon request of the hospital, execute releases acknowledging the immunity and protections set forth in this section in favor of the individuals and organizations specified in paragraph B, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of this state. Execution of such releases is not a prerequisite to the effectiveness of this section.

I. All provisions in these Bylaws and in other forms used in the credentials process relating to authorizations, confidentiality of information and immunity from liability are in addition to and not in limitation of other immunities provided by law.

J. The Hospitals shall indemnify and hold harmless any Medical Staff member against any threatened or pending claim, loss, damage or expense (including reasonable attorneys' fees and disbursements) incurred by the Medical Staff member and arising out of his/her service on any Hospital or Medical Staff committee or assisting in peer professional review or quality assurance activities involving patient care provided at the Hospitals, so long as the Medical staff member acted in good faith and has not violated confidentiality or any other requirements associated with peer and professional review activities. In the event a Medical Staff member is named or threatened to be named as a party to any claim, action or suit covered by the foregoing indemnification commitment, the Medical staff member shall tender the defense to the Hospitals, in which case the Hospitals shall assume and undertake the defense. The foregoing indemnification commitment from the Hospitals shall also apply to the Medical Staff collectively.

ARTICLE XIII
CONFIDENTIALITY

A. The Medical Staff recognizes that it is vital to maintain the confidentiality of certain information, for reasons of both law and policy. Practitioners participate in credentialing, peer review, and quality improvement activities, and others contribute to these activities, in reliance upon the preservation of confidentiality. The confidentiality of these activities, and of all Medical Staff records, is to be preserved and these communications, information and records will be disclosed only in the furtherance of credentialing, peer review, and quality improvement activities, and only as specifically permitted under the conditions described in these Bylaws and Medical Staff policy. This requirement of confidentiality extends to the records and minutes of all Medical Staff committees, to the records of all Medical Staff credentialing, peer review and quality improvement activities, to the credentials and peer review files concerning individual Practitioners, and to the discussions and deliberations which take place within the confines or under the aegis of Medical Staff committees.

B. Each member of the Medical and Allied Staff, by acceptance of appointment or reappointment, therefore pledges to: (1) maintain all such information and any and all discussions and deliberations regarding the same in strict confidence; (2) agree to make no disclosures of such confidential information outside of appropriate meetings, except when: (a) the disclosures are to another authorized member of the Medical or Allied Health Professional Staff or authorized employee of Hospital and are for the purposes of conducting legitimate Medical Staff affairs; (b) the disclosures have been authorized, in writing, by the CEO or designee and the Chief of Staff; or (c) as otherwise permitted by the Medical Staff Policy. Any such disclosures shall be made only in a private setting for the specified purpose regarding the disclosure.

ARTICLE XIV
COLLEGIAL EFFORTS TO CORRECT BEHAVIORS AND ADMINISTRATIVE TIME OUT

A. Collegial Efforts to Correct Behaviors

1. The CEO or designee and Chief of Staff or designee will strive to use progressive steps, beginning with collegial and education efforts, to address questions relating to a Member's clinical practice and/or professional conduct. The goal of these progressive steps is to help the Member voluntarily respond and resolve questions that have been raised. All collegial intervention efforts by the CEO or designee and Chief of Staff shall be considered confidential and part of the Hospital's performance improvement and professional peer review activities as defined by applicable state and federal law, and as addressed in "Privileges and Immunities," above.

2. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the Chief of Staff and CEO or designee. Collegial intervention efforts may include but are not limited to the following:

    a. Educating and advising Members of all applicable bylaws, policies, procedures, rules and/or regulations including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

b. Following up on any questions or concerns raised about the clinical practice and/or conduct and recommending such steps as proctoring, monitoring, consultation, or letters of guidance;

c. Sharing summary comparative quality, utilization, and other relevant information to assist Members to conform their practices to appropriate norms.

3. Following collegial intervention efforts, if it appears that the Member's performance does not improve, or in cases where it appears that collegial intervention is inappropriate, the CEO or designee and Chief of Staff may request that the Medical Staff Council authorize an investigation into the matter. If the CEO or designee and Chief of Staff disagree whether an investigation is needed, the Medical Staff Council will make the determination. If questions involve a member of the Medical Staff Council, that member will recluse him/herself from such deliberations.

B. Administrative Time Out

1. As a part of its progressive approach to Member conduct and performance issues, the Medical Staff Council may, with approval of the CEO or designee, give a Member one or more Administrative Time Outs, not to exceed five (5) total days of Administrative Time Out in a calendar year. The Administrative Time Out is intended, in good faith, to serve as a last resort by the Medical Staff Council prior to making a recommendation to suspend or terminate membership or privileges for a significant period or permanently. During an Administrative Time Out, the Member must continue to fulfill his/her emergency patient call obligations, if any, but may not exercise any other clinical privileges except in an emergency situation or to address an imminent delivery. An Administrative Time Out may be instituted only under the following circumstances:

a. When the action that has given rise to the time out relates to an administrative policy of the Hospital or Medical Staff such as: completion of medical records, practitioner behavior or requirements for emergency department coverage; and

b. When the action(s) have been reviewed by the Medical Staff Council and the Medical Staff Council has determined that one or more of the above policies have been violated; and

c. When the Member has received prior notice regarding the conduct in question; and

d. When the affected Member has been offered an opportunity to meet with the Medical Staff Council prior to the imposition of the Administrative Time Out. Failure on the part of the Member to comply with the Medical Staff Council’s request for a meeting will constitute a violation of the Bylaws and will not prevent the Medical Staff Council from issuing the Administrative Time Out.

