



ST. JOSEPH MERCY CHELSEA

**THE BYLAWS
OF THE MEDICAL STAFF
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TABLE OF CONTENTS

	Page
DEFINITIONS	1
INTERPRETATIONAL GUIDELINES	5
ARTICLE I: PREAMBLE	7
ARTICLE II: PURPOSE	8
ARTICLE III: MEDICAL STAFF MEMBERSHIP	
3.1 Nature of Staff Membership	8
3.2 Basic Requirements and Responsibilities for Those Seeking or Holding Medical Staff Membership and/or Privileges	8
3.3 Hospital-Focused Considerations for Those Seeking or Holding Medical Staff Membership and Privileges	12
3.4 Requirements for Completing Histories and Physicals (H&PS)	13
3.5 Ethical and Religious Directives and Ethical Relationships	13
3.6 Special Responsibility Regarding Material Inaccuracies or Omissions	14
3.7 Dues and Special Assessments	14
3.8 Provisional Status	14
3.9 Insufficient Activity	15
3.10 Leave of Absence	16
3.11 Resignation	16
3.12 Non-Discrimination	16
ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF	
4.1 Primary Active	17
4.2 Associate Active	18
4.3 Limited Active	18
4.4 Telemedicine	19
4.5 Non-Clinically Active	19
4.6 Medical Administrative Officers	21
4.7 Limitation of Functions	21
4.8 Changing to a Category with More Privileges or Prerogatives	21
ARTICLE V: ADVANCED PRACTICE PROFESSIONALS (APPs) AND ALLIED HEALTH PROFESSIONALS (AHP's)	
5.1 Advanced Practice Professionals	21
5.2 Allied Health Professionals who are Not Advanced Practice Professionals	22

ARTICLE VI: INITIAL APPOINTMENT AND REAPPOINTMENT

6.1	General	22
6.2	Special Definitions for Appointment and Reappointment	22
6.3	Application for Initial Appointment and Reappointment	23
6.4	Requirements for Appointment and Reappointment	23
6.5	Processing the Application	24
6.6	Reappointment Process and Renewal	26
6.7	Reapplication After Adverse Appointment or Reappointment Decision	27
6.8	Requests for Modification of Appointment or Privileges	27
6.9	Conditional Grants of Privileges	27
6.10	Reinstatement after Termination	28
6.11	Electronic Signature	28

ARTICLE VII: PRIVILEGES

7.1	Exercise of Privileges	28
7.2	Delineation of Privileges	28
7.3	Special Conditions for Dental and Podiatric Privileges	29
7.4	Temporary Privileges	29
7.5	Emergency Privileges	31
7.6	Visitors, Observers and Non-Physician Consultants	31

ARTICLE VIII: CORRECTIVE ACTION

8.1	Corrective Action for a Specific Reason	31
8.2	Disruptive Behavior	32
8.3	Impairment	32
8.4	Alternative Action	32

ARTICLE IX: OFFICERS OF THE MEDICAL STAFF

9.1	Officers of the Staff and Services	32
9.2	Regular Election Process	33
9.3	Nomination Process for Officers	34
9.4	Term of Elected Office	35
9.5	Removal of an Officer of the Medical Staff	35
9.6	Leave of Absence from Officership	36
9.7	Vacancies in Staff Offices	36
9.8	Duties of Elected Officers	36
9.9	Service Chief	38
9.10	Service Vice-Chief	40
9.11	Standing Committee Chairs	41
9.12	Chief Emeritus	41
9.13	APP Advisor	41
9.14	Additional Appointment	41

ARTICLE X: SERVICES OF THE MEDICAL STAFF

10.1	Organization of Services	41
10.2	Assignment to Service	42
10.3	Designation of Contract Service Area	42
10.4	Functions of Service	42
10.5	Service Policies and Procedures	43

ARTICLE XI: MEDICAL STAFF FUNCTIONS AND COMMITTEES

11.1	Introduction	43
11.2	Functions of the Medical Staff	43
11.3	Communication & Coordination with Governance and Administration	44
11.4	Committees	45
11.5	Medical Executive Committee	45
11.6	Participation on other Committees	47
11.7	Focused Professional Practice Evaluation (FPPE) Within an Established Review Committee	48
11.8	Ongoing Professional Practice Evaluation (OPPE) within an Established Review Committee	48
11.9	Conflict Between the Medical Staff and MEC	48

ARTICLE XII: MEETINGS

12.1	General Medical Staff Meetings	49
12.2	Service Meetings	50
12.3	Quorum	50
12.4	Manner of Action	50
12.5	Special Appearance Requirement	51
12.6	Other Attendance Requirements	51
12.7	Rules of Order	51

ARTICLE XIII: CONFIDENTIALITY, IMMUNITY, AND RELEASE

13.1	Definitions	52
13.2	Authorizations and Conditions	53
13.3	Confidentiality of Information	53
13.4	Immunity from Liability	54
13.5	Waiver of Privilege by Health Professional	55
13.6	Releases and Authorizations	55
13.7	Cumulative Effect	55

ARTICLE XIV: GENERAL PROVISIONS

14.1	Professional Liability Insurance	55
14.2	Physical and Mental Health Qualifications Review	55
14.3	Time Limits	56
14.4	Transmittal of Reports	56
14.5	Notices	56
14.6	Board Obligations	56

ARTICLE XV: ADOPTION, AMENDMENT, AND INTERPRETATION OF MEDICAL STAFF BYLAWS, POLICIES AND PROCEDURES

15.1	Nature of Bylaws and Other Medical Staff Documents	56
15.2	Medical Staff Responsibility and Authority	57
15.3	Ongoing Bylaws Review Process	57
15.4	Interpretation	57
15.5	Methodology for Adoption Amendment and Repeal	58

ARTICLE XVI: PROCEDURES TO OPT-IN TO OR OUT OF UNIFIED MEDICAL STAFF

16.1	Unification With Other Medical Staffs	61
16.2	Opt Out From the Unified Medical Staffs	61

ARTICLE XVII: REVIEW PROCEDURES

17.1	Process for Scheduling Hearings	62
17.2	Composition of Hearing Committee For Basic Hearing	62
17.3	Composition of Hearing Committee For Special Hearing	63
17.4	Process For Conducting Hearings	63
17.5	Right to Appeal	64
17.6	Parallel Events or Proceedings	64

DEFINITIONS AND INTERPRETATION

PART 1 DEFINITIONS

Administration: Means the CEO and other officers and administrators involved in the management of St. Joseph Mercy Chelsea.

Advanced Practice Professional or APP: Means a health care professional (other than a Physician, Podiatrist or Dentist) who exercises judgment within the areas of his/her professional competence and the limits established by the Board and the Medical Staff, and in accordance with statutes governing licensure, registration and certification, the Credentialing Policies and Procedures and the Policy Manual. APPs include both individuals who are employed by the Hospital and those who are not employed. APPs are not eligible for Medical Staff Membership. The Board shall designate the categories of health professionals eligible for APP status. An APP shall provide direct patient care at the Hospital only within the scope of his or her Privileges.

Advanced Practice Registered Nurse or APRN: Means a registered nurse recognized as an APRN by the State of Michigan, which includes a certified nurse practitioner, a certified nurse midwife and certified clinical nurse specialists (but not a certified registered nurse anesthetist).

Adverse Action: Means a recommendation, actual or proposed action of the Medical Executive Committee or Board that, according to the Review Procedures Appendix, entitles a Member or Initial Applicant to a basic hearing or special hearing.

Allied Health Professional or AHP: Means a health care provider who is not a Physician, Dentist Podiatrist or a health care professional who is defined as an APP, but is licensed, holds a certificate or such other legal credentials, if any, as required by the State of Michigan, which authorizes the AHP to provide certain professional services and/or is certified by their respective professional association. Except as otherwise provided in accordance with Section 5.2 of these Bylaws or the Policy Manual, AHPs shall be credentialed through Hospital human resources mechanisms.

APP Advisor: Means an APP selected in accordance with Article IX as an advisor to the MEC.

Appendix or Appendices: Means the Committee Protocol Appendix, Review Procedures Appendix, and the Health Professional Evaluation, Support and Intervention Appendix, which are considered to be effective extensions of these Bylaws.

Applicant: Means a Practitioner applying for initial Membership and Privileges or Member requesting reappointment of Membership and Privileges.

Approval of/Approved by the Board: Without modification, means the initiation and completion of the Board approval process required by the Hospital corporate bylaws, applicable policies and procedures, and the Medical Staff Bylaws.

Board: Without modification, means the St. Joseph Mercy Chelsea, Inc. Board of Directors or such committee of the Board of Directors to which applicable governance functions have been delegated pursuant to the St. Joseph Mercy Chelsea Inc. corporate Bylaws or the Board's own action.

Board Certified: Means that a Practitioner, if:

- a. A Physician, is certified as a specialist by a specialty board organization, recognized as such by the American Medical Association's Council for Graduate Medical Education or the American Osteopathic Association;
- b. An Oral Surgeon, is specialty licensed as such by the Michigan Board of Dentistry and certified by the American Board of Maxillo-Facial Surgery;
- c. A Podiatrist, is certified by the American Board of Podiatric Surgery.

Whether a Practitioner who does not meet criteria a., b., or c. above will be considered Board Certified is a matter within the sole discretion of the MEC, unless the Board determines otherwise.

Board Eligible: Means a Practitioner has met the educational, post-graduate training and skill qualifications to be eligible to sit for the board certification examination of the specialty Board recognized by the Council for Graduate Medical Education, the American Osteopathic Association, the American Dental Association (if applicable), the American Board of Podiatric Surgery, and:

- a. Has not had the opportunity to meet minimum experience following post-graduate training required by a certifying board before taking its board certification examination; or
- b. Has had one opportunity to take the examination but has not, and the reason is approved by the Medical Staff; or
- c. Has unsuccessfully taken any part of the board certification examination on no more than one prior occasion, unless the reason is approved by the Medical Staff; or
- d. Has successfully passed a prior board certification examination but is not currently recertified in accordance with their certifying board's requirements.

Bylaws: Means (without qualifications) the Medical Staff Bylaws of the Hospital's Medical Staff.

Chief Executive Officer or CEO: Means the individual approved by the Board to act on its behalf in the overall administrative management of the Hospital. Any duty of the CEO may be performed by a person or persons designated by the CEO, directly or by means of an organizational chart that the CEO approves.

Chief Medical Officer or CMO: Means the Physician designated by the CEO to work with Medical Staff leadership on matters of medical administration and quality oversight.

Chief of Staff or COS: Means the Member duly elected in accordance with these Bylaws to serve as the head of the Medical Staff.

Contract Area: Means a Hospital administrative department or Service staffed as to Practitioners, APPs and AHPs by means of an exclusive contract, as described in Section 10.3.

Corporate Board: Means the St. Joseph Mercy Chelsea Inc. Board.

Credentialing Health Organization or CHO: Means an organization engaged in the delivery of, or payment for, health care that examines and monitors, on a critical basis, qualifications of Health

Professionals to participate in the performance of services it delivers or for which it pays on a continuing basis. CHO includes, by way of example and not limitation, a: hospital; health maintenance organization; physician-hospital and physician organizations structured for managed care purposes and accountable care organizations, which credential autonomously (not in total reliance upon a hospital or health system); specialty boards that recertify; some large medical practices. Whether a health organization other than a hospital or an HMO qualifies as a CHO is a matter in the discretion of the MEC.

Credentialing Policies and Procedures: Means those policies and procedures relating to credentialing at the Hospital that have been recommended by the Credentials Committee and the Trinity system-wide credentialing body, and approved by the Board.

Dentist: Means a duly licensed dentist in the state of Michigan who has been awarded the degree of Doctor of Dentistry (DDS) or Doctor of Dental Medicine (DMD).

Ex-officio: Means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights.

Focused Professional Practice Evaluation or FPPE: Means the time-limited evaluation of a Health Professional's competence in performing specific Practice Authority and professional behavior.

Full Majority Vote: Means the affirmative vote of a majority of all voting members of the relevant body (excluding from the whole for such vote only a member who is the subject of such vote).

