Northwestern Medicine®
Northwestern Memorial Hospital

Medical Staff Administration / 251 E. Huron, Galter 3-104, Chicago, IL 60611 / Office: 312/926-2267 / Fax: 312/926-2019

THE MEDICAL STAFF ORGANIZATIONAL DOCUMENTS

Bylaws

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February 27, 2019

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BYLAWS OF THE MEDICAL STAFF
OF NORTHWESTERN MEMORIAL HOSPITAL

PREAMBLE

WHEREAS, the Northwestern Memorial Hospital is a nonprofit corporation organized under the laws of the State of Illinois; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, and participating in education and research in an academic medical center setting; and

WHEREAS, the members of the Medical Staff are committed to providing quality medical care at the Hospital in an academic environment of consistently high standards of medical care, research and education;

THEREFORE, the members of the Medical Staff hereby organize themselves for purposes of self-governance, subject to the ultimate authority of the Board of Directors, in the manner set forth in these Bylaws and in the Credentialing Plan, the Corrective Action and Fair Hearing Plan and the Committee Plan, all of which shall be considered a part of these Bylaws.

DEFINITIONS

1. BOARD OF DIRECTORS or BOARD means the board of directors of Northwestern Memorial Hospital.

2. CREDENTIAL VERIFICATION OFFICE ("CVO") - authorized on behalf of the Chief of Staff office to perform primary source verification of information bearing on a practitioner's professional ability and other qualifications.

3. CHIEF OF STAFF means the chief administrative officer and principal elected official of the organized medical staff.

4. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to a practitioner by the board to render specific diagnostic, therapeutic, medical, dental, surgical services or other patient care services and permission to use hospital resources, including equipment, facilities and personnel that are necessary to effectively provide medical or other patient care services. This definition shall not be construed to require the hospital to acquire additional equipment, facilities, or personnel to accommodate the granting of privileges.

5. COMMITTEE PLAN means those medical staff committees set forth in the Committee Plan document.

6. CORRECTIVE ACTION AND FAIR HEARING PLAN ("Hearing Plan") means those disciplinary actions and hearing procedures set forth in the Hearing Plan document.

7. CREDENTIALING PLAN ("Credentialing Plan") shall mean the appointment, reappointment and other related policies and procedures set forth in the Credentialing Plan document.

8. DENTIST means an individual who has been awarded the degree of doctor of dentistry (DDS) or doctor of dental medicine (DMD) or the equivalent.

9. DOCTORATE LEVEL HEALTH PROFESSIONAL means an individual who has attained the doctor of philosophy or doctor of psychology degree or other doctorate in a healthcare discipline, and whose clinical privileges or other authority to perform specific patient care services require processing through medical staff channels, but is not a member of the medical staff. This term is further defined in the Credentialing Plan.

10. EX-OFFICIO means service as a member of a body by virtue of an office or position held.

11. GOOD STANDING means the staff member has met the membership requirements during the previous medical staff year, is not in arrears in dues payment, and is not under a suspension of his/her appointment or admitting or clinical privileges.

12. HOSPITAL means Northwestern Memorial Hospital.

13. AFFILIATED HEALTH PROFESSIONAL means an individual, other than a licensed physician or dentist whose patient care activities require that his/her authority to perform specified patient care services be processed through medical staff channels or with involvement of medical staff representatives, but not as a member of the medical staff. This term is further defined in the Credentialing Plan.

14. MEDICAL EXECUTIVE COMMITTEE or MEC means the executive committee of the medical staff.

15. MEDICAL STAFF or STAFF means the formal organization of all licensed physicians and dentists.

16. MEDICAL STAFF ORGANIZATIONAL DOCUMENTS means the Medical Staff Bylaws, the Credentialing Plan, the Corrective Action and Fair Hearing Plan, the Committee Plan, the Rules and Regulations and all supporting and related medical staff and applicable Hospital policies and procedures.

17. MEDICAL STAFF YEAR means the period from September 1 to August 31.

18. PEER REVIEW means any and all activities and conduct used in the course of internal quality control or of medical study for the purpose of reducing morbidity and mortality or for improving patient care. These include privileging and credentialing efforts and the evaluation of a practitioner's competence, performance, and behavior. These activities and conduct may be conducted by the Medical Staff, Medical Staff Office, Central Verification Office, Medical Staff officers, and the committees of the Medical Staff described in the Committee Plan and their designees.

19. PHYSICIAN means an individual who has been awarded the degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO).

20. PRACTITIONER means, unless otherwise expressly limited as in the Fair Hearing and Appellate Review of the Hearing Plan, any appropriately licensed physician or dentist applying for appointment Clinical Privileges in this Hospital.

21. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, and which is exercisable subject to the conditions imposed in these bylaws and in other hospital and medical staff policies.

22. PRESIDENT means the individual appointed by the board as the President of the hospital.

23. SENIOR VICE PRESIDENT, CHIEF MEDICAL OFFICER means that hospital corporate officer appointed annually by the board who reports to the hospital President and who as a member of senior hospital management serves as liaison between medical staff and hospital management and provides administrative support to the Chief of Staff as provided herein.

24. SPECIAL NOTICE means written notification sent by certified mail, return receipt requested, or by personal service or messenger delivery to the addressee's last known office address as evidenced by contemporaneous documentation of the delivery date.

ARTICLE I: NAME

The name of this organization shall be the Medical Staff of Northwestern Memorial Hospital.

ARTICLE II: PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Staff are:

A. To be the formal organizational structure through which:

1. The benefits of membership on the Staff may be obtained, and

2. The obligations of Staff membership may be fulfilled.

B. To provide oversight of the quality of medical care, treatment and services provided by practitioners privileged through the Medical Staff process.

C. To serve as the primary means for accountability to the Board for the effectiveness and appropriateness of the professional performance and ethical conduct of its members and privileged providers and to strive toward assuring that a uniform standard of patient care, treatment and service in the Hospital is consistently maintained at the level of quality and efficiency achievable by the state of the healing arts and the resources locally available.

D. To approve and amend medical staff organizational documents.

E. To provide a means through which the Staff may participate in the Hospital's policy-making and planning process.

F. To support research and educational activities in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of the community.

G. To be bound by the Affiliation Agreement in effect between the Hospital and Northwestern University and dated June 25, 1973, as amended. A copy of the text of these Sections is appended hereto.

2.2 RESPONSIBILITIES

The responsibilities of the Staff, to be fulfilled through the actions of its officers, departments and committees, include:

2.2-1 To account for the effectiveness and appropriateness of patient care rendered by all practitioners and doctorate level health professionals and Affiliated Health Professionals authorized to practice in the Hospital through the following measures:

A. A credentialing program, including mechanisms for appointment and reappointment, and the matching of clinical privileges to be exercised or of specified services to be performed, with the verified credentials and current demonstrated performance of the applicant or Staff member or Doctorate Level Health Professional or Affiliated Health Professional.

B. A continuing education program, fashioned at least in part on the needs demonstrated through the quality/utilization/risk management program;

C. A utilization review program which endeavors to assure appropriate allocation of Hospital resources by striving to provide quality patient care in the most cost-effective manner;

D. An organizational structure that allows continuous monitoring of patient care practices;

E. Review and evaluation of the quality of patient care through a valid and reliable quality management procedure;

F. An evaluation process of professional performance that includes, as appropriate, focused professional practice evaluation, performance monitoring, performance improvement, and ongoing practice evaluation.

2.2-2 To recommend to the Board action with respect to appointments, reappointments, staff category, departmental assignments, clinical privileges, and corrective action.

2.2-3 To account to the Board for the quality and efficiency of patient care rendered to patients in the Hospital through regular reports and recommendations concerning the implementation, operation and results of the quality/utilization/risk management activities.

2.2-4 To initiate and pursue corrective action with respect to Medical Staff Members, Doctorate Level Health Professionals and Affiliated Health Professionals, when warranted.

2.2-5 To develop, administer and seek compliance with these bylaws, the rules and regulations of the staff, and other patient care related Hospital policies.

2.2-6 To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

2.2-7 To provide appropriate supervision of house staff members in their clinical training.

2.2-8 To provide a system for the assignment to Medical Staff members of patients admitted to the hospital who do not have a member of the Medical Staff as their regular physician.

2.2-9 To exercise the authority granted by these bylaws as necessary to adequately fulfill the foregoing responsibilities.

2.2-10 To develop and administer Hospital policies related to the completion of medical records on a timely basis.

ARTICLE III: STAFF MEMBERSHIP

3.1 NATURE OF STAFF MEMBERSHIP

Membership on the Staff of Northwestern Memorial Hospital is a privilege which may be extended only to professionally competent Physicians and Dentists who continuously meet the qualifications, standards and requirements set forth in these bylaws. Appointment to and membership on the Staff shall confer on the Staff member only such clinical privileges and prerogatives as have been granted by the Board in accordance with these bylaws, and shall include staff category, and department assignments.

3.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

3.2-1 Basic Qualifications

Only Physicians and Dentists currently licensed to practice in the State of Illinois shall be qualified for membership on the Staff and who:

A. Document their current competence, experience, background, training, demonstrated ability, litigation and peer review experience and their ability to perform the privileges requested with sufficient adequacy to demonstrate to the Staff and the Board that they will provide care to patients at the generally recognized professional level of quality, in an efficient manner, taking into account patients' needs, the available hospital facilities and resources, and utilization standards in effect at the hospital; and

B. For all areas in which clinical privileges are requested, are and remain board certified in a medical specialty approved by the American Board of Medical Specialties or American Osteopathic Association; or who have completed the number of years of medical specialty residency in a program approved by the Accreditation Council for Graduate Medical Education sufficient to satisfy the specialty board requirements for eligibility to become certified, which requirements are in effect when the program was completed and who become board certified within seven years thereafter or within the time limit established by the respective board whichever comes first (except for practitioners with staff appointments on the date these medical staff bylaws became effective on 6/25/90 or as may be waived by the board upon the recommendation of the Medical Executive Committee as provided in the Fair Hearing Plan); and

C. Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of staff responsibilities; and

D. Are and continue as members of the faculty of Northwestern University Feinberg School of Medicine; and

E. Are dedicated to the interests of the Staff, the Hospital and the university; and

F. Provide to the Chief of Staff upon request, acceptable written evidence (including, but not limited to, financial statements and independent ratings) of continuing professional liability insurance coverage with reputable and financially secure insurers covering the full scope of proposed delineated clinical privileges in coverage amounts as mutually determined by the Board and the Medical Executive Committee.

3.2-2 Professional Liability Insurance

The requirement for professional liability insurance shall apply to any member of the Staff, any Doctorate Level Health Professional, or Affiliated Health Professional, who furnishes information upon which clinical decisions may be made about patients in this institution. The requirement for professional liability insurance is waived for Staff members while they are not involved in the care of registered Hospital patients, to mean those who do not see, examine, write orders for, nor make recommendations for patients, but this waiver shall apply only to that period of time. Such Staff members voluntarily relinquish clinical privileges during that period of time without a right to a hearing.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Staff shall:

A. Provide his/her patients with care at the generally recognized professional level of quality and efficiency;

B. Abide by the Medical Staff Organizational Documents, and by all other established standards, policies and rules of the hospital;

C. Discharge such staff, department, service, committee and Hospital functions for which he/she is responsible by appointment, election, or otherwise;

D. Prepare and complete in timely and legible manner the medical and other required records for all patients he/she admits or in any way provides care to in the Hospital including a complete history and physical (H&P) to be completed no more than thirty (30) days prior to, or within 24 hours after, inpatient admission, but prior to surgery or procedure requiring anesthesia. If H&P is completed within 30 days prior to inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after inpatient admission but prior to surgery or procedure requiring anesthesia. An H&P must be performed by a physician, an oral-maxillofacial surgeon, or other qualified individual in accordance with State law and hospital policy. Additional requirements regarding minimal content of the medical history and physical examination for inpatient or non-inpatient services may be set forth in the Hospital policies.

E. Abide by the ethical principles of his/her profession, including, but not limited to: refraining from fee splitting or other unlawful inducements relating to patient referral; providing for continuous care of his/her patients; refraining from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner who is not qualified to undertake this responsibility and/or who is not adequately supervised; seeking consultation whenever necessary;

F. Promptly notify the Chief of Staff within five (5) business days in writing of the following, whether voluntary or involuntary: revocation or suspension of his/her professional license, or the imposition of terms of probation or limitation of practice by any state or other governmental body or unit, or of his/her loss of staff membership or loss or restriction of privileges at any hospital or other health care institution, or of receipt of notice of any formal charges or the commencement of a formal investigation by any professional regulatory or licensing agency or by Northwestern University, or the filing of charges by the Department of Health and Human Services, Peer Review Organization, or any law enforcement agency or health regulatory agency of the United States or the State of Illinois, or of the filing of a claim against the practitioner alleging professional liability; and

G. Promptly notify the office of the Chief of Staff within 45 days of any other change in the credentialing information from the date the Practitioner knew of the change; and

H. Provide services to medical assistance patients and other patients without personal physicians at the Hospital in accordance with the protocol adopted by the staff delineating responsibilities for services to such patients.

I. Provide adequate supervision of house staff members in their clinical training as requested by the appropriate department Chairman.

J. Make such written disclosure to the Chief of Staff and President of the Hospital of actual or potential conflicts of interest as may be required by law, the Hospital's corporate bylaws, medical or dental professional ethics or by Hospital policy.

K. Consent to mental, physical or toxicological examinations to be conducted by person(s) appointed by the Chief of Staff when the Chief of Staff, in exercising his/her reasonable discretion, has a reasonable suspicion that the individual is suffering from some condition that may directly affect clinical judgment, when requested to do so and to produce full reports thereof.

3.4 DURATION OF APPOINTMENTS

3.4-1 Duration of Initial Appointments

All initial appointments to the Staff shall be for a period of not more than twenty-four (24) months and may be terminated sooner as provided in these bylaws.

3.4-2 Reappointments

Reappointments to the Staff shall be for a period of not more than two (2) years.

3.4-3 Contract Practitioners

The Staff appointment of any Staff member which came about initially and solely as the result of a contractual relationship with the Hospital, or by reason of his/her being either an employee, partner, or principal of, or in, an entity that has a contractual relationship with the Hospital, relating to providing services to patients at the Hospital, shall terminate automatically and immediately upon:

A. The expiration or other termination of the contractual relationship with the Hospital; or

B. The expiration or other termination of the relationship of the Staff member with the entity that has a contractual relationship with the Hospital.

In the event of such a termination of staff appointment, the affected staff member shall have the right to hearing set forth in the Hearing Plan, but with no right of appellate review as set forth in the Hearing Plan. The scope of the Hearing shall be strictly limited to a determination as to whether the Staff Member's contractual relationship with the hospital or other entity, as determined by the hospital or such entity, has been terminated. Any termination effected solely pursuant to the provisions of this Section shall be deemed to be administrative only for purposes of mandatory reporting of adverse credentialing decisions by the Hospital.

3.5 LEAVE OF ABSENCE

3.5-1 Leave Status

A Staff member may request a voluntary leave of absence from the Staff by submitting a written request to the department Chair (or the Chief of Staff if the member requesting the leave is a department chair) which states the reason(s) for the request and when known, the scheduled period of time for the leave, which may not exceed a period of two (2) years commencing with the first day of such approved leave. In urgent or unexpected leave circumstances, the department Chair in consultation with and with the consent of the Staff member may initiate a request for leave of absence on behalf of the Staff member. The department Chair shall give his/her recommendation to the Medical Executive Committee. A leave of absence request may be granted by the Medical Executive Committee specifying the leave period including a scheduled expiration date, subject to such conditions or limitations as the Medical Executive Committee shall determine to be appropriate. While on leave, the Staff member voluntarily relinquishes Privileges and Prerogatives but may have access to appropriate clinical information on their own patients being care for at the Hospital while he or she is on leave. A Staff member granted a leave of absence shall not be required to pay dues or attend meetings. In cases where the leave period exceeds the expiration date of the then current Staff appointment period, the Staff member must comply with the reappointment process.

3.5-2 Reinstatement following Leave of Absence

Prior to the expiration date of the leave, the staff member shall request reinstatement of his/her Privileges and Prerogatives by submitting a written notice to that effect to the department Chair with a copy to the Chief of Staff for transmittal to the Medical Executive Committee. The department Chair shall include with include with the transmittal his/her recommendation for reinstatement of Staff member and a plan for Focused Professional Practice Evaluation (FPPE) when Staff member's leave is six (6) months or longer. The Staff member shall submit a written summary of his/her relevant activities during the leave, if the department Chair, Medical Executive Committee or the board so requests. The Medical Executive Committee shall make a recommendation to the Board concerning the reinstatement of the member's Privileges and Prerogatives. Reinstatement of the member's Privileges and Prerogatives shall be effective on the day of approval by the board and Staff member will be notified in writing of the effective reinstatement date. Failure to request reinstatement or to provide a requested summary of activities as above provided before expiration of the scheduled leave shall constitute a voluntary resignation of staff membership, privileges and prerogatives, to be effective on the predetermined expiration date. However, such voluntary resignation alone shall be deemed to be administrative only for purposes of mandatory reporting by hospitals of adverse credentialing actions. A request for Staff membership subsequently received from a Staff member who so resigns shall be submitted and processed in the manner specified for applications for initial appointments.

ARTICLE IV: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.1 GENERAL PROCEDURES

In addition to this Article, the terms and conditions as specified in the details of the Credentialing Plan shall also apply to this Article.

4.2 PROCESSING THE APPLICATION

4.2-1 Applicant's Burden

The applicant shall have the burden of producing and fully disclosing all information as requested and/or material to a proper evaluation of his/her competence and experience, professional ethics, background, training, demonstrated ability, and ability to perform Privileges requested, and for resolving any doubts about these or any of the other basic qualifications specified in the Medical Staff Organizational Documents, or otherwise.

4.2-2 Transmittal for Evaluation

The applicant shall deliver his/her application form(s) to the CVO through approved methods. After determining that the forms are filled in completely, the CVO shall initiate the primary source verification process. Only after all pertinent materials have been secured and the verification process finalized shall the CVO transmit the application forms and verified documents to the office of the Chief of Staff.

The Chief of Staff shall determine whether the application is complete and all pertinent materials have been secured for the medical staff review process. The Chief of Staff shall transmit through approved methods and in a timely fashion a copy of the completed application form and all supporting materials to the Chairman of each department in which the applicant seeks privileges. A copy of the completed application form and all supporting materials shall also be sent by the Chief of Staff to the Credentials Committee Chairman for processing.

4.2-3 Verification of Information

Upon receipt of the fully complete application form, the CVO or designee as directed by the Chief of Staff's office shall seek to collect, verify, and assess the references, licensure, DEA status, federal data bank information and other qualification evidence submitted. The department Chairman, Chief of Staff, and Credentials Committee may (but are not required to) request and conduct an interview of the applicant.

4.2-4 Departmental Action

Each department in which the applicant seeks Privileges may review the application, the supporting documentation, and such other information available to it that may be relevant to assessment of the applicant's qualifications for the staff category, department and Clinical Privileges requested. Within 15 days of receipt of

application, the department Chairman shall transmit to the Chief of Staff for forwarding to the Credentials Committee a written report and recommendations as to Staff appointment and, if appointment is recommended, as to staff category, department affiliations, Clinical Privileges proposed to be granted, any special conditions to be attached to the appointment and a statement as to the applicant's ability to perform Privileges requested.

4.2-5 Credentials Committee and Medical Executive Committee Action

At its next regular meeting after receipt of the departmental report and recommendations, the Credentials Committee shall consider the report and such other relevant information as is available to it. Within fifteen (15) days of such meeting, the Committee shall then forward to the Chief of Staff for transmittal to the Medical Executive Committee a written report and recommendations, both positive and negative, as to Staff appointment and, if appointment is recommended, as to Staff category and department affiliations, Clinical Privileges proposed to be granted, and any special conditions to be attached to appointment or Privileges.

4.2-6 Board Action

Within thirty (30) days the Chief of Staff shall forward the recommendations of the Medical Executive Committee, whether positive or negative, to the Board. The Board shall adopt or reject, in whole or in part, recommendations of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and optionally setting a time limit within which a subsequent recommendation shall be made. Initial applicants to the Medical Staff against whom an adverse decision is made will receive a written response within 10 days following the Board action from the Chief of Staff which explains the reason or reasons for the adverse decision.

4.3 REAPPOINTMENT PROCESS

4.3-1 Application for Reappointment

Each such Staff Member who desires reappointment shall, within thirty (30) days, send his/her fully completed application for reappointment as provided by the CVO, utilizing forms as approved by the Chief of Staff.

4.3-2 Verification of Information

The CVO shall seek to collect or verify the additional information made available on each application for reappointment and to collect any other materials or information deemed pertinent. After determining that the application forms are filled in completely and all pertinent materials have been secured, the CVO shall transmit the document to the office of the Chief of Staff. The office of Chief of Staff shall transmit the fully complete reappointment application to each department Chair in which the applicant seeks reappointment/renewal of Privileges. Upon review of the application, the department Chair will transmit to the Chief of Staff the reappointment application and all supporting documentation along with his/her written recommendation no later than fifteen (15) days after receipt. The Chief of Staff shall then, in a timely fashion, determine the completion of the reappointment application and transmit the fully complete application for reappointment to the Credentials Committee with his/her recommendation. The Credentials Committee, after reviewing each fully complete application for reappointment and all other relevant information available to it, shall forward to the Chief of Staff for transmittal to the Medical Executive Committee its report and recommendation that appointment be either renewed, renewed with modified staff category, department affiliation, and/or Clinical Privileges, or terminated. The Medical Executive Committee shall likewise make its recommendations to the Board.

4.4 REQUESTS FOR MODIFICATION OF TERMS OF APPOINTMENT

A Staff Member may, either in connection with reappointment or at any other time, request modification of his/her Staff category, department assignment, or Clinical Privileges by submitting a written application to the Chief of Staff and department Chairman. Such application shall be processed in substantially the same manner as provided in the reappointment process. However, denial of such a request shall not entitle the affected Staff Member to any redress, hearing or appellate review rights, including those set forth in Routine Corrective Action or Fair Hearing and Appellate Review of the Hearing Plan.

4.5 EXPEDITED APPOINTMENT, REAPPOINTMENT, OR PRIVILEGES

In the event that an applicant qualifies for an expedited appointment, reappointment, or Privileges in accordance with requirements in this Section, the Medical Executive Committee, after receiving positive recommendations from the

Chairman of the department in which the applicant will be a member and the Chairman of the Credentials Committee, shall have the discretion of forwarding its positive recommendation to the Professional Standards Committee of the Board for final decision. An applicant qualifies for this expedited review if he or she meets the following standards:

A. The applicant submits a complete and verified application which provides all necessary or required information and all primary source verification procedures have been completed.

B. The Medical Executive Committee makes a positive recommendation without any limitations.

C. There are no current or previously successful challenges to the applicant's licensure or registration.

D. The applicant has not been subject to any involuntary termination or summary suspension of Medical Staff Membership or Clinical Privileges at another hospital.