2. An Administrative Time Out will take effect after the Member has been given an opportunity to either arrange for his/her patients currently at the Hospital to be cared for by another qualified Member or until he/she has had an opportunity to provide needed care prior to discharge, but in no event later than forty-eight (48) hours after written notice from the MEC of the imposition of the Administrative Time Out. During this period, the Member will not be permitted to schedule any elective admissions, surgeries, or procedures. The Chief of Staff will determine details of the extent to which the Member may continue to be involved with hospitalized patients prior to the effective date of the Administrative Time Out.

3. Issuance of an Administrative Time Out does not trigger hearing or appeal rights.

ARTICLE XV
CORRECTIVE ACTION

A. The following procedures address the rights and obligations of Medical Staff members in the event that the Member has allegedly engaged in unacceptable clinical practice or professional conduct. Such concerns of AHPs are addressed in Medical Staff policies and procedures. Therefore, except for the Section entitled "Automatic Relinquishment" below, this "Corrective Action for Medical Staff Members" provision, does not apply to AHPs.

B. Corrective action may be requested by any Member of the Medical Staff or a senior member of the Hospital's administrative staff. All requests for corrective action must be made in writing to the CEO or designee and Chief of Staff and must be supported by reference to the specific activities or conduct which constitutes the grounds for the request.

C. Documentation created and obtained in the review or evaluation of practitioners is confidential and shall not be disclosed or released except as permitted by law and Hospital policy.

D. Initiation of Investigation

1. The Medical Staff Council shall address and appropriately document its determination and reasons for determining that an investigation should or should not be commenced following a request by the CEO or designee and Chief of Staff. In the event the Board believes the Medical Staff Council has incorrectly determined that an investigation is unnecessary, it may direct the Medical Staff Council to proceed with an investigation. The date of the determination by the Medical Staff Council to conduct an investigation (or the date on which the Medical Staff Council receives direction from the Board to so act) shall be considered the investigation commencement date.

E. Investigation

1. The Medical Staff Council may conduct the investigation itself or may assign the task to an appropriate standing or special committee of the Medical Staff.

2. The investigating body shall proceed with the investigation promptly. It shall notify the Member in question that the investigation is being conducted and provide an opportunity for the Member to meet to provide information in a manner and upon such terms as the investigating body deems appropriate. Any meeting between the Member in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) will not constitute a hearing, is preliminary in nature, and none of the procedural rules provided in these Bylaws, including but not limited to right to representation, apply.

3. The investigating body has the authority to review all documents and previous findings it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the CEO or designee and Chief of Staff. The investigating body may also require the Member under review to undergo a physical and/or mental examination and may access the results of such examinations.

4. An external peer review consultant should be considered when:

   a. Litigation seems likely.

b. The Hospital is faced with ambiguous or conflicting recommendations from Medical Staff or Hospital leaders, or where there does not appear to be a strong consensus for a particular recommendation.

c. There is no one on the Medical Staff with expertise in the subject under review, or when the only physicians on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the physician under review.

5. The Member under review cannot compel the Medical Staff to engage external consultation. The investigating body shall forward a written report of its findings, conclusions, and recommendations to the Medical Staff Council as soon as practicable.

6. Despite the status of any investigation, the CEO or designee or Chief of Staff shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action within their authority pursuant to these Bylaws.

F. Medical Staff Council Action

1. As soon as practicable after the conclusion of its investigation, the Medical Staff Council will take action that may include, without limitation:

a. Determining no corrective action will be taken.

b. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein should be deemed to preclude the issuance of informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected Member may make a written response which will be placed in the Member's Medical Staff file.

c. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring (so long as the Member's ability to practice independently is not otherwise affected).

d. Recommending denial, restriction, modification, reduction, suspension or revocation of clinical privileges.

e. Recommending reductions of membership status or limitation of any prerogatives directly related to the Member's delivery of patient care.

f. Recommending suspension, revocation, or probation of Medical Staff membership.

g. Taking other actions deemed appropriate under the circumstances.

G. Subsequent Action

1. If the Medical Staff Council recommends any termination or restriction of the Member's membership or privileges, that recommendation shall be transmitted in writing to the Member, as set forth in "Medical Staff Hearing and Appellate Review" below, and to the Board. Such adverse recommendation shall be held in abeyance until the Member has waived or exercised his/her rights to hearing and, if applicable, appeal, under these Bylaws.