Good Standing: Means a status describing a Health Professional who: (1) is not currently in arrears in dues payments; (2) has not received or does not continue under modification, limitation or suspension of medical staff appointment or clinical privileges or other practice authority at any hospital or other Credentialing Health Organization, either by formal medical staff action or by a voluntary agreement or memorandum, at any hospital in the previous 48 months; (3) has not had his/her Michigan healthcare provider license suspended or limited for punitive, corrective or rehabilitative purposes in the previous 48 months; (4) is not currently suspended or terminated from participation in any state or federal program; (5) is not currently charged or convicted for any crime related to professional practice or any felony; (6) has no Adverse Action proceedings pending in the Hospital; and (7) has not had recurrent medical record suspensions under the Delinquent Medical Record Policy, as provided in the Health Professional Evaluation Support and Intervention Appendix.

H&P: Means the document in which the history and physical examination is recorded.

Health Professional: Means a Practitioner or APP or other licensed or certified individual provider of health care services who has applied for or has Practice Authority in the Hospital or who is credentialed by Medical Staff processes, including those individuals credentialed by the Medical Staff in accordance with Section 5.2.

Hospital: Means St. Joseph Mercy Chelsea as a corporate entity, or the Hospital facility or other clinical sites operated by St. Joseph Mercy Chelsea that operates in Chelsea, Michigan, depending upon the context.

House Physician: Means a Physician in a residency or fellowship program who holds an unlimited license from the State of Michigan and who is engaged, directly or indirectly, as an

independent contractor or employed by Hospital to provide services in the Hospital on a time-limited basis.

Joint Conference Committee: Means a joint meeting of an even number of representatives of the MEC and Board, which may be initiated on an ad hoc basis by the MEC or Board for the representatives of each body to discuss issues or disagreements and make reports and/or recommendations to the Board.

Letter of Concern: Means a written communication by a Medical Staff Officer, CMO, Service Chief or Medical Staff committee to a Member advising of an area of concern about the Member. A Letter of Concern is intended to be educational and conscious-raising and not in the nature of a disciplinary action. While the fact that such a letter was sent may be referenced in the Member's permanent credentials file, the actual letter will not be placed in the credentials file.

Letter of Reprimand: Means a written communication by the MEC or its designee regarding a finding by the MEC censuring a Member for ethics, conduct or competence that will be placed in the Member's permanent file and is considered a form of formal corrective action.

Medical Administrative Officer: Means a Practitioner, employed by or otherwise serving the Hospital on a full or part-time Hospital-compensated basis, as an Administrator but who has clinical responsibilities as part of that administrative role. "Clinical responsibilities" are defined for this purpose as those involving professional capability as a Practitioner, such as requiring the exercise of judgment with respect to the quality performance of clinical services by others, and would include such individuals who serve as CMO, Medical Director, Medical Staff Physician Advisor and Program Director. If they are not already a Member of another category, they may serve on the Medical Administrative category of the Medical Staff.

Medical Executive Committee or MEC: Means the Executive Committee of the Medical Staff.

Medical Staff: Means the Physicians, Podiatrists and Dentists who are granted Privileges and admitted to the Medical Staff of a Hospital in accordance with these Bylaws.

Medical Staff Documents: Means the Medical Staff Bylaws, Rules, and Appendices.

Medical Staff Physician Advisor: Means a Medical Staff Member who has delegated responsibility for assuring that a certain required Medical Staff function is being accomplished by obtaining Medical Staff input from relevant constituencies, working with designated Hospital staff, and reviewing or developing new policies and procedures as needed to accomplish the required activities in a capacity other than as designated Medical Director or Program Director.

Medical Staff Policy Manual or Policy Manual: Without modification, means the policies and procedures of the Medical Staff.

Medical Staff Year: Commences January 1 and ends December 31.

Member (Capitalized and without modification): Means a member of the Medical Staff.

Officers: Means the Chief of Staff, Vice Chief of Staff, Secretary/Treasurer and Members-At-Large of the MEC.

Officials: Means the Service Chiefs, Vice Service Chiefs, standing committee chairs, Chiefs Emeritus, and APP Advisor.

Ongoing Professional Practice Evaluation or OPPE: Means ongoing collection, verification and evaluation of data relevant to a Health Professional's competence in performing specific Practice Authority and professional behavior.

Oral Surgeon: Means a Dentist who has successfully completed a residency program in oral and maxillofacial surgery accredited by the American Dental Association's Commission on Dental Accreditation, and who holds Michigan specialty certification licensure in oral and maxillofacial surgery.

Peer-Professional Review Function: Means each of the following actions:

- (a) Review of professional practices of the Hospital in an effort to reduce morbidity and mortality;
- (b) Review of professional practices in an effort to improve the care and treatment provided to patients in the Hospital, which shall include monitoring Hospital and Medical Staff Policy Manual, requirements for alternate coverage and consultations, and recommending methods of enforcement and changes when appropriate;
- (c) Review of quality and necessity of care provided to patients in the Hospital;
- (d) Review of preventability of complications and deaths occurring in the Hospital;
- (e) Directing, ordering and requiring the collection of records, data and knowledge in furtherance of its duties; and
- (f) Submittal of reports to the MEC or Board concerning:
 - (i) Findings of the committee's review and evaluation activities, actions taken thereon, and the results of such action;
 - (ii) Recommendations for maintaining and improving the quality of care provided in the Hospital; and
 - (iii) Such other matters as may be requested from time to time by the MEC or Board.

Physician: Means an individual who has been awarded the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathic Medicine (D.O.) and is duly licensed to practice the same in the state of Michigan.

Physicians Assistant or PA: Means an appropriately licensed physicians assistant who has a practice agreement in place that complies with Michigan law.

Podiatrist: Means an individual who has been awarded the degree of Doctor of Podiatric Medicine (P.M.) and is licensed to practice such in the state of Michigan.

Practice Authority: Means Privileges for a Practitioner, Privileges for an APP and Service Authority for an AHP.

Practitioner: Means an individual who is a Physician, Dentist or Podiatrist, as defined herein.

Privileged Practitioner: Means Medical Staff Members, as well as Practitioners who hold Privileges but are not Medical Staff Members.

Privileges (capitalized and except as otherwise modified): Means the permission or other authorization granted to a Member or a House Physician, in accordance with these Bylaws to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services at the Hospital. Privileges are listed on the appropriate individual or specialty Privileges form for the individual's Service or clinical specialty.

Professional Practice Evaluation Committee or PPEC: Means the Professional Practice Evaluation Committee, as described in the Health Professional Evaluation Support and Intervention Appendix.

Program Director: Means the director, chief, chair, etc., of a recognized clinical program in any clinical facility in which the Practitioner has been practicing; when used with regard to recommendations, in the event that the director, chief or chair of such program is unavailable or would have a conflict of interest supplying information concerning a Practitioner or APP, it shall mean and include an "assistant director" or an "immediate past" director who has knowledge of the specialty practice of the Practitioner for whom such recommendation is furnished.

Review Procedures: Means the procedures set forth in Appendix I of these Bylaws. Formerly known as the Fair Hearing Plan in versions of the Bylaws prior to 1999.

Rules (capitalized and without further modification): Means the rules of the Medical Staff.

Service: Means a clinical administrative subdivision of the Medical Staff as more fully described in Article IX.

Service Authority: Means, the specific patient care functions that an AHP is authorized to perform that are comparable to clinical Privileges for a Physician.

Simple Majority Vote: Means the affirmative vote of a majority of the members of a relevant body present at a meeting at which a quorum is present (excluding from the whole, for such voting only, a member who is the subject of such vote).

SJMHS: Means Saint Joseph Mercy Health System, a Michigan nonprofit corporation and regional health ministry of Trinity.

Special Notice: Means written notice that is transmitted by any two of the following methodologies: (1) personal delivery; (2) registered or certified mail, return receipt requested; (3) mail by a nationally recognized overnight delivery service; (4) email to the email address then on file with the Hospital; (5) secure messaging systems utilized by the Hospital (currently HALO), to the person to whom the notice is directed.

Supervisory Member: Means a Practitioner who is a Member and who is approved pursuant to these Bylaws to supervise the exercise of Privileges by an Advanced Practice Professional and/or Service Authority by an Allied Health Professional.

Telemedicine Practice Authority: Means Practice Authority that authorizes provision of clinical services to Hospital patients by a Health Professional from a distance via electronic communications, which are equivalent to Privileges for a Member.

Temporary Absence: Means an occurrence when an individual is unavailable to perform his or her functions for a period of three (3) months or less.

Trinity: Means Trinity Health-Michigan, a Michigan nonprofit corporation.

Voting Member: Means an individual who is eligible to vote at the applicable committee meeting, Medical Staff meeting or election process.

PART 2 Interpretational Guidelines for These Bylaws:

Terms used shall be read in the singular or plural, as the context requires.

When one gender is used in these Bylaws, the term shall represent the masculine, feminine or neuter gender.

Use of the word “including” in these Bylaws is not intended to be exclusive and is the equivalent of “including, but not limited to.”

The word “or” is intended to be disjunctive (alternatives) and not exclusive unless the context clearly requires otherwise.

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 provisions of the Bylaws.

Unless these Bylaws expressly require otherwise, references to the Chief of Staff, a Service Chief, or the Chair of the Credentials Committee include that individual’s qualified designee, who is selected and authorized pursuant to these Bylaws to act in the individual’s place and stead during a Temporary Absence or, if the Bylaws contain no such designation, who is authorized to act by resolution of the MEC. Unless these Bylaws expressly require otherwise, references to the CEO or CMO include that individual’s qualified designee who is selected and authorized to act in the CEO’s or CMO’s place and stead directly or in accordance with Hospital administrative policy.

ARTICLE I: PREAMBLE

WHEREAS, St Joseph Mercy Chelsea is a hospital within the ambit of Saint Joseph Mercy Health System (“SJMHS”), a regional health ministry of Trinity Health-Michigan, a Michigan nonprofit corporation and the University of Michigan Health System; and

WHEREAS, Hospital’s purpose to provide patient care, research and other services promoting good health; and

WHEREAS, laws, regulations, customs, and generally recognized professional standards that govern hospitals require that all Physicians practicing at a hospital be formally organized into a body of professionals that constitute the hospital’s medical staff; and

WHEREAS, it is recognized that the medical staff of a hospital is accountable to the Board for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Board, and that the cooperative efforts of the medical staff, hospital executives and the Board are necessary to fulfill the hospital's obligations to its patients;

NOW THEREFORE, the Practitioners practicing in Hospital hereby organize themselves into a medical staff in conformity with the Medical Staff Documents and the corporate bylaws and policies of Hospital and SJMHS.

ARTICLE II: PURPOSE

The purpose of organizing the Medical Staff is to promote quality medical care by bringing Health Professionals who practice at the Hospital together into a cohesive body. To this end, among all other activities, the Medical Staff will provide a mechanism by which Members may meaningfully participate in policy making and planning within the Hospital; review and make recommendations regarding Applicants for Medical Staff appointment, and granting of Privileges to Practitioners and to Advanced Practice Professionals (as appropriate); review and make recommendations for appropriate action regarding quality of care issues related to competence or conduct; make recommendations regarding such to the Board; evaluate and assist in improving the clinical work of Health Professionals; participate in graduate medical education, participate in medical research; and make recommendations to the CEO and the Board. In carrying out its purpose, the Medical Staff shall act in coordination with Hospital executives and under the overall authority of the Board. In fulfilling these Purposes, the Medical Staff shall conduct all its affairs involving Medical Staff, patients and employees in a professional and ethical manner and in an atmosphere free of discrimination.

ARTICLE III: MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF STAFF MEMBERSHIP

Membership on the Medical Staff of, and Privileges at, the Hospital are considered a privilege, and not a right, that shall be extended by the Board to professionally competent Practitioners who continuously meet the qualifications and requirements set forth in these Bylaws and Policy Manual. The Medical Staff shall make recommendations to the Board regarding the granting and continuation of Membership and Privileges.