E. The applicant has not been subject to any involuntary limitation, reduction, denial or loss of membership or Clinical Privileges at the Hospital or any other hospital; or

F. There has not been a final adverse judgment entered against the applicant in a professional liability action.

ARTICLE V: DETERMINATION OF CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Every Practitioner, Doctorate Level Health Professional or Affiliated Health Professional providing direct clinical services at the Hospital by virtue of staff membership, or otherwise, shall, in connection with such practice, and except as provided in Emergnecy Privileges, be entitled to exercise only those Clinical Privileges or provide patient care services as are specifically granted pursuant to the provisions of these Medical Staff Organizational Documents.

The Board shall consult with the Medical Executive Committee prior to closing membership in the entire or any portion of the Medical Staff. If the Board closes membership in the Medical Staff or any portion of the Medical Staff, over the objections of the Medical Executive Committee, then the Board shall provide a detailed written explanation for the decision to the Medical Executive Committee ten (10) days prior to the effective date of any closure.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 Requests

Each application for appointment and reappointment to the Staff must contain a request for the Clinical Privileges desired by the applicant. A request by a Staff Member for a modification of Privileges must be supported by documentation of training and/or experience supportive of the request.

5.2-2 Basis for Privileges Determination

Requests for Clinical Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, and demonstrated current competence and judgment, current licensure, and ability to perform Privileges requested and other factors set forth in the Credentialing Plan.

5.2-3 Procedure

All requests and recommendations for Clinical Privileges shall be processed pursuant to the procedures outlined in these Bylaws and the Credentialing Plan.

5.3 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

A Physician member of the Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

5.4 CLINICAL FELLOWS

Fellows shall be granted Clinical Privileges in accordance with medical staff policy.

5.5 DOCTORATE LEVEL HEALTH PROFESSIONALS

5.5-1 Definition

Doctorate Level Health Professionals have attained the doctor of philosophy degree, doctor of psychology degree, or other doctorate in a healthcare discipline. They are required to have and maintain a faculty appointment with Northwestern University as a condition of being granted and holding privileges.

5.5-2 Process for Granting Privileges

Any member of the active staff of the Medical Staff, as defined in these Bylaws, may submit a written recommendation to the Chief of Staff for the granting of Clinical Privileges to Doctorate Level Health Professionals. This recommendation must describe the education, training, experience and demonstrated ability and judgment of the particular health professional. The Chief of Staff shall investigate the written recommendation according to the procedures outlined in the Bylaws and the Credentialing Plan. Thereafter, the procedures and levels of review outlined in Procedures for Appointment and Reappointment, up to an including the Board, shall be followed for the purpose of granting privileges to Doctorate Level Health Professionals.

5.6 AFFILIATED HEALTH PROFESSIONALS

Affiliated Health Professionals are other non-physicians and non-dentists who have not attained the doctor of philosophy degree, are not permitted by law to be members of the Medical Staff and who are supervised by members of the Medical Staff and hold practice Privileges granted in accordance with the process and subject to the applicable conditions as described in the Bylaws, or such other policy as adopted by the Board of Directors, except that they are not required to have a faculty appointment with Northwestern University and they are not eligible to attend Medical Staff meetings or to be appointed to Medical Staff committees. Affiliated Health Professionals shall be subject to the provisions of the Bylaws and of the Hearing Plan concerning professional liability insurance.

5.7 TEMPORARY PRIVILEGES

5.7-1 Circumstances

A. Pendency of Application

B. Care of Specific Patients

5.7-2 Conditions

Temporary Privileges shall be granted upon the written concurrence of the Chairman of applicable department(s), the Chief of Staff, and the President, or their respective authorized designees, only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, upon verification of current licensure, relevant training and experience, current competency and ability to perform privileges requested, as current or previously successful challenge to licensure or involuntarily reduction or termination of medical staff membership or clinical privileges at another hospital, and only after the practitioner has provided evidence of professional liability insurance coverage as required by these bylaws.

5.7-3 Termination of Temporary Privileges

On the discovery of any information, or the occurrence of any event of a professionally questionable nature, pertinent to a Practitioner's qualifications or ability to exercise any or all of the temporary Privileges granted, the department Chairman responsible for supervision, or the President, after consultation with the department Chairman responsible for supervision, or the Chief of Staff, may terminate any or all of such Practitioner's temporary Privileges. (Refer to Credentialing Plan for additional details.)

5.8 EMERGENCY PRIVILEGES

For the purposes of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any Practitioner, to the degree permitted by his/her license, regardless of department, staff status or Clinical Privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm. A Practitioner utilizing emergency privileges shall promptly provide to the Medical Executive Committee in writing a statement explaining the circumstances giving rise to the emergency.

5.9 DISASTER PRIVILEGES

5.9-1 Circumstances

Licensed independent practitioners (physicians and dentists) who are not members of the Northwestern Memorial Hospital Medical Staff and/or who do not possess medical staff privileges may be allowed to volunteer during a disaster, defined as an officially declared emergency, whether local, state, or national.

As authorized by the medical staff bylaws, disaster privileges may be granted when the emergency management plan has been activated and a senior vice president in consultation with medical staff leadership determines that available medical staff is unable to handle immediate patient care needs. In the event a senior vice president is unavailable; the incident commander makes the determination.

5.9-2 Conditions

A. The Chief Executive Officer or Chief of Staff or their designee has the authority to grant disaster privileges to a practitioner who is not a member of the medical staff. Decisions are made on a case by case basis and it is not required that privileges be granted to any individual.

B. To be eligible for disaster privileges, the volunteer practitioner must present:

1. Valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport)

2. AND at least one of the following:

- current picture hospital ID card that clearly identifies professional designation
- current license to practice
- identification indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups
- identification indicating the individual has been granted authority to render patient care, treatment, and services in disaster circumstances by a federal, state or municipal entity identification by current hospital or medical staff member(s) with personal knowledge regarding volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

3. Approval process:

a) Practitioner shall sign a statement attesting the information provided is accurate.

b) Individual authorized to grant disaster privileges shall approve or not approve the request.

c) All documentation shall be forwarded to Medical Staff Administration as soon as possible.

C. Volunteer identification is to be worn by practitioners practicing in this capacity. The medical staff oversees the professional practice of volunteer practitioners. To the extent feasible, these practitioners shall be paired with current medical staff members of the same specialty and should act under direct observation.

ARTICLE VI: CATEGORIES OF THE STAFF

6.1 CATEGORIES

The staff shall be divided into Active Staff, Associate Staff, Affiliate Staff, Senior Staff, Emeritus Staff, and Visiting Staff.

6.2 ACTIVE STAFF

6.2-1 Qualifications

The Active Staff shall consist of Physicians and Dentists, each of whom either:

A. Direct Patient Care:

1. Meets the basic qualifications for Staff Membership, except that he/she must actually have attained board certification in a medical specialty approved by the Accreditation Council for Graduate Medical Education or American Osteopathic Association unless he or she had a medical staff appointment prior to June 25, 1990 or such requirement is waived by the board upon the recommendation of the Medical Executive Committee as provided in the Hearing Plan; and

2. Is professionally based in the community served by the Hospital so that he/she is available for patient care; and

3. Regularly admits patients to, or is otherwise regularly involved in the care of patients at, the Hospital so that he/she is available for patient care or otherwise demonstrates an active local practice and is available for patient care.

B. Administrative Role

1. Meets the basic qualifications for Staff Membership except (i) for direct patient care responsibilities and (ii) that he/she must actually have attained board certification in a medical specialty approved by the Accreditation Council for Graduate Medical Education unless he or she had a medical staff appointment prior to June 25, 1990 or such requirement is waived by the Board upon the recommendation of the Medical Executive Committee as provided in the Hearing Plan; and

2. Is professionally based in the community served by the Hospital; and

3. Currently holds a Medico-Administrative position at the Hospital or other administrative role in an entity directly related or affiliated with the Hospital.

4. Voluntarily relinquish their right to exercise existing Clinical Privileges and agrees that at the conclusion of such administrative role, shall seek review of their current competence, consistent with Medical Staff Organizational Documents, prior to the exercise of such clinical privileges.

6.2-2 Prerogatives

The prerogatives of an Active Staff member shall be to:

A. Admit patients to the Hospital as follows:

1. A Physician member may admit patients according to his/her Privileges; and

2. A Dentist member may admit patients in conformity with the requirements of the Credentialing Plan.

B. Except for those members in Administrative Roles , exercise such Clinical Privileges as are granted to him/her pursuant to Determination of Clinical Privileges of the Credentialing Plan.

C. Vote on all matters presented at general and special meetings of the staff, and the department and committees of which he/she is a member, and hold office in the staff organization, and in the department and committees of which he/she is a member.

6.2-3 Responsibilities

Each member of the Active Staff shall:

A. Meet the basic responsibilities set forth in these Bylaws;

B. Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision;

C. Actively participate in the quality/utilization/risk management activities required of the Staff, attend as assigned patients admitted to the Hospital who have no member of the medical staff as their regular Physician, and discharge such other staff functions as may from time to time be required;

D. Satisfy the requirements for attendance at meetings of the Staff and of the department and committees of which he/she is a member;

E. Pay dues and assessments as determined by the Staff and approved by the Board unless exempted by these bylaws.

F. Provide adequate supervision of house staff in their clinical training as may be requested by the appropriate department Chairman.

6.3 ASSOCIATE STAFF

6.3-1 Qualifications

The Associate Staff shall consist of Physicians and Dentists each of whom:

A. May become eligible for advancement to Active Staff membership and may be advanced to Active Staff status after serving not less than three (3) years on the Associate Staff; and

B. Meets the qualifications specified for members of the Active Staff.

6.3-2 Prerogatives

The prerogatives of an Associate Staff member shall be to:

A. Admit patients to the Hospital under the same conditions as specified for Active Staff members; and

B. Exercise such Clinical Privileges as are granted to him/her pursuant to the Credentialing Plan; and

C. Attend as assigned patients admitted to the Hospital who have no member of the Medical Staff as their regular Physician; and

D. Vote on all matters presented at meetings of the department and committees of which he/she is a member.

A member of the Associate Staff shall not be eligible to hold office in the Staff organization.

6.3-3 Responsibilities

Each member of the Associate Staff shall be required to discharge the same responsibilities as those specified in for members of the Active Staff. Failure to fulfill those responsibilities shall be non-exclusive grounds for denial of advancement to Active Staff status.

6.3-4 Probationary Status

All appointments to the Associate Staff are probationary and may be renewed no more than three (3) times. However, appointments to the Associate Staff may, in a given case, be renewed up to three (3) more times solely for the purpose of allowing an Associate Staff member additional time within which to try to achieve board certification by action of the Board upon the recommendation of the department Chairman and Medical Executive Committee. Probationary means that this type of appointment may not be renewed, may be terminated at any time and/or that all or any Clinical Privileges may be revoked, subject to the right of hearing set forth in the Hearing Plan, but with no right of appellate review set forth in the Hearing Plan.

6.4 AFFILIATE STAFF

The affiliate Staff shall consist of Practitioners who desire to be part of the Medical Staff but who do not wish to exercise clinical privileges on an inpatient basis.

Candidates for the Affiliate Staff must meet all of the basic qualifications for Staff membership.

A. The Affiliate Staff shall consist of members of the Medical Staff who shall not be granted any Clinical Privileges to perform medical services at the Hospital but will otherwise be bound by all Medical Staff Bylaws, Rules and Regulations and Policies.

B. A member of the Affiliate Staff may serve on committees and has the same voting rights as an Active or Associate Staff member.

C. Affiliate Staff members must pay dues in accordance with these Bylaws.

D. Affiliate Staff members may have access to appropriate clinical information on their own patients being cared for at the Hospital.

E. Affiliate Staff shall demonstrate they have made arrangements with a Medical Staff member to admit their patients to the Hospital.

F. Failure to reappoint shall entitle the affected Staff member to the right of hearing set forth in the Hearing Plan, but with no right to appellate review, set forth in the Hearing Plan.

6.5 SENIOR STAFF

Members of the Active Staff, Associate Staff or Visiting Staff shall, if reappointed to the Staff, assume Senior Staff Status on September 1 following such member's sixty-eighth birthday and shall be notified to this effect by the Chief of Staff. Senior Staff status may be elected earlier. All Senior Staff appointments shall be for two years but the member shall be reviewed on an annual basis. The qualifications, Prerogatives and responsibilities shall remain the same as their Staff category immediately prior to attaining Senior Staff status. They are required to pay dues and assessments as determined by the Staff.

6.6 EMERITUS STAFF

Members of the Active Staff, Associate Staff, Affiliate Staff or Visiting Staff who notify the Chief of Staff in writing of their election to retire totally from the practice of medicine at the Hospital may be classified as Emeritus Staff by action of the Medical Executive Committee. Emeritus Staff may have access to Staff member meetings and lounge. This is an honorary classification only and carries with it no Prerogatives or required responsibilities.

6.7 VISITING STAFF

Candidates for the Visiting Staff must meet all of the basic qualifications for Staff membership, except for the faculty appointment with Northwestern University. Candidates shall be recommended by the appropriate department Chairman, the Credentials Committee and Medical Executive Committee for appointment by the Board. Visiting Staff may not admit patients or write orders but may write notes in patient charts. They will be permitted to see patients on a continuing basis with the permission of the patient's staff physician, but the latter shall remain responsible for the patient's general care. Visiting Staff may attend staff meetings, but may not vote, hold office or serve on committees. They are required to pay dues and assessments as determined by the Staff. Failure to reappoint shall entitle the affected Staff member to the right of hearing set forth in the Hearing Plan, but with no right of appellate review, set forth in the Hearing Plan. Action upon the Hearing Committee's recommendation is final.

6.8 LIMITATION OF PREROGATIVES

The Prerogatives set forth under each staff category are general in nature and may be subject to limitation by special conditions attached to a Physician's or Dentist's Staff appointment, by other sections of these Medical Staff Organizational Documents, or by policies of the Hospital.

6.9 WAIVER OF QUALIFICATIONS

Any qualifications, requirements or limitations in this article or any other article of these bylaws, not required by law or governmental regulation, may be waived in the discretion of the Medical Executive Committee and the Board, upon determination that such waiver will serve the best interests of the patient and the Hospital.

ARTICLE VII: OFFICERS OF THE STAFF AND ELECTIONS

7.1 OFFICERS OF THE STAFF

7.1-1 Identification

A. Chief of Staff

B. Vice Chief of Staff

C. Secretary-Treasurer

7.1-2 Qualifications

Officers (as well as each of the six (6) at-large members of the Medical Executive Committee) must be members of the Active Staff in good standing at the time of nomination and election and must remain members in good standing during their terms of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The officers of the Staff shall serve no more than two (2) consecutive annual terms in addition to any partial term to which they may have succeeded or been elected. Each officer shall hold office until the next annual meeting or until his/her successor has been elected.

7.1-3 Nominations

A. By Nominating Committee: The Nominating Committee shall be appointed ad hoc by the Chief of Staff and be approved by the Medical Executive Committee and shall convene at least sixty (60) days prior to the annual meeting and shall submit to the secretary-treasurer of the staff a list of one or more qualified nominees for each office, as well as for each of the six (6) at-large members of the Medical Executive Committee, to which shall be attached a statement of the Nominating Committee chairman that each nominee has agreed to stand for election to office. The names of such nominees shall be reported by mail to the staff at least thirty (30) days prior to the annual meeting;

B. By Petition: Nominations may also be made by petition signed by at least twenty-five (25) members of the Active Staff with voting rights, to which shall be attached a statement signed by the nominee attesting to his/her willingness to stand for election to the office, and filed with the Secretary-Treasurer of the staff at least fifteen (15)

days prior to the annual meeting. As soon after filing of such a petition as is reasonably possible, the name(s) of these additional nominee(s) shall be reported to the Staff by mail;

7.1-4 Election

Officers (as well as six (6) at-large members of the Medical Executive Committee) shall be elected at the annual meeting of the Staff. A nominee shall be elected upon receiving a majority of the votes cast.

7.1-5 Term of Elected Office

Each elected officer (and at-large member of the Medical Executive Committee) shall serve a one (1) year term, commencing on the first day following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected.

7.1-6 Removal of Officers

An officer shall be removed from office if a majority of the Active Staff present at a meeting of the staff at which a quorum is present vote in favor of removal. Grounds for removal shall include, but not be limited to, mental and/or physical impairment or inability and/or unwillingness or failure to perform the duties and responsibilities of the office. Action directed towards removing an officer from office may be initiated by submission to the Medical Executive Committee of a petition seeking removal of an officer, signed by not less than twenty-five percent (25%) of the voting members of the Active Staff with voting rights.

7.1-7 Vacancies in Staff Offices

The Vice Chief of Staff shall automatically succeed to the office of Chief of Staff if for any reason the elected Chief of Staff is unable to fill out his/her term of office. A new Vice Chief of Staff shall be elected in accordance with this Article as soon as practicable thereafter.

7.1-8 Duties of Elected Officers

A. Chief of Staff: The Chief of Staff shall serve as the chief administrative officer and principal elected official of the staff. As such, he/she shall:

1. Serve as a spokesman of the staff in its external professional and public relations.

2. Aid in coordinating the activities and concerns of the hospital administration and of the nursing and other patient care services with those of the Staff;

3. Be accountable to the Board, in conjunction with the Medical Executive Committee, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of the quality/utilization/risk management program;

4. Develop and implement, in cooperation with the President and Senior Vice President, , department and committee chairmen, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice, quality management and risk management;

5. Appoint the staff representatives to staff committees, unless otherwise expressly provided by these Medical Staff Organizational Documents or Hospital bylaws, policies or procedures;

6. Communicate and represent the opinions, policies, concerns, needs and grievances of the staff to the Board and the President and Senior Vice President,;

7. Be responsible for the enforcement of these Medical Staff Organizational Documents, for implementation of sanctions where these are indicated, and for the staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Staff member;

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

9. Serve as chairman of the Medical Executive Committee, and as an ex officio member of all other staff committees;

10. Serve as a member of the Board.

B. Vice Chief of Staff: The Vice Chief of Staff shall be a member of the Medical Executive Committee. In the temporary or permanent absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He/she shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the Medical Executive Committee, or the board.

C. Secretary-Treasurer: The secretary-treasurer shall be a member of the Medical Executive Committee. His/her duties shall be to:

1. Give proper notice of all Staff meetings on order of the appropriate authority;

2. Prepare accurate and complete minutes for all meetings;

3. Supervise the collection and accounting for any funds that may be collected in the form of Staff dues, assessments, or application fees, and maintain proper records of such funds;

4. Serve on Bylaws Committee;

5. Render an annual report for presentation at the last Staff meeting of the year;

6. Perform such other duties as ordinarily pertain to his/her office.

It shall be the privilege of any Staff member to inspect the records of the Secretary - Treasurer at any time. The records of the Secretary - Treasurer shall be audited at least annually by Hospital auditors as requested by the Chief of Staff. The regular audit year shall be the same as the medical staff year.

ARTICLE VIII: MEDICAL EXECUTIVE COMMITTEE

8.1 MEDICAL EXECUTIVE COMMITTEE

A. **Function and Authority**

The Medical Executive Committee has the primary authority for activities related to the medical staff. The medical staff delegates authority to the Medical Executive Committee to carry out medical staff responsibilities as defined in the Committee Plan. Such authority is delegated or removed by amendment to the Medical Staff Organizational Documents.

B. **Composition**

The Medical Executive Committee of the Staff shall consist of the members as indicated below, with the Chief of Staff as its Chairman.

1. Chief of the Medical Staff
2. Vice Chief of the Medical Staff
3. Secretary-Treasurer of the Medical Staff
4. Immediate Past Chief of the Medical Staff
5. President of the Hospital
6. Dean of the Northwestern University Feinberg School of Medicine
7. Chief Nurse Executive
8. 3 Permanent Department Chairmen:
   a. Medicine
   b. Obstetrics-Gynecology
   c. Surgery
9. 3 Other Department Chairmen (1 of whom must be hospital based i.e.: anesthesiology, pathology, radiology)

10. 6 Medical Staff members elected at large (all Active medical staff members are eligible)
11. Chief Medical Officer

In the event that a department Chairman representative occupies an elective office, the members of such department will elect another representative.

8.2 Removal of Members

Grounds for removal of Medical Executive Committee members for cause only, which shall include, but not be limited to, mental and/or physical impairment or inability and/or unwillingness or failure to perform the duties and responsibilities of committee membership. Action directed towards removing a member may be initiated by the Chief of Staff. The Medical Executive Committee renders a final decision.

ARTICLE IX: DEPARTMENTS, SECTIONS AND SPECIAL CARE UNITS

9.1 DEPARTMENTS

9.1-1 Recognition

The Staff shall be organized into clinical departments corresponding to those in effect at Northwestern University Feinberg School of Medicine without further change in these bylaws. Each such department shall be governed by these Medical Staff Organizational Documents and the Hospital bylaws. The recognized departments are:

1. Anesthesiology
2. Dermatology
3. Emergency Medicine
4. Family Medicine
5. Medicine
6. Neurological Surgery
7. Neurology
8. Obstetrics and Gynecology
9. Ophthalmology
10. Orthopedic Surgery
11. Otolaryngology and Head & Neck Surgery
12. Pathology
13. Pediatrics
14. Physical and Rehabilitation Medicine
15. Preventive Medicine
16. Psychiatry and Behavioral Sciences
17. Radiation Oncology
18 Radiology
19. Surgery
20. Urology

9.1-2 Department Chairmen Selection and Review

The Chairmen of various clinical departments of Northwestern University Feinberg School of Medicine shall also serve as the Chairmen of the corresponding departments of the hospital, subject to the right of the board to approve such appointments or to rescind its approval. There shall be a regular review of the department Chairmen and this information will be presented to the Board.

Qualifications: Each department Chairman shall be and remain a member in good standing of the Active Staff and a member of the department of which he/she is to head, shall be qualified by training, experience, interest, demonstrated current ability, and board certification in the clinical area covered by the department, and shall be willing and able to discharge the administrative qualifications of his/her office.

9.1-3 Duties

Each department Chairman has ultimate responsibility for patient care with respect to his/her departmental affairs and is authorized by these bylaws to, and shall:

A. Account to the Medical Executive Committee and the board for all professional, administrative, clinically related and quality management functions within his/her department;

B. Develop and implement departmental programs, in cooperation with the President and other members of Hospital management and consistent with other provisions of these bylaws, for credentials review and Privilege delineation, orientation and continuing medical education, and quality/utilization/risk management and the integration of these functions with the departmental credentialing process;

C. Maintain continuing review of the professional performance of all practitioners with Clinical Privileges and of all Affiliated Health Practitioners with Privileges in his/her department; and report this information regularly to the Medical Executive Committee and the medical staff quality management process as set forth in the Committee Plan, as appropriate;

D. Be responsible for monitoring on an ongoing basis the clinical performance of individual department members, house staff assigned to the department and the quality of care rendered by each, individually in the capacity as a member of the departmental quality management committee, and continuous assessment and improvement of the quality of care, treatment, and services being rendered within the department.