2. The Board may accept the Medical Staff Council report and recommendations or it may prescribe other actions or interventions. If the Board recommends termination or restriction of the Member's membership or privileges, that recommendation shall be transmitted in writing to the affected Member. The recommendation of the Board shall become final unless the Member timely requests a hearing. Such a request and hearing is permitted only if the decision of the Board is more severe than the recommendation of the Medical Staff Council and the Member has not previously had a hearing concerning the matters that gave rise to the adverse action. In those circumstances in which the Board decision is more severe than the recommendation of the Medical Staff Council and the Member has previously had a hearing concerning the matters, the Member will have ten (10) days from his/her receipt of such determination in which to submit a written appeal to the CEO or designee for consideration by the Board. The written appeal must be sent to and received by the CEO or designee within the ten (10)-day period. Such written appeal shall be based only upon the records upon which the adverse decision was made, and may be accompanied by the appellant's written statement. The Board may, however, at its sole discretion, accept additional oral or written evidence.

3. A Member who fails to request a hearing or, if applicable, appeal within the time specified is deemed to have waived all rights to any hearing and appeal to which he/she might otherwise have been entitled. Such waiver constitutes acceptance of that action, which then becomes and remains effective pending the final decision of the Board.

4. If the affected Member is employed by the Hospital, the Board will copy the Chief Human Resources Officer on its determination. Members who are employed by the Hospital may be subject to employment action consistent with the Hospital's employment policies and procedures. Such employment action is separate and distinct from any action taken by the Board regarding membership or privileges and is not subject to the hearing or appeal rights of the Bylaws.

H. Precautionary Restriction or Suspension

1. Criteria for Initiation

   a. A precautionary restriction or suspension may be imposed when the CEO or designee and Chief of Staff believe in good faith that they need to take immediate action to carefully consider any event, concern, or issue that, if confirmed, has the potential to significantly affect patient or employee safety, the effective operation or the reputation of the Medical Staff and/or the Hospital. For example, a suspension of all or any portion of a Member's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the Member's clinical privileges at this Hospital.

   b. Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and prompt written notice shall be given to the Member. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein.

   c. The precautionary suspension or restriction is an interim step in which an investigation is being conducted to determine the need for a professional review action. It is not punitive, but is a temporary, administrative remedy that implies no finding of incompetent medical practice or improper conduct. It is not a complete professional review action in and of itself. A precautionary suspension or restriction does not imply any finding of responsibility for the situation(s) that triggered the suspension or restriction.

2. Medical Staff Council Action

a. As soon as practicable and within five (5) calendar days after such precautionary suspension has been imposed, the Medical Staff Council shall meet to review and consider the action and, if necessary, engage in collegial intervention or begin the investigation process as noted above. Upon request, the Member will be given the opportunity to address the Medical Staff Council concerning the action, on such terms and conditions as the Medical Staff Council may impose, although in no event shall any meeting of the Medical Staff Council, with or without the Member, constitute a "hearing" as the term is used in these Bylaws, nor shall any procedural rules with respect to hearing and appeal apply. The Medical Staff Council may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the Member with written notice of its decision.

3. Procedural Rights

a. The Member shall be entitled to the procedural rights afforded by these Bylaws if the restriction or suspension extends for more than fourteen (14) calendar days.

I. Automatic Suspension, Limitation or Termination

1. Medical Staff membership and clinical privileges shall be automatically suspended, limited or terminated, as indicated, under the following circumstances, which action shall be deemed automatic and final and without any procedural rights under Article XV (Corrective Action) and Article XVI (Medical Staff Hearing and Appellate Review).

a. Whenever a Medical Staff member's license is limited, suspended, placed on probationary or other oversight status, or revoked by the Medical Examining Board, his/her Medical Staff membership and clinical privileges shall be automatically limited in conformance with such licensing restrictions.

b. Whenever a Medical Staff member's Drug Enforcement Administration certificate or prescribing authority is limited, suspended, surrendered, or revoked, his/her clinical privileges shall be automatically limited and correspondingly divested in conformance with said limitations.

c. Whenever a Medical Staff member has pled guilty of, agreed not to contest, or been convicted of a serious crime (by definition but without limitation, all felony offenses), *or* whenever a unit of government has made a finding that the Medical Staff member has abused or neglected any patient, misappropriated the property of any patient, or has abused or neglected a child, as these terms are more specifically defined from time to time in regulations promulgated by the Wisconsin Department of Health and Family Services ("DHFS"), such Medical Staff member's clinical privileges and Medical Staff membership shall be automatically terminated. This section applies to offenses set forth on the DHFS Offenses List related to Caregiver misconduct as well as to convictions of serious crimes or governmental findings that bear substantial relationship to quality of patient care and potential for risk of harm to patients such as by way of example but without limitation, serious crimes or governmental findings concerning abuse or sale of controlled substances or dishonesty with respect to the procurement or dispensing of controlled substances.

d. Whenever a Medical Staff member is excluded from a federally funded health care program, his/her Medical Staff membership and clinical privileges shall be automatically terminated.

e. A Medical Staff member's admitting privileges shall be automatically suspended in accordance with the Medical Staff policy governing delinquency in or failure to complete medical records.

2. The Chief of Staff will cooperate with the Chief Executive Officer or designee in enforcing all automatic suspensions.