3.2 BASIC REQUIREMENTS AND RESPONSIBILITIES FOR THOSE SEEKING OR HOLDING MEDICAL STAFF MEMBERSHIP AND/OR PRIVILEGES

To be a Member and hold Privileges a Practitioner must, at the time of appointment, establish to the MEC and the Board, compliance with the Bylaws and Policy Manual and thereafter, if appointed, must continuously fulfill the following basic requirements and responsibilities:

3.2.1 Education. Graduation from an Accredited professional school or program generally recognized for its quality of education, which meets the requirements for graduate education necessary for board certification by a specialty board as specified below.

3.2.2 Licensure.

- a. Current and legal licensure in good standing for practice in the Practitioner's profession by the State of Michigan;
- b. Current Federal Drug Enforcement Administration (DEA) Registration Certificate and/or Michigan Board of Pharmacy Controlled Substance License if it is necessary to exercise the Privileges sought or granted.

3.2.3 Background Experience and Competency. Documentation of qualifications will include, without limitation, background, education, training, experience, judgment, and demonstrated clinical competence and a fund of knowledge that are sufficient to demonstrate to the satisfaction of the Board that the Practitioner can capably and safely exercise Privileges within the Hospital. Members of the Medical Staff shall be Board Certified or Board Eligible in the Practitioner's specialty according to the definitions contained in these Bylaws, or under specific, rare circumstances (e.g. unanticipated events not the responsibility of the Practitioner or for special needs of Hospital) otherwise demonstrate education, training, experience and qualifications which are equal to or greater than that expected of a Board Certified Practitioner in the field in which that Practitioner wishes to practice. The foregoing notwithstanding, Board Certification or Board Eligibility shall not be required for House Physicians in the Limited Active Category or for general Dentists so long as no recognized procedure exists for general dentist Board Certification. Under special circumstances, an Applicant requesting appointment to Visiting or Medical Administrative categories only may request MEC waiver of this requirement. Members are required to take certification and recertification exams if required to maintain Board Certification. If the examination is failed, the Member is required to retake the exam at the first available time. If there are further failures, the Member must continue to take the examination at the first available time, as more fully explained in the Medical Staff Policy Manual.

3.2.4 Resource Use. Demonstrate effective and efficient use of resources in accordance with Trinity's Code of Conduct Supplement for Medical Staff.

3.2.5 Ethics. Adherence to the ethics of the Member's profession and maintenance of the Member's good reputation, regardless of profession.

3.2.6 Work Cooperatively With Others. Demonstrated interest, conduct and ability to work cooperatively and harmoniously with the Board, Corporate Board, Administration, staff, patients and other Health Professionals so that the Hospital and Medical Staff can operate in an orderly, productive manner that promotes efficient, high quality patient care, supports patient safety and patient rights, rules and policies and promotes the community's confidence in the Hospital and its staff.

3.2.7 Physical and Mental Capacity to Practice. Freedom from physical or mental illness, or injury, or chemical dependency that would interfere with the Member's ability to safely exercise Privileges. In this respect, the MEC and/or Board may mandate universal substance testing and/or pre-condition the exercise of Privileges upon the Applicant undergoing a physical and/or mental health examination conducted by one or more health care professionals selected in accordance with the Medical Staff Documents.

3.2.8 Recognized Quality of Care. Provision of care at the professional level of quality and efficiency, as recognized by the Medical Staff and within the scope of the Member's Privileges. This includes demonstrated ability to effectively meet the needs of patients and

the expectations of other stakeholders with an interest in quality and efficiency of care delivered. When appointed as a Member, each Member shall meaningfully fulfill his/her role in continuity of care for his/her patients that meets the prevailing standards of quality and efficiency, including:

- a. exercising sound medical judgment commensurate with training and experience,
- b. recognizing and staying within one's limitations, and
- c. seeking consultation and advice from recognized sources of information when there is any indication of the need for such.

3.2.9 Compliance with Medical Staff Documents. Compliance with the Medical Staff Documents and the Policy Manual, as well as all policies and procedures of the Hospital, as applicable to Practitioners.

3.2.10 Discharge of Medical Staff Responsibilities. Discharge of such Medical Staff and Hospital functions for which the Member is responsible by appointment, election, or otherwise, including meaningful service on Medical Staff, Hospital and Board committees, as appointed.

3.2.11 Charitable Care. Assist the Hospital in fulfilling its responsibilities for providing charitable care to patients.

3.2.12 Timely Completion of Records. Preparation and timely completion of medical and other required records, including H&Ps, for any patients admitted or in any way cared for by the Member at the Hospital, including all affiliated facilities and services, as may be more fully explained in the Medical Staff and Hospital policy manuals.

3.2.13 Compliance with Law. Demonstrated compliance with applicable local, Michigan and Federal law regarding medical practice. This includes not giving to, or receiving payment from, another provider or supplier, either directly or indirectly, any part of a fee received for professional services, except where legitimate agreement for services or an employee relationship exists.

3.2.14 Minimum Activity. Meet requirements, as may be delineated in Policy or established by the Medical Executive Committee (MEC) or Services, for sufficient activity to permit adequate review and assessment of the Member's competence.

3.2.15 Risk Management. Cooperatively participate in the Hospital's programs for risk management, promote patient, staff and visitor safety and support activities designed to address risk management issues.

3.2.16 Proximity of Practice/Residence. Meet proximity of practice and/or residency requirements that may, pursuant to the Bylaws, be recommended by the MEC and approved by the Board, unless exempted by specific action of the Board in the interests of the Hospital and/or its patients, which assure that the Member is close enough to provide timely and responsive care to the Member's patients, and in all cases arranges for alternate care for the Member's patients when the Member is not available.

3.2.17 Evidence of Financial Responsibility. Shall provide evidence of maintenance of professional liability insurance of the nature and limits specified by the Board if the Member holds Privileges. This requirement does not apply to Members who do not hold Privileges.

3.2.18 Preserve Confidentiality. Preserve and affirmatively protect confidential patient, Hospital and Medical Staff information, except as appropriately authorized through the Hospital or as otherwise required by law.

3.2.19 Reporting of Resignations Lapses and Adverse Action Procedures. Report to Office of Medical Affairs in a timely manner relevant facts and documents regarding whether any of the following have ever been voluntarily or involuntarily denied, limited, modified, not renewed (due to lapse or otherwise), reduced, relinquished, resigned, restricted, revoked, sanctioned, subject to probationary terms, surrendered, suspended, terminated, withdrawn or ever been or are currently subject to pending potential disciplinary or corrective action(s), challenges, investigations or other discipline regarding:

- a. medical staff appointment or employment at any healthcare facility or managed care entity;
- b. privileges at any healthcare facility or managed care entity;
- c. state or federal health insurance program (i.e., Medicare, Medicaid, Tricare);
- d. membership in any local, state, or national professional organization or society;
- e. professional license to practice in this or any other state;
- f. DEA registration and/or Michigan Controlled Substance license; and
- g. specialty board certifications

In addition, it shall be the responsibility of each Member to report to the Office of Medical Affairs any absence from clinical practice of more than eight (8) weeks or any formal leave of absence (medical or administrative) from an educational or other health care employer. The Member will include substantive information regarding the reason(s) for the absence.

3.2.20 Continuing Education. Participate in continuing education programs and activities that relate, in part, to the Member's delineated Privileges and meet State licensure requirements.

3.2.21 On-Call and Consultation Requirement. Participate in providing inpatient consultations, Emergency Room consultations and inpatient attending coverage for those patients who are not under the ongoing care of a Member, according to on-call coverage mechanisms described in the Medical Staff Documents and/or MEC procedures.

3.2.22 Participation in Medical Education. Participate in the education process for fellows, residents or medical students who are involved in the care of the Member's patients and assume all education-related responsibilities if serving as a faculty member of an

academic program affiliated with the Hospital (including but not limited to medical education, response time, teaching assignments, and clinic and services assignments).

3.2.23 Peer Review and Quality Improvement Process. Participate in, and provide information, as requested, for peer review and quality improvement activities, including practice evaluation processes (e.g., FPPE and OPPE).

3.2.24 Reappointment. Respond appropriately to requests for application for reappointment or be deemed to have voluntarily resigned.

3.2.25 Reporting of Legal Actions. Report within forty-five (45) days to the Chief of Staff and CMO (through the Office of Medical Affairs) the facts and circumstances of any judgment or settlement arising from professional practice in civil cases, any current formal criminal charges (e.g., indictment), and any conviction of a felony or any other conviction of a crime specific to the Member's professional practice.

3.2.26 Impairment. Report in a timely manner to the Chief of Staff if believing that oneself may be or is impaired, or is subject to a rehabilitation program through the Michigan Health Professionals Recovery Program, or other program approved by the Medical Staff as is more fully explained in the Medical Staff Policy Manual.

3.2.27 Use of Hospital Name. Not use the Hospital's name or other service marks in any commercial message, advertisement, or other writing for the purpose of promoting the services of the Member, or any entities of which he or she is owner, partner, shareholder, or employee without the advance written authorization of the CEO.

3.2.28 Reporting of Dangerous Contagious Disease. Report immediately to the COS if he or she contracts a contagious disease which is reportable to public health authorities under law and which could endanger the health of the patients, the Member, or others working with the Member if the Member practices within the Hospital.

3.3 HOSPITAL-FOCUSED CONSIDERATIONS FOR THOSE SEEKING OR HOLDING MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

In addition to the professional qualifications and competence of a Practitioner (or any other Health Professional), appointments and grants of Privileges shall take into account the present and future needs of the Hospital and the community it serves. Denial of Membership and/or Privileges solely for these Hospital-focused considerations is not, and will not be, considered an expression as to the competence or professional conduct of the Practitioner as an Applicant. These Hospital-focused considerations include the following:

3.3.1 Service Continuity. Maintains a continuity of service on the Medical Staff and in the Hospital;

3.3.2 Adaptation. Adapts to changes in medical science, including the provision of new skills to meet the constant and rapid evolution of medical science and technology;

3.3.3 Hospital Programs. Supplies the medical skills and experience necessary for the continued ability of the Hospital or Medical Staff to carry out the programs and projects of the Hospital;

3.3.4 Quality and Efficiency. Delivers quality care in an efficient manner; first taking into account patient needs and understanding the nature and limited resources of the Hospital and utilization standards in effect at the Hospital;

3.3.5 Adequate Facilities. Hospital has adequate facilities and supportive services for the Practitioner and the Practitioner's patients;

3.3.6 Hospital Needs. Hospital needs the professional skills of the Practitioner for the delivery of care to its patients;

3.3.7 Available Services. Hospital has existing, available and sufficient services which are redundant to the services offered by the Practitioner; and

3.3.8 Contractual Obligations, Board Actions, Corporate Board Actions and Organizational Plans. Is consistent with Hospital contractual obligations, Board actions, Corporate Board actions and organizational plans.

3.4 REQUIREMENTS FOR COMPLETING HISTORY AND PHYSICAL EXAMINATIONS.

The medical history and physical examination shall be completed and documented through an H&P by a Member who is a Physician or, subject to Section 7.3, an appropriately trained Oral Surgeon, or Podiatrist with Privileges to do so, or by an APP with the Privileges to do so. The history and physical examination must be completed in accordance with other Medical Staff Documents or Policy Manual, which may set more focused requirements, but shall, at a minimum, comply with the following:

a. For inpatient admissions and certain outpatient procedures: Completion of the history and physical examination and H&P no more than thirty (30) days before, or twenty four (24) hours after, inpatient admission and in any event before inpatient or outpatient surgery or procedure requiring anesthesia (other than local). If the history and physical examination was conducted more than thirty (30) days prior to admission and/or surgery/anesthesia, a legible copy of the H&P may be placed in the patient's hospital record, provided the history and physical examination was performed and recorded by a Privileged Practitioner or APP, and an updated history and physical examination and H&P that includes all additions to the history and any subsequent changes in the physical findings is performed and recorded by a Privileged Practitioner or APP whose Practice Authority permit them to do so, no later than twenty four (24) hours after admission and prior to surgery or a procedure requiring anesthesia. Additional requirements regarding histories and physicals are defined in the Medical Staff Documents.

b. For other outpatients: A history and physical examination sufficient to support the services being provided is required for all outpatients that includes the elements defined in Policy Manual.