E. Transmit on a timely basis to the appropriate authorities his/her department's recommendation concerning appointment and staff category; reappointment, delineation of clinical privileges, and corrective action with respect to applicants to, and staff members of, his/her department;

F. Appoint and act as an ex-officio member of a quality management process that functions as described in the Committee Plan;

G. Appoint such other intra-departmental committees as are necessary to conduct the functions of the department specified in the Functions of the Departments and designate a chairman and secretary for each;

H. Enforce the Hospital bylaws, Medical Staff Organizational Documents, and policies and regulations within his/her department, including initiating corrective action and investigation of clinical performance, ordering required consultations and impose monitoring and proctoring conditions that do not otherwise affect Clinical Privileges as required;

I. Implement within his/her department actions taken by the Medical Executive Committee, the President or the Board;

J. Integrate the department into the primary functions of the organization;

K. Integrate and coordinate interdepartmental and intradepartmental services;

L. Recommend qualifications and competence, and recommend sufficient staffing, of department personnel who provide care, treatment, and services;

M. Recommend space and other resources needed by the department;

N. Assess and recommend to the Hospital outsourced sites for needed patient care, treatment, and services not provided by the department or the organization;

O. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Medical Executive Committee, the President, or the Board;

P. Act as presiding officer at all department meetings;

Q. Perform such duties commensurate with his/her office as may from time to time be reasonably requested of him/her by the Chief of Staff, the Medical Executive Committee, the President or the Board.

R. Establish rules and schedules for the appropriate supervision of house staff by the members of the department.

S. Appoint from members of the department, a Vice-Chair to perform the duties and exercise the responsibilities of the Chairman in the absence of the Chairman.

9.1-4 Functions of Departments

The departments shall be responsible for patient care, teaching and education, and as part of this duty, they are responsible for implementing and conducting specific reviews and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility, each department shall:

A. Participate in the quality/utilization/risk management and ongoing monitoring for the purpose of reviewing and evaluating the quality of care rendered by each member of the department. Each department shall review the clinical work performed by each department member as well as house staff assigned to the department;

B. Recommend criteria for the granting of Clinical Privileges within the department and submit written recommendations;

C. Conduct or participate in orientation and continuing education programs;

D. Monitor, on a continuing and concurrent basis, adherence to:

1. Staff and hospital policies and procedures,

2. Requirements for alternate coverage and for consultations,

3. Sound principles of clinical practice, and

4. Hospital-wide safety programs.

E. Coordinate the patient care provided by the department's members with nursing and other professional patient care services and with administrative support services;

F. Through appropriate intra-departmental committees, submit written reports to the Medical Staff Quality Management Committee on a regularly scheduled basis concerning:

1. Findings of the department's review and evaluation activities, actions taken thereon, and the results of such action,

2. Recommendations for maintaining and improving the quality of care provided in the department and the hospital, and

3. Such other matters as may be requested from time to time by the Medical Staff Quality Management Committee.

G. Establish rules and schedules for the appropriate supervision of house staff by the members of the department;

H. Meet as necessary for the purposes of receiving, reviewing and considering findings of the quality/ utilization/risk management programs and the results of the department's review, evaluation and education activities and of performing, or receiving reports on, other department and staff functions;

I. Establish a quality management process that conforms in all respects to that described in the Committee Plan.

J. Establish such other committees or mechanisms as are necessary and desirable to perform properly the functions assigned to it.

9.2 SECTIONS AND DIVISIONS

9.2-1 Establishment

The establishment of any clinical department or section or division requires the recommendation of the Medical Executive Committee and the approving action of the Board.

9.2-2 Section and Division Chiefs

A. Qualifications: Each section or division Chief shall be and remain a member in good standing of the Active Staff and a member of the section or division which he/she is to head, shall be qualified by training, experience, interest and demonstrated current ability and board certification in the clinical area covered by the section, and shall be willing and able to discharge the administrative responsibilities of his/her office.

B. Selection: Each department Chairman shall recommend to the Medical Executive Committee a member of each section within his/her department who meets the qualifications of Active Staff for appointment as section or division Chief after consultation with the members of the section. The Medical Executive Committee shall, in turn, make its recommendations for appointment to the Board which shall make all such appointments.

C. Term of Office: Each section or division Chief shall serve a term, commencing on his/her appointment and continuing until his/her successor is appointed. All section and division Chief appointments shall be reviewed regularly by the Medical Executive Committee and the results shall be reported to the Board. The appointment of a section or division Chief may be terminated either by a department Chairman; or by the Board after receiving the recommendation of the Medical Executive Committee.

D. Duties: Each section or division Chief shall:

1. Account to his/her department Chairman for the effective operation of his/her section or division and for his/her section's or division's discharge of all patient care, education and research tasks delegated to it;

2. Develop and implement, in cooperation with his/her department Chairman, programs to carry out the quality/utilization/risk management functions assigned to his/her section or division;

3. Exercise general supervision over all clinical work performed within his/her section or division;

4. Perform such other duties commensurate with his/her office as may from time to time be reasonably requested of him/her by his/her department Chairman.

9.3 SPECIAL CARE UNITS AND AREAS

9.3-1 Establishment

The establishment of any Special Care Unit or Area requires the recommendation of the Medical Executive Committee and the approving action of the Board.

9.3-2 Directors of Special Care Units and Areas

A. Appointment and Operation: Medical Directors of Special Care Units or Areas shall be appointed by the Board after receiving the recommendations of the appropriate department Chairman and the Medical Executive Committee. Each Special Care Unit or Area shall be operated in accordance with policies approved by the Board. Medical Directors of Special Care Units or Areas and the Medical Executive Committee shall make recommendations to the Board concerning medical policies and protocols.

B. Termination: Appointments of Medical Directors of Special Care Units or Areas may be terminated by the Board upon the recommendation of the appropriate department Chairman and the Medical Executive Committee.

9.4 ADDITIONAL MEDICO-ADMINISTRATIVE POSITIONS

The establishment of any new medico-administrative position of the Medical Staff, i.e., in addition to those set forth in this Article, shall require the prior approval action of the Board upon recommendation of the Medical Executive Committee.

9.5 REMOVAL

Removal from any medico-administrative position alone shall not affect Medical Staff membership or existing Clinical Privileges and therefore shall not entitle the affected staff member to any redress, hearing or appellate review rights under Articles Routine Corrective Action or Fair Hearing and Appellate Review of the Hearing Plan.

ARTICLE X: MEETINGS

10.1 GENERAL STAFF MEETINGS

10.2 Regular Meetings

The Staff shall hold regular meetings. The mid-year meeting constitutes the annual meeting at which the election of officers and the six (6) at-large staff members of the Medical Executive Committee for the following medical staff year shall be conducted.

10.3 Special Meetings

Special meetings of the Staff may be called at any time by the Board, the Chief of Staff, the Medical Executive Committee, or shall be called by the Chief of Staff within fifteen (15) days after receipt of a written request signed by at least fifty (50) members of the Active Staff, and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

10.4 Order of Business and Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at least:

A. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting;

B. Administrative reports from the President, the Chief of Staff as chair of the Medical Executive Committee, departments and committees as selected by the Chief of Staff;

C. The election of officers and of representatives to staff committees, when required by these bylaws;

D. Reports by responsible officers, committees, and departments on the overall results of quality/ utilization/risk management programs and other quality maintenance activities of the Staff, and on the fulfillment of the other required staff functions;

E. Recommendations for improving patient care within the hospital;

F. Matters placed on the agenda at the request of members of the Active Staff.

G. Old business.

H. New business.

10.5 COMMITTEE AND DEPARTMENT MEETINGS

10.5-1 Regular Meetings

Departments shall meet as necessary to perform required functions.

10.5-2 Special Meetings

Special meetings may be called by or at the request of the Chief of Staff, Vice Chief of Staff, Chair, or any three (3) members of the committee upon at least three (3) days written notice sent via mail, email, fax, or personal delivery to the committee member's last known home or office address. Notice by mail shall be deemed given when deposited in the mail with postage prepaid. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

10.6 NOTICE OF MEETINGS

Written or printed notice stating the place, day and hour of any general Staff meeting, of any special meeting of the general Staff, or of any regular Staff committee meeting not held pursuant to resolution shall be delivered either personally, by fax, by email, or by mail to each person entitled to be present, not less than five (5) days before the date of such meeting. Notice of special meetings of committees and departments is set forth above. If mailed, the notice of meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each person entitled to such notice at his/her address as it appears on the records of the hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

10.7 QUORUM

10.7-1 General Staff Meetings

A quorum for all properly called Medical Staff meetings shall consist of those eligible voting members present at the meeting.

10.7-2 Department and Committee Meetings

Except as set forth in Special Meetings, there shall be no quorum requirements for any department or committee meetings. The passage of any action or the transacting of any business shall only require the support of a majority of those present and eligible to vote under the bylaws.

10.7-3 Core Medical Staff Meetings

The personal presence of fifty percent (50%) of the voting members of the Medical Executive Committee, the Credentialing Committee, the Quality Management Committee or successor committee as set forth in the Committee Plan, and the Patient Care Committee (the “Core Committees”) shall constitute a quorum at any meeting of said committee. The action of a majority of members present and voting at a meeting at which a quorum is present, shall be the action of the group.

10.8 MANNER OF ACTION

Except as otherwise specified in these bylaws, the action of a majority of the members present and voting at a meeting at which a quorum is present, shall be the action of the group. Action may be taken without a meeting by a department or committee by a writing setting forth the action so taken signed by each member entitled to vote on the issue.

Except as otherwise specified in these bylaws, members of a committee may participate in and act at any meeting by means of conference telephone or similar communications equipment if all persons participating in the meeting can hear each other simultaneously. Participation by such means shall constitute presence in person at the meeting.

10.9 MINUTES

Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the attendees, forwarded to the Medical Executive Committee, and made available to the Staff in accordance with the Confidentiality Statement of Medical Staff Files and Records approved by the Medical Executive Committee. A permanent file of the minutes of each meeting shall be maintained in accordance with the Confidentiality Statement on Medical Staff Files and Records approved by the Medical Executive Committee.

10.10 ATTENDANCE REQUIREMENTS

10.10-1 Regular Attendance

Each member of the Active Staff should strive to attend staff meetings duly convened pursuant to these bylaws and department meetings to which assigned.

10.10-2 Special Appearance

A Staff Member whose patient's clinical course of treatment is scheduled for discussion at a regular department or committee meeting, or other involved Staff Member or Doctorate Level Health Professional or Affiliated Health Professional, shall be given written notice of the matter and of the time and place of the meeting at least fifteen (15) days prior to the meeting. Whenever apparent or suspected deviation from standard clinical practice is involved, Special Notice shall be given and shall include a statement of the issue involved and that the Staff Member's appearance is mandatory. Failure to appear at any meeting with respect to which he/she was given such Special Notice shall, unless excused by the Medical Executive Committee upon a showing of good cause, result in an automatic suspension of all or such portion of the Staff Member's Clinical Privileges as the Medical Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee, or the Board, or through corrective action if necessary.

ARTICLE XI: CONFIDENTIALITY, IMMUNITY & RELEASE

11.1 SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply:

A. INFORMATION means records of proceedings, transcripts, minutes, records, reports, memoranda, statements, recommendations, dates and other disclosures whether in oral or written form and video, audio and other electronic recordings relating to any of the subject matter specified in the section titled Activities and Information Covered.

B. PRACTITIONER means a Staff Member or applicant.

C. REPRESENTATIVE means the Board and any member or committee thereof, the President, officers, employees or agents of the Hospital, the staff organization and any member, officer, department, service, committee or subcommittee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

D. THIRD PARTIES means both individuals and organizations including, but not limited to, other educational or health-related institutions providing information to any representative.

11.2 AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, Clinical Privileges within this Hospital, a Practitioner:

A. Authorizes representatives of the Hospital, the Credential Verification Office (“CVO”), and the staff to solicit, provide and act upon information bearing on his professional ability and other qualifications;

B. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative to the maximum extent permitted by law; and

C. Acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, Staff membership, reappointment, or his/her exercise of Clinical Privileges at this Hospital.

D. Authorizes all third parties to release to any representatives all information bearing on Practitioner's professional ability and other qualifications as requested by representatives including without limitation, copies of all documents in Practitioner's Medical Staff credentialing file at third party institutions, quality management information, risk management information, any corrective actions taken and medical charts for cases handled by Practitioner.

E. Waives voluntarily the provisions of Section 412(b) of the Health Care Quality Improvement Act of 1986 (Act) [42 U.S.C. 11112(b)] which waiver is expressly permitted by Section 412(b). This waiver means that no variance between these bylaws and Section 412(b) concerning notice and hearing rights may be asserted by a practitioner to defeat the peer review immunity provisions in Section 411(a) of the Act [42 U.S.C. 11111(a)].

11.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any Practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of credentialing, peer review or improving the quality of patient care, or reduce morbidity and mortality, shall, consistent with applicable law, be treated as confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties.

11.4 IMMUNITY FROM LIABILITY

Neither the Hospital nor any Hospital representative as defined in the Credentialing Plan and of these Bylaws shall be liable for any activity under these bylaws in any judicial proceeding for damages.

11.5 ACTIVITIES AND INFORMATION COVERED

11.5.1 ACTIVITIES

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other educational or health-related institution's or organization's activities concerning, but not limited to:

A. Applications for appointment, reappointment and Clinical Privileges,

B. Periodic reappraisals for reappointment and Clinical Privileges,

C. Corrective action as defined in the Routine Corrective Action of the Hearing Plan,

D. Hearings and appellate reviews,

E. Quality assurance activities,

F. Utilization reviews, and

G. Other Hospital, department, section, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

11.5.2 INFORMATION

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, professional ethics, ability to work cooperatively with others, economic efficiency or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.

11.6 RELEASES

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article, and such releases or copies thereof may be submitted to third parties from whom information is sought. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

11.7 CUMULATIVE EFFECT

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

ARTICLE XII: GENERAL PROVISIONS

12.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of staff organizational activities as well as embody the level of practice that is to be required of each Staff Member or Doctorate Level Health Professional or Affiliated Health Professional in the Hospital, and shall be reviewed at least every two (2) years. Such rules and regulations shall be a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

12.2 DEPARTMENT, SECTION AND DIVISION RULES AND REGULATIONS

Subject to the approval of the Medical Executive Committee and the Board, each department, section and division shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these bylaws, the general rules and regulations of the staff, or other policies of the Hospital. A permanent file of current department, section or division rules and regulations shall be maintained by the Chief of Staff.

12.3 FORMS

Application forms required or permitted by these bylaws for use in connection with staff appointments, reappointments, and delineation of Clinical Privileges, and substantive modifications to such forms, shall be adopted by the Board after considering the advice of the Medical Executive Committee, except as required by law.

12.4 HEADINGS

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these bylaws.

12.5 TRANSMITTAL OF REPORTS

Reports and other information which these bylaws require the Staff to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the President.

12.6 DESIGNEES TO PERFORM FUNCTIONS OF THE PRESIDENT

Any duty or responsibility assigned, or authority granted, to the President may be fulfilled or exercised by another administrative official of the Hospital, designated in writing by the President or the Board to perform such function, except as otherwise provided by the Board or in the Hospital bylaws.

12.7 GOOD STANDING

The Prerogatives and rights provided by these bylaws to Staff Members to vote at staff meetings, to be nominated for and to hold staff office or serve as a member of the Medical Executive Committee, and to serve as a department head or section or division chief or committee chairman, shall be limited to Staff Members in good standing.

12.8 CONTROLLING LAW

These bylaws, including Exhibits A and B and Attachments A, B and C, shall be interpreted and construed in accordance with the laws of the State of Illinois, and the invalidation or unenforceability of any particular provision by a court of competent jurisdiction shall not serve to invalidate or render unenforceable any other provision.

12.9 ENTIRE DOCUMENT

These bylaws, including Exhibits A and B and Attachments A, B and C, constitute the entire set of provisions that govern the subject matter hereof.

12.10 VENUE

Any lawsuit brought by anyone against any Hospital representative, as defined in the Credentialing Plan, challenging any activity covered by these bylaws must be brought in a federal or state court located in Chicago, Illinois.

12.11 LIMITATIONS PERIOD

Any lawsuit challenging any decision or action under these bylaws that is not filed within 60 days of such decision or action shall be time-barred.

ARTICLE XIII: ADOPTION AND AMENDMENT OF BYLAWS, RULES & REGULATIONS, POLICIES

13.1 STAFF RESPONSIBILITY AND AUTHORITY

The Staff shall have the initial responsibility to formulate and to submit recommendations to the Board regarding medical staff bylaws, rules and regulations, and amendments. Unless amendments are being proposed directly to the Board, proposed amendments shall first be considered by a special (ad hoc) committee of the staff. All amendments or revisions shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner. A special (ad hoc) committee of the staff shall review the medical staff bylaws at least every two (2) years.

13.2 METHODOLOGY

Medical Staff bylaws may be adopted, amended, or repealed by the following combined action:

13.2.1 Medical Executive Committee

Any recommended amendments made by a special (ad hoc) committee of the staff shall be reviewed and considered by the Medical Executive Committee. Medical Executive Committee recommendations shall be submitted to the Staff for consideration

13.2-2 Staff

The affirmative vote of a majority of the Staff Members eligible to vote on this matter who are present at a meeting at which a quorum is present, provided at least fifteen (15) days written notice, accompanied by the proposed bylaws and/or alterations, or summary thereof, has been given of the intention to take such action; and

13.2-3 Board

Adoption and amendment shall be final upon approval of the Board. In the event that the Board does not approve the recommendations, the medical staff has the option of requesting the conflict management process.

In the event that the Staff shall fail to exercise its responsibility and authority, and after notice from the Board to such effect including a thirty (30) day period of time for response unless exigent circumstances require a more timely or immediate response, the Board may resort to its own initiative in formulating or amending Medical Staff bylaws. The Board's right to formulate or amend bylaws under this section is limited to situations where the medical staff's failure to act may result in some adverse impact on the Hospital or Medical Staff including, but not limited to, threat of investigation from any governmental, licensing or similar authority or threat of loss or material impairment of the Hospital's tax exempt status, Medicare eligibility, license, accreditation, insurance coverage or other similar significant event which could adversely affect Hospital operations.

13.3 NON UNILATERAL ACTION

Resort to the above methodology shall not constitute unilateral bylaws amendment by the Board. These bylaws shall not be amended by the Board's action alone except in the circumstances set forth above.

13.4 MEDICAL STAFF POLICIES

The Medical Executive Committee can propose to adopt a medical staff policy or revision thereto without obtaining the approval of the medical staff as long as it is compatible with any existing bylaws, rule, regulation, plan, or other policy. The medical staff shall have the option of pursuing the conflict management process. If this option is chosen, the policy shall not be implemented until the conflict is resolved.

ARTICLE XIV: ADOPTION AND AMENDMENT OF PLANS

14.1 STAFF RESPONSIBILITY AND AUTHORITY

The staff shall adopt amendments to the Credentialing Plan, the Corrective Action and Fair Hearing Plan and the Committee Plan (together the "Plans" which are made a part of these Bylaws as Attachment A, Attachment B and Attachment C, respectively) as may be necessary to implement more specifically the general principles found within these Plans and Bylaws. The Plans shall be considered part of the Bylaws and the Medical Staff Organizational Documents and shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each Physician at the Medical Center facility.

14.2 METHODOLOGY

With the exception of Application for Initial Appointment in the Committee Plan, the procedure for amending the Plans shall be as follows:

A. A recommendation to change or amend the Plan may be proposed by any member of the Medical Staff. Such amendment shall be submitted in writing to the Chief of Staff who shall then forward the amendment to the Medical Executive Committee.

B. The Medical Executive Committee shall consider the recommended change at its next scheduled meeting. The Medical Executive Committee may work with the recommending individual or body to refine the recommendation prior to voting on the recommendation.

C. If the Medical Executive Committee concurs with the proposed change to the Plans, the proposed changes will be posted in an appropriate manner for twenty (20) days. Any medical staff member wishing to comment on the proposed change shall submit their comments in writing to the Medical Executive Committee.

D. At the next regularly scheduled meeting, the Medical Executive Committee shall consider any comments received from the medical staff and will vote to approve, disapprove, or modify the recommendation.

E. The decision of the Medical Executive Committee shall be forwarded to the board of directors for its final review and decision.

ARTICLE XV: BYLAWS AND PLANS PROPOSED BY THE MEDICAL STAFF DIRECTLY TO THE BOARD

A bylaw, plan, or amendment, may be proposed directly to the Board by the medical staff by an affirmative vote of a majority of the Staff Members eligible to vote on this matter who are present at a meeting provided at least fifteen (15) days written notice, accompanied by the proposal and/or alterations, or summary thereof, has been given of the intention to take such action. If approved, the proposal is communicated to the Medical Executive Committee which shall have the option of either forwarding its comments and recommendations for the Board's consideration, or pursuing the conflict management process. The Board shall not act on any proposed bylaw, plan, or amendment, pending the outcome of this process.

If the conflict management process does not result in resolution between the medical staff and the Medical Executive Committee, the Board has the option of whether or not to consider the proposal. The decision on this matter shall be final and shall not trigger the conflict management process under the corporate bylaws. If the medical staff and the Medical Executive Committee do reach resolution but the proposal is not approved by the Board, the conflict management process under corporate bylaws shall be followed.

ARTICLE XVI: CONFLICT MANAGEMENT PROCESS

16.1 REQUIREMENTS

In the event that one-tenth (1/10) of the voting members of the medical staff each signed a petition or otherwise evidence disagreement with any action taken by the Medical Executive Committee including, but not limited to, any proposed bylaw or plan, these members can engage the conflict management process under this Article.

16.2 METHODOLOGY

The petition shall clearly state the basis of the disagreement and may include any other information by way of additional explanation to medical staff members. The petitioner must acknowledge that he/she has read the petition and all attachments, if any, in order for his/her signature to be considered valid.

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

If the Medical Executive Committee and the petitioners are able to resolve the conflict, the resolution shall be submitted to the voting members. If a majority of the voting members approve the proposed resolution at a meeting where a quorum is present, the proposal will be forwarded to the Board for its review and consideration.

Should the parties fail to reach resolution, or if the voting members do not approve any proposed solution agreed to by the petitioners and Medical Executive Committee, the petition and all accompanying materials will be forwarded to the Board for its review and consideration. The decision of the Board shall be final and shall not serve as a basis for conflict management under the corporate bylaws.

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

Nothing under this section precludes direct communication between an individual member(s) and the Board of Directors on any bylaws or plans already adopted by the medical staff or the Medical Executive Committee. Such communication shall be forwarded to the Executive Committee of the Board through the President of the Hospital and to the Medical Executive Committee through the Chief of Staff. The Chair of the Board shall determine the manner and method of responding to any physician(s) communicating to the Board under this Section.