J. Summary Suspension

1. The CEO or designee and Chief of Staff each shall have the authority, whenever he/she believes, in good faith, that immediate action must be taken to protect the life of any patient or to reduce the likelihood of imminent danger to the health or safety of any individual and that no further investigation of the Member or matter is necessary, to summarily suspend all or any portion of the clinical privileges of a Member. Such summary suspension shall become effective immediately. Written notice of the adverse action must be provided to the Member consistent as provided below:

a. A Member whose clinical privileges have been summarily suspended shall be entitled to request that the Medical Staff Council hold a hearing on the matter, as soon as practicable, but not later than five (5) business days following the Member's request for the hearing.

b. Following the hearing, the Medical Staff Council may recommend modification, continuance or termination of the terms of the summary suspension. If, as a result of such hearing, the Medical Staff Council does not recommend immediate termination of the summary suspension, the affected Member shall be entitled to submit a written appeal to the Board, but the terms of the summary suspension as sustained or as modified by the Medical Staff Council shall remain in effect pending a final decision by the Board.

K. Patient Care Applicable to All Suspensions

1. Immediately upon the imposition of any suspension, the Chief of Staff shall provide for alternative medical coverage for the patients of the affected Member still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such alternative provider. All Members have a duty to cooperate with the Chief of Staff in these circumstances.

L. Loss of Voting and Office

1. Any suspension of membership and/or privileges also suspends voting on Medical Staff matters and right to serve as an officer of the Medical Staff until such suspension is lifted.

ARTICLE XVI
MEDICAL STAFF HEARING AND APPELLATE REVIEW

A. The following procedures address the rights and obligations of Medical Staff members in the event that adverse action has been recommended for a Member. Such concerns of AHPs are addressed in Medical Staff policy. This Section, Medical Staff Hearing and Appellate Review, does not apply to AHPs.

B. Right to Hearing

1. The following actions, if deemed a professional review action as described below, entitle the affected Member/Prospective Member to a hearing upon a timely and proper request:

    a. Denial of initial Medical Staff appointment except for rejection of administrative denial.

    b. Denial of reappointment except for administrative denial.

    c. Suspension of Medical Staff membership except for Administrative Time-Outs, pre-cautionary suspensions lasting fourteen (14) days or less, or automatic suspensions.

    d. Revocation of Medical Staff membership.

    e. Denial of requested appointment to or advancement in Medical Staff category.

    f. Reduction in Staff category.

    g. Limitation of the right to admit patients.

    h. Denial of requested clinical privileges.

    i. Involuntary reduction in clinical privileges.

    j. Suspension of clinical privileges except for Administrative Time-Outs, precautionary suspensions lasting fourteen (14) days or less, or automatic suspensions.

    k. Revocation of clinical privileges.

2. An action listed above is a professional review action only when it is or has been:

    a. Recommended by the Medical Staff Council;

    b. Taken by the Board subject to the limitation below;

    c. A summary suspension; or

    d. A precautionary restriction or suspension lasting more than fourteen (14) days.

3. In formulating such action or recommendation, the acting body should conclude that:

    a. There is a reasonable belief that the action is in furtherance of quality health care; and,

    b. Reasonable efforts are taken to obtain the pertinent facts; and,

    c. A reasonable belief exists that the action is warranted by the facts.

4. When the action involves a decision of the Board, the Member/Prospective Member may request a hearing only if the decision of the Board is more severe than the recommendations of the Medical Staff Council and the Member/Prospective Member has not previously had a hearing concerning the matters that gave rise to the adverse recommendation or action.

5. The following are examples of recommendations that will not adversely affect the individual's appointment to or status as a Member of the Medical Staff or the exercise of clinical privileges, and therefore are not professional review actions:

a. Administrative denials;

b. Letters of warning, censure or admonition;

c. Imposition of monitoring, proctoring, consultation or review requirements that do not restrict the Member's ability to exercise clinical privileges and are not reportable to the National Practitioner Data Bank;

d. Requiring provision of information or documents, such as office records, or notice of events or actions;

e. Imposition of educational or training requirements;

f. Placement on probationary or other conditional status;

g. Failure to place a Member on any on-call or interpretation roster, or removal of any Member from any such roster;

h. Appointment or reappointment for less than two (2) years;

i. Continuation of Focused Professional Practice Evaluation period;

j. The refusal of the Board to waive or extend the time for compliance with any requirement of these Bylaws;

k. Termination or refusal to reappoint for failure to comply with any objective requirement such as but not limited to board certification or recertification, malpractice insurance coverage, licensure, or failure to meet any objective requirement imposed on all Members that specific numbers of procedures be performed to maintain or demonstrate clinical competence;

l. Employment action;

m. Administrative Time-Out, precautionary suspensions lasting fourteen (14) days or less, and automatic suspensions;

n. Any action that is not related to the Member's professional conduct or competence and not reportable to the state or the National Practitioner Data Bank, such as termination for failure to pay dues or assessments, denial of request for privileges because the Hospital does not permit certain services or procedures to be performed in the Hospital, or the Hospital elects to enter into an exclusive contract for the provision of certain services.