3.5 ETHICAL AND RELIGIOUS DIRECTIVES AND ETHICAL RELATIONSHIPS

The Ethical and Religious Directives for Catholic Health Care Services and principles of the Medical Ethics of the American Medical Association, or Code of Ethics of the American Dental Association, or the Code of Ethics of the American Podiatric Medical Association, or Code of Ethics of the American Osteopathic Association, and the Trinity Health and SJMHS Code of Conduct shall govern the professional conduct of all Health Professionals. Furthermore, it is

understood that any Health Professional who violates the provisions of any applicable code of ethics enumerated above shall be subject to reduction or loss of Membership, as applicable, and/or Practice Authority, in accordance with the procedures provided in these Bylaws. A copy of the Ethical and Religious Directives for Catholic Health Care Services will be provided to each Health Professional during the initial appointment process and as changes in the document occur.

3.6 SPECIAL RESPONSIBILITY REGARDING MATERIAL INACCURACIES OR OMISSIONS

Each Practitioner seeking or holding Membership shall timely provide materials and information in the application and reappointment processes and when otherwise requested by the Medical Staff or Hospital necessary to document their qualifications including, and without limitation, the Practitioner's background, education, training, experience, judgment, mental and emotional stability, ethics, demonstrated clinical competence, conduct, and ability to work harmoniously with Physicians, patients, Hospital employees, Administration, the Board, and the Corporate Board as well as resolving any doubts about these or any other qualifications. This may include providing office patient records, when requested, as part of the appointment or reappointment process or other professional/peer review. This responsibility includes obtaining meaningful and timely responses to Hospital reference requests from persons the Hospital deems appropriate. The Practitioner shall further have the responsibility of completing any application or reappointment form or responding to inquiries during credentialing or peer review in a full, complete and honest manner and to update any information which changes while the application is pending. In this respect, if the Practitioner has any doubt as to whether disclosure of any information is required during the application or reappointment process, the Practitioner shall disclose the information with an explanation of the Practitioner's uncertainty as to whether the information is required or not. Sanctions for non-compliance with this provision may range for a new Applicant from no further processing of the application or rejection of the application, and for a Member from reprimand to rejection of the reapplication or immediate voluntary relinquishment of Membership and Privileges. Sanctions will depend upon the significance and willfulness of the inaccuracy or omission as determined by the MEC. It is the Applicant's burden to satisfy the Hospital and resolve any doubt about his/her qualifications.

3.7 DUES AND SPECIAL ASSESSMENTS

Annual dues shall be established by the MEC. Special Assessments may be approved by vote of the Medical Staff. The MEC may also establish time limits for payment, lower dues for timely payment and/or penalties for failure to timely pay in a timely fashion.

3.8 PROVISIONAL STATUS

3.8.1 Duration. Initial appointments to the Medical Staff, any additional Privileges granted after initial appointment, and Members who are changed to a Category with more Privileges and prerogatives due to an increase in their activity at the Hospital shall be Provisional for a period of no less than one (1) year.

3.8.2 Waiving Provisional Appointment. The requirement that a Practitioner's initial appointment be Provisional may be waived or reduced by a unanimous vote of the MEC, with final Approval by the Board. A waiver may be considered in the case of an extensively experienced Practitioner, or in such other circumstances wherein a Provisional period is deemed an unnecessary use of Hospital, Staff and Member time and resources (e.g., Contract Area Practitioners who are closely overseen by experienced Members also in

the Contract Area). Additionally, Provisional status is automatically waived for new Members in Non-Clinically Active category, unless the MEC decides otherwise.

3.8.3 Individual Review of Provisional Status Members.

a. The practice of each Practitioner on Provisional status shall be subject to individual review during the first year of practice and such additional periods of Provisional status as the Service Chief directs, with the Credentials Committee's concurrence.

b. The scope, nature and method for reviewing a Practitioner on Provisional status shall be determined by the appropriate Service Chief, taking into account the Practitioner's post-graduate training, experience at other institutions, the type of Privileges sought and granted, recommendations given, the ability demonstrated during any earlier periods of special review; and Service requirements. The means of individual review selected by the Service Chief shall be reported to the Credentials Committee and then to the MEC. The MEC, in its discretion, may alter the individual review.

c. The Service Chief will report the results of the individual review prior to the end of the Provisional period.

3.8.4 Provisional Status Continuance. Prior to the end of the first year of the Provisional period, upon the written recommendation of the Service Chief, the Credentials Committee may recommend to the MEC continuing the Provisional status of the Practitioner for one (1) year or less.

3.8.5 Restrictions. During the Provisional period, a Member of the staff shall have such other prerogatives and be subject to such other restrictions for that category of the Medical Staff as are set forth in these Bylaws with the exceptions that there will be no prerogative to vote or to hold office as an Officer or Official, regardless of category. However, Provisional status Members may serve as special or ad hoc committee chairs. During the Provisional period, non-Member Privileged Practitioners shall have such prerogatives and be subject to such other restrictions as determined by the MEC, Board and/or the terms of a contractual arrangement with the Hospital.

3.8.6 The failure of a Member to qualify for removal of Provisional status within two (2) years after initial appointment to the Medical Staff shall require non-renewal of appointment and Privileges at the time of reappointment review. Such provision shall not apply to Practitioners for whom Provisional status is not required or has been waived.

3.9 INSUFFICIENT ACTIVITY (FOR MEANINGFUL REVIEW)

3.9.1 A Member (except those in Non-Clinically Active Categories as described in Article IV) must have sufficient activity to permit adequate review and assessment of the Member's capabilities. As may be more fully explained in the Policy Manual, if a Provisional Member (or a regular Member at the time of reappointment), has had insufficient activity in the Hospital to meaningfully assess the Member's professional capabilities, the Member may withdraw from the Medical Staff or may submit evidence satisfactory to the MEC of sufficient activity of acceptable quality at another health care facility. If another health care facility is recognized by the Credentials Committee as being

consistently reliable, the need to provide detailed documentation for reappointment after the initial reappointment may be adjusted by the Credentials Committee. Failure of the Member to comply may cause the MEC to recommend a voluntary resignation of Membership and Privileges and so notify the Member after obtaining the recommendation of the relevant Service Chief.

3.9.2 A Practitioner deemed to have resigned in such a manner may reapply as an initial Applicant only when the Practitioner can demonstrate to the satisfaction of the MEC that the Practitioner will have sufficient activity to permit adequate review and assessment of the Member's capabilities if again appointed.

3.10 LEAVE OF ABSENCE

3.10.1 Health Professionals wishing to apply for a Leave of Absence must submit a written request explaining precisely the purpose and proposed duration of the leave. The leave may not be less than thirty (30) days nor exceed one (1) year (except for military service) and may be granted within the discretion of the Board. One extension (resulting in total leave of absence not to exceed 24 months) may be granted by the Board, in its discretion, upon the written request of the Health Professional. The Credentials Committee shall consult with the relevant Service Chief and provide the Board with a recommendation with respect to all requests for Leave of Absence and extensions thereof. The process and timelines for application are further described in the Policy Manual. Health Professionals on Leave of Absence who seek reinstatement of their Practice Authority shall apply for reinstatement in the circumstances and according to the procedure described in the Policy Manual. The MEC may precondition the grant of, and/or return from, a leave absence upon the submission of a summary of the Health Professional's activities while on leave of absence or evidence of recovery if the leave of absence was related to a mental or physical disorder, or upon the execution of a memorandum of understanding with the MEC regarding the responsibilities of a Practitioner while on leave, and expectations necessary to be met upon return from the leave, which expectations may be modified upon return from leave.

3.10.2 If a Member leaves for voluntary or involuntary treatment due to Medical Staff concerns about clinical competence or behavior, the Member will be notified that the Medical Staff will, if it has not already, immediately commence an investigation and any resignation or departure from the Medical Staff will be considered to have occurred "while under investigation", unless a waiver is provided by the MEC.

3.11 RESIGNATION

A Member who intends to voluntarily resign from the Medical Staff shall notify the Credentials Committee in writing. The request shall be deemed accepted once approved by the Credentials Committee, the MEC and the Board.

3.12 NONDISCRIMINATION

The Hospital and Members will not discriminate in the appointment process or practice on any basis which would violate applicable law.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

The Medical Staff is divided into four regular (clinically active) categories, which are Primary Active, Associate Active, Limited Active (which has 2 subcategories for Limited Practitioners and House Physicians), and Telemedicine, and one Non-Clinically Active Category (which has 3 subcategories for Visiting, Honorary and Medical Administrative). Initial appointees to the Primary Active, Associate Active and Limited Active categories shall initially have a Provisional Status designation. Medical Staff categories will be assigned, based on the qualifications outlined below and on a review by the MEC of the patient care volumes, level of participation in appropriate Medical Staff affairs, community need and other relevant factors.

4.1 PRIMARY ACTIVE

4.1.1 Qualifications. The Primary Active category shall consist of those qualified Practitioners whose primary health care organization, as determined by the MEC, is the Hospital by virtue of one or both of the following:

- a. A substantial portion (typically a majority) of the Practitioner's clinical activity is performed at or on behalf of the Hospital, and the Practitioner is generally involved in the clinical affairs of the Hospital and Medical Staff;
- b. The Practitioner does not have regular clinical activity at the Hospital but has high non-clinical participation in Medical Staff activities, including committee work, and seeks to be in the Primary Active Category;

4.1.2 Responsibilities. Primary Active category Members:

- a. Must assume all the functions and responsibilities of a member of the Primary Active category, including emergency service care, and consultation assignments. This includes those who primarily provide outpatient services on Hospital property or in Hospital facilities of the main Hospital campus;
- b. Are encouraged to attend Medical Staff meetings, and shall attend applicable Medical Staff committee meetings and participate in Service activities, as required by the Medical Staff Documents;
- c. Must serve on Medical Staff committees and/or as a Medical Staff Physician Advisor, to which the Member is elected or assigned;
- d. Must maintain activity or other criteria required of the Primary Active category. If not met, the Member may be placed in review for a period of one year or their category may be immediately reassigned. Continued failure to meet the requirement for Primary Active category will result in the Member being asked to request assignment to a different category or be reassigned;
- e. Must faithfully perform the duties of any office or position to which elected or assigned;
- f. Must participate in performance improvement, practice evaluation, monitoring and peer review activities as may be assigned by a Service Chief or a committee chair; and

- g. Must pay dues.

4.1.3 Prerogatives. Except as may be limited for Provisional Members, Primary Active category Members:

- a. Are eligible to attend and vote on all matters in general Medical Staff and appropriate Service meetings, elections and assigned committees;
- b. May serve on committees and act as committee chairs;
- c. May hold Medical Staff office, be a Service Chief or a member of the MEC as delineated in Article IX: Officers of the Medical Staff.

4.2 ASSOCIATE ACTIVE

4.2.1 Qualifications. The Associate Active category shall consist of those qualified Practitioners who provide Medical Staff or clinical activity but do not meet the “primary health care organization” requirements for Primary Active or who do not desire to have Primary Active status.

4.2.2 Responsibilities and Prerogatives. Associate Active category Members:

- a. May serve and vote on committees;
- b. May act as chair of special or ad hoc committees (but not standing committees);
- c. Must assume all the functions and responsibilities of Membership in the Associate Active category, including emergency service care and consultation assignments as defined in Medical Staff Documents and monitored by the MEC, on a regular basis;
- d. May be required to participate in teaching assignments as appropriate;
- e. Are encouraged to attend but are not eligible to vote at general Medical Staff and appropriate Service meetings or elections;
- f. May not serve as an Officer of the Medical Staff
- g. Must participate in performance improvement, practice evaluation, monitoring and peer review activities as may be assigned by Service Chief or committee chairs; and
- h. Must pay dues.