ARTICLE XVII: CREDENTIALING PLAN

The Staff, with the assistance of the administration, through its designated departments, committees, and officers, shall investigate and consider each application for appointment or reappointment to the Staff and privileging and reprivileging, and modification of Staff Membership status and shall adopt and transmit recommendations thereof to the Board which shall have the final authority in granting appointments, reappointments and Privileges. Neither the Hospital nor the Medical Staff shall discriminate in granting staff membership and/or Clinical Privileges on the basis of national origin, culture, race, gender or gender identity, sexual orientation, ethnic background, religion, or disability unrelated to the provision of patient care to the extent the applicant or member is otherwise qualified. Associated details are contained in the Credentialing Plan.

ARTICLE XVIII: ROUTINE REMEDIAL ACTION

18.1 ROUTINE REMEDIAL ACTION THROUGH THE MEDICAL STAFF

18.1-1 Criteria for Initiation

Whenever the activities or professional conduct of any Staff Members are believed to be detrimental to patient safety or inconsistent with the efficient delivery of patient care at the generally recognized professional level of quality, or are disruptive to Hospital operations or violate these Medical Staff Organizational Documents, departmental rules or other Medical Staff or Hospital policies, or a Medical Staff member exhibits signs of physical or mental impairment, or for other reasonable cause, corrective action against such Staff Member may be initiated by the Chief of Staff, by the Chairman of the department involved, by the President, or by the Board. Initiation of routine corrective action does not preclude imposition of summary suspension as provided for in these bylaws, nor does it require the prior imposition of such a suspension.

18.1-2 Requests and Notices

All requests for corrective action shall be in writing submitted to the Chief of Staff, and be supported by reference to the specific conduct or activities which constitute the grounds for the request.

18.1-3 Investigation

Investigation means the formal medical staff process that begins with a written notification to a Practitioner upon the commencement of formal process and terminates with the Hospital's final action on the medical staff recommendation or the conclusion of the medical staff formal process without recommendation or adverse action. Associated details are contained in the Hearing Plan.

After consideration of the request, the Medical Executive Committee shall either reject the request and report the reasons for its decision to the President, or forward the request either to the Chairman of the department in which the questioned activities or conduct occurred, or to an ad hoc committee appointed by the Medical Executive Committee, to conduct an investigation which may take the form of an internal or external review.

18.1-4 Medical Executive Committee Action

Within thirty (30) days following receipt of the report of the investigation, the Medical Executive Committee shall take action upon the request.

18.1-5 Board Review

When the Medical Executive Committee, after review of a report of investigation, or after review of summary suspension imposed, determines that no corrective action should be taken, the President shall report such determination to the Board.

18.1-6 Procedural Rights

See Hearing Plan.

18.2 ROUTINE CORRECTIVE ACTION THROUGH THE BOARD

18.2-1 Criteria for Initiation

Whenever the activities or professional conduct of any Staff Member are believed to be detrimental to patient safety or inconsistent with the efficient delivery of patient care at the generally recognized professional level of quality, disruptive to Hospital operations or in violation of these Medical Staff Organizational Documents, departmental rules or other Hospital policies; or whenever a Medical Staff member exhibits signs of physical or mental impairment; or for other reasonable cause, any three members of the Board may initiate corrective action against such Staff Member. Initiation of routine corrective action does not preclude imposition of summary suspension as provided for in these bylaws, nor does it require the prior imposition of such a suspension.

18.2-2 Requests and Notices

Any three members of the Board may request routine corrective action pursuant to the Hearing Plan.

18.2-3 Investigation

Investigation means the formal medical staff process that begins with a written notification to a Practitioner upon the commencement of formal process and terminates with the Hospital's final action on the medical staff recommendation or the conclusion of the medical staff formal process without recommendation or adverse action. Associated details are contained in the Hearing Plan.

After consideration of the request, the Board shall either reject the request and report its decision to the Medical Executive Committee, the department Chairman, the Chief of Staff and the President or appoint an ad hoc committee, to conduct an investigation of the alleged conduct or activities.

18.2-4 Board Action

Within thirty (30) days following receipt of the report of the investigation, the Board shall take action upon the request.

18.2-5 Procedural Rights

See Hearing Plan.

18.3 SUMMARY SUSPENSION

18.3-1 Criteria for Initiation

Whenever a continuation of a physician's practice constitutes an immediate danger to the health or safety of the public, including patients, visitors, and hospital employees and staffs a combination of the President and either the Chief of Staff or the Chairman of the department in which the affected physician is a member (the Summary Suspension Committee), shall have the authority to summarily suspend the medical staff membership status or any portion of the clinical privileges of such physician. A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists which must be available when the suspension decision is made. Such summary suspension shall become effective immediately upon imposition, and the CEO shall promptly give special notice stating the cause of the suspension to the physician and of the physician's right to request a hearing. In the event of any such suspension, the physician's patients then in the hospital whose treatment by such physician is terminated by the summary suspension shall be assigned to another member of the medical staff with similar clinical privileges by the department Chairman. The wishes of the patient shall be considered, where feasible, in choosing a substitute physician.

18.3-2 Medical Executive Committee Deliberation

After a summary suspension is imposed, the MEC convenes as soon as it is reasonably possible, but in no event longer than five (5) days after the suspension was imposed, to review and consider the facts under which such action was taken. The MEC may affirm, list, expunge or modify the suspension. The MEC may also recommend such further corrective action as is appropriate to the facts, including limitation of prerogatives, which recommendation if subject to

hearing rights under these bylaws, would be combined with any remaining summary suspension action as the bases for the hearing. An MEC recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights is transmitted immediately, together with all supporting documentation, to the board, or a committee of the board for review on an expedited basis. If the suspension is re-imposed or other adverse action is taken, the physician shall be entitled to those hearing rights set forth under this Article.

18.3-3 Procedural Rights

The physician so affected is entitled to the procedural rights contained in these bylaws, except that the time basis shall be as follows:

A.The physician must request the hearing within ten (10) days of receiving special notice.

B.A fair hearing shall be commenced within fifteen (15) days after the suspension (unless an extension is agreed to in writing by the parties) and shall be completed without delay.

18.4 AUTOMATIC SUSPENSION AND/OR REVOCATION

Grounds for automatic suspension and/or revocation include:

18.4-1 Loss of License

18.4-2 Failure to Satisfy Special Appearance Requirement

18.4-3 Conviction of a Felony

18.4-4 Medical Records

18.4-5 Dues Delinquency

18.4-6 Reappointment Forms

18.4-7 Faculty Appointment

18.4-8 Board Certification

18.4-9 Professional Liability Insurance

18.4-10 Exclusion from Federally Funded Programs

18.4-11 Failure to Comply with Hospital and Medical Staff Policy

18.4-12 Effectiveness

18.4-13 Procedural Rights

See Hearing Plan

ARTICLE XIX: FAIR HEARING AND APPELLATE REVIEW

19.1 INITIATION OF HEARING

19.1-1 Recommendation or Actions

Unless otherwise provided for in these Bylaws, only the following recommendations or actions by the Medical Executive Committee, or by the Board if not previously recommended by the Medial Executive Committee pursuant to these Medical Staff Organizational Documents, shall entitle the Qualified Practitioner affected thereby to a hearing:

A. Denial of reappointment,

B. Suspension of staff appointment,

C. Revocation of staff appointment,

D. Reduction in staff category,

E. Reduction in clinical privileges,

F. Suspension of clinical privileges,

G. Revocation of clinical privileges,

19.2 HEARING AND APPELLATE REVIEW PROCESS

19.2-1 Adverse Recommendation or Action of the Medical Executive Committee or Board of Directors

The following procedures shall apply to an adverse action or recommendation, as described in more detail in the Hearing Plan, of the Medical Executive Committee or the Board of Directors on its own initiative:

A. Notice of Adverse Recommendation or Action: A Qualified Practitioner against whom adverse action has been taken or recommended shall promptly be given Special Notice of such action by the Chief of Staff.

B. Request for Hearing: Other than for summary suspensions invoked for imminent danger and for automatic suspensions and/or revocations, a Qualified Practitioner shall have thirty (30) days following his/her receipt of a notice to file a written request for a hearing.

C. Waiver by Failure to Request a Hearing: A Qualified Practitioner who fails to request a hearing within the time and in the manner specified waives any right to such hearing and to any appellate review to which he/she might otherwise have been entitled, and shall be deemed to have accepted the adverse action or recommendation as final and unappealable under the Bylaws and the Hearing Plan.

D. Appointment of Hearing Committee: A hearing resulting from a Medical Executive Committee or Board of Directors recommendation or action shall be conducted by a mutually agreed hearing officer or by a Hearing Committee appointed by the Chief of Staff and the President and composed of at least three (3) members of the Active Staff, none of whom shall be direct economic competitors of the Qualified Practitioner or initiators of the adverse action and nor shall they have had any prior significant involvement in the decisions leading up to the recommended adverse action.

E. Notice of Time and Place of Hearing: Upon receipt of a timely request for hearing, the Chief of Staff shall promptly schedule and arrange for a hearing. The Chief of Staff shall send the Qualified Practitioner Special Notice of the time, place and date of the hearing by certified mail, return receipt requested. The initial hearing date shall be no earlier than thirty (30) days from the date of receipt of the hearing notice sent by the Chief of Staff.

F. Statement of Charges: The notice of hearing shall contain a concise statement of the Qualified Practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question, if any, the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing, if any, as well as a list of witnesses then expected to testify.

19.2-2 Personal Presence

The personal presence of the Qualified Practitioner who requested the hearing shall be required.

19.2-3 Presiding Officer

Either the hearing officer or the chairman of the Hearing Committee, as the case may be, shall be the presiding officer.

19.2-4 Representation

The Qualified Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a person of his/her choice, including an attorney. (See Hearing Plan regarding role of Counsel)

19.2-5 Rights of Parties

During a hearing, each of the parties shall have the right to:

A. Call and ask questions of their own witnesses and witnesses called by the other party on any matter relevant to the issues;

B. Introduce any information deemed relevant and acceptable by the presiding officer;

C. Rebut any information;

D. Inspect all pertinent information in the Hospital's possession as determined by the Hearing Committee, with respect to the decision and information which the parties expect to submit;

E. Receive a copy of the proceedings either as transcribed by a court reporter or recorded with an electronic recording unit and all documents considered by the hearing officer or committee, with all related costs to be equally shared.

F. Provide a written statement at the hearing's conclusion or at a later date as determined by the committee,

G. Receive lists of proposed witnesses as much in advance of their appearances as reasonably possible.

If the Qualified Practitioner who requested the hearing does not testify in his/her own behalf, he/she may be called and examined by the Hearing Committee and the other party.

19.2-6 Procedure and Evidence

The hearing need not be conducted strictly in accordance to the rules of law relating to the examination of witnesses or presentation of information.

19.2-7 Record of Hearing

A record of hearing will be made either as transcribed by a court reporter or recorded with an electronic recording unit with all related costs to be equally shared.

19.2-8 Postponement

Requests for postponement of a hearing shall be granted by the hearing officer or committee only upon a showing of good cause.

19.2-9 Recesses and Adjournment

The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional information or consultation.

19.3 HEARING COMMITTEE REPORT AND FURTHER ACTION

19.4 HEARING COMMITTEE REPORT

Within thirty (30) days after final adjournment of the hearing, or such other period as may be required to complete the transcription of the proceeding and review final written statements submitted by the parties, the Hearing Committee shall make a written report of the findings and recommendations in the matter, including the basis on which the decision was made, and shall forward the same, together with the hearing record and all other documentation

considered by it, to the board of directors. A copy of the report shall also be sent to the Medical Executive Committee and the affected Qualified Practitioner.

19.5 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

19.5-1 Request for Appellate Review

A Qualified Practitioner and/or the Medical Executive Committee or the Board, whichever is appropriate, shall have fifteen (15) days following his/her/its receipt of the written report of findings to file a written request for an appellate review.

19.5-2 Waiver by Failure to Request Appellate Review

A Qualified Practitioner who fails to request an appellate review within the time and in the manner waives any right to such review. Such waiver shall have the same force and effect as that provided in these bylaws.

19.5-3 Notice of Time and Place for an Appellate Review

Upon receipt of a timely request for appellate review, the Chief of Staff shall deliver such request to the Board. The Board shall promptly schedule and arrange for commencement of an appellate review which shall be no more than thirty (30) days from the date of the board's receipt of the appellate review request.

19.5-4 Appellate Review Body

The Appellate Review Committee shall be composed of at least three (3) members appointed by the Chairman of the Board, at least one of whom shall be a member of the Active Staff and not a direct economic competitor of the Qualified Practitioner or initiator of the adverse action and nor shall they have had any prior significant involvement in the decisions leading up to the recommended adverse action.

19.6 APPELLATE REVIEW PROCEDURE

19.6-1 Nature of Proceedings

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee or agreed hearing officer, as the case may be, that committee's report, and all subsequent results and actions thereon.

19.6-2 Written Statements

The Qualified Practitioner and/or the Medical Executive Committee or the Board seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, if any, and his/her/its reasons for such disagreement.

19.6-3 Presiding Officer

The chairman of the Appellate Review Body shall be the presiding officer. He/she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

19.6-4 Oral Statement

The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

19.6-5 Recesses and Adjournment

The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

19.6-6 Action Taken

The Appellate Review Body may recommend that the Board affirm, modify or reverse the adverse result or action taken by the Medical Executive Committee or by the Board, or, in its discretion, may refer the matter back to the Hearing Committee or hearing officer, as the case may be, for further review and recommendation to be returned to it within twenty (20) days. Within twenty (20) days after receipt of such recommendation after referral, the Appellate Review Body shall make its recommendation to the Board. All actions of the Appellate Review Body shall be in writing with a copy to the Qualified Practitioner and the Medical Executive Committee.

19.6-7 Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps have been completed or waived.

19.7 FINAL DECISION OF THE BOARD

19.7-1 Board Action

The Board shall consider the Hearing Committee's and/or Appellate Review Committee's recommendation and make a preliminary determination on the matter. Whenever the Board's preliminary determination will be contrary to the Medical Executive Committee's last recommendation, the Board shall invite the Medical Executive Committee to submit a response to the Board's preliminary determination within thirty (30) days of the Medical Executive Committee's receipt of the preliminary determination. If the Board's determination is consistent with the Medical Executive Committee's last recommendation, it shall be considered final and no response from the Medical Executive Committee is necessary.

19.7-2 Board Decision Final

The Board shall consider the Medical Executive Committee's response, if applicable, and take action on the matter. If the Medical Executive Committee does not submit a response within the time required or if no response is required, the Board's action on the Appellate Review Committee recommendation shall be considered final. The Board's action on any response submitted by the Medical Executive Committee shall be considered final. The Chief of Staff shall notify the Qualified Practitioner and the Medical Executive Committee by special notice of the Board's final action. Except as in circumstances described in the Hearing Plan, the Board's decision shall be effective immediately.

ARTICLE XX: COMMITTEE PLAN

There shall be such standing and special (ad hoc) committees and subcommittees of the Staff as may from time to time be necessary and desirable to perform the functions of the Staff required by these Medical Staff Organizational Documents or necessarily incidental thereto.

ARTICLE XXI: BOARD OF DIRECTORS

Nothing in these bylaws shall abridge the right of the Board of Directors of the hospital to take such actions as seem to them necessary or desirable under the circumstances.

ADOPTED by the Medical Staff on May 24, 1990
APPROVED by the Board of Directors on June 25, 1990

REVISED by the Medical Staff on September 5, 1991
APPROVED by the Board of Directors on September 30, 1991

REVISED by the Medical Staff on December 2, 1993
APPROVED by the Board of Directors on December 20, 1993

REVISED by the Medical Staff on December 1, 1994
APPROVED by the Board of Directors on December 19, 1994

REVISED by the Medical Staff on March 6, 1997
APPROVED by the Board of Directors on March 24, 1997

REVISED by the Medical Staff on March 12, 1998
APPROVED by the Board of Directors on March 23, 1998

REVISED by the Medical Staff on March 15, 2001
APPROVED by the Board of Directors on March 26, 2001

REVISED by the Medical Staff on September 11, 2003
APPROVED by the Board of Directors on October 27, 2003

REVISED by the Medical Staff on December 4, 2003
APPROVED by the Board of Directors on December 22, 2003

REVISED by the Medical Executive Committee on February 9, 2004 (Credentialing Plan)
APPROVED by the Board of Directors on February 23, 2004

REVISED by the Medical Staff on December 14, 2006 (Bylaws) and the
Medical Executive Committee on December 2006 (Credentialing and Hearing Plans)
APPROVED by the Board of Directors on February 26, 2007

REVISED by the Medical Staff on March 5, 2008 (Bylaws and Rules and Regulations) and the
Medical Executive Committee on March 9, 2009 (Credentialing, Hearing and Committee Plans)
APPROVED by the Board of Directors on June 22, 2009

REVISED by the Medical Staff on February 8, 2011 (Bylaws and Rules and Regulations) and the
Medical Executive Committee on February 14, 2011 (Credentialing and Hearing Plans)
APPROVED by the Board of Directors on February 28, 2011

REVISED by the Medical Staff on February 21, 2012 (Bylaws and Rules and Regulations) and the
Medical Executive Committee on March 9, 2012 (Credentialing and Hearing Plans)
APPROVED by the Board of Directors on April 30, 2012

REVISED by the Medical Staff on June 18, 2013 (Bylaws and Rules and Regulations) and the
Medical Executive Committee on June 10, 2013 (Credentialing and Committee Plans)
APPROVED by the Board of Directors on October 21, 2013

REVISED by the Medical Staff on June 18, 2014 (Bylaws and Rules and Regulations) and the
Medical Executive Committee on April 17, 2014 (Fair Hearing Plan)
APPROVED by the Board of Directors on July 28, 2014

REVISED by the Medical Staff on June 14, 2016 (Bylaws and Rules and Regulations) and the
Medical Executive Committee on July 15, 2016 (Credentialing Plan)
APPROVED by the Board of Directors on July 28, 2016

REVISED by the Medical Staff on September 13, 2018 (Bylaws and Rules and Regulations) and the Medical Executive Committee on September 10, 2018 (Credentialing Plan, Hearing Plan, Committee Plan)
APPROVED by the Board of Directors on February 27, 2019.

EXHIBIT A: AFFILIATION AGREEMENT

SECTIONS 5, 6 AND 7 OF THE AFFILIATION AGREEMENT BETWEEN
NORTHWESTERN MEMORIAL HOSPITAL AND NORTHWESTERN UNIVERSITY
AND DATED JUNE 25, 1973, AS AMENDED.

5. Selection of Medical Staff.

The hospital shall continue to select physicians and dentists for its Medical Staff exclusively from the faculties of the University. The University shall verify to the Chief of Staff or Chief Executive Officer of the hospital whether the applicant for appointment to the hospital's Medical Staff has a faculty appointment at the University. Since the hospital is dependent upon the University for a supply of physicians and dentists sufficient for the hospital's needs, the University agrees in good faith to admit to faculty status qualified physicians and dentists recommended by the Chief of Staff or the Chief Executive Officer of the hospital and without regard to whether any such individual does or does not belong to, intend to belong to, or favor any group or association of physicians or dentists. In the event that any individual whom the hospital desires to have on its Medical Staff is denied faculty membership, the Chief of Staff and Chief Executive Officer of the hospital shall consult with the Dean of the University's Medical or Dental School, as the case may be, to seek a satisfactory resolution of the matter.

6. Severance from University Faculty.

If a physician or dentist on the Medical Staff of the hospital is severed from the faculty of the University, such person's membership on the Medical Staff of the hospital shall likewise terminate (except that the hospital may, in its discretion, grant to such person visiting staff privileges); provided, however, that members of the University's non-salaried clinical faculty who are also members of the Attending or Associate Attending Medical Staff of the hospital will not be severed from the faculty of the University, either by failure of the University to renew an appointment or other act of termination, without the opportunity for such affected individual to appeal a faculty severance or termination decision or action upon such procedures as may be in effect from time to time in the administrative policies and administrative procedures established by Northwestern University Medical School for such purposes; and provided further, that persons who were members of the Medical Staff of the hospital on September 1, 1972 but were not then members of the University's faculty may be retained by the hospital on its Medical Staff, if the hospital so elects.

7. Selection of Department Chairmen.

The Medical Staff of the hospital shall be organized into clinical Departments corresponding to those from time to time in effect at the University's Medical School. The Chairmen of the various clinical Departments of the University's Medical School and Dental School shall also serve as Chairmen of the corresponding Departments of the hospital, subject to the right of the Board of Directors of the hospital and the Board of Trustees of the University to approve such appointments applicable to its institution. The search committee utilized by the University to fill such positions shall be appointed by the Dean of the University's Medical School or Dental School, as the case may be, but the University agrees to afford representation to the hospital on any such search committee, appropriate to the hospital's interest in such appointment. The hospital's representation on such committee shall be mutually agreed upon between the Chief Executive Officer of the hospital, the Chief of Staff of the hospital, and the Dean of the University's Medical School or Dental School, as the case may be.

EXHIBIT B: MEDICAL STAFF RULES & REGULATIONS

I. Receipt and Transmittal of Medical Staff Licensure and Disciplinary Information

A. Prior to the granting of any medical staff privileges to an applicant, or in reviewing a current medical staff member's privileges, the Medical Staff Office, through the CVO, shall secure, verification from the Director of the Department of Financial and Professional Regulation information concerning the licensure status and any disciplinary action taken against the applicant's or medical staff member's license.

B. This obligation on the Medical Staff Office is in addition to its duty to verify all information on completed applications for admission to the medical staff and completed internal information forms for reappointment to the medical staff.

C. The obligation to request information from the Director of the Department of Financial and Professional Regulation shall not apply to medical personnel who enter Northwestern Memorial Hospital to obtain organs and tissues for transplant from a deceased donor in accordance with applicable law.

II. Clinical Privileges Allied Health Personnel

If a medical staff member requests permission to use his/her employed allied health personnel in the hospital (other than affiliated health professionals who have individually delineated privileges or registered nurses who have been granted clinical practice privileges by the hospital), the medical staff member's clinical privileges shall identify the duties that may be carried out by such allied health personnel. The medical staff member requesting such privileges shall furnish information concerning the qualifications of his/her employed allied health personnel and their duties as required by applicable law, accreditation standards, Hospital, and departmental policy.

III. Use of Computer Generated or Electronic Signatures

A computer-generated signature or electronic signature may be used by Medical Staff members in compliance with the policy adopted by the Hospital's medical staff and Board.

V. Consultations

A. Any member of the medical staff with clinical privileges may be called for a consultation within his or her area of expertise. Such consultation shall be consistent with current Northwestern Medical Staff and Hospital policy on consultations.

VI. Operating Rooms

A. Tissue - All specimens and tissue shall be sent to the Department of Pathology for appropriate examination. The findings upon pathological examination shall be made a part of the patient's medical record.

B. Surgical Assistant - Each department whose members perform surgical procedures shall assure through the credentialing process that qualified surgical assistants, whether physicians or non-physicians, assist the operating surgeons in the operating room. A member of the medical staff or house staff shall serve as first assistant during all major and/or hazardous surgery. Each department whose members perform surgical procedures shall develop written criteria for determining when an assistant is necessary and such criteria shall be part of the departmental manual.