6. If any action is taken that does not entitle a Member to a hearing, the Member shall be offered the opportunity to submit a written statement or any information which the Member wishes to be considered. Such statement or information shall be included in the Member's Medical Staff records along with the documentation regarding the action taken.

7. All hearings shall be in accordance with the procedural safeguards set forth in this Section to assure that the affected Member/Prospective Member is accorded all rights to which he/she is entitled.

C. Notice of Adverse Action

1. The CEO or designee shall promptly give the Member/Prospective Member written notice of the action which shall:

c. Advise that a professional review action has been taken or proposed to be taken, set forth the reasons for the action and advise that the Member/Prospective Member has the right to request a hearing pursuant to the provisions of these Bylaws.

b. Specify that the Member/Prospective Member has forty-five (45) days after receiving the notice within which to submit a request for a hearing and that the request must satisfy the conditions of below.

c. State that the Member/Prospective Member's failure to request a hearing within the forty-five (45)-day time period and in the proper manner constitutes a waiver of rights to a hearing and any appeal on the matter.

d. Summarize the hearing procedure and the Member/Prospective Member's rights including:

1) The right to be represented by an attorney or other person of the individual's choice;

2) The right to have a record made of the hearing proceedings, copies of which may be obtained upon payment of reasonable charges associated with the preparation of such copies;

3) The right to call, examine and cross-examine witnesses;

4) The right to present evidence and exhibits determined to be relevant by the Hearing Officer, or Hearing Committee Chairperson regardless of their admissibility in a court of law; and

5) The right to present a written statement at the close of the hearing.

2. State that he/she will be notified of the date, time, and place of the hearing after he/she has made a timely and proper request.

3. Advise of the right to review the hearing record and report, if any, and to submit a written statement on his/her own behalf as part of the hearing.

D. Request for Hearing

1. Other than following a summary suspension, the Member/Prospective Member must file a written request for a hearing within forty-five (45) days after receipt of the notice described above. The Member/Prospective Member's request must be sent to and received by the CEO or designee within the forty-five (45)-day period.

2. Following a summary suspension, the Member must file a written request for a hearing within five (5) days after receipt of the notice of same. The Member's request must be sent to and received by the CEO or designee within the five (5) day period.

E. Waiver by Failure to Request a Hearing

1. A Member/Prospective Member who fails to request a hearing within the time specified above is deemed to have waived all rights to any hearing to which he/she might otherwise have been entitled.

2. Such waiver in connection with an adverse action by the Board constitutes acceptance of that action, which then becomes the final decision of the Board.

3. Such waiver in connection with an adverse recommendation by the Medical Staff Council constitutes acceptance of that action, which then becomes and remains effective pending approval of the Board.

F. Notice of Hearing

1. Within ten (10) days after receipt of a timely and proper request for hearing, the Medical Staff Council or the Board, whichever is appropriate, shall schedule and arrange for such a hearing and shall, through the CEO or designee, notify the individual, in writing, of the hearing. The hearing date shall be not less than thirty (30) nor more than sixty (60) days following the date the individual is notified of the hearing unless the Member has been suspended, in which case the time limits may be adjusted in order to expedite the process.

2. The notice of hearing given to the Member/Prospective Member must include the following:

   a. The place, time, and date of the hearing;

   b. A preliminary list of the witnesses (if any) expected to testify at the hearing in support of the professional review action and a statement that each party must submit a final list of witnesses expected to testify at least ten (10) days prior to the hearing; and

   c. A summary of the individual's alleged acts or omissions or the other reasons forming the basis for the professional review action that is the subject of the hearing.

G. Composition of Hearing Committee

1. When a hearing relates to an adverse recommendation of the Medical Staff Council, the hearing shall be conducted by a special committee appointed by the Chief of Staff, consisting of at least two (2) Members of the Active Medical Staff and two (2) other Members of the Medical Staff who have not previously participated in the formulation of the decision and who are not in direct economic competition with the Member/Prospective Member. The Chief of Staff will appoint one of these committee members as Hearing Committee Chairperson. For purposes of this Section, direct economic competition shall be defined to mean those practitioners actively engaged in practice in the primary medical D of the affected Member, and who practice in the same medical specialty or subspecialty as the affected Member/Prospective Member. The Hearing Committee may use, on a non-voting consulting basis, members of the same medical specialty or subspecialty.

2. When a hearing relates to an adverse decision of the Board under circumstances where no prior right to a hearing existed, the Board shall appoint a Hearing Committee to conduct the hearing and shall designate one of the members of this committee as chairperson.

3. As an alternative to a Hearing Committee, a sole Hearing Officer may be selected to conduct the hearing. The use and appointment of a Hearing Officer shall be determined by the chairperson of the body whose decision is being contested, after consultation with the CEO or designee. The Hearing Officer shall act in an impartial manner as the chairperson and presiding officer of the hearing.

4. A Medical Staff Member or member of the Board shall not be disqualified from serving on a Hearing Committee because he/she has requested the corrective action or heard of the case or has knowledge of the facts involved, or what he/she supposes the facts to be, or

has participated in the investigation of the matter at issue. All members of a Hearing Committee shall be required to consider and decide the case with good faith objectivity.