4.3 LIMITED ACTIVE

The Limited Active Medical Staff shall consist of Members who are assigned to one of the following subcategories:

4.3.1 Limited Practitioner Subcategory. These are Members who will temporarily carry out the patient care responsibilities for a Member of the Medical Staff or will temporarily

fill a staff vacancy and have exceeded the time period permitted for temporary Privileges. The application and credentialing process for a Limited Practitioner Applicant will be the same as for an Applicant to a clinically active Membership category. To qualify for Membership in the Limited Practitioner subcategory, Applicants must meet requirements for Medical Staff Membership as delineated in Article III. Practitioners in the Limited Practitioner Subcategory may be subject to recredentialing more frequently than every two (2) years, as determined by the MEC.

4.3.2 House Physician Subcategory. These are House Physicians who provide off-hour or weekend coverage in the Hospital or on the Hospital campus, or provide interpretive services via a telemedicine link. House Physician Members will be reviewed and subject to reappointment annually and limited to a maximum total of three one-year appointments absent a specific waiver for good cause by the MEC.

4.3.3 Prerogatives.

- a. Not eligible to vote, to hold office, or to be a member of a Medical Staff committee;
- b. Not required to pay dues;
- c. May attend Service or Medical Staff meetings.

4.4 TELEMEDICINE

4.4.1 Qualifications. The Telemedicine category shall consist of Practitioners who are recognized by the Medical Staff for their ability to provide specialized services for patients of the Hospital through telemetry and other telemedicine technology (at the request of a Member with Privileges to order such services), but do not reside in the community and are not already in another category of the Medical Staff with Privileges to practice in-person at Hospital facilities. Telemedicine Category Applicants shall provide evidence of the Applicant's proven understanding and ethics of the technology to be used. Telemedicine Members shall be credentialed through standard Medical Staff credentialing processes.

4.4.2 Responsibilities and Prerogatives. Telemedicine category Members:

- a. Are not eligible to vote, to hold office, or to be a member of a Medical Staff committee;
- b. Must pay dues;
- c. May attend Service or Medical Staff meetings.

4.5 NON-CLINICALLY ACTIVE

A Member who is not clinically active may have affiliation with the Hospital in the following subcategories. Members in this category shall not be requested to meet in-Hospital activity requirements for Provisional status or reappointment and shall be required to submit information for appointment and reappointment as described in the Policy Manual.

4.5.1 Visiting Subcategory. Consists of Practitioners qualified for Membership who only want to visit their own patients and participate in a limited way in the activities of the Hospital and its Medical Staff.

- a. May visit their patients only in the capacity of advisor and may communicate with the attending or other treating Practitioners, but may not examine the patient;
- b. Do not have Privileges, pay dues, or vote;
- c. Cannot document in the medical record, including orders, or progress notes;
- d. Are encouraged to attend staff meetings of the Service to which they are assigned;
- e. May attend all professional educational programs of the Medical Staff or Hospital and may serve on committees if requested and if the Visiting Member agrees;
- f. Are not subject to FPPE or OPPE requirements.

4.5.2 Honorary subcategory. Former Primary Active or Associate Active category Members who have retired from medical practice, but who wish to retain affiliation with the Hospital may request appointment to Honorary category.

- a. May attend appropriate Service or Medical Staff meetings and professional educational programs;
- b. May serve on committees if requested and desired by the Member;
- c. Do not hold Privileges, pay dues or vote;
- d. Are not subject to FPPE or OPPE requirements; and
- e. May not visit patients or document in the medical record, including orders or progress notes.

4.5.3 Medical Administrative Subcategory.

- a. Practitioners who meet on the basic qualifications set forth in Article III and are Medical Administrative Officers;
- b. May attend appropriate Service or Medical Staff meetings and professional educational programs;
- c. May and serve and vote as a member of a committee and serve and vote as chair of a special or ad hoc committee (but not standing committee), if requested and desired by the Member;
- d. Do not hold Privileges, pay dues, or vote at Medical Staff meetings;

- e. Are not subject to FPPE or OPPE requirements; and
- f. May not visit patients or document in the medical record, including orders or progress notes.

4.6 MEDICAL ADMINISTRATIVE OFFICERS

Except as otherwise provided in a written contract, the termination of the medical administrative duties of a Medical Administrative Officer who has clinical Privileges or is in a clinically active Membership category, shall not affect the Member's Privileges or Membership. The foregoing notwithstanding, where a Medical Staff Officer has Membership in the Medical Administrative Subcategory, termination of the medical administrative duties of the Medical Administrative Officer shall terminate his/her Membership, unless the Medical Staff Officer applies for, and is approved to join, another category.

4.7 LIMITATION OF FUNCTIONS

The prerogatives set forth under each Medical Staff category are general in nature and may be subject to limitation by special conditions attached to a Medical Staff appointment, by other sections of these Bylaws, the other Medical Staff Documents, the Policy Manual or by policies of the Hospital.

4.8 CHANGING TO A CATEGORY WITH MORE PRIVILEGES OR PREROGATIVES

A Member, whose activity is appropriate for a category with more Privileges or prerogatives, may apply for the higher category. Such application shall be subject to the Medical Staff review process comparable to reappointment except those currently in a Non-Active Category whose application shall be subject to the Medical Staff review process comparable to initial appointment for Membership and Privileges. If successful, a Provisional appointment will be utilized.

ARTICLE V: ADVANCED PRACTICE PROFESSIONALS (APPs) AND ALLIED HEALTH PROFESSIONALS (AHPs)

5.1 ADVANCED PRACTICE PROFESSIONALS

5.1.1 Assignment, Supervision and Compliance. Each APP may furnish patient care at the Hospital only within the limits of the Privileges granted in accordance with these Bylaws and the APP Governance Policy. Each APP acts under the overall supervision of an identified Supervisory Member, acting on the recommendation of the Medical Executive Committee. Each APP shall be assigned to a Service. The APP shall immediately notify the applicable Service Chief in writing if the APP's supervisory arrangement with the Supervisory Member ends. An APP may not be granted Privileges that exceeds the Privileges of the APP's Supervisory Member. The Hospital may grant Privileges that are less extensive than the scope of activities an APP is licensed to perform. APPs shall comply with the requirements imposed by the APP Governance Policy.

5.1.2 Qualifications. APPs must possess a license or registration to practice their profession in the state of Michigan, if applicable. Applications for initial, renewed and increased Privileges will be processed using the procedures and criteria set forth in the APP Governance Policy.

5.1.3 Suspension and Termination. An APP's Privileges may be suspended, revoked, or not renewed in accordance with the APP Governance Policy, as well as in accordance with the terms of any employment or contractual relationship the APP may have with the Hospital and, in the case of Hospital-employed APPs, any applicable Hospital policy.

5.1.4 Conversion from AHP Status. Individuals who have been AHPs prior to the adoption of these Bylaws (and categorization of APPs separately from AHPs), but have been functioning as and otherwise meet the requirements of being an APP described in these Bylaws and the Policy Manual, may be converted to APP designation and status by a written communication to that effect from the CMO and Chief of Staff.

5.1.5 APPs Not Members. An APP is not eligible for Medical Staff Membership and shall not be entitled to either the procedural rights set forth in these Bylaws or its Appendix, the Review Procedures Appendix for Members; however, they are entitled to those rights provided in the APP Governance Policy.

5.1.6 APP Policies. An APP shall be subject to, and governed by, the applicable provisions set forth in the APP Governance Policy and Policy Manual, including but not limited to those specifically regarding APPs.

5.2 HEALTH PROFESSIONALS WHO ARE NOT PRACTITIONERS OR ADVANCED PRACTICE PROFESSIONALS

Generally, all Health Professionals who are not Practitioners who require credentialing through Medical Staff processes (in distinction to Hospital human resources credentialing processes) must be credentialed as an APP. However, where a non-Practitioner cannot be credentialed through a human resources credentialing process, and does not meet the requirements to be considered an APP, such individual shall be jointly credentialed through the relevant Hospital Service and the Credentials Committee, and will be professionally monitored and potentially disciplined in accordance with the APP Governance Policy. For any unlicensed individual or individual who requires more of different supervision than an APP, any grant of Privileges must define the scope of supervision required.

ARTICLE VI: INITIAL APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL

The Medical Staff, with the assistance of the Office of Medical Affairs, through its designated Services, committees, Officers and Officials, shall review and consider each application for appointment or reappointment to the Medical Staff and each request for modification of Membership status and Privileges. Associated details of the review process and timelines for processing shall be set forth in the Policy Manual, consistent with these Bylaws.

6.2 SPECIAL DEFINITIONS FOR APPOINTMENT AND REAPPOINTMENT

6.2.1 Favorable. "Favorable", as used in an MEC recommendation or Board action on a Medical Staff application, means a recommendation or action that supports appointment and the same Privileges which are ordinarily possessed by Members of like training, experience, Hospital activity and Medical Staff category, taking into account the Privileges requested.

6.2.2 Unfavorable. “Unfavorable”, as used in these Bylaws, means a MEC recommendation or Board action that is not “favorable.”

6.2.3 Category 1. “Category 1” shall have the meaning ascribed in the Credentialing Policies and Procedures.

6.2.3 Non-Processable Application. As provided in the Credentialing Policies and Procedures, “Non-Processable Application” means that although an application has been satisfactorily filled out, before verification has taken place or, after verification, but before the Credentials Committee has fully reviewed the merits of the application, it has been determined that further processing of the application at that time would be futile based on the objective threshold qualifications in Section 3.2 (e.g., licensure, minimum training) not being met and/or Hospital-focused considerations in Section 3.3 to be a Member.

6.3 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

6.3.1 Application Form. Each Applicant for appointment and reappointment to the Medical Staff shall thoroughly fill out and authenticate an application form (which may include an electronic form) and is responsible for assuring provision of such information that is required in accordance with the Policy Manual and these Bylaws.

6.3.2 Professional/Peer Review Protection. Records, reports, data, knowledge and other material and information collected in the appointment process are deemed to be professional/peer review materials and shall be protected and confidential to the fullest extent of the law, consistent with the Medical Staff Documents.

6.3.3 Membership is a Privilege. Medical Staff Membership is a privilege and no one is entitled to such Membership or the exercise of Privileges in the Hospital merely by virtue of licensure in Michigan, membership in a professional organization, past or present Membership on the Medical Staff, or membership and/or privileges at any other health care organization. Any Practitioner who meets the basic requirements and responsibilities for those seeking or holding Medical Staff Membership and Privileges (see Article III) may apply.

6.4 REQUIREMENTS FOR APPOINTMENT AND REAPPOINTMENT

6.4.1 Authorizations. By applying for appointment or reappointment to the Medical Staff or requesting Privileges, the Applicant:

- a. Signifies the willingness to appear for interviews regarding the application and pursuant to the provisions in Sections 6.4.2, 6.5.8 and 6.6.5;
- b. Authorizes Hospital representatives, as defined in Article XIII, to consult with former associates or others who may have information bearing on the Applicant’s previous performance and to the inspection of quality improvement materials, including medical records of patients cared for or treated by the Applicant, that may be material to an evaluation of the Applicant’s professional and ethical qualifications;
- c. Extends immunity to, and releases from any and all liability, to the fullest extent permitted by law, its authorized representative(s) or other persons for acts

performed in connection with evaluating the Applicant and the Applicant's credentials and other aspects of the appointment and reappointment process, corrective action, professional and utilization reviews and other matters as may be more fully explained in the Policy Manual. This includes information that would otherwise be privileged or confidential;

d. Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters the Hospital may have concerning the practitioner and releases the Hospital representatives from liability for so doing.

6.4.2 Appear or Answer Questions. Because the Applicant shall have the responsibility of producing information for a proper evaluation of the basic requirements and responsibilities specified in Article III, at any time in the appointment or reappointment review process, the Applicant may be required by the Credentials Committee, the MEC or the Board to answer questions in person or in writing.

6.4.3 Applicant's Burden. Policies are designed to permit review of appropriate information so that the Board is able to grant the privilege of practicing at the Hospital to qualified Applicants. It is the burden of the Applicant to timely provide or assure provision by others of materials and information necessary to document that the Applicant meets the basic requirements and responsibilities according to Article III and qualifies for the Privileges sought. This burden includes providing other information satisfactory to the Hospital for a proper evaluation of all relevant criteria and resolving any doubt about the Applicant's qualifications. The range of sanctions for non-compliance is described in Article III.