VII. Sterilization

If an operation to accomplish sterilization of a competent adult consenting female patient is recommended by the attending physician for medical indications, the recorded opinion of at least two knowledgeable consultants should be obtained.

If sterilization is requested by the patient and her physician agrees, consultation is not necessary.

VIII. Psychiatric Patients

In general, a patient for whom continuing psychiatric treatment is indicated will be transferred to the Institute of Psychiatry unless medical arrangements appropriate for a given patient cannot readily be provided at the Institute. The Illinois Mental Health and Developmental Disabilities Code shall be observed in any transfer to a psychiatric unit.

IX. Emergency Room

A. Any person presenting himself to the Emergency Room shall receive an appropriate medical examination, regardless of race, religion, or the ability to pay. Persons having emergency medical conditions shall receive treatment necessary to stabilize the patient or shall be transferred to another facility in accordance with law.

B. Individuals who present to the hospital for emergency care will receive an appropriate medical screening examination by qualified medical personnel to determine if the individual has an emergency medical condition. The qualified medical personnel may be a licensed physician; a licensed advanced practice provider with applicable collaboration agreements, and privileges at NMH; or, in conjunction with physician consultation, a labor and delivery nurse who has been trained and evaluated by NMH as qualified through demonstrated competencies to certify false labor. If the patient is in labor, a medical screening exam will be performed by a qualified, licensed medical personnel other than a registered nurse.

C. An appropriate medical record shall be made on each patient receiving service and shall be signed by the licensed provider who saw the patient.

D. Each patient who is discharged from the Emergency Room will be provided with necessary instructions for follow up care.

E. If a patient examined in the Emergency Room is to be admitted, and if the patient does not have a private physician on the medical staff, the patient will be assigned to a member of the Staff in the appropriate clinical department.

X. Removal of Cadaveric Organs For Transplantation

Certification of Death in patients who are potential organ donors will be made by the Attending Physician using the criteria enumerated in applicable Hospital and Medical Staff Policy and consistent with those adopted by our regulatory designated Organ Procurement Organization, Gift of Hope (GOH) of Illinois.

XI. Investigational Drugs and Use of Human Subjects

A. The investigational or experimental use of any drug or drug combination must have the written approval of the Institutional Review Board and must be dispensed by the hospital Department of Pharmacy and only on the order of the investigator or his/her named designee. A copy of the research protocol covering use of the investigational drug must be filed in Pharmacy. This should include pertinent information relating to mechanism of drug action, route of administration, toxicity, and side effects. The appropriate department chairman shall be informed.

B. Any investigation or experiment involving human subjects also must be approved by the Institutional Review Board

C. Drugs which are not classified as investigational (including anesthetic agents), but which the medical staff member intends to use in a manner other than as described in the package insert, shall not be subject to these procedures unless the use of the drug in that manner is part of an investigational project. Medical Staff and house staff members may order drugs for such uses provided that the safety and efficacy of the drug is established by scientific data.

XII. Utilization Review

A. All members of the medical staff are expected to comply with certification of admission on hospitalization procedures and Utilization Review Plan as required by all applicable laws and implemented by the Utilization Management Subcommittee of the Quality Management Committee of the medical staff.

B. Contemporary standards of hospital medical care are required, in addition to appropriate diagnostic and treatment procedures, attention to admission policies, appropriate bed utilization, prompt and selective use of consultations, careful use of ancillary hospital services, as well as timely and efficient discharge planning procedures. Deviation from such contemporary standards of care, as determined by the Utilization Management Subcommittee, and/or the physician's department Chairman and/or his advisory committee shall be documented to the affected Staff member in writing, delivered in accordance with the Medical Staff Organizational Documents with a copy to the department Chairman who shall confer with him/her.

XIII. Supervision of House Staff (Residents and Fellows)

It is the responsibility of each department Chairman to assume, directly or through delegation, the task of assigning appropriate department members who are also members of the medical staff to provide appropriate supervision of residents and fellows (house staff) assigned to their department for the rendering of patient care in the hospital. The department Chairman shall assure that supervision of Housestaff complies with the House Staff Supervision policy as well as the Essentials of Accredited Residencies in Graduate Medical Education established by the Accreditation Council for Graduate Medical Education.

Attending Staff members are responsible for ascertaining all diagnostic, therapeutic and surgical procedures performed by house staff are medically indicated and are executed by house staff members with a sufficient degree of training and experience for the procedure involved.

Each department shall assure that all elements of the hospital policy concerning house staff supervision and the respective departmental policies concerning house staff supervision are adhered to by all staff members.

XIV. Maintenance of Records

The Medical Staff Office shall implement procedures for maintaining medical staff credentialing files. Such procedures shall include procedures for preserving medical staff credentialing files in the event of closure of the hospital.

XV. On-Call Schedules

It is the responsibility of each department Chair to establish an on-call procedure for each clinical department to ensure that appropriate and effective coverage is available at all times for on-call and emergency needs of hospitalized patients. The on-call schedules will be updated by each clinical department via the approved physician on-call system and posted to the Northwestern Medicine internal website for broad distribution to all system users.

CREDENTIALING PLAN OF THE MEDICAL STAFF
OF NORTHWESTERN MEMORIAL HOSPITAL ("CREDENTIALING PLAN")

ARTICLE I: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

1.1 GENERAL PROCEDURE

The Staff, with the assistance of the administration, through its designated departments, committees, and officers, shall investigate and consider each application for appointment or reappointment to the Staff and each request for modification of Staff Membership status and shall adopt and transmit recommendations thereof to the Board which shall have the final authority in granting appointments, reappointments and Privileges. In making decisions regarding granting or denying of membership and/or clinical privileges, the applicant's national origin, culture, race, gender or gender identity, sexual orientation, ethnic background, religion, or disability unrelated to the provision of patient care are not used.

1.2 APPLICATION FOR INITIAL APPOINTMENT

1.2-1 Application Form

Each application for appointment to the Staff shall be in writing, on forms prescribed by the Medical Executive Committee and the Board from time to time which are consistent with state law requirements, and signed by the applicant. All written requests for application forms from Physicians or Dentists with verified faculty appointment at Northwestern University Feinberg School of Medicine shall be filled promptly by the Chief of Staff, and a copy of the staff bylaws, rules and regulations shall be furnished to each such person.

1.2-2 Content

The application form shall include such provisions as are necessary to secure information useful for evaluation of the applicant and must comply with state law requirements. In addition, the form shall include a statement that the applicant has been furnished a copy of the Bylaws, Rules and Regulations of the Staff, and that he/she agrees to be bound by the terms thereof.

1.3 EFFECT OF APPLICATION

By applying for appointment or reappointment to the Staff, the applicant:

A. Signifies his/her willingness to appear for interviews in regard to his/her application, if requested to do so;

B. Authorizes Hospital Representatives (who may be members of the Medical Staff) to consult with others who have been associated with him/her and/or who may have information bearing on his/her competence and qualifications; including persons at any other institutions;

C. Consents to the inspection and copying by Hospital Representatives of all records and documents (including those of other institutions) that may be material to an evaluation of his/her personal and professional qualifications and ability to carry out the Clinical Privileges he/she requests as well as of his/her ethical qualifications for Staff Membership;

D. Releases from any liability to the maximum extent permitted by law all Hospital Representatives for their acts performed in connection with evaluating the applicant and his/her credentials;

E. Releases from all liability to the maximum extent permitted by law all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital Representatives concerning the applicant's ability, professional ethics, character, ability to perform

Privileges requested, emotional stability, and other qualifications for Staff appointment and Clinical Privileges;

F. Waives voluntarily, in the case of a rejected initial applicant, any right to file a court action based on state law claims challenging the rejection upon penalty of paying the Hospital all of its costs and expenses, including attorney fees, if this waiver is dishonored;

G. Consents to mental, physical or toxicological examination by person(s) appointed by the Chief of Staff if requested to do so and to produce full reports thereof;

H. Waives voluntarily the provisions of Section 412(b) of the Health Care Quality Improvement Act of 1986 (Act) [42 U.S.C. 11112(b)] which waiver is expressly permitted by Section 412(b). This waiver means that no variance between these Medical Staff Organizational Documents and Section 412(b) concerning notice and hearing rights may be asserted by a practitioner to defeat the peer review immunity provisions in Section 411(a) of the Act [42 U.S.C. 11111(a)];

I. Agrees that the substantially prevailing party or parties in any lawsuit brought by the applicant against any or all Hospital Representatives shall be entitled to recover his/her or their reasonable attorneys' fees and costs from the other party or parties, as the case may be;

J. Agrees that any lawsuit that is not filed within 60 days of the Board's final decision regarding the application shall be time-barred;

K. Consents to the performance of a criminal background check at the time of initial application by hospital representatives, in accordance with Medical Staff policy, as amended from time to time;

L. Consents to the performance of a drug screening at the time of initial application by hospital representatives, in accordance with Medical Staff policy, as amended from time to time.

For purposes of this Section, the term "Hospital Representative" includes the Hospital, the Board, its members and committees; the President; the Staff organization; all Staff Members, departments and committees and Hospital and Staff officers, employees and agents which have responsibility, directly or indirectly, for collecting or evaluating the applicant's credentials or acting upon his/her applications; and any authorized representative of any of the foregoing.

1.4 PROCESSING THE APPLICATION

1.4-1 Applicant's Burden

The applicant shall have the burden of producing and fully disclosing all information as requested and/or material to a proper evaluation of his/her competence and experience, professional ethics, background, training, demonstrated ability, and ability to perform Privileges requested, and for resolving any doubts about these or any of the other basic qualifications specified in the Medical Staff Organizational Documents, or otherwise. He/she shall also have the burden of demonstrating his/her qualifications, competence and fitness to the satisfaction of the Medical Staff and the Board. If the applicant fails to comply within 120 days to the satisfaction of the Medical Staff, the application for appointment and/or Clinical Privileges will be considered voluntarily withdrawn by the applicant. Such action shall not entitle the applicant to a Hearing under the Medical Staff Organizational Documents.

1.4-2 Transmittal for Evaluation

The applicant shall deliver his/her application form to the Chief of Staff who shall, only after determining that the application is fully complete and all pertinent materials have been secured, transmit in a timely fashion a copy of the completed application form and all supporting materials to the Chairman of each department in which the applicant seeks privileges. A copy of the completed application form and all supporting materials, including the department Chairman's written recommendation shall also be sent by the Chief of Staff to the Credentials Committee Chairman for processing. In order to be considered fully complete and ready for processing by the Credentials Committee, the application documents must include at a minimum:

1. All items in the application form filled in and the application signed and dated by the applicant.
2. All related forms fully answered, signed and dated by the applicant.
3. Proposed delineation of Clinical Privileges signed by the applicant and department Chairman and dated.

4. Written verification by Northwestern University of a faculty appointment.
5. Satisfactory evidence of professional liability insurance coverage as required by these Medical Staff Organizational Documents.
6. Copies of drug prescription writing licenses, where applicable.
7. Proof of board certification or board eligibility, as the case may be.
8. Copies of all data received by the Chief of Staff's office or CVO concerning the applicant from the federal data bank of information mandatorily reportable under the Health Care Quality Improvement Act of 1986.
9. Verification in writing from the primary source whenever feasible: Illinois license, education, and relevant training.
10. Verification of experience, ability and current competence in performing the requested privileges by peers knowledgeable about the applicant to include an assessment for proficiency in patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.
11. Verification of identity by viewing one of the following: current picture hospital ID card or valid picture ID issued by a state or federal agency.
12. Written recommendation of the department Chairman is required.

1.4-3 Verification of Information

Upon receipt of the fully complete application form, the Chief of Staff's office or CVO shall seek to collect, verify, and assess the references, licensure, DEA status, federal data bank information and other qualification evidence submitted. After transmittal of application forms from the CVO or medical staff office, the Chief of Staff shall have final determination whether the application is complete. The Chief of Staff, or his/her designee, shall promptly notify the applicant of any failures in such collection or verification efforts. Copies of any additional information secured shall be provided to the department or departments in which the applicant seeks privileges. The department Chairman, Chief of Staff, and Credentials Committee may (but are not required to) request and conduct an interview of the applicant.

1.4-4 Departmental Action

Each department in which the applicant seeks Privileges may review the application, the supporting documentation, and such other information available to it that may be relevant to assessment of the applicant's qualifications for the staff category, department and Clinical Privileges requested. Within 15 days of receipt of application, the department Chairman shall transmit to the Chief of Staff for forwarding to the Credentials Committee a written report and recommendations as to Staff appointment and, if appointment is recommended, as to staff category, department affiliations, Clinical Privileges proposed to be granted, any special conditions to be attached to the appointment and a statement as to the applicant's ability to perform Privileges requested. A department Chairman's adverse recommendation alone shall not terminate the application process. The reason for each recommendation shall be stated and supported by reference to the completed application and all other documentation considered by the department, all of which shall be transmitted to the Chief of Staff and Credentials Committee Chairman with the report.

1.4-5 Credentials Committee and Medical Executive Committee Action

At its next regular meeting after receipt of the departmental report and recommendations, the Credentials Committee shall consider the report and such other relevant information as is available to it. Within fifteen (15) days of such meeting, the Committee shall then forward to the Chief of Staff for transmittal to the Medical Executive Committee a written report and recommendations, both positive and negative, as to Staff appointment and, if appointment is recommended, as to Staff category and department affiliations, Clinical Privileges proposed to be granted, and any special conditions to be attached to appointment or Privileges. The reasons for each recommendation of the Medical Executive Committee, both positive and negative, shall be stated and supported by reference to the completed application and all other documentation considered by the Executive Committee, which shall be transmitted within thirty (30) days with the report to the Board for action.

1.4-6 Board Action

The Board has final authority for granting or denying membership and/or privileges and shall adopt or reject, in whole or in part, recommendations of the Medical Executive Committee, whether positive or negative, or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and optionally setting a time limit within which a subsequent recommendation shall be made. The Chief of Staff shall inform the applicant in writing of the Board's final action within ten (10) days of its being taken, except for a Qualified Practitioner against whom adverse action has been taken or recommended, who shall promptly be given Special Notice as provided in these Medical Staff Organizational Documents. Initial applicants to the Medical Staff

against whom an adverse decision is made will receive a written response from the Chief of Staff which explains the reason or reasons for the adverse decision.

1.4-7 Conflict Resolution

Whenever the Board's proposed decision will be contrary to the Medical Executive Committee's last recommendation, the Board shall submit the matter to the Professional Standards Committee of the Board, or special subcommittee of the Medical Executive Committee appointed by the Chief of Staff, for review and recommendation before making its final decision and giving notice of final decision.

1.4-8 Notice of Final Decision

A. Additional notice of the Board's final decision shall be given to the Chief of Staff and the Chairman of each department concerned.

B. A decision and notice to appoint shall include:

1. The Staff category to which the applicant is appointed;
2. The department to which he/she is assigned;
3. The Clinical Privileges delineated in writing which he/she may exercise; and
4. Any special conditions, if any, attached to the appointment or Privileges.

1.5 REAPPOINTMENT PROCESS

1.5-1 Application for Reappointment

The Chief of Staff shall, by no later than March 1 each year, provide each Staff Member whose then current Staff appointment is due to expire by the following August 31, with an application for reappointment approved by the Board and the Medical Executive Committee for use in considering reappointment. Each such Staff Member who desires reappointment shall, within thirty (30) days, send his/her fully completed application for reappointment to the Chief of Staff. Failure, without good cause, to so return the fully complete and signed application for reappointment by or before June 30 shall constitute grounds for automatic suspension on July 1 of admitting privileges as provided in these Medical Staff Organizational Documents. However, such automatic suspension alone shall be deemed to be administrative only for purposes of mandatory reporting by Hospitals of adverse credentialing actions. The Chief of Staff shall not accept or process any application for reappointment while the applicant is under summary or automatic suspension pursuant to these Medical Staff Organizational Documents.

1.5-2 Verification of Information

The CVO shall be directed to collect or verify the additional information made available on each application for reappointment and to collect any other materials or information deemed pertinent, including without limitation, information regarding the Staff Member's license, professional activities, performance and conduct in the Hospital, his/her litigation experience, federal data bank information, quality management information, risk management information, information from the intra-departmental quality assurance committee as described in the Committee Plan. The CVO shall provide a completed verifications file to the office of the Chief of Staff. The Chief of Staff shall transmit the fully complete reappointment application to each department Chair in which the applicant seeks reappointment/renewal of Privileges. Upon review of the application, all supporting documentation, and such other information available to him/her, the department Chair will transmit to the Chief of Staff the reappointment application and all supporting documentation along with his/her written recommendation no later than fifteen (15) days after receipt. A member of the Medical Staff has the right to inspect all such information pertaining to himself or herself, if adverse, to provide rebuttal information. The Chief of Staff shall then, in a timely fashion, determine the application to be complete and transmit the fully complete application for reappointment to the Credentials Committee with his/her recommendation. The Credentials Committee, after reviewing each fully complete application for reappointment and all other relevant information available to it, shall forward to the Chief of Staff for transmittal to the Medical Executive Committee its report and recommendation that appointment be either renewed, renewed with modified staff category, department affiliation, and/or Clinical Privileges, or terminated. The Medical Executive Committee shall likewise make its recommendations to the Board. Each such report shall satisfy the requirements of Considerations for Recommendations.

1.5-3 Final Processing and Board Action

Thereafter, the procedure provided above shall be followed. For purposes of reappointment, the terms "applicant" and "appointment" as used in those sections shall be read, respectively, as "Staff Member" and "reappointment".

1.5-4 Considerations for Recommendations

The evaluation of each medical Staff Member for recommendations concerning reappointment and Clinical Privileges shall be demonstrably based on the Staff Member's performance and capabilities in as many of the following areas as are appropriate without limitation: upon evaluation of such member's ongoing ability to perform Privileges requested, professional ability and clinical judgment in the treatment of patients, quality management information, risk management information, information from the intra-departmental quality assurance committee as described in the Committee Plan, loss or lessening of Privileges or membership at other institutions, his/her professional ethics, his/her litigation experience, federal data bank information, his/her discharge of staff obligations, his/her compliance with the Medical Staff bylaws, rules and regulations, fact and outcome of professional licensure compliance, and all other established standards, policies and rules of the Hospital, interactions with Hospital personnel and with patients, his/her participation in teaching programs, continuing education, and the supervision of the clinical training of house staff members, and other matters bearing on his/her ability and willingness to contribute to good patient care practices at the Hospital.

1.5-5 Time Periods for Processing

Transmittal of the application for reappointment to a Staff Member and his/her return of it shall be carried out in accordance with the Credentialing Plan. Thereafter, except for good cause, all actions by the Credentials Committee, the Medical Executive Committee and the Board shall be completed prior to the expiration date of the Staff Membership of the member being considered for reappointment.

If the processing of a reappointment has not been completed by the date of the expiration of the Staff Member's current appointment, the member shall be temporarily reappointed prior to expiration, with the concurrence of the Medical Executive Committee and the Board of Directors, with the expectation that the process will be completed and a final decision rendered as soon as is reasonable consistent with the process described in this plan and Medical Staff Organizational Documents.

1.6 REQUESTS FOR MODIFICATION OF TERMS OF APPOINTMENT

A Staff Member may, either in connection with reappointment or at any other time, request modification of his/her Staff category, department assignment, or Clinical Privileges by submitting a written application to the Chief of Staff and department Chairman. Such application shall be processed in substantially the same manner as provided for reappointment. However, denial of such a request shall not entitle the affected Staff Member to any redress, hearing or appellate review rights, including those set forth in Routine Corrective Action or Fair Hearing and Appellate Review of the Hearing Plan.

1.7 BOARD APPLIED CRITERIA

The Board shall apply, in making its decisions in respect to initial appointments, reappointments, Clinical Privileges and modifications of appointments or privileges, the criteria stated in these Medical Staff Organizational Documents and, in addition, shall consider the adequacy of the hospital's facilities and supportive services needed by the practitioner for rendering care to his/her patients, and the need for additional practitioners with the skill and qualifications of the practitioner. Only the Board of the Hospital shall have the right to close appointments to the staff or any department or section thereof.

1.8 EXPEDITED APPOINTMENT, REAPPOINTMENT, OR PRIVILEGES

In the event that an applicant qualifies for an expedited appointment, reappointment, or Privileges in accordance with requirements in this Section, the Medical Executive Committee, after receiving positive recommendations from the Chairman of the department in which the applicant will be a member and the Chairman of the Credentials Committee, shall have the discretion of forwarding its positive recommendation to the Professional Standards Committee of the Board for final decision. An applicant qualifies for this expedited review if he or she meets the following standards:

A. The applicant submits a complete and verified application which provides all necessary or required information and all primary source verification procedures have been completed.

B. The Medical Executive Committee makes a positive recommendation without any limitations.

C. There are no current or previously successful challenges to the applicant's licensure or registration.

D. The applicant has not been subject to any involuntary termination or summary suspension of Medical Staff Membership or Clinical Privileges at another hospital.

E. The applicant has not been subject to any involuntary limitation, reduction, denial or loss of membership or Clinical Privileges at the Hospital or any other hospital; or

F. There has not been a final adverse judgment entered against the applicant in a professional liability action.

If the Professional Standards Committee decides to deny the applicant's request for appointment, this recommendation shall be submitted to the Board for action.

Irrespective of the fact that an applicant meets the standards for expedited credentialing under this Section, either the department Chairman, the Credentials Committee Chairman, the Medical Executive Committee, the Chief of Staff, the President, the Professional Standards Committee or the Board of Directors can require that the applicant instead go through the complete appointment or reappointment process as set forth in these Medical Staff Organizational Documents.

ARTICLE II: DETERMINATION OF CLINICAL PRIVILEGES

2.1 EXERCISE OF PRIVILEGES

Every Practitioner, Doctorate Level Health Professional or Affiliated Health Professional providing direct clinical services at the Hospital by virtue of staff membership, or otherwise, shall, in connection with such practice, and except as provided, be entitled to exercise only those Clinical Privileges or provide patient care services as are specifically granted pursuant to the provisions of these Medical Staff Organizational Documents.

All grants of Clinical Privileges shall be subject to the provisions of any exclusive contracts approved and ratified by the Board after consultation with the Medical Executive Committee and entered into from time to time by the Hospital. If an exclusive contract results in total or partial termination or reduction of a Practitioner's appointment or privileges, the affected practitioner shall be provided sixty days prior, Special Notice of the effect of the exclusive contract on such appointment or privileges, and fourteen days after such notification to request a hearing under Sections 2.3 to 2.6 and Sections 2.9 and 2.10 of the Hearing Plan, but with no right of appellate review under Sections 2.7 to 2.9 of the Hearing Plan. The scope of the Hearing shall be strictly limited to a determination as to whether such exclusive contract, as determined by the Board, has been approved or terminated by the Board. Failure to request such hearing within said fourteen days shall operate as a waiver of all hearing rights. The decision of the Board to enter into an exclusive contract, after consultation with the MEC, shall not be affected by such hearing. Fifteen day notice of an adverse decision based on exclusive contracting may not be given under Section 2.9-3 of the Hearing Plan until exhaustion of hearing rights, unless waived.