H. Conduct of Hearing

1. At least a majority of the members of the Hearing Committee must be present when the hearing and deliberations takes place, and no member may vote by proxy or electronically. If a committee member is absent for any significant part of the proceedings, as determined in the chairpersons sole discretion, he/she shall not be permitted to participate in the deliberations or decision.

2. An accurate record of the hearing must be kept. The mechanism shall be established by the Hearing Committee, and may be accomplished by use of a court reporter, electronic recording unit, detailed transcription or by taking of adequate minutes. The affected Member/Prospective Member may obtain copies of the record upon the payment of reasonable fee.

3. The affected Member/Prospective Member must personally appear at the hearing. An affected individual who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner as provided above and to have accepted the adverse recommendation or decision involved.

4. Postponement of hearings beyond the time set forth in these Bylaws shall be made only with the express approval of the Hearing Committee for good cause shown.

5. The affected Member/Prospective Member shall be entitled to be accompanied by or represented at the hearing by a Member of the Medical Staff in good standing or by a member of his/her local professional society. "Good standing" for purposes of this Section means that the Member is licensed to practice medicine in the state of Wisconsin, has no license or DEA limitation, restriction or sanction, and has no limitation or restriction on his/her Hospital privileges.

6. Either the Hearing Officer, if one is appointed, or the Hearing Committee Chairperson shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence, and to maintain decorum.

7. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in civil or criminal action. The affected Member/Prospective Member and the body taking or recommending the professional review action shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact. These memoranda shall become a part of the hearing record.

8. The Chief of Staff, when the Medical Staff Council action has prompted the hearing, shall present the reasons for the recommended course of action and may present witnesses and other evidence in support of the adverse recommendation. The Board, when its action has prompted the hearing, shall appoint one of its members to represent it at the hearing, to present the reasons for the recommended course of action and may present witnesses and other evidence in support of its adverse decision. The affected Member/Prospective Member is responsible for supporting his/her challenge to the adverse recommendation or decision by an appropriate showing that the charges or

grounds involved lack any factual basis or any action based thereon is arbitrary or capricious.

9. During the hearing, each party has the right:

    a. To have a record made of the proceedings, copies of which may be obtained by the Member/Prospective Member upon payment of any reasonable charges associated with the preparation of such copies;

    b. To call, examine, and cross-examine witnesses;

    c. To present evidence and exhibits determined to be relevant by the Hearing Officer, or the Hearing Committee Chairperson regardless of their admissibility in a court of law and to rebut the same; and

    d. To present a written statement at the close of the hearing.

10. Either side may formally request assistance of legal counsel or of some other person in these proceedings by giving the Hearing Committee notice at least ten (10) days prior to the hearing of such assistance. In such cases, the Hearing Committee Chairperson or Hearing Officer may define the role of such legal counsel or other person, as a participant or strictly as an observer in the proceeding. Any Member/Prospective Member who incurs legal fees in his/her behalf shall be solely responsible for payment.

11. In reaching a decision, the Hearing Officer or Hearing Committee may take official notice, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration. All other information that can be considered under these Bylaws in connection with credentialing matters may also be considered.

12. The Member/Prospective Member has the burden of proving by clear and convincing evidence that the professional review action or recommendation lacks any substantial factual basis or that the conclusions drawn from the facts are arbitrary or capricious.

13. The Hearing Committee may, without notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee may then, at a time convenient to itself, conduct its deliberations outside the presence of the Member/Prospective Member for whom the hearing was convened.

I. Hearing Committee Report and Further Action

1. Within thirty (30) days after close of the hearing, the Hearing Committee or Hearing Officer shall submit a written report of its findings and recommendations to the body whose review action occasioned the hearing. The report must include a statement of the bases for the recommendation.

2. Within thirty (30) days after receiving the recommendation of the Hearing Committee or Hearing Officer, the body whose review action occasioned the hearing shall consider the report and prepare its own report affirming, modifying, or reversing its previous action. This report must include a statement of the bases for the decision. Notice of the body's determination must be provided, in writing, to the Member/Prospective Member within ten (10) days of its decision, and include a summary of the bases for the determination, any rights of appeal, and the procedure for obtaining such appeal.

3. If the recommendation resulted from Medical Staff Council action and remains adverse to the Member/Prospective Member, he/she will have ten (10) days from his/her receipt of such determination in which to submit a written appeal to the CEO or designee for consideration by the Board. The written appeal must be sent to and received by the CEO or designee within the ten (10)-day period.

4. Such written appeal shall be based only upon the records upon which the adverse decision was made, and may be accompanied by the appellant's written statement. The Board may, however, at its sole discretion, accept additional oral or written evidence.

5. A Member/Prospective Member who fails to request an appeal within the time specified above is deemed to have waived all rights to any appeal to which he/she might otherwise have been entitled. Such waiver constitutes acceptance of that action, which then becomes and remains effective pending the final decision of the Board.

6. The Board shall, within forty-five (45) days following receipt of the final Medical Staff Council recommendation, consider the Member/Prospective Member's appeal, if any, and render its final decision in the matter. The decision of the Board shall be sent to the Member/Prospective Member and shall not be subject to further review.