6.5 PROCESSING THE APPLICATION

6.5.1 Preliminary Review. If the Applicant does not meet the objective threshold qualifications (e.g., licensure, minimum training) and Hospital-focused considerations in Section 3.3 to be a Member or hold the Privileges sought, the application cannot be further processed and the Applicant will be so notified, as may be more fully explained in the Policy Manual.

6.5.2 Application Processing. If an application form is thoroughly filled out and meets objective threshold criteria and is consistent with Hospital-focused considerations, then verification efforts will be undertaken by the Central Verification Office with the results reported to the Office of Medical Affairs, which will, in turn, appropriately communicate to the Service Chief and Credentialing Committee. During the application process, the Applicant will be responsible for reporting to the Office of Medical Affairs any event that changes information that is required to be reported in Article III. No further action will be taken on an application under consideration until the application is complete in all respects and with all additional information requested by the Hospital having been fully supplied and verified, as may be more fully explained in the Policy Manual.

6.5.3 Credentials Committee Review. Once an application is complete, the application will be considered by the Credentials Committee, which shall forward its recommendations to the MEC. If an incomplete file is forwarded to the Credentials Committee, it may choose

not to review it. The Credentials Committee may make any inquiry it deems reasonably necessary to supply a meaningful recommendation.

6.5.4 MEC Recommendation. The MEC shall make a recommendation to the Board to appoint, appoint with modifications or to reject the application for Membership and request for granting of Privileges. In lieu of making a recommendation for appointment or reappointment, the MEC, if it so elects or if the Board requests, may determine whether the Applicant is qualified or not qualified for the requested Membership and Privileges.

6.5.5 Notice to Applicant.

a. If the MEC's recommendation is favorable, the application will be submitted to the Board without notice to the Applicant for action at the Board's next regularly scheduled meeting or to a Board Committee as may be otherwise described in the Medical Staff Policy Manual.

b. If the MEC's recommendation is unfavorable, the CMO shall advise the Applicant of the unfavorable recommendation by Special Notice. Within thirty (30) days after the receipt of the CEO's notice of an unfavorable MEC recommendation, the Applicant may either voluntarily withdraw the application without the Board taking final action or may pursue options, including Review Procedures as specified in an Appendix to these Bylaws.

6.5.6 Board Review. The Board shall consider those initial applications in which appointment is recommended by the MEC or in which the MEC recommendation is unfavorable, but the Applicant did not timely pursue the option for Review Procedures and did not withdraw the application. If the Applicant requests Review Procedures, the Board will review the matter as part of the appellate process of the Review Procedures Appendix and only if an appellate process is necessary and requested. The Board may invoke Section 6.4.2 during the course of its review. Category 1 applications with favorable recommendations may be reviewed by a subcommittee of at least two members of the Board, provided that the full Board shall have an opportunity to review such subcommittee's recommendation, as more fully described in the Credentialing Policies and Procedures.

6.5.7 Board in Substantial Concurrence with MEC Recommendation. If the Board substantially concurs with an MEC recommendation that is favorable or one that is unfavorable and Review Procedures were not timely requested, the MEC recommendation shall become the final action of the Board.

6.5.8 Contemplated Board Action that Varies Significantly from MEC's Recommendation. Whenever the Board contemplates taking action on an application for Membership and/or Privileges which significantly varies from the recommendation of the MEC, the Board shall refer the matter back to the MEC for further review, with the reasons for its contemplated actions and any additional reasons for the referral stated in writing. Upon receipt of the referral and written reasons, the MEC shall, within thirty (30) days (unless the Board referral provides for a longer time period), reconsider its prior recommendation and either reverse or supplement the prior recommendation by a written report to the Board. In the circumstances where the Board, after receipt of the new MEC report, still contemplates non-appointment or unfavorable action on Membership and/or Privileges that are contrary to an MEC recommendation, the Board shall direct the CEO

to either offer by Special Notice a hearing at the Board level according to the Review Procedures Appendix, or invite the Applicant to appear before the Board at its next regularly scheduled meeting to informally present the reasons why the Board should accept the MEC recommendation, or submit additional written documentation the Applicant deems appropriate in support of the MEC recommendation, and answer questions members of the Board may pose. Failure to timely request a hearing or to appear, when so invited, shall be considered a waiver of this opportunity. After exhaustion of the foregoing processes, if the Board still contemplates action contrary to the MEC recommendation, the matter is referred to the Joint Conference Committee for review and recommendation. The Joint Conference Committee will report to the Board, which will take final action. The CEO shall then notify the Applicant of the Board's final action by Special Notice.

6.6 REAPPOINTMENT PROCESS AND RENEWAL

6.6.1 Medical Staff Action.

a. With the exception of Members on Leave of Absence, Members whose appointments or Privileges are scheduled to expire, will be given a minimum of thirty (30) days to complete a Reappointment and Privileges Application form, the contents of which shall be described in the Policy Manual. This information, other information concerning the Applicant's activity, current competence and behavior will be used by the appropriate Service Chief to formulate a recommendation that will be submitted to the Credentials Committee. The Credentials Committee will review the application, consider the results of OPPE as it relates to the Member, consider, if applicable, the results of any FPPE conducted during the prior term(s), conduct additional review as it deems necessary and will make a recommendation to the MEC. Considering the Service Chief and Credentials Committee recommendations, the MEC will then recommend a course of action to the Board whether to approve, modify or deny the Member's requested appointment, category, status and/or Privileges.

b. Where a Member is on an approved leave of absence, such Member's Privileges, prerogatives and responsibilities are withheld during the period of time of the leave. If the Member's leave of absence was for more than ninety (90) days, or if the Member's current appointment and Privileges expired while the Member is on an approved Leave of Absence, the Member must successfully go through the reappointment process prior to reinstatement to the Medical Staff, as may be more fully explained in the Policy Manual.

6.6.2 Notice of Unfavorable Recommendation of MEC. Whenever an MEC recommendation is unfavorable, the CEO shall promptly notify the Member by Special Notice. Such unfavorable recommendation shall entitle the Member to such procedures as are specified in the Review Procedures Appendix for the particular type of recommendation involved. Failure to timely request review pursuant to the Review Procedures Appendix provisions shall result in the MEC's unfavorable recommendation becoming the final action of the Board unless the Board, in its sole discretion, elects to modify the MEC recommendation.

6.6.3 Board Review. The Board shall consider those applications for which reappointment is recommended by the MEC or in which the MEC recommendation is

unfavorable, but the Applicant did not pursue a hearing option and did not withdraw the application. If the Applicant requests a hearing, the Board will review the matter as part of the appellate process of the Review Procedures Appendix and only if an appellate review is necessary and requested. The Board may pursue the procedures specified in 6.4.2 during the course of its review.

6.6.4 Board Concurrence with MEC Recommendation. If the Board substantially concurs with an MEC recommendation which is favorable, or which is unfavorable and Review Procedures were not timely requested, the MEC recommendations shall become the final action of the Board.

6.6.5 Contemplated Board Action that Varies Significantly from MEC's Recommendation. Whenever the Board contemplates taking action on a Member's application for reappointment and/or Privileges which significantly varies from the recommendation of the MEC, the procedures will be the same as the procedures in Section 6.5.8.

6.7 REAPPLICATION AFTER ADVERSE APPOINTMENT OR REAPPOINTMENT DECISION

Except as provided elsewhere in these Bylaws or the Policy Manual (such as for denial, inaccuracy in the application, insufficient activity to evaluate or non-processable applications placed on hold), an Applicant for appointment or reappointment who is denied shall not be eligible to reapply for Medical Staff Membership and Privileges for a period of three (3) years after the denial is final, unless the decision, or other action of the Board, shall provide otherwise. Further, before submitting a new application, a Practitioner whose application was previously denied or withdrawn, shall be obliged to demonstrate to the satisfaction of the MEC and Board that there is reason to believe the circumstances or information which resulted in previous denial or withdrawal are no longer a factor in the consideration of a new application from such Applicant. Any such reapplication shall be processed as an initial application and the Practitioner shall submit such additional information as the MEC or the Board may require. The basis for any previous denial may again be considered as it may form the basis for denial or withdrawal of the renewed application.

6.8 REQUESTS FOR MODIFICATION OF APPOINTMENT OR PRIVILEGES

A Member may request an increase in Privileges, during the term of an appointment by submitting a written request in accordance with the Policy Manual. Any such request will be processed using substantially the same procedures as for a request for reappointment. A Member may request a decrease in Privileges, during the term of an appointment by written request to the Credentials Committee. The Credentials Committee shall promptly notify the Medical Executive Committee and the Board of any Privileges reductions request that it approves.

6.9 CONDITIONAL GRANTS OF PRIVILEGES

A process for addressing disabilities and the safe exercise of Privileges with or without accommodations will be set forth in the Policy Manual.

6.10 REINSTATEMENT AFTER TERMINATION

If, after voluntary termination of Membership that was not a result of adverse action and not made when adverse action was being considered or during an investigation into the Practitioner's professional competence or conduct, an Applicant requests reinstatement within 30 days of the termination date, then the process of credentialing for initial application will not be required. The application process for reinstatement will be the same as for reappointment. If reinstatement is requested more than 30 days after the termination date, the request for appointment will be treated as a request for initial application.

6.11 ELECTRONIC SIGNATURE

All signatures and acknowledgments required or permitted by the Hospital and Medical Staff may be submitted electronically by an Approved Execution Method. For the purposes of this Section 6.11, an Approved Execution Method is a system, website, application, or other technological method for recording a signature that has been approved by the MEC.

ARTICLE VII: PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every Member providing direct clinical services at the Hospital or in any office or building on the Hospital campus (including the Professional Building, U-M Chelsea Health Center and Chelsea Health and Wellness Center) and other Hospital-owned or leased facilities shall, in connection with such practice, except as provided in this Article VII, be entitled to exercise only those clinical Privileges or provide patient care services as are specifically granted pursuant to the provisions of these Bylaws and as may be more fully delineated in the Policy Manual. Further, patients may be admitted to the Hospital only by those Practitioners with admitting Privileges.

7.2 DELINEATION OF PRIVILEGES

7.2.1 Requests. Each Applicant for appointment and reappointment to the Medical Staff or as a Practitioner seeking Privileges without Medical Staff Membership, will complete a request for desired Privileges with documentation of training and/or experience supportive of the request.

7.2.2 Basis for Privileges Determination.

a. Individual Knowledge and Capabilities. Requests for Privileges related to an Applicant's knowledge and capabilities shall be evaluated on the basis of the: Basic Requirements and Responsibilities as well as the Hospital-Focused Considerations for Appointments delineated in the Bylaws, Article III; the Applicant's education, training, experience, demonstrated ability, judgment, and observed clinical performance, the frequency of exercise of Privileges, and the documented results of the quality improvement/utilization management activities in the Hospital, when required, or at other health care facilities and settings where the Applicant's practice is monitored (if available). Where the Applicant's requested Privileges involve the use of certain device(s) or technology, the Applicant's individual skill, knowledge and experience with the device or technology shall also be considered. Individual Privilege determinations may also be based on pertinent information concerning clinical performance obtained from

other sources including, but not limited to, other CHOs, including facilities where the Applicant exercises Privileges.

b. New Device or Technology at the Hospital. When the Privileges being sought are related to or involve new or advanced technology or device not previously approved and used in the Hospital, such device or technology must be separately approved by Trinity, or an appropriate committee designated to review and credential such technology and device. The Applicant shall have the obligation to demonstrate that using the technology will be beneficial to Hospital patients, such as, but not limited to, being reasonably safe, being in compliance with current professional knowledge/literature, and not otherwise requiring excessive use of Hospital resources.

c. All information shall be added to and maintained in the Office of Medical Affairs confidential file established for the Member.

7.3 SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES

7.3.1 Requests for Privileges from Dentists and Podiatrists shall be processed in the manner specified in the Policy Manual related to appointment and reappointment. Surgical procedures performed by Dentists shall be under general supervision of the Surgery Service Chief or the Chief's designee. A medical assessment shall be done and recorded by a Physician Member (the same as other patients admitted to the surgical services) including a history and physical examination, before dental or podiatric surgery is performed. If the History and Physical examination was performed by a Physician who is not on the Medical Staff, the History and Physical will be reviewed and co-signed by the anesthesiologist. The MEC may designate Oral Surgeons who may perform the physical examinations and prepare the histories for their own patients.