The Board shall consult with the Medical Executive Committee prior to closing membership in the entire or any portion of the Medical Staff. If the Board closes membership in the Medical Staff or any portion of the Medical Staff, over the objections of the Medical Executive Committee, then the Board shall provide a detailed written explanation for the decision to the Medical Executive Committee ten (10) days prior to the effective date of any closure.

2.2 DELINEATION OF PRIVILEGES IN GENERAL

2.2-1 Requests

Each application for appointment and reappointment to the Staff must contain a request for the Clinical Privileges desired by the applicant. A request by a Staff Member for a modification of Privileges must be supported by documentation of training and/or experience supportive of the request.

2.2-2 Basis for Privileges Determination

Requests for Clinical Privileges shall be evaluated on the basis of the Practitioner's education, training, experience, and demonstrated current competence and judgment, current licensure, and ability to perform Privileges requested. The bases for Privileges determinations to be made in connection with periodic reappointment or otherwise shall include those factors identified in Considerations and Recommendations as well as observed clinical performance and the documented results of the quality management/utilization and risk management activities required by these and the Hospital corporate bylaws to be conducted at the Hospital. Privileges determinations shall also be based on pertinent information concerning clinical performance obtained from other sources including, but not limited to, other health care facilities where a Practitioner exercises clinical privileges. Privileges are granted for a period not to exceed two years. This information shall be added to and maintained in the Staff file established for a Staff Member which can be examined by the Staff Member in the Chief of Staff's office during regular office hours in accordance with current policy.

2.2-3 Procedure

All requests and recommendations for Clinical Privileges shall be processed pursuant to the procedures outlined in Procedures for Appointment and Reappointment.

2.3 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

A Physician member of the Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

2.4 CLINICAL FELLOWS

Fellows shall be granted Clinical Privileges in accordance with medical staff policy.

2.5 DOCTORATE LEVEL HEALTH PROFESSIONALS

2.5-1 Definition

Doctorate Level Health Professionals have attained the doctor of philosophy degree, doctor of psychology degree, or other doctorate in a healthcare discipline. They are required to have and maintain a faculty appointment with Northwestern University as a condition of being granted and holding privileges. They may also be appointed to committees of the Medical Staff and attend Medical Staff meetings. They are non-physicians and non-dentists whose specific skills and knowledge may be required in a consulting or advisory capacity to Medical Staff Members but who are not members of the Medical Staff. They are holders of delineated practice Privileges ultimately granted by the Board.

2.5-2 Process for Granting Privileges

Any member of the active staff of the Medical Staff, as defined in the Bylaws, may submit a written recommendation to the Chief of Staff for the granting of Clinical Privileges to Doctorate Level Health Professionals. This recommendation must describe the education, training, experience and demonstrated ability and judgment of the particular health professional. The Chief of Staff shall investigate the written recommendation according to the procedures outlined in the Credentialing Plan. Thereafter, the procedures and levels of review outlined in the Credentialing Plan, up to an including the Board, shall be followed for the purpose of granting privileges to Doctorate Level Health Professionals. If accepted, Doctorate Level Health Professionals shall be individually assigned to a clinical department, and their Privileges shall be reviewed at least every two (2) years by the department.

Nothing contained in the bylaws shall be interpreted to entitle a Doctorate Level Health Professional to the procedural rights set forth in the Hearing Plan. However, a Doctorate Level Health Professional shall have the right to challenge any actions that would constitute grounds for a hearing under the Hearing Plan by filing a written request for review of such action with the Medical Executive Committee within fifteen (15) days of such action. Upon receipt of such a request, the Medical Executive Committee or its designee shall conduct an investigation that shall afford a Doctorate Level Health Professional an opportunity for an interview concerning the action. Any such interview shall not constitute a "hearing" as defined by the Hearing Plan and shall not be conducted according to the procedural rules applicable to such hearings. Before the interview, the Doctorate Level Health Professional shall be informed of the general nature and circumstances giving rise to the action, and the Doctorate Level Health Professional may present information relevant thereto at the interview. Minutes of the interview shall be made. The Medical Executive Committee or its designee shall make a decision based on the interview and all other information available to it. Such decision shall be subject to Board of Directors review and approval.

2.5-3 Prerogatives

Doctorate Level Health Professionals may exercise independent judgment within their delineated Privileges and participate in the management of patients under the general supervision and direction of a member of the medical staff with the permission of the patient's Staff Physician. A member of the Medical Staff must remain responsible for the general medical care of the patient as the attending physician. Doctoral Level Health Professionals may record reports and progress notes, but orders must be written by the appropriate member of the Medical Staff. Doctorate Level Health Professionals shall be subject to the provisions of the Bylaws and of the Hearing Plan concerning professional liability insurance.

2.6 AFFILIATED HEALTH PROFESSIONALS

Affiliated Health Professionals are other non-physicians and non-dentists who have not attained the doctor of philosophy degree, are not permitted by law to be members of the Medical Staff and who are supervised by members of the Medical Staff and hold practice Privileges granted in accordance with the process and subject to the applicable conditions described in the Bylaws, Credentialing Plan, or such other policy as adopted by the Board of Directors, except that they are not required to have a faculty appointment with Northwestern University and they are not eligible to attend Medical Staff meetings or to be appointed to Medical Staff committees. Affiliated Health Professionals shall be subject to the provisions of the Bylaws and of the Hearing Plan concerning professional liability insurance.

2.7 TEMPORARY PRIVILEGES

2.7-1 Circumstances

Upon the written concurrence of the Chairman of the department where the Privileges will be exercised consistent with Medical Staff policy, the Chief of Staff, and the President, or their authorized designee, temporary privileges may be granted for a period not to exceed 120 days in the following circumstances:

A. Pendency of Application: After receipt of an application for Staff appointment, including a request for specific temporary Privileges, and in accordance with the conditions specified in the Credentialing Plan, an appropriately licensed applicant may be granted temporary Privileges during the pendency of a complete application. In exercising such privileges, the applicant shall act under the supervision of the Chairman of the department to which he/she is assigned;

B. Care of Specific Patients: Upon receipt by the department Chairman of a written request from the Practitioner seeking temporary privileges, an appropriately licensed or credentialed Practitioner who is not an applicant for membership may be granted temporary privileges for the care of one or more specific patients to fulfill an important patient care need, upon verification of current license and current competence excluding other verification requirements set forth below.

2.7-2 Conditions

Temporary Privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has provided evidence of professional liability insurance coverage as required by these bylaws and upon verification of current licensure, relevant training and experience, current competency and ability to perform privileges requested, no current or previously successful challenge to licensure or involuntary

reduction or termination of medical staff membership or clinical privileges at another hospital. Special requirements of consultation and reporting may be imposed by the Chairman of the department responsible for supervision of a practitioner granted temporary privileges. Before temporary privileges are granted, the practitioner must acknowledge in writing that he/she has received and read the Medical Staff bylaws, and staff rules and regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

2.7-3 Termination of Temporary Privileges

On the discovery of any information, or the occurrence of any event of a professionally questionable nature, pertinent to a Practitioner's qualifications or ability to exercise any or all of the temporary Privileges granted, the department Chairman responsible for supervision, or the President, after consultation with the department Chairman responsible for supervision, or the Chief of Staff, may terminate any or all of such Practitioner's temporary Privileges; provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the Practitioner, the termination may be effected by any person entitled to impose summary suspensions. In the event of any such termination, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the department Chairman responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. The terminated Practitioner shall confer with the substitute Practitioner to the extent necessary to safeguard the patient.

2.7-4 Rights of the Practitioner

A Practitioner shall not be entitled to any redress, hearing or appellate review rights, including those set forth in Routine Corrective Action and Fair Hearing and Appellate Review of the Hearing Plan because of his/her inability to obtain temporary Privileges or because of any termination or suspension of temporary Privileges.

2.8 EMERGENCY PRIVILEGES

For the purposes of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any Practitioner, to the degree permitted by his/her license, regardless of department, staff status or Clinical Privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm. A Practitioner utilizing emergency privileges shall promptly provide to the Medical Executive Committee in writing a statement explaining the circumstances giving rise to the emergency.

2.9 DISASTER PRIVILEGES

Practitioners who are not members of the Medical Staff and/or who do not possess Privileges may be allowed to volunteer during a disaster, defined as an officially declared emergency, whether local, state, or national. Disaster privileges may be granted in accordance with medical staff policy.

ARTICLE III: AMENDMENTS TO CREDENTIALING PLAN

Any proposed amendments to the Credentialing Plan must be reviewed and adopted consistent with the process set forth in the Medical Staff Bylaws.

REVISED by the Medical Executive Committee on February 9, 2004
APPROVED by the Board of Directors on February 23, 2004

REVISED by the Medical Executive Committee on December 11, 2006
APPROVED by the Board of Directors on February 26, 2007

REVISED by the Medical Executive Committee on March 9, 2009
APPROVED by the Board of Directors on June 22, 2009

REVISED by the Medical Executive Committee on February 14, 2011
APPROVED by the Board of Directors on February 28, 2011

REVISED by the Medical Executive Committee on July 15, 2016
APPROVED by the Board of Directors on July 28, 2016

REVISED by the Medical Executive Committee on September 10,2018
APPROVED by the Board of Directors on February 27, 2019

CORRECTIVE ACTION AND FAIR HEARING PLAN OF THE MEDICAL STAFF OF NORTHWESTERN MEMORIAL HOSPITAL ("HEARING PLAN")

ARTICLE I: ROUTINE CORRECTIVE ACTION

1.1 ROUTINE CORRECTIVE ACTION THROUGH THE MEDICAL STAFF

1.1-2 Criteria for Initiation

Whenever the activities or professional conduct of any Staff Members are believed to be detrimental to patient safety or inconsistent with the efficient delivery of patient care at the generally recognized professional level of quality, or are disruptive to Hospital operations or violate these Medical Staff Organizational Documents, departmental rules or other Medical Staff or Hospital policies, or a Medical Staff member exhibits signs of physical or mental impairment, or for other reasonable cause, corrective action against such Staff Member may be initiated by the Chief of Staff, by the Chairman of the department involved, by the President, or by the Board. Initiation of routine corrective action does not preclude imposition of summary suspension as provided in the Hearing Plan, nor does it require the prior imposition of such a suspension.

1.1-2 Requests and Notices

All requests for corrective action shall be in writing submitted to the Chief of Staff, and be supported by reference to the specific conduct or activities which constitute the grounds for the request. The Chief of Staff shall send a copy of all such written requests to the Practitioner, the Medical Executive Committee, the department Chairman and the President. The Chief of Staff shall keep the President fully informed of all actions taken in connection with any such requests.

1.1-3 Investigation

Routine professional practice evaluation does not constitute an investigation. Investigation means the formal medical staff process targeted to review an issue or issues with the competence or professional conduct of a specific Practitioner identified by a medical staff committee or department. Investigations begin with the Medical Executive Committee decision to begin an inquiry, and terminates with the Board's final action on the medical staff recommendation or the conclusion of the medical staff investigation without recommendation of adverse action.

The Practitioner shall receive written notice upon the commencement of any investigation, disclosing the initiation and scope of investigation and advising the Practitioner that any resignation, surrender, relinquishment or cessation of membership and/or clinical privileges, including a leave of absence, whether related to the investigation or not, while the investigation is ongoing, will be reported to the National Practitioner Data Bank.

After consideration of the request, the Medical Executive Committee shall either reject the request and report the reasons for its decision to the President, or forward the request either to the Chairman of the department in which the questioned activities or conduct occurred, or to an ad hoc committee appointed by the Medical Executive Committee, to conduct an investigation which may take the form of an internal or external review. The Staff Member who is under investigation shall be invited to appear before the investigating committee before a recommendation is issued. Any such appearance shall be informal in nature, and attorneys shall not be permitted to attend unless otherwise permitted by the Medical Executive Committee. The department Chairman or the investigating committee shall forward a written report of the investigation to the Medical Executive Committee.

1.1-4 Medical Executive Committee Action

Within thirty (30) days following receipt of the report of the investigation, the Medical Executive Committee shall take action upon the request. The affected Staff Member and department Chairman shall have the right to appear before the Medical Executive Committee on the date it meets to act on the matter. Such action may include, without limitation:

A. Rejecting the request for corrective action.

B. Issuing a warning, a letter of admonition, or a letter or reprimand,

C. Recommending terms of probation not otherwise provided for in these bylaws or requirements of consultation, or use of a monitoring protocol for observation and review of clinical performance for a period of time,

D. Any actions listed in Initiation of Hearing, Recommendations or Actions other than a summary or automatic suspension.

1.1-5 Board Review

When the Medical Executive Committee, after review of a report of investigation, or after review of summary suspension imposed, determines that no corrective action should be taken, the President shall report such determination to the Board. The Board, in its discretion, may appoint a committee to conduct an investigation (which may take the form of an internal or external review) of the conduct that served as the basis for the request for corrective action and, after receipt of the report of the investigation, take any such action as is set forth in the Hearing Plan.

1.1-6 Procedural Rights

Any action taken by the Medical Executive Committee, or any combination of such actions, or similar action by the Board, and not agreed to by the affected Staff Member shall entitle the Staff Member to the hearing, and appellate review rights, if the affected Staff Member is entitled to same under the Hearing Plan, if, and only if, the following conditions are satisfied: (1) the affected Staff Member is a Qualified Practitioner as defined in the Bylaws; and (2) the actions taken fall within those listed in Initiation of Hearing, Recommendation or Actions. If any of these two conditions is not satisfied, the action takes effect immediately as a final action with no further recourse for the affected Staff Member.

1.2 ROUTINE CORRECTIVE ACTION THROUGH THE BOARD

1.2-1 Criteria for Initiation

Whenever the activities or professional conduct of any Staff Member are believed to be detrimental to patient safety or inconsistent with the efficient delivery of patient care at the generally recognized professional level of quality, disruptive to Hospital operations or in violation of these Medical Staff Organizational Documents, departmental rules or other Hospital policies; or whenever a Medical Staff member exhibits signs of physical or mental impairment; or for other reasonable cause, any three members of the Board may initiate corrective action against such Staff Member. Initiation of routine corrective action does not preclude imposition of summary suspension, nor does it require the prior imposition of such a suspension.

1.2-2 Requests and Notices

Any three members of the Board may request routine corrective action pursuant to this Hearing Plan. All such requests shall be in writing and submitted to the Chairman of the Board and be supported by reference to the specific conduct or activities which constitute the grounds for the request. The Chairman of the Board or his designee, shall send a copy of all such written requests to the Medical Executive Committee, the department Chairman, the Chief of Staff and the President.

1.2-3 Investigation

The Practitioner shall receive written notice upon the commencement of any investigation, disclosing the initiation and scope of investigation and advising the Practitioner that any resignation, surrender, relinquishment or cessation of membership and/or clinical privileges, including a leave of absence, whether related to the investigation or not, while the investigation is ongoing, will be reported to the National Practitioner Data Bank.

After consideration of the request, the Board shall either reject the request and report its decision to the Medical Executive Committee, the department Chairman, the Chief of Staff and the President or appoint an ad hoc committee, to conduct an investigation of the alleged conduct or activities. The ad hoc committee need not be comprised of members of the Board but shall be comprised of a majority of Physicians or Dentists. The Staff Member who is under investigation shall be invited to appear before the investigating committee before a final recommendation is initiated. Any such appearance shall be informal in nature, and attorneys shall not be permitted to attend unless otherwise permitted by the Board. The Chairman of the investigating committee shall forward a written report of the investigation to the Board and the Medical Executive Committee.

1.2-4 Board Action

Within thirty (30) days following receipt of the report of the investigation, the Board shall take action upon the request. Such action may include, without limitation:

A. Rejecting the request for corrective action;

B. Issuing a warning, a letter of admonition, or a letter of reprimand;

C. Recommending terms of probation not otherwise provided for in these bylaws or requirements of consultation, or use of a monitoring protocol for observation and review of clinical performance for a period of time;

D. Any actions listed in Initation of Hearing, Recommendation or Actions, other than a summary or automatic suspension.

The President shall report the Board's decision on the request for corrective action to the affected Staff Member, the Medical Executive Committee, the Chief of Staff and the department Chairman.

1.2-5 Procedural Rights

Any action taken by the Board, and not agreed to by the affected Staff Member shall entitle the Staff Member the hearing and appellate review rights described in the Bylaws, if and only if the following conditions are satisfied: (1) the affected Staff Member is a Qualified Practitioner as defined in the Bylaws; and (2) the actions taken fall within those listed in Initiation of Hearing, Recommendation or Actions. If any of these two conditions are not satisfied, the action of the Board takes effect immediately as a final action with no further recourse for the affected Staff Member.

1.3 SUMMARY SUSPENSION

1.3-1 Criteria for Initiation

Whenever a continuation of a physician’s practice constitutes an immediate danger to the health or safety of the public, including patients, visitors, and hospital employees and staff a combination of the President and either the Chief of Staff or the Chairman of the department in which the affected physician is a member (the Summary Suspension Committee), two shall have the authority to summarily suspend the medical staff membership status or any portion of the clinical privileges of such physician. A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists which must be available when the suspension decision is made. Such summary suspension shall become effective immediately upon imposition, and the CEO shall promptly give special notice stating the cause of the suspension to the physician and of the physician’s right to request a hearing. In the event of any such suspension, the physician’s patients then in the hospital whose treatment by such physician is terminated by the summary suspension shall be assigned to another member of the medical staff with similar clinical privileges by the department chairman. The wishes of the patient shall be considered, where feasible, in choosing a substitute physician.

The Chief of Staff shall make a reasonable effort to advise orally the affected Staff member, the President and the Medical Executive Committee of the summary suspension action and shall promptly give Special Notice of the suspension to the Staff Member, and notice to the President and Medical Executive Committee of such action, setting forth the criteria upon which the summary suspension is invoked and the restrictions imposed by the summary suspension. Such suspension shall become effective immediately upon the concurrence of the appropriate officials pursuant to this Section.

1.3-2 Medical Executive Committee Deliberation

After a summary suspension is imposed, the MEC convenes as soon as it is reasonably possible, but in no event longer than five (5) days after the suspension was imposed, to review and consider the facts under which such action was taken. The MEC may affirm, list, expunge or modify the suspension. The MEC may also recommend such further corrective action as is appropriate to the facts, including limitation of prerogatives, which recommendation if subject to hearing rights under these bylaws, would be combined with any remaining summary suspension action as the bases for the hearing. An MEC recommendation to terminate or modify the suspension to a lesser sanction not triggering procedural rights is transmitted immediately, together with all supporting documentation, to the board, or a committee of the board for review on an expedited basis. If the suspension is re-imposed or other adverse action is taken, the physician shall be

entitled to those hearing rights set forth under this Article.

1.3-3 Procedural Rights

The physician so affected is entitled to the procedural rights contained in these bylaws, except that the time basis shall be as follows:

A. The physician must request the hearing within ten (10) days of receiving special notice.

B. A fair hearing shall be commenced within fifteen (15) days after the suspension (unless an extension is agreed to in writing by the parties) and shall be completed without delay.

1.4 AUTOMATIC SUSPENSION AND/OR REVOCATION

1.4-1 Loss of License

If a Staff Member's license to practice his/her profession in the State of Illinois is revoked or suspended, or the licensing agency imposes a limitation of practice on the Practitioner, the member's Staff appointment and Clinical Privileges shall immediately, automatically, and indefinitely be suspended unless or until the Board, upon recommendation of the Medical Executive Committee, acts to stay the suspension or terminate the suspension because of proper documentation produced by the staff member of license reinstatement or removal of the limitation.

All Staff Members and health professionals have ongoing obligation to promptly provide the Chief of Staff with copies of renewed state and federal licenses when requested. Failure to provide such copies within ten (10) days of written request shall result in automatic suspension of admitting and Clinical Privileges.

1.4-2 Failure to Satisfy Special Appearance Requirement

A Staff Member who fails to satisfy the requirements of the Bylaws shall immediately and automatically be suspended from exercising all or a portion of his/her Clinical Privileges in accordance with the provisions of the Bylaws.

1.4-3 Conviction of a Felony

Upon exhaustion of appeals after conviction of a felony of a Staff Member in any court, either federal or state, the member's Staff appointment and Clinical Privileges are automatically and permanently revoked. The fact that a Physician's appeals have not been exhausted does not preclude the Medical Staff and/or Hospital from imposing a summary suspension pursuant to standards set forth in the Hearing Plan.

1.4-4 Medical Records

Except for emergency admissions, an automatic suspension of admitting and Clinical Privileges shall be imposed for failure to complete medical records in accordance with Administrative Policy Medical Staff Medical Records Content and Completion, and shall remain in effect until the incomplete medical records are fully completed. However, such automatic suspension alone shall be deemed to be administrative only and shall not be subject to mandatory reporting of adverse credentialing decisions by the Hospital.

1.4-5 Dues Delinquency

An automatic suspension of admitting Privileges shall be imposed for failure to pay Medical Staff dues within four (4) months of initial billing and shall continue until such dues are paid. However, such automatic suspension alone shall be deemed to be administrative only and shall not be subject to mandatory reporting of adverse credentialing decisions by the Hospital.

1.4-6 Reappointment Forms

An automatic suspension of admitting and Clinical Privileges shall be imposed by reason of a Staff Member's failure to make timely return of his/her completed application for reappointment as provided in the Credentialing Plan and shall continue until compliance occurs. However, failure to make timely return of his/her completed application for

reappointment as provided in Basic Qualifications for Membership sections of the bylaws relating to a leave of absence shall result in a voluntary resignation of Medical Staff appointment and all Hospital clinical privileges.

1.4-7 Faculty Appointment

An automatic revocation and termination of Medical Staff appointment and all Hospital Clinical Privileges shall result from the loss or non-existence of a Staff Member's faculty appointment with Northwestern University Feinberg School of Medicine.

1.4-8 Board Certification

An automatic revocation and termination of Medical Staff appointment and all Hospital Clinical Privileges shall result (a) from the permanent loss of a Staff Member's board certification or (b) due to a Staff Member's failure to maintain board certification within three (3) years from expiration date, or (c) a board eligible Staff Member's failure to secure board certification within seven (7) years of the date of the initial eligibility or within the time limit established by the respective board whichever comes first as set forth in Basic Qualifications for Membership sections of the Bylaws. However, the Board, upon the recommendation of the Medical Executive Committee, may waive the application of this Hearing Plan section, as well as Basic Qualifications for Membership and Probationary Status of the Bylaws in exceptional circumstances such as to attract and retain outstanding and extraordinarily accomplished members of the Medical Staff.

1.4-9 Professional Liability Insurance

An automatic suspension of admitting and all Clinical Privileges shall result from a Staff Member's failure to satisfy the requirements of Basic Qualifications for Membership of the Bylaws for professional liability insurance, and will continue until appropriate documentation of required insurance coverage is received by the Chief of Staff.