7. Notwithstanding any other provision of these Bylaws, no Member/Prospective Member shall be entitled as a right to more than one (1) hearing and one (1) appeal, if applicable, on any matter which shall have been the subject of professional review action by the Medical Staff Council, or by the Board, or by a duly authorized committee of the Board, or by both.

J. Substantial Compliance

1. Technical or insignificant deviations from the procedures set forth in this Section shall not be grounds for invalidating action taken.

K. Waiver of Time Limits

1. Any time limits set forth in this Section may be extended or accelerated by mutual agreement of the Member/Prospective Member and the CEO or designee. The time periods specified in this Section for action by the Medical Staff Council, the Board, the CEO or designee and the committees are to guide those bodies in accomplishing their tasks and shall not be deemed to create any right for reversal of the professional review action if the hearing process is not completed within the time periods specified.

L. Notices Under This Section

1. All notices under this Section shall be sent by certified or registered mail, or by such other means as to evidence receipt by the Member/Prospective Member.

M. Agreements with Practitioners

1. Notwithstanding any other provision of the Bylaws, the Hospital may provide by agreement that a Practitioner's membership on the Medical or Allied Staff and clinical privileges are contingent on and shall expire simultaneously with such agreement or understanding. In the event that an agreement has such a provision or there is such an understanding, the provisions of these Bylaws with respect to hearings, appeals, appellate review, etc., shall not apply.

ARTICLE XVII
LEAVE OF ABSENCE

A leave of absence of up to one (1) year shall be granted to any Medical Staff member in good standing who requests such leave for legitimate reasons. A written request detailing the specific dates of the leave of absence and the reason for the request shall be submitted to CSM Central Credentials and subsequently reviewed by the CSM Credentials Committee, the Medical Staff Council, BQSS and the Hospital Board of Directors. Final approval rests with the Hospital Board of Directors. Such leave shall release the individual from Medical Staff requirements for the extent of leave. Medical Staff members granted a leave of absence shall not exercise clinical privileges at any CSM facility and CSM Medical Staff membership rights and responsibilities are inactive. If the leave encompasses a fiscal year, dues will be waived until the individual returns.

A. Reinstatement of membership and privileges must be requested in writing. Requests shall be submitted to the Chief of Staff and subsequently reviewed by the CSM Credentials Committee, the Medical Staff Council, and the Hospital Board of Directors. Final approval rests with the Hospital Board of Directors. The Medical Staff member shall submit a summary of relevant activities during his/her leave, as well as, status of current licensure, status of current DEA certification, evidence of malpractice insurance, including without limitation insurer information and coverage limits, and a release letter (detailing any work restrictions with notation of temporary or permanent) from his/her attending physician for medical leave of absence. Reinstatement shall be contingent upon reappointment if the appointment expired during his/her leave of absence.

B. Failure of a practitioner to timely request reinstatement of privileges or timely request an extension of leave shall constitute a resignation from the Medical Staff and shall not be subject to any procedural rights set forth in these Bylaws.

ARTICLE XVIII
RESIGNATION FROM THE MEDICAL STAFF

A. Any Practitioner may resign his/her membership and privileges at any time by providing written notice to the Chief of Staff via CSM Central Credentials.

B. Practitioners who resign from the Medical Staff are expected to complete all clinical and record-keeping responsibilities including call obligations. Practitioners are required to notify the Hospital, in writing, of the arrangements made for continued care of patients following their resignation.

ARTICLE XIX
MEDICAL STAFF POLICIES AND PROCEDURES

A. Adoption and Implementation

1. The Medical Staff shall adopt such policies and procedures as are necessary to implement more specifically the general principles found in these Bylaws, as well as to establish standard for the proper conduct of Medical Staff activities including, but not limited to the policies that address Committees; Credentialing and Privileging (including Disaster Privileges; Telemedicine Privileges; Temporary Privileges); Governance; Medical Records (Health Records); Peer Review; and Research. All CSM Medical Staff policies and procedures, including Division-specific Medical Staff policies and procedures, and subsequent revisions will be periodically reviewed and approved by the

Medical Staff Council and authorized the Board of Directors prior to implementation. Substantial revisions to CSM Medical Staff policies and procedures and Division-specific Medical Staff policies and procedures shall be communicated to affected Medical Staff members in a timely manner.

2. The Medical Staff in each Division shall operate under these Bylaws, associated CSM Medical Staff policies and procedures, and under their specific Medical Staff Division policies and procedures, but only to the extent they are not in conflict with, preempted by, or superseded by these Bylaws and associated CSM Medical Staff policies and procedures.

ARTICLE XX
ADOPTION AND AMENDMENTMENT OF MEDICAL STAFF BYLAWS

A. Medical Staff Responsibility and Authority

1. The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt, and directly propose recommendations to the Board of Directors regarding Medical Staff Bylaws and Amendments thereto, which shall be effective when approved by the Board of Directors. Such responsibility and authority shall be executed in good faith and in a reasonable, timely, and responsible manner, so as to have Bylaws of generally recognized quality, to provide a basis for acceptance by accrediting agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review. These Bylaws shall be reviewed as needed by the Medical Staff Council (Medical Executive Committee) to determine if any amendments are necessary. However, approval of amendments to these Bylaws may not be delegated to the Medical Staff Council.