7.3.2 A Physician Member in the Primary Active or Associate Active category shall be responsible for the care of any medical problem that may be present at the time of the dental, oral, or podiatric procedure or admission, or that may arise following such procedure or during hospitalization and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient. The Dentist is responsible for the dental care of the patient, including the dental history and examination, discharge summary, and all other appropriate elements of the patient's record. The Podiatrist is responsible for the podiatric care of the patient, including the podiatric history and examination, discharge summary, and all other appropriate elements of the patient's record. Except in the event of an emergency, the responsible Physician Member shall be identified by the Dentist or Podiatrist Member of the Medical Staff.

7.4 TEMPORARY PRIVILEGES

Temporary Privileges, although generally discouraged, may be granted for no more than one hundred twenty (120) days if needed to fulfill an important patient care, treatment or service need. In situations where professional skills are to be exercised for a limited time only a Practitioner may be granted specific temporary Privileges in accordance with the Policy Manual. Such Privileges shall be Service-specific and may be granted in the categories specified in this Section. Practitioners holding temporary Privileges are not Members.

7.4.1 Application in Process. A Practitioner who has submitted an initial application for Membership, or a Practitioner who has submitted an initial application for Privileges pursuant to Section 6.3, whose application is complete, whose key credentials have been verified, and who is not/has not been subject to licensure sanction, adverse action on medical staff membership or privileges at another facility, or any other disqualifying criteria specified in the Policy Manual may be granted temporary Privileges, including, where appropriate, Telemedicine Privileges, provided that such Practitioner has demonstrated an understanding of the technology to be used for exercise of the Telemedicine Privileges and ethics. Temporary Privileges shall be granted for a limited time only, not to exceed the shorter of one hundred twenty (120) days or pending action by the Medical Staff and Board on a Membership, Privileges application, but always subject to revocation or suspension as provided in the Medical Staff Documents and Policy Manual.

7.4.2 Care of Specific Patients.

a. An appropriately licensed Practitioner who is not an Applicant for Membership may be granted temporary Privileges to care for one or more specific patients when that Practitioner's care is requested by the attending Physician, including, where appropriate, Telemedicine Privileges, provided that such Practitioner has demonstrated an understanding of the technology to be used for exercise of the Telemedicine Privileges and ethics. This will generally be requested when the Practitioner has specific skills, knowledge, or specialty, not otherwise available on the Medical Staff.

b. An Applicant for temporary Privileges in circumstances outlined in Section 7.4.2(a) immediately above will contact the Office of Medical Affairs and request Temporary Privileges. The applicant will be provided an Application Form. This form will be accompanied by, as a minimum, their name, social security number, birth date, Michigan medical and controlled substance license numbers, DEA certificate, specialty board certificate, current professional liability insurance face sheet, picture identification (driver's license or passport) and a signed consent and release section from the Medical Staff Application Form.

c. A Member requesting additional Privileges for the urgent care of a patient or filling a slot as a substitute shall document the medical or practice reason for such a request and the Member's skills, knowledge and experience relevant to the Privilege request, then consult with the Service Chief. The request will be submitted in writing including the Privilege(s) requested and reason why it should be granted. Should the Service Chief have concerns about Hospital's ability to support the requested Privileges, the Member will be asked to review such issues with Hospital Administration.

7.4.3 Approval. Temporary Privileges shall be recommended in writing by the Chief of Staff and the appropriate Service Chief, the CMO, as designee of the CEO, or CEO, and the recommending individual shall have reviewed verification of the education, clinical competence, professional conduct and other basic requirements for Membership (see Section 3.2). Temporary Privileges will be granted by the CEO.

7.4.4 Conditions. In exercising such Privileges, a Practitioner with temporary Privileges shall act under the oversight of the Service Chief for the Service to which he/she is assigned. Special requirements of consultation and reporting may be imposed by the

Service Chief responsible for the oversight of a Practitioner granted temporary Privileges. Prior to Temporary Privileges being granted, an Applicant must agree in writing to be governed by the Bylaws of the Medical Staff and Hospital and the Policy Manual.

7.4.5 Termination. On the discovery of any information pertinent to the qualifications or ability of the person with temporary Privileges, or the occurrence of any event of a professionally questionable nature, the Service Chief responsible for oversight, or the CMO (after consultation with the Service Chief responsible for oversight), or the Chief of Staff, may terminate any or all of such Practitioner's temporary Privileges. In the event of any such termination, any patients then in the Hospital whose care would be affected by such termination, shall be assigned to a Member by the Service Chief responsible for oversight. The wishes of the patient shall be considered, where feasible, in choosing the Member as substitute. The terminated Practitioner shall confer with the Member substitute to the extent necessary to safeguard the patient. The terminated Practitioner shall have the right to an informal review, as provided in Section 1.3 of the Review Procedures Appendix. The terminated Practitioner shall not have any right to a formal hearing.

7.5 EMERGENCY PRIVILEGES

7.5.1 For Treatment of Individual Patients With an Emergency Medical Condition. For the purposes of this section, an "emergency" is defined as a situation in which there is an imminent risk of serious or permanent harm or of death to a patient and any delay in administering treatment would add to that risk. In the case of an emergency, any Practitioner, to the degree permitted by his license regardless of Service, Medical Staff status or Privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the patient from serious harm or death. When any emergency situation no longer exists, such Practitioner will turn over the patient's care to a Member with appropriate Privileges. A Practitioner utilizing emergency Privileges shall promptly provide to the CMO and Medical Executive Committee, in writing, a statement explaining the circumstances giving rise to the emergency. If there is any question as to whether a situation is an emergency situation, as defined here, the Service Chief, the Chief of Staff, CMO or, if unavailable, the Administrator On Call will be contacted.

7.5.2 In the Event of Disaster/Bioterrorism. In the event of a disaster requiring activation of the Hospital's emergency management plan and exceeding the professional resources of the Hospital to meet immediate patient needs, the Chief of Staff or CEO may grant temporary disaster Practice Authority to qualified volunteers in a manner consistent with the Hospital's emergency management plan and the Policy Manual.

7.6 VISITORS, OBSERVERS AND CONSULTANTS

The presence of visitors, observers and consultants in patient care areas shall be managed through the use of a Hospital Policy.

ARTICLE VIII: CORRECTIVE ACTION

8.1 CORRECTIVE ACTION

Members of the Medical Staff shall comply with the requirements for Medical Staff Membership, Medical Staff Documents, and the standards of ethical conduct. Any Officer of the Medical Staff, Service Chief, CMO or the CEO may initiate requests for corrective action, including summary,

automatic and administrative action, in the event of the occurrence of any of the defined criteria for correction action, details of which are set forth in the Health Professional Evaluation Support and Intervention Appendix.

8.2 DISRUPTIVE BEHAVIOR

A Health Professional who meets the criteria for Disruptive Behavior according to the Medical Staff Documents shall be required to proceed through the process specified in such policy. However, nothing therein shall limit the availability of corrective, automatic, administrative or summary action where the frequency or nature of the acts or omissions in question is deemed to require it. Collegial intervention may be used in managing a Health Professional's disruptive behavior, as may be more fully described in the Medical Staff Documents.

8.3 IMPAIRMENT

The Medical Staff Documents will contain a description of policies and procedures to be utilized in considering a situation in which a Health Professional may be or is impaired.

8.4 ALTERNATIVE ACTION

When the MEC believes that corrective action or other traditional means of behavior modification are either not feasible or not as appropriate for remedying a concern with a Health Professional, alternative action procedures may be used. This is a voluntary program that may be more fully documented in the Medical Staff Bylaws.

ARTICLE IX: OFFICERS AND OFFICIALS OF THE MEDICAL STAFF

9.1 OFFICERS AND OFFICIALS OF THE MEDICAL STAFF

The Officers of the Medical Staff shall be the Chief of Staff; Vice Chief of Staff; Secretary-Treasurer; and Members(s)-at-Large as provided in Section 9.8.4. The Officials of the Medical Staff are the Service Chief and Vice Chief of each Service, Chief Emeritus, standing committee chairs, and the APP Advisor.

9.1.1 Qualifications of Officers and Officials. Officers and Officials must meet the following qualifications:

- a. Membership Category or APP Status:
 - i. At the time of nomination, the Chief of Staff must have been a Primary Active member for at least four (4) consecutive years.
 - ii. Member(s)-at-Large must, at the time of nomination, be Primary Active and must have been a Member of the Medical Staff in an Active Category for at least two (2) years.
 - iii. Vice Service Chiefs must have been a Member in an Active category for at least two (2) consecutive years.

- iv. The APP Advisor must, at the time of nomination, be a credentialed APP at the Hospital.
 - v. A Chief Emeritus must be a Member in Good Standing.
 - vi. All other elected Officers and Officials must have been Primary Active Members for at least two (2) consecutive years;
- b. All Officers and Officials must maintain their required Membership category or other status in Good Standing during the time of nomination, election and their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved;
 - c. Have no pending MEC or Board recommendation or action or past final Board action that constitutes an Adverse Action that qualifies for a Special Hearing as defined in the Fair Review/Hearing Plan and has not in the past five (5) years been removed as an Officer or Service Chief. Also, Officers and Officials must disclose any action instituted under Article VII of the Bylaws (or analogous sections of the APP Governance Policy) and the outcome, other than an action that is an Administrative Action;
 - d. Not simultaneously hold a leadership position on another hospital medical staff that would interfere with their ability to effectively serve as an Officer or Official of the Medical Staff;
 - e. Possess leadership capability and be willing to receive training in leadership and management skills;
 - f. Have trusted relationships with other Members;
 - g. Be competent in their fields of practice;
 - h. Have demonstrated qualifications including but not limited to interest, availability, organizational skills, reputation for objectivity and fairness, the ability to consistently work harmoniously with the Medical Staff, Administration, Board, Corporate Board and Hospital employees, and have the respect of peers all of which are necessary to best provide Medical Staff participation in Hospital affairs.

9.2 REGULAR OFFICER ELECTION PROCESS

Regular elections for Officers shall be held in odd numbered years at the Annual Meeting of the Medical Staff. The MEC at its discretion will establish voting procedures consistent with the Bylaws. Voting shall be by secret ballot if there are multiple candidates for the position; voting by proxy shall not be permitted. A nominee shall be elected upon receiving a Simple Majority Vote. If no candidate for the office receives a Simple Majority Vote on the first ballot, a runoff election shall be held at the same meeting between the two candidates receiving the highest number of votes. All Officers elected by the Medical Staff are subject to ratification by the Board. If the Board fails to ratify an elected Officer, the Medical Staff may initiate Joint Conference Committee review.

9.3 NOMINATION PROCESS FOR OFFICERS

9.3.1 By Nominating Committee.

- a. There shall be an ad hoc Nominating Committee composed of three or more Members appointed by the Chief of Staff. The Chief of Staff shall not serve on this committee.
- b. Responsibilities. The Nominating Committee shall be responsible for:
 - i. Identifying nominees for election to general Medical Staff offices and to other elected positions in the Medical Staff organizational structure.
 - ii. Preparing brief biographical summaries if there is more than one nominee for an office.
 - iii. Consulting with Members, the MEC and Administration concerning the qualifications and acceptability of prospective nominees in the nomination process.
 - iv. Convening at least ninety (90) days prior to the annual meeting, when the election shall occur, and submitting to the MEC a list of one or more qualified nominees for each office, attaching a statement of the chair that each nominee has agreed to stand for election to office. The names (and brief biographical summary if applicable) of such nominees shall be reported to the Medical Staff at least sixty (60) days prior to the annual meeting.
 - v. Accepting additional nominations from the Members, when and if adequately supported by a petition in accordance with Section 9.3.2 below.
 - vi. Preparing a written ballot containing the names of nominees for election of Officers and Members-at-Large of the MEC.