1.4-10 Exclusion from Federally Funded Programs

An automatic suspension of admitting and all clinical privileges shall result from the suspension of a Staff Member for more than thirty (30) days from Federally Funded Healthcare Programs as indicated on database maintained by the Office of Inspector General or other designated agency and shall continue until satisfactory evidence of the completions of such suspension is received by the Chief of Staff.

An automatic revocation and termination of Medical Staff appointment and all Hospital Clinical Privileges shall result from the final exclusion and termination of the Staff Member from Federally Funded Healthcare Programs as indicated on databases maintained by the Office of Inspector General or other designated agency.

1.4-11 Failure to Comply with Hospital and Medical Staff Policy

An automatic suspension of admitting and all clinical privileges shall result from the failure to comply with Hospital and Medical Staff Policies which have been appropriately approved by either the Hospital or Medical Staff policy approval process. However, such automatic suspension alone shall be deemed to be administrative only and shall not be subject to mandatory reporting of adverse credentialing decisions by the Hospital.

1.4-12 Effectiveness

Any suspension, revocation or termination described above, becomes effective when the affected Medical Staff Member has been given Special Notice to that effect by the Chief of Staff.

1.4-13 Procedural Rights

The Chief of Staff shall send a Special Notice of automatic suspension to the affected Staff Member. A Staff Member whose Staff appointment and/or admitting and/or Clinical Privileges have been automatically suspended or revoked by operation of sections of the Hearing Plan above, shall be entitled to request a hearing, upon written request to the Chief of Staff, to hearing rights only under Sections 2.3 to 2.6 and Sections 2.9 and 2.10 hereof, and is not entitled to appellate review rights under Sections 2.7 to 2.8 hereof. The scope of the Hearing shall be strictly limited to whether the decision made that lead to the automatic suspension or revocation was either made or not made by the respective individual, organization, or entity responsible for such decision. The prescribed suspension and/or revocation shall continue in effect pending completion of the hearing process, and longer until the condition giving rise to the suspension and/or revocation

has been eliminated, unless the hearing establishes that it was invoked in error. The hearing will be commenced within fifteen (15) days after the automatic suspension and/or revocation is invoked, and completed as promptly as is reasonable unless otherwise extended by mutual agreement of the parties. The Qualified Practitioner's failure to request a hearing within ten (10) days of notification of the automatic suspension and/or revocation will constitute a waiver of all hearing rights.

1.5 CONTINUITY OF PATIENT CARE

Upon the imposition of summary suspension or the occurrence of an automatic revocation or suspension, the Chairman of the department to which the suspended Staff Member is assigned, shall provide for alternative coverage for the patients of the suspended Staff Member in the Hospital. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner. The suspended Staff Member shall confer with the substitute Practitioner to the extent necessary to safeguard the patient.

ARTICLE II: FAIR HEARING AND APPELLATE REVIEW

2.1 DEFINITIONS

The following definitions shall apply to the provisions of this Article:

1. APPELLATE REVIEW BODY means the group designated to hear a request for appellate review properly filed and pursued by a Qualified Practitioner or the medical staff, to the extent that a Qualified Practitioner has any appellate review rights as defined in these bylaws.

2. HEARING COMMITTEE means the committee appointed to hear a request for a hearing properly filed and pursued by a Qualified Practitioner.

3. PARTIES means the Qualified Practitioner who requested the hearing or appellate review and the body upon whose adverse action a hearing or appellate review is predicated.

4. QUALIFIED PRACTITIONER means a member of the medical staff whose right to a hearing only, or to a hearing and appellate review, in accordance with the processes described in this Article of the Hearing Plan, has not been taken away or limited by any provision of these bylaws. Circumstances under which a Qualified Practitioner has no appellate rights are defined in these bylaws.

2.2 INTERVIEWS

When the Medical Executive Committee or the Board receives or is considering initiating an adverse recommendation concerning a Qualified Practitioner, the Qualified Practitioner may, but need not, be afforded an interview. The interview shall not constitute a hearing, shall be preliminary in nature, shall not be conducted according to the procedural rules provided with respect to hearings and attorneys are not permitted to attend unless permitted by the Medical Executive Committee. The Qualified Practitioner shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of such interview shall be made.

2.3 INITIATION OF HEARING

2.3-1 Recommendation or Actions

Unless otherwise provided for in these Bylaws, only the following recommendations or actions by the Medical Executive Committee, or by the Board if not previously recommended by the Medial Executive Committee pursuant to these Medical Staff Organizational Documents, shall entitle the Qualified Practitioner affected thereby to a hearing:

2.3.1 Denial of reappointment,

2.3.2 Suspension of staff appointment,

2.3.3 Revocation of staff appointment,

2.3.4 Reduction in staff category,

2.3.5 Reduction in clinical privileges,

2.3.6 Suspension of clinical privileges,

2.3.7 Revocation of clinical privileges,

2.3-2 Effectiveness of Routine Corrective Action and Summary Suspension

Before any of the actions or recommendations listed in Iniation of Hearing, Recommendation or Actions, may become effective against a Qualified Practitioner, it must become final under the provisions of the Hearing Plan. Summary suspensions imposed against a Qualified Practitioner take effect immediately and continue in effect pending the outcome of the hearing and appellate review process, if the Qualified Practitioner is entitled to same under this Hearing Plan.

2.4 HEARING AND APPELLATE REVIEW PROCESS

2.4-1 Adverse Recommendation or Action of the Medical Executive Committee or Board of Directors

The following procedures shall apply to an adverse action or recommendation, as described in Initiation of Hearing, Recommendation or Actions, and Effectiveness of Routine Corrective Action and Summary Suspension, of the Medical Executive Committee or the Board of Directors on its own initiative:

2.4.1 Notice of Adverse Recommendation or Action: A Qualified Practitioner against whom adverse action has been taken or recommended pursuant to Initiation of Hearing, Recommendation or Actions, shall promptly be given Special Notice of such action by the Chief of Staff. The notice shall indicate the reasons for the taken or recommended action and that the Qualified Practitioner may request a hearing within thirty (30) days in accordance with these Medical Staff Organizational Documents, or ten (10) days for summary suspension invoked for immediate or imminent danger and for automatic suspensions and/or revocations. A summary of the rights in the hearing or a copy of the Hearing Plan shall also be included.

2.4.2 Request for Hearing: Other than for summary suspensions invoked for immediate or imminent danger, and for automatic suspensions and/or revocations, a Qualified Practitioner shall have thirty (30) days following his/her receipt of a notice to file a written request for a hearing. Such request shall be deemed to have been made when delivered to the Chief of Staff in person or when sent, as indicated by postmark, by registered mail to the Chief of Staff, properly addressed and postage prepaid.

2.4.3 Waiver by Failure to Request a Hearing: A Qualified Practitioner who fails to request a hearing within the time and in the manner specified in the Hearing Plan waives any right to such hearing and to any appellate review to which he/she might otherwise have been entitled, and shall be deemed to have accepted the adverse action or recommendation as final and unappealable under this Hearing Plan.

2.4.4 Appointment of Hearing Committee: A hearing resulting from a Medical Executive Committee or Board of Directors recommendation or action pursuant to Initiation of Hearing, Recommendation or Actions shall be conducted by a mutually agreed hearing officer or by a Hearing Committee appointed by the Chief of Staff and the President and composed of at least three (3) members of the Active Staff, none of whom shall be direct economic competitors of the Qualified Practitioner or initiators of the adverse action and nor shall they have had any prior significant involvement in the decisions leading up to the recommended adverse action. In the event that the Chief of Staff and President cannot reach agreement on the members of the Hearing Committee, the matter shall be reviewed and the Hearing Committee appointed by the Board on an expedited basis. The Chief of Staff shall either appoint one of the Hearing Committee members as chairman or appoint an impartial hearing officer to assist the Hearing Committee. The Hearing Committee chairman or the hearing officer, as the case may be, shall have the duties set forth in the Hearing Plan.

2.4.5 Notice of Time and Place of Hearing: Upon receipt of a timely request for hearing, the Chief of Staff shall promptly schedule and arrange for a hearing. The Chief of Staff shall send the Qualified Practitioner Special Notice of the time, place and date of the hearing by certified mail, return receipt requested. The initial hearing date shall be no earlier than thirty (30) days from the date of receipt of the hearing notice sent by the Chief of Staff.

2.4.6 Statement of Charges: The notice of hearing required and shall contain a concise statement of the Qualified Practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question, if any, the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing, if any, as well as a list of witnesses then expected to testify.

2.5 HEARING PROCEDURE FOR ALL HEARINGS UNDER THIS ARTICLE

2.5-1 Personal Presence

The personal presence of the Qualified Practitioner who requested the hearing shall be required. A Qualified Practitioner 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 and with the same consequences as provided in the Hearing Plan.

2.5-2 Presiding Officer

Either the hearing officer or the chairman of the Hearing Committee, as the case may be, shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing, shall make all rulings including those based on procedure and the admissibility of information, and shall have the right to develop procedural rules consistent with this Hearing Plan.

2.5-3 Representation

The Qualified Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a person of his/her choice, including an attorney. The Medical Executive Committee or the Board, depending upon whose recommendation has prompted the hearing, shall appoint a person of its choice, including an attorney, to represent it at the hearing, to present the facts in support of its adverse recommendation or action, and to examine witnesses. Representation of either party by an attorney at law shall be governed by the provisions of the Hearing Plan.

2.5-4 Rights of Parties

During a hearing, each of the parties shall have the right to:

2.5.1 Call and ask questions of their own witnesses and witnesses called by the other party on any matter relevant to the issues;

2.5.2 Introduce any information deemed relevant and acceptable by the presiding officer;

2.5.3 Rebut any information;

2.5.4 Inspect all pertinent information in the Hospital’s possession as determined by the Hearing Committee, with respect to the decision and information which the parties expect to submit;

2.5.5 Receive a copy of the proceedings either as transcribed by a court reporter or recorded with an electronic recording unit and all documents considered by the hearing officer or committee, with all related costs to be equally shared.

2.5.6 Provide a written statement at the hearing's conclusion or at a later date as determined by the committee,

2.5.7 Receive lists of proposed witnesses as much in advance of their appearances as reasonably possible.

If the Qualified Practitioner who requested the hearing does not testify in his/her own behalf, he/she may be called and examined by the Hearing Committee and the other party.

2.5-5 Procedure and Evidence

The hearing need not be conducted strictly in accordance to the rules of law relating to the examination of witnesses or presentation of information. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such information in a court of law. Each party shall, prior to, during or at the conclusion of the hearing or at a later date as determined by the committee, be entitled

to submit memoranda concerning any issue relevant to the hearing, and such memoranda shall become part of the hearing record. The Hearing Committee may require one or both parties to prepare and submit to the committee, written statements of their position on the issues, prior to, during, or after, the hearing. The Hearing Committee may establish rules of procedure, including, but not limited to, requiring the submission prior to the hearing of lists of proposed witnesses and exhibits and the scope of legal counsel's role during the hearing. The presiding officer may, but shall not be required to, order that oral information be taken only on oath or affirmation administered by any person designated by him/her and entitled to notarize documents.

2.5-6 Record of Hearing

A record of hearing will be made either as transcribed by a court reporter or recorded with an electronic recording unit with all related costs to be equally shared.

2.5-7 Postponement

Requests for postponement of a hearing shall be granted by the hearing officer or committee only upon a showing of good cause.

2.5-8 Recesses and Adjournment

The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional information or consultation. Upon conclusion of the presentation of oral and written information, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of its deliberations, the hearing shall be declared finally adjourned.

2.6 HEARING COMMITTEE REPORT AND FURTHER ACTION

2.6-1 Hearing Committee Report

Within thirty (30) days after final adjournment of the hearing, or such other period as may be required to complete the transcription of the proceeding and review final written statements submitted by the parties, the Hearing Committee shall make a written report of the findings and recommendations in the matter, including the basis on which the decision was made, and shall forward the same, together with the hearing record and all other documentation considered by it, to the board of directors. A copy of the report shall also be sent to the Medical Executive Committee and the affected Qualified Practitioner.

2.7 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

2.7-1 Request for Appellate Review

A Qualified Practitioner and/or the Medical Executive Committee or the Board, whichever is appropriate, shall have fifteen (15) days following his/her/its receipt of the written report of findings to file a written request for an appellate review. Such request shall be deemed to have been made when delivered to the Chief of Staff in person or when sent, as determined by postmark, by registered mail to the Chief of Staff, properly addressed and postage prepaid and may include a request for a copy of the record of the Hearing Committee and all other material, favorable or unfavorable, that was considered in making the adverse action or result.

2.7-2 Waiver by Failure to Request Appellate Review

A Qualified Practitioner who fails to request an appellate review within the time and in the manner specified waives any right to such review. Such waiver shall have the same force and effect as that provided in the sections above.

2.7-3 Notice of Time and Place for an Appellate Review

Upon receipt of a timely request for appellate review, the Chief of Staff shall deliver such request to the Board. The Board shall promptly schedule and arrange for commencement of an appellate review which shall be no more than thirty (30) days from the date of the board's receipt of the appellate review request. At least fifteen (15) days prior to the appellate review, the Chief of Staff shall send the Qualified Practitioner and the Medical Executive Committee or the

board, whichever is appropriate, a Special Notice of the time, place and date of the review. The time for the appellate review may be extended by the Appellate Review Body for good cause.

2.7-4 Appellate Review Body

The Appellate Review Committee shall be composed of at least three (3) members appointed by the Chairman of the Board, at least one of whom shall be a member of the Active Staff and not a direct economic competitor of the Qualified Practitioner or initiator of the adverse action and nor shall they have had any prior significant involvement in the decisions leading up to the recommended adverse action. If a committee is appointed, one of its members shall be designated as chairman. The committee also shall be entitled to obtain the assistance of legal counsel, which, in its discretion, can include the Hospital's Office of General Counsel.

2.8 APPELLATE REVIEW PROCEDURE

2.8-1 Nature of Proceedings

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee or agreed hearing officer, as the case may be, that committee's report, and all subsequent results and actions thereon. The Appellate Review Body shall also consider the written statements submitted and such other materials as may be presented and accepted.

2.8-2 Written Statements

The Qualified Practitioner and/or the Medical Executive Committee or the Board seeking the review shall submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, if any, and his/her/its reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Appellate Review Body through the Chief of Staff at least fifteen (15) days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by, or on behalf of, the Medical Executive Committee or the Board or the Qualified Practitioner, as the case may be, and, if submitted, the Chief of Staff shall provide a copy thereof to the other party at least seven (7) days prior to the scheduled date of the appellate review.

2.8-3 Presiding Officer

The chairman of the Appellate Review Body shall be the presiding officer. He/she shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

2.8-4 Oral Statement

The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

2.8-5 Consideration of New or Additional Matters

New or additional matters or information not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The Appellate Review Body, in its sole discretion, shall determine whether such matters or information shall be considered or accepted.

2.8-6 Powers

The Appellate Review Body shall have all power granted to a Hearing Committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

2.8-7 Recesses and Adjournment

The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon

the conclusion of oral statements, if allowed, the appellate review shall be closed. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations the appellate review shall be declared finally adjourned.

2.8-8 Action Taken

The Appellate Review Body may recommend that the Board affirm, modify or reverse the adverse result or action taken by the Medical Executive Committee or by the Board, or, in its discretion, may refer the matter back to the Hearing Committee or hearing officer, as the case may be, for further review and recommendation to be returned to it within twenty (20) days. Within twenty (20) days after receipt of such recommendation after referral, the Appellate Review Body shall make its recommendation to the Board. All actions of the Appellate Review Body shall be in writing with a copy to the Qualified Practitioner and the Medical Executive Committee.

2.8-9 Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps have been completed or waived.

2.9 FINAL DECISION OF THE BOARD

2.9-1 Board Action

The Board shall consider the Hearing Committee's and/or Appellate Review Committee's recommendation and make a preliminary determination on the matter. Whenever the Board's preliminary determination will be contrary to the Medical Executive Committee's last recommendation, the Board shall invite the Medical Executive Committee to submit a response to the Board's preliminary determination within thirty (30) days of the Medical Executive Committee's receipt of the preliminary determination. If the Board's determination is consistent with the Medical Executive Committee's last recommendation, it shall be considered final, and no response from the Medical Executive Committee is necessary.

2.9-2 Board Decision Final

The Board shall consider the Medical Executive Committee's response, if applicable, and take action on the matter. If the Medical Executive Committee does not submit a response within the time required by the Hearing Plan or if no response is required, the Board's action on the Appellate Review Committee recommendation shall be considered final. The Board's action on any response submitted by the Medical Executive Committee shall be considered final. The Chief of Staff shall notify the Qualified Practitioner and the Medical Executive Committee by special notice of the Board's final action. Except as otherwise provided, the Board's decision shall be effective immediately.

2.9-3 Notice Before Implementation Based on Economic Factors

Notice to an affected Staff Member is to be given fifteen days before implementation of any adverse and final board action based substantially on economic factors, defined as any information or reasons for decisions unrelated to quality of care or professional competence. If the adverse action is the granting of an exclusive contract under provisions of the Credentialing Plan, such notice cannot be given until at the earliest: (a) the exhaustion of the sixty (60) day prior notice provision set forth in the Credentialing Plan and/or (b) completion of hearing and appellate review rights (if available), if the affected Staff Member makes timely request for such hearing. If the adverse action is not based upon the granting of an exclusive contract, such notice cannot be given until completion of hearing and appellate review rights (if available), if the affected Staff Member makes timely request for such hearing.

2.10 GENERAL PROVISIONS

2.10-1 Hearing Officer Appointment and Duties

The use of a mutually agreed upon hearing officer to preside at an evidentiary hearing is optional. A hearing officer may or may not be an attorney at law, but must have experience in the conduct of hearings. He/she shall act in an impartial manner as the presiding officer of the hearing.

2.10-2 Attorneys

If the affected Qualified Practitioner desires to be represented by an attorney at any hearing or at any appellate review appearance, his/her request for such hearing or appellate review must so state. If the Qualified Practitioner elects not to be so represented, neither shall the Medical Executive Committee or the Board be allowed representation at the hearing or appellate review session by an attorney. The foregoing shall not be deemed to limit the Qualified Practitioner, the Medical Executive Committee or the Board in the use of legal counsel in connection with preparation for a hearing or an appellate review. Because of the intraprofessional nature of this hearing, attorneys will not be permitted to engage in direct or cross examination of witnesses but may be allowed to raise procedural and similar objections if permitted by the Hearing Committee which has the final authority to determine the scope of the attorney's role during the hearing.

2.10-3 Waiver

If at any time after receipt of Special Notice of an adverse recommendation, action or result, a Qualified Practitioner fails to timely make a required request or appearance or otherwise fails to timely comply with Fair Hearing and Appellate Review, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under the medical staff organizational documents then in effect including this Article with respect to the matter involved. Such waiver shall have the same force and effect as that provided in the Hearing Plan.

2.10-4 Number of Reviews

Notwithstanding any other provision of the medical staff organizational documents including this Article, no Qualified Practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

2.10-5 Release

By requesting a hearing or appellate review under this Article, a Qualified Practitioner agrees to be bound by the provisions of all Articles of the Hearing Plan.

ARTICLE III: AMENDMENTS TO FAIR HEARING PLAN

Any proposed amendments to the Fair Hearing Plan must be reviewed and adopted consistent with the provisions of the Medical Staff Bylaws.

REVISED by the Medical Staff on September 11, 2003
APPROVED by the Board of Directors on October 27, 2003

REVISED by the Medical Executive Committee on March 9, 2009
APPROVED by the Board of Directors on June 22, 2009

REVISED by the Medical Executive Committee on February 14, 2011
APPROVED by the Board of Directors on February 28, 2011

REVISED by the Medical Executive Committee on January 9, 2012
APPROVED by the Board of Directors on April 30, 2012

REVISED by the Medical Executive Committee on April 17, 2014
APPROVED by the Board of Directors on July 28, 2014

REVISED by the Medical Executive Committee on September 10, 2018
APPROVED by the Board of Directors on February 27, 2019

COMMITTEE PLAN OF THE MEDICAL STAFF OF NORTHWESTERN MEMORIAL HOSPITAL ("COMMITTEE PLAN")

ARTICLE I. COMMITTEES

1.1 DESIGNATION, STRUCTURE AND FUNCTION

There shall be such standing and special (ad hoc) committees and subcommittees of the Staff as may from time to time be necessary and desirable to perform the functions of the Staff required by these Medical Staff Organizational Documents or necessarily incidental thereto. All Staff Members to serve on committees and committee chairmen shall be appointed by the Chief of Staff except as otherwise provided in these Medical Staff Organizational Documents. All Hospital personnel, other than Staff Members, to serve on committees shall be appointed by the Chief of Staff. Committee appointments are for the Medical Staff year as determined by the election of the Medical Staff Officers.

All committees shall:

A. Meet as necessary to perform required functions but shall meet at least annually and maintain a record of attendance at their meetings;

B. Maintain a record of their proceedings;

C. Upon request, submit reports of their activities and copies of the minutes of their meetings to the Medical Executive Committee and Chief of Staff;

D. Submit a summary report of its activities during the year for the Hospital annual report.

E. Channel all informational communication to the staff through the office of the Chief of Staff.

The Medical Staff, through the Medical Executive Committee, with the exception of the Core Committees described in the Medical Staff Organizational Documents, shall be permitted to discontinue committees and may establish new Medical Staff and multidisciplinary committees on an as needed basis in consultation with the President of the Hospital, or his designee.

The standing committees of the Medical Staff shall be the following:

1.2 MEDICAL EXECUTIVE COMMITTEE

1.2.1 **Composition**

The Medical Executive Committee of the Staff shall consist of the members as indicated below, with the Chief of Staff as its Chairman.

- Chief of the Medical Staff
- Vice Chief of the Medical Staff
- Secretary-Treasurer of the Medical Staff
- Immediate Past Chief of the Medical Staff
- President of the hospital
- Dean of the Northwestern University Feinberg School of Medicine
- Chief Nurse Executive
- 3 Permanent Department Chairmen:
  - Medicine
  - Obstetrics-Gynecology
  - Surgery
- 3 Other Department Chairmen (1 of whom must be hospital based i.e.: anesthesiology, pathology, radiology)
- 6 Medical Staff members elected at large (all Active medical staff members are eligible)

- Chief Medical Officer

In the event that a department Chairman representative occupies an elective office, the members of such department will elect another representative.