B. Methodology

1. These Bylaws may be reviewed or amended by a majority vote of votes cast by the Active Staff members eligible to vote who are present at any Medical Staff meeting called for such purposes, or by a majority of the votes cast by the Active Medical Staff members eligible to vote in an electronic mail ballot, provided that ten (10) calendar days prior written notice accompanied by the proposed alterations (or electronic access to the proposed alterations) has been given to the voting members of the Medical Staff by the Medical Staff Council. Once approval by the Active Staff members eligible to vote, the amendments shall be forwarded to the Board of Directors for approval.

2. Amendments may be proposed by written petition to the Chief of Staff by ten percent (10%) of the eligible voting Active Staff members, by a Medical Staff Council member, or by any standing Medical Staff committee. The Chief of Staff shall present the petition for discussion to the Medical Staff Council within sixty (60) calendar days. Following its review and comment, the Medical Staff Council shall present the proposed Amendment in writing to the Active Medical Staff members eligible to vote as herein required.

3. The Medical Staff Council has the power to adopt such amendments to the Bylaws as are, in the Council's judgment, technical modifications or clarification; reorganizing or renumbering; or amendments necessary because of spelling, punctuation, or other errors of grammar or expression. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or Board of Directors within ninety (90) calendar days of adoption by the Medical Staff Council. The action to amend, in such circumstances may be taken by motion acted upon in the same manner as any other motion before the Medical Staff Council.

4. Amendments to Medical Staff Bylaws are accomplished through a cooperative process involving both the Medical Staff and Board of Directors and are effective upon approval by the Board of Directors. The Board of Directors gives full consideration to the recommendations and views of the Medical Staff before taking final action.

5. All Medical Staff members shall be advised in writing of Medical Staff Bylaws changes that are implemented pursuant to the procedure described above, and they will be provided with revised texts or electronic copies of the revised affected pages, as appropriate.

C. Adoption

1. These Bylaws shall be effective when adopted by a majority vote of the Active Staff voting and have been approved by the Board of Directors and shall replace ay previous Bylaws. All members of the Medical Staff shall receive written notification of any amendments to these Bylaws once approved. They shall be equally binding to the Board of Directors and the Medical Staff.

D. Unified Medical Staff and Opt Out

1. A majority of Medical Staff members who hold privileges at an individual respective Hospital (the "Eligible Members"), voting in the affirmative at the meeting described below, is required to opt out of the unified medical staff created by these Bylaws. To hold a vote to opt out, a petition, signed by one third (1/3) of the Eligible Members must first be presented to the Medical Staff Council and Governing Body. Within sixty (60) days following the Governing Body's receipt of the written petition and its verification that the requisite number of bona fide signatures are present, the Governing Body shall direct the Medical Staff Council to hold an opt out vote at a meeting held for that purpose. The Medical Staff Council shall provide thirty (30) days' advance written notice to each of the Eligible Members of the Hospital subject to the petition, and the opt out vote shall occur by written ballot of those Eligible Members present at the meeting. If the Eligible Members present at the meeting and voting in the affirmative to opt out represent a majority of all of the Eligible Members, then the Governing Body will establish a separate medical staff at the Hospital under Bylaws substantially in the form as set forth in these Bylaws, but for the provisions that created the unified medical staff.

ARTICLE XXI
CONFLICT RESOLUTION

A. When there is a conflict between Medical Staff members, the Medical Staff Council, and the Board of Directors with regard to new and/or amended Medical Staff policies and procedures, including Division-specific policies and procedures:

1. A special meeting to discuss the conflict may be called by a petition signed by at least 25% of the voting members of the Medical Staff (or 25% of the voting members of the involved Division for a Division-specific policy and procedure). The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

2. If the differences cannot be resolved, the Medical Staff Council shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the Board for final action.

B. When there is a conflict between an individual Medical Staff member and Medical Staff Leadership concerning matters not directly related to individual privileges and not involving the items in Article XXI (Conflict Resolution) above, the affected Medical Staff member may make a written request to the Chief of Staff for a review by the Medical Staff Council whose decision shall be final.

C. This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

Adopted by the active Medical Staff of Columbia St. Mary's Hospital Milwaukee, Columbia St. Mary's Hospital Ozaukee, and Sacred Heart Rehabilitation Institute.

4/5/2017 — Date

Robert D Gunn MD. — Chief of Staff

Approved by the Governing Board of Directors of Columbia St. Mary's Hospital Milwaukee

4/5/17 — Date

George A. Lo — Chair, Governing Board of Directors

Approved by the Governing Board of Directors of Columbia St. Mary's Hospital Ozaukee

4/5/17 — Date

George A. Lo — Chair, Governing Board of Directors

Approved by the Governing Board of Directors of Sacred Heart Rehabilitation Institute

4/5/17 — Date

George A. Lo — Chair, Governing Board of Directors