1.2.2 **Duties**:

The duties of the Medical Executive Committee, acting on behalf of the Medical Staff between annual meetings, shall be to:

A. Receive and act upon reports and recommendations from the departments, committees and officers of the Staff concerning the findings of the quality/utilization/risk management program and other quality maintenance activities, and the discharge of their delegated administrative responsibilities;

B. Coordinate the activities of and implement policies adopted by the Staff, departments and committees;

C. Recommend to the Board on matters relating to initial appointments, Staff category, department assignments, Clinical Privileges, and corrective action;

D. Review periodically all information available including corrective actions, regarding the performance and clinical competence of staff members and, as a result of such reviews, make recommendations for reappointments, renewals, modifications, or changes in clinical privileges;

E. Account to the Board and to the Staff for the overall quality and efficiency of care rendered to patients in the Hospital;

F. Request evaluations of practitioners privileged through the Medical Staff process in instances where there is doubt upon an applicant's ability to perform the privileges requested;

G. Initiate and pursue corrective action, when warranted, in accordance with these Medical Staff Organizational Documents;

H. Make recommendations on medico-administrative and Hospital management matters to the board through the President and the Chief of Staff;

I. Serve as liaison between the Medical Staff and the Chief Executive Officer and the Hospital Board; recommend action to the Chief Executive Officer or the Hospital Board on clinical and administrative matters;

J. Represent and act on behalf of the Staff, subject to such limitations as may be imposed by these Medical Staff Organizational Documents.

K. Determine the amount of annual dues for the Staff.

These delegated duties may be amended or removed from the Medical Executive Committee by amendment to these Medical Staff Organization Documents; additional duties may be delegated to the Medical Executive Committee by amendment to these Medical Staff Organizational Documents.

1.2.3 **Meetings**

A. Regular Meetings. The Medical Executive Committee shall meet regularly and maintain a record of its proceedings and actions. A summary of the activities of these meetings shall be presented by the Chief of Staff at each general Staff meeting.

B. Special Meetings. Special meetings may be called by or at the request of the Chief of Staff, Vice Chief of Staff, or any three (3) members of the Medical Executive Committee upon at least three (3) days written notice sent via mail, email, fax, or personal delivery to the committee member's last known home or office address. Notice by mail shall be deemed given when deposited in the mail with postage prepaid. Personal attendance at a special meeting shall constitute a waiver of notice of such meeting.

1.2.4 **Removal of Members**

Grounds for removal of Medical Executive Committee members for cause only, which shall include, but not be limited to, mental and/or physical impairment or inability and/or unwillingness or failure to perform the duties and responsibilities of committee membership. Action directed towards removing a member may be initiated by the Chief of Staff. The Medical Executive Committee renders a final decision.

1.3 QUALITY MANAGEMENT COMMITTEE

1.3.1 **Composition**

The membership of the Quality Management Committee (QMC) shall include representatives selected by Quality Management Committee co-chairs from among Interdisciplinary Departmental Quality Committee co-chairs, and leadership of patient care, clinical quality, and other departments. The Chair of Quality Management Committee shall be appointed by the Chief of Staff.

1.3.2 **Duties**

The duties of the Quality Management Committee shall be to:

A. Oversee, evaluate and make recommendations concerning the quality and appropriateness of patient care provided in the Hospital. This committee shall have regular meetings and special meetings as deemed necessary to deal with issues of quality of care which arise between regularly scheduled meetings. The committee shall review and evaluate reports from its subcommittees on a regular basis.

B. Assure compliance with the Hospital Quality Management Plan by the organized Medical Staff;

C. Monitor problem identification and resolution process;

D. Refer to appropriate Medical Staff committees and departments recommendations developed as a result of quality management activity;

E. Participate in the establishment, approval and modification of the Hospital Quality Management Plan in conjunction with the hospital Executive Quality Management Committee;

F. Participate in risk management activities including without limitation, identification and prevention of risks to improve the quality of patient care and safety; development of criteria for risk identification; correction of problems identified by risk management activities;

G. Review on a regular basis the work and reports of the Quality Management Committee subcommittees, and the Interdisciplinary Quality Management Committees.

1.3.3 **Meetings**

A. Regular Meetings. The Quality Management Committee shall meet regularly and maintain a record of its proceedings and actions. A summary of the activities of these meetings shall be presented by the Chair to the Medical Executive Committee.

B. Subcommittee Meetings. The subcommittees of the Quality Management Committee shall meet regularly and maintain a record of membership, attendance, and proceedings and actions. A summary of the activities of these meetings shall be reported to the Quality Management Committee.

1.3.4 **Subcommittees**

The subcommittees of the Quality Management Committee:

1.3.4.1 Medical Quality Executive Committee

A. **Composition**: The membership of the Medical Quality Executive Committee shall consist of the Chief of Staff (who shall act as its chair), the Vice Chief of Staff, the Secretary-Treasurer, the immediate past Chief of Staff, and such other appointees as determined by the Chief of Staff. The Chief of Staff may designate members of the committee or other non-members to investigate and report to the committee on any quality, peer review or patient care issues that may come to his/her attention.

B. **Duties**: The Medical Quality Executive Committee shall review, evaluate and make recommendations concerning the quality of patient care provided at the Hospital by individuals who provide care under these Medical Staff Organizational Documents. The committee shall meet regularly to review the quality of care provided at the Hospital. The duties of the Medical Quality Executive Committee shall be as follows:

1. Review and evaluate on a regular basis selected issues concerning the quality of patient care at the hospital through the review and analysis of information used in the course of internal quality control or of medical study for the purpose of reducing morbidity or mortality, or for improving patient care;

2. Review and evaluate on a regular basis the quality of patient care provided by persons credentialed under these Medical Staff Organizational Documents;

3. Receive regular reports from Hospital and Medical Staff committee concerning the quality of patient care provided at the Hospital;

4. Report on a regular basis to the Quality Management Committee on its activities and findings.

5. Designate a Physician Health Liaison, who shall be appointed by the Chief of Staff, with the following duties:

    a. Facilitates diagnosis, treatment and rehabilitation of Medical Staff members who are ill and maintains confidentiality in all cases; if appropriate, makes recommendations to the Chief of Staff concerning impaired Medical Staff members;

    b. Determines the credibility of complaints, allegations, or concerns raised in regards to Medical Staff members expressed confidentially to the Physician Health Liaison, and consults with the Chief of Staff if issues rise to the level of impairment;

    c. Conducts initial evaluations and fitness for evaluation of Medical Staff members referred to the Physician Health Liaison or at the request of the Medical Staff member;

    d. Refers Medical Staff members for appropriate evaluation and treatment;

    e. Reviews reports concerning Medical Staff members referred for evaluation and treatment;

    f. Maintains confidential records and files confidential reports, as appropriate concerning impaired Medical Staff members or where the health and safety of patients is at issue, to the Chief of Staff;

    g. Attends Medical Staff Quality Management Committee meetings and reports on Physician Health Liaison activities;

    h. Maintains the confidentiality of Medical Staff members seeking or referred for assistance, except as limited by applicable law, ethical obligation or where the health and safety of patients is at issue;

    i. Regularly reports on his/her activities to the Medical Quality Executive Committee.

1.3.4.2 Infection Control and Prevention.

A **Composition**: The membership of the subcommittee of Infection Control and Prevention shall consist of the Chair who shall be appointed by the Chief of Staff, appointed medical staff members and other

membership shall include representatives from diverse clinical departments, nursing, and hospital management. Medical Staff members shall be appointed by the Chief of Staff.

B. **Duties**: The Infection Control and Prevention Subcommittee shall meet regularly and its duties shall be to:

1. Review infection and infection data and make recommendations with regard to their proper management, reduction and epidemic potential;

2. Review cultures of personnel or the environment as required by the Hospital, Medical Staff or governmental bodies or regulations;

3. Develop infection sampling activities and protocols to improve standards of patient care, maintenance and personnel practices or equipment selection and maintenance;

4. Review trends in study results of antimicrobial susceptibility resistance;

5. Review proposals and protocols for all special infection control studies conducted throughout the Hospital;

6. Review medical records for the documentation of infections in the final diagnosis;

7. Report on a regular basis to the clinical departments all hospital acquired and surgical site infections;

8. Report on a regular basis to the Quality Management Committee of the Medical Staff all hospital acquired and wound infections and the results of any reviews as described above.

1.3.4.3 Pharmacy and Therapeutics.

A. **Composition**: The membership of the subcommittee of Pharmacy and Therapeutics shall consist of the Chair who shall be appointed by the Chief of Staff, appointed medical staff members and other membership shall include representatives from diverse clinical departments, nursing, and hospital management. Medical Staff members shall be appointed by the Chief of Staff.

B. **Duties**: The Pharmacy and Therapeutics Subcommittee shall meet regularly and its duties shall be to:

1. Develop and approve policies and procedures relating to the selection, distribution, handling, use and administration of drugs and related diagnostic testing materials;

2. Develop and maintain a Hospital drug formulary;

3. Evaluate protocols concerned with the lawful use of investigational or experimental drugs, and approve such protocols when no other such approval mechanism exists;

4. Monitor and review adverse drug events;

5. Develop and implement a criteria-based, systematic process for the ongoing monitoring and evaluation of prophylactic, therapeutic and empiric use of drugs to help assure their appropriate and effective use;

6. Collect and assess information to identify opportunities to improve the effectiveness of drug use;

7. Report on a regular basis to the clinical departments all major adverse drug reactions and results of drug review studies;

8. Report on a regular basis to the Quality Management Committee of the Medical Staff summaries of adverse drug events and drug review studies.

1.3.4.4 Utilization Subcommittee.

A. **Composition**: The membership of the Utilization Subcommittee shall consist of the Chair who shall be appointed by the Chief of Staff, appointed medical staff members and other membership shall include representatives from diverse clinical departments, corporate compliance and integrity, clinical coding, clinical documentation, quality utilization, hospital revenue cycle, patient care services, social services, and at least two standing Medical Staff members who shall serve as physician advisors. The chair and Medical Staff members shall be appointed by the Chief of Staff

B. **Duties**: The Utilization Subcommittee shall meet regularly and its duties shall be to:

1. Analyze results of review activities and data generated through the quality utilization program and where appropriate, make recommendations for change in policies, procedures or practices; monitor utilization patterns including overutilization, underutilization, inefficient scheduling of services, cases determined to be not medically necessary and payment or other denials.

2. Designate and continually update the types of utilization review processes and the medical criteria to be used.

3. Maintain prospective, concurrent and retrospective review systems to support the monitoring and evaluating systems used in Hospital and Medical Staff quality management programs.

4. Maintain an ongoing utilization management plan and program in compliance with all applicable regulations and signed agreements for all patients regardless of payment source.

5. Monitor the appropriateness and effectiveness of the level of care program.

6. Monitor non-delegated utilization review activities.

7. Develop and conduct quality utilization education programs for Hospital administration, Medical Staff and Physician advisors using, where appropriate, results of data analysis.

8. Provide regular and/or periodic reports relative to utilization practices and outcomes to the clinical departments and individual physicians that impact utilization within the organization.

9. Report on a regular basis to the Quality Management Committee of the Medical Staff all relevant information and recommendations through regular committee minutes.

10. Monitor the appropriateness, effectiveness, and efficiency of ancillary services delivered through development and application of criteria consistent with patient care standards.

1.3.4.5 Interdisciplinary Departmental Quality Management Committees

A. **Composition:** Each clinical department shall participate in an interdisciplinary departmental quality management committee with medical staff membership appointed by the clinical Department Chairman or designee. The committees are co-chaired by a Department Chairman or Chief of Staff appointee and a Chief Nurse Executive appointee.

B. **Duties**:

1. Establish and implement for the department an ongoing monitoring and evaluation process whose review methodology meets the requirements set forth in the Hospital Quality Management Plan including, but not limited to: identification of metrics and establishment of thresholds and benchmarks for collection and evaluation; delineation of metrics for ongoing professional practice evaluation; and identification of peer review triggers;

2. Review on a regular basis departmental practitioners not in compliance with medical record policies;

3. Provide to the department Chairman on a regular basis quality management reports and activity summaries;

4. Refer to the applicable Medical Staff Peer Review Committee, information determined by the respective Committees to be relevant to the functions of the Peer Review Committees.

C. **Meetings**:

1 Regular Meetings. The Committee shall meet regularly and maintain a record of its proceedings and actions. A summary of the activities of these meetings shall be provided to the department Chairmen on a regular basis.

1.3.4.6 Medical Staff Peer Review Committees

A. **Composition**: There shall be three multi-department Committees:

1. Surgical Peer Review Committee shall be responsible for surgical cases and shall have representation from multiple surgical departments which may include Neurosurgery, Ophthalmology, Orthopaedics, Surgery, Urology, Emergency Medicine, Anesthesiology and Radiology.

2. Obstetrics and Pediatrics Peer Review Committee which may include representation from Obstetrics Gynecology, Pediatrics, Emergency Medicine, Anesthesiology and Radiology.

3. Medical Peer Review Committee which may include representation from Medicine, Emergency Medicine, Psychiatry, Neurology and Radiology.

The members of the Committees shall be appointed by the respective Department Chairs or designee after consultation and the approval of the Chief of Staff.

B. **Duties**: Activities include, but are not limited to the evaluation of medical care, addressing the quality of care provided to patients, the evaluations of complaints, incidents and other similar communications filed against members of the Medical Staff and others granted Clinical Privileges. They also include the receipt, review, analysis, acting on and issuance of incident reports, quality and utilization review functions, and other functions and activities related thereto or referenced or described in any Peer Review policy or Quality Plan. The Medical Staff Peer Review Committees shall be responsible for the evaluation of individual physician professional performance for all relevant performance parameters by using multiple sources of performance data. The Committees shall receive information from the quality review process and evaluate such information in a manner consistent with Committee protocols and procedures for the purpose of improving the quality of patient care provided at the hospital. The duties of the Medical Staff Peer Review Committees also include:

1. Review and evaluate selected outcome measures for specific practitioners related to patients care;

2. Review and evaluate the quality of care provided by practitioner at the hospital;

3. Review and assign in accordance with Committee protocols and the Quality Plan, peer review ranks to practitioners and report such ranks to appropriate committees and individuals;

4. Relevant activities and findings are reviewed by Medical Quality Executive Committee and reported to Quality Management Committee on a regular basis.

1.4 PATIENT CARE COMMITTEE

1.4.1 Composition

The members of the Patient Care Committee shall consist of a Physician Chairman appointed by the Chief of Staff, the Senior Vice President/CMO, the Vice President, Operations and Chief Nurse Executive (or designate) of the Hospital, and members at large appointed by the Chief of Staff.

1.4.2 **Duties**

This committee shall review and make recommendations to the Medical Executive Committee concerning all patient care policies and protocols, whether existing or newly proposed, and all revisions or amendments thereto for the purpose of improving the quality of patient care at the hospital. This committee shall be responsible for steering such policies, protocols and revisions to all appropriate constituencies for comment before making its recommendations to the Medical Executive Committee. Any member of the Medical Staff may propose new policies or protocols or revisions of existing ones to the Patient Care Committee.

1.4.3 **Meetings**

A. Regular Meetings. The Patient Care Committee shall meet regularly and maintain a record of its proceedings and actions. A summary of the activities of these meetings shall be presented by the Chair to the Medical Executive Committee.

1.5 MEDICAL ETHICS COMMITTEE

1.5.1 **Composition**

The members of the Medical Ethics Committee shall consist of a Physician Chairman appointed by the Chief of Staff and diverse, multi-disciplinary members at large appointed by the Chief of Staff.

1.5.2 **Duties**

This committee shall assist in the review of the ethical and human values that may be applied for resolving patient care questions posed to the committee, all for the purpose of improving the quality of care provided to patients at the hospital. The committee shall be specifically prohibited from exercising decisional authority, and from concerning itself with situations that can be resolved by medical knowledge alone in the course of routine consultative services.

This committee's opinion can be written or oral, at the request of the attending physician of record.

1.5.3 **Meetings**

A. Regular Meetings. Medical Ethics Committee shall meet regularly and maintain a record of its proceedings and opinions.

1.6 CREDENTIALS COMMITTEE

The Credentials Committee shall consider the qualifications of initial applicants for appointment to the staff as well as those of candidates for reappointment, promotions and for the granting of delineated Clinical Privileges as provided in these Medical Staff Organizational Documents for the purpose of improving the quality of care of patients at the hospital. It shall make recommendations concerning same to the Medical Executive Committee.

1.6.1 **Composition**

The members of this committee are appointed by the Chief of Staff and shall include past presidents and other members of the Medical Staff chosen to ensure representation from a broad range of services. The Senior Vice President, as well as the immediate past Chief of Staff shall both serve as ex officio members of this committee. The Vice Chief of Staff shall serve as the chair and the Secretary/Treasurer shall serve as a member of the Credentials Committee.

1.6.2 **Duties**

A Assure the Medical Executive Committee that the provisions related to credentialing processes of the Medical Staff Organization Documents and the Credentialing Plan are being fulfilled;

B. Monitor compliance with all credentialing policies and procedures;

C. Evaluate recommendations made by Department chairs for completeness, thoroughness, and adherence to credentialing and privileging policies and standards;

D. Review and make recommendations to the Medical Executive Committee concerning credentialing criteria proposed for use by clinical departments; assure the Medical Executive Committee that department-specific standards for clinical privileges are in compliance with the provisions of the Medical Staff Organizational Documents and Credentialing Plan, and that these standards are uniformly and fairly applied to each applicant;

E. Monitor and evaluate reports of Focused Professional Practice Evaluation and report findings and recommendations to the Medical Executive Committee;

F. Recommend revisions to all credentialing forms and procedures, including the forms and formats to be used for the delineation of Clinical Privileges, to assure documents are consistent with current practice and updated as necessary.

1.6.3 **Meetings**

A. Regular Meetings. Credentials Committee shall meet regularly and maintain a record of its proceedings and opinions. A summary of the activities of these meetings shall be presented by the Chair to the Medical Executive Committee.

1.7 CANCER COMMITTEE

1.7.1 **Composition**

The Cancer Committee shall be a multidisciplinary committee and shall consist of a Chairman appointed by the Chief of Staff and include representatives from surgery, medical oncology, radiation oncology, diagnostic radiology, and pathology, and the cancer liaison physician. Nonphysician membership may include administration, nursing, social services, cancer registry, and quality assurance. Other Physician and non-physician representatives should be included based on the cancer experience of the institution.

1.7.2 **Duties**

The Cancer committee is responsible for providing program leadership and improving the quality of care of patients at the hospital with duties and responsibilities as follows:

A. Develops and evaluates the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer

B. Promotes a coordinated, multidisciplinary approach to patient management

C. Ensures that educational and consultative cancer conferences cover all major sites and related issues

D. Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes

E. Promotes clinical research

F. Supervises the cancer registry and ensures accurate and timely abstracting, staging, and follow-up reporting

G. Performs quality control of registry data

H. Encourages data usage and regular reporting

I. Publishes the annual report

1.7.3 **Meetings**

A. Regular Meetings: The Cancer Committee shall meet at least quarterly and shall submit its findings and recommendations to the Medical Executive Committee

1.8 PRACTITIONER HEALTH COMMITTEE

1.8.1 Composition

The members of this committee are appointed by the Chief of Staff and shall include a Physician Health Liaison who may also serve as chair, and members of the Medical Staff chosen to ensure representation from a broad range of services. The committee shall be organized as needed to perform its duties for the purpose of improving the quality of care of patients at the hospital.

1.8.2 Duties:

A. Provide support to Medical Staff members, Doctorate Level staff, and Allied Health Professionals who involved in adverse care outcomes.

B. Promote programs to Medical Staff to enhance and support the prevention of illness;

C. Provide evaluation of positive or negative with safety concern drug screening of all Medical Staff applicants.

1.8.3 Meetings:

A. Regular Meetings: The committee shall meet at least quarterly but may meet more frequently as determined by the Chair. Chair reports committee activities and recommendations on a regular basis to the Medical Executive Quality Committee.

1.8.4 Subcommittees:

The Practitioner Health Committee shall be organized by subcommittees which shall meet regularly and maintain a record of membership, attendance, and proceedings and actions.

1.8.4.1 Practitioner Support:

A. **Composition**: The composition of the subcommittee of Practitioner Support shall consist of the Chair appointed by the Chief of Staff in consultation with the Chair of Practitioner Health Committee and other members chosen to ensure representation from a broad range of services.

B. **Duties**: The Practitioner Support subcommittee shall meet regularly and its duties shall be to:

1. Upon notification, provide support to Medical Staff members and other practitioners involved in an adverse care outcome event.

2. Assist with evaluation of positive or negative with safety concern drug screening of applicants to Medical Staff.

1.8.4.2 Practitioner Wellness:

A. **Composition**: The composition of the subcommittee of Practitioner Wellness shall consist of a Chair or Co-Chairs who shall be appointed by the Chief of Staff in consultation with the Chair of Practitioner Health Committee and other members chosen to ensure representation from a broad range of services.

B. **Duties**: The Practitioner Wellness subcommittee shall meet regularly and its duties shall be to:

1. Develop policies and programs that enhance and support the prevention of illness in the Medical Staff and non-Hospital employed doctorate level health professionals and allied health professionals with privileges under the medical staff processes; Hospital employed doctorate level

health professionals and allied health professional with privileges shall follow Hospital resources available.

2. Sponsor and/or publish educational programs which deal with impairment and physician health.

3. Report a summary of the activities of the subcommittee to Practitioner Health Committee.

1.9 BYLAWS COMMITTEE

1.9.1 **Composition**:

The members of this committee are appointed by the Chief of Staff and shall include the Secretary-Treasurer and immediate Past Chief of Staff along with members of the Medical Staff chosen to ensure representation from a broad range of services. The immediate Past Chief of Staff shall serve as Chair. The committee shall meet at least annually but may be more frequently as determined by the Chair.

1.9.2 **Duties**:

The Bylaws Committee shall serve to assure the Medical Staff Organizational Documents, to include rules and regulations and plans considered part of the Bylaws, are in compliance with licensing, regulatory and accreditation requirements and that the documents are consistent with each other, reflect current practice, and reviewed and updated as necessary.

1.9.3 **Meetings**:

A. Regular Meetings: The Bylaws Committee shall meet at least annually and maintain a record of its proceedings and recommendation. The Bylaws Committee shall submit its recommendations to the Medical Executive Committee.

1.10 SPECIAL (AD HOC) COMMITTEES

The Chief of Staff may appoint special (ad hoc) committees from time to time as may be desirable to carry on the activities of the Medical Staff including, without limitation: Nominating, Finance, and House Staff.

ARTICLE II. AMENDMENTS TO THE COMMITTEE PLAN

With the exception of the Medical Executive Committee, any proposed amendments to the Committee Plan must be reviewed and adopted consistent with provisions of the Articles of the Medical Staff Bylaws. Amendments to the Medical Executive Committee Section and any of its subparts can only be amended pursuant to provisions of the Medical Staff Bylaws.

REVISED by the Medical Executive Committee on December 11, 2006
APPROVED by the Board of Directors on February 26, 2007

REVISED by the Medical Executive Committee on March 9, 2009
APPROVED by the Board of Directors on June 22, 2009

REVISED by the Medical Executive Committee on June 10, 2013
APPROVED by the Board of Directors on October 21, 2013

REVISED by the Medical Executive Committee on July 15, 2016
APPROVED by the Board of Directors on July 28, 2016

REVISED by the Medical Executive Committee on September 10, 2018
APPROVED by the Board of Directors on February 27, 2019