9.3.2 By Petition. Nominations may also be made by petition signed by at least ten (10) Members eligible to vote, five (5) for Member-at-Large, to which is attached a statement signed by the nominee attesting to the willingness to stand for election to the office. These documents shall be filed at the Office of Medical Affairs at least thirty (30) days prior to the annual meeting. As soon after filing of a petition as is reasonably possible, the name(s) of these additional nominee(s) and a brief biographical summary shall be reported to the Medical Staff, but not less than fourteen (14) days before the annual meeting.

9.3.3 By Other Means. Before the election, if all of the individuals nominated for an office shall be disqualified from, or otherwise be unable to accept, nomination, then that office shall not be filled by vote at the annual meeting. The Nominating Committee shall convene again within thirty (30) days and shall submit to the MEC a list of one or more qualified nominees for each office, to which is attached a statement from the chair that each nominee has agreed to stand for election to office. The MEC shall determine the date of the special election and then a process similar to that described above will be used.

9.4 TERM OF ELECTED OFFICE FOR OFFICERS

Each Officer shall serve a two (2) year term that shall begin on the first day of the Medical Staff year following election and continue until a successor is elected and takes office, unless the Officer is earlier removed or is unable to serve. Prior to the end of an individual's third consecutive term (and each subsequent term thereafter), the Medical Executive Committee may, within its discretion, by a 2/3 majority vote, extend the individual's eligibility for reelection for one additional two-year term, subject to ratification by the Board. Otherwise, an Officer of the Medical Staff shall serve no more than three (3) two-year terms consecutively, after which the Officer is not eligible for election to the same office for a period of two (2) years.

9.5 REMOVAL OF AN OFFICER OF THE MEDICAL STAFF

9.5.1 Removal by the Medical Staff.

- a. Grounds for Removal. In addition to automatic removal pursuant to the loss of Good Standing in Section 9.1.1(b), grounds for removal by the Medical Staff shall include an inability and/or unwillingness and/or failure to perform the duties and responsibilities of the assigned office and/or no longer meets the qualifications for an Officer.
- b. Initiation. Action directed toward removing an Officer from office may be initiated by submission to the Medical Executive Committee of a petition seeking removal of an Officer, including an explanation for the requested action. A petition must be signed by not less than twenty five (25) voting Members.
- c. Medical Staff Vote on Petition. The petition will be presented to the next meeting of the MEC, which shall verify the signatures and the requisite number. If the petition complies with this section, the MEC shall call a special meeting of the Medical Staff to vote on the issue. Such meeting shall be held within thirty (30) days of MEC action. The announcement of the meeting will include an explanation for the requested action. The involved Officer shall be given the opportunity to provide a written response that shall be included with the announcement.
- d. Removal Vote. Removal of an Officer by the MEC shall be effected by a Full Majority Vote after an opportunity is provided for discussion at the Special Meeting of the Medical Staff as noted above. Voting shall be by secret ballot; voting by proxy shall not be permitted.

9.5.2 Removal by the Board. The Board may remove an Officer for cause, but only after a Joint Conference Committee review with the affected individual not present. "For cause" required for Board action means and includes but is not limited to:

- a. Any act or omission that would justify corrective action or summary action;
- b. Willful public statements that substantially damage the reputation of the Hospital or interfere with its ability to provide services; or
- c. An adverse vote of confidence by the Medical Staff or MEC.

9.6 LEAVE OF ABSENCE FROM OFFICERSHIP OR OFFICIALSHIP

A Health Professional, who by reason of temporary incapacity or pending Adverse Action proceedings is not currently qualified to serve as an Officer or Official will, by MEC action, absent Board objection, be placed on leave of absence from an Officer or Official position. While on leave of absence the subject Officer or Official may not vote or participate as an Officer of the Medical Staff, Official of the Medical Staff, committee member, or Board member. While the position shall remain vacant during the leave of absence, the Officer's or Official's duties may be assigned by the MEC to one or more other Health Professionals. If the purpose of the leave of absence is a pending Adverse Action that is not resolved in the Health Professional's favor within one hundred twenty (120) days, the leave of absence and the Health Professional's Officer or Official position will be automatically terminated. If the purpose of the leave of absence is incapacity, then the leave of absence shall terminate when the Board and MEC determines that the incapacity no longer exists or will not be timely resolved. In the latter case, the Health Professional's Officer or Official position shall automatically terminate. For the purpose of this section, if there is any question raised about definitions, "temporary incapacity" shall be defined by the MEC with Board approval.

9.7 VACANCIES IN STAFF OFFICES

Vacancies in the Officer positions, other than that of Chief of Staff, may be filled by the MEC. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall become the Chief and serve out the remaining term. In the event the Vice Chief is unable to fill the remaining term of the Chief of Staff, the MEC may appoint a qualified Chief Emeritus, or if none, another qualified Member, to assume the function of Chief of Staff until a special election can be held, within 60 days, to fill the remaining term. Filling an uncompleted term will not apply to the maximum of three terms for an Officer. Special meetings of the Medical Staff may be called for these purposes by the discretion of the MEC.

9.8 DUTIES OF ELECTED OFFICERS

9.8.1 Chief of Staff. Shall serve as the Chief Administrative (or "Medical") Officer and principal elected official of the Medical Staff. As such the Chief of Staff shall:

- a. Provide leadership for the Medical Staff and in accordance with the terms of these Bylaws and Policy Manual;
- b. Act in coordination and cooperation with the CMO and/or the CEO in all matters of mutual concern within the Hospital;
- c. Aid in coordinating the activities and concerns of the Hospital administration and nursing and other patient care services with those of the Medical Staff;
- d. Appoint or remove, after consultation with the CMO, the Medical Staff representatives to, and Chairs of, all standing Medical Staff committees with the exception of the MEC, and the Medical Staff representatives of all Hospital, Board and Corporate Board committees, unless otherwise expressly provided by the Medical Staff Documents;

- e. Communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Board and/or the CEO;
- f. Participate in collegial intervention and informal discussion as part of the peer review process;
- g. Take action to enforce these Bylaws, other Medical Staff Documents and Policy Manual, for implementation of sanctions where these are indicated, and or the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Member or other Health Professional;
- h. Call, preside at, and be responsible for, the agenda of all general meetings of the Medical Staff and the MEC;
- i. Serve as Chair of the MEC;
- j. Be permitted to attend all Medical Staff committees, except the Nominating Committee, as an ex-officio Member with vote unless otherwise expressly provided by the Medical Staff Documents or Policy Manual;
- k. Serve as a spokesperson of the Medical Staff in its external professional and public relations matters;
- l. Serve as a Member of the Board and regularly report appropriate MEC actions including, but not limited to, recommendations for appointment and reappointment to the Medical Staff, granting or restricting Privileges or other Practice Authority, corrective actions to take against individual Members, or amendments to the Medical Staff Bylaws;
- m. Report appropriate actions of the MEC to the Medical Staff.

9.8.2 Vice Chief of Staff. The Vice-Chief shall:

- a. Be a member of the MEC. In the absence of the Chief of Staff, assume all the duties and have the authority of the Chief;
- b. Perform such additional duties as may be assigned by the Chief of Staff or the MEC.
- c. Be a member of the Bylaws Committee.
- d. Fill a vacancy in the office of Chief of Staff until a new Chief of Staff is elected.

9.8.3 Secretary-Treasurer. The Secretary-Treasurer shall:

- a. Be a member of the MEC;
- b. Arrange for the provision of proper notice of all Medical Staff meetings on order of the appropriate authority;

- c. Record or cause to be recorded complete and accurate minutes of all general meetings of the Medical Staff and the Medical Executive Committee.
- d. Oversee the collection, accounting for, and maintenance of records in the Office of Medical Affairs including keeping track of the exact account of all funds that are collected in the form of Medical Staff dues, assessments, application fees and those funds used for expenses;
- e. Oversee the collection of annual dues as described in these Bylaws;
- f. Oversee the submission of a quarterly report of Chelsea Medical Staff Trust account action to the MEC;
- g. Assume the duties of the Chief of Staff in the temporary absence of the Chief of Staff, Vice Chief of Staff and Chief Emeritus (if any);
- h. Perform such other duties as are assigned by the Chief of Staff or the MEC.

9.8.4 Members-at-Large. The Members-at-Large shall each be a voting member of the MEC and shall, when assigned by the Chief of Staff or the MEC, assume membership and/or chair of various committees and carry out other responsibilities. The MEC shall determine if there shall be one or more Members-at-Large according to the plans for development of future Medical Staff Officers. One consideration for the nomination and appointment of Members-at-Large shall be the development of new leadership talent.

9.9 SERVICE CHIEF

9.9.1 Term of Office.

- a. Except as otherwise provided in a written contract for a Service operated as Contract Area, a Service Chief shall serve a term of two (2) years, and until his successor is elected.
- b. There are no limits on Service Chiefs' number of terms in office.

9.9.2 Election. Except as otherwise provided in a written contract for a Service operated as Contract Area, the Medical Staff Documents and Policy Manual shall set forth the process for Service Chief elections.

9.9.3 Removal.

- a. By the Service:

- i. Initiation. Action directed toward removing a Service Chief may be initiated by submission to the Medical Executive Committee of a petition seeking removal of a Service Chief, including an explanation for the requested action. A petition must be signed by not less than twenty five percent (25%) of the voting Members of the Service;
- ii. Service Vote. A vote will subsequently be called by the Chief of Staff. The Service Chief will be removed by a two-thirds (2/3) majority of

voting Members of the Service after consultation with the MEC, with the affected Member not present.

b. By the Board. A Service Chief may be removed by the Board, for cause, but only after Joint Conference Committee review, with the affected Member not present. "For cause" for this purpose is the same as for removal of Officers of the Medical Staff.

9.9.4 Vacancy. Except as otherwise provided in a written contract for a Service operated as Contract Area, upon a vacancy in the office of Service Chief, the Service Vice-Chief (if any) shall become Service Chief until a successor is appointed by the MEC to serve out the remainder of the term.

9.9.5 Duties. Each Service Chief shall:

- a. Represent and act on behalf of the Service and its members;
- b. Review file documents, interview, check references and determine the qualifications and competence of all Applicants and Health Professionals seeking Practice Authority for initial appointment to that Service, and make a recommendation to the Credentials Committee;
- c. Review all reappointment information and make a recommendation to the Credentials Committee;
- d. Determine the qualifications and competence of Service personnel who are not licensed independent practitioners and who provide patient care, treatment and services, taking into account the input of the applicable Program Director, if any, and others knowledgeable about the applicant;
- e. Recommend Practice Authority for each Health Professional in the Service, taking into account the input of the applicable Program Director, if any, and others knowledgeable about the applicant;
- f. Recommend privileging criteria to be used within the Service;
- g. In coordination with the MEC and CMO, carry out collegial and corrective intervention with Health Professionals of the Service whenever there are concerns about professional performance or conduct;
- h. Provide input for, and, if applicable, conduct continuing education and new member orientation for the Service;
- i. Review, on an ongoing basis, the professional performance of all individuals in the Service who have Practice Authority;
- j. Recommend to the MEC policies and procedures as are needed to guide and support provision of services;
- k. Integrate the Service into the primary functions of the Hospital;

- l. Coordinate and integrate inter-Service and intra-Service services;
- m. Appoint a Service Vice-Chief and, where applicable, fill vacancies in the Service Vice-Chief position;
- n. Implement actions taken by the MEC within the Service;
- o. Preside at all Service meetings;
- p. Perform such duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff, the MEC, the CEO, or the Board;
- q. Be a member of the MEC;
- r. Participate in assessment and improvement activities related to the quality of care, treatment services provided by the Service, including Ongoing Professional Practice Evaluation.
- s. Provide overall guidance regarding the policies of the Hospital, and make specific recommendations and suggestions regarding the Service, including those for space, off-site sources, treatment, services or other resources that may be needed for patient care;
- t. Undertake clinically related activities of the Service;
- u. Undertake administratively related activities of the Service, unless otherwise provided by the Hospital.

9.9.6 Delegation. In the event that the Service Chief is unavailable, or may not appropriately participate in an activity for which the Service has or shares responsibility because of a conflict of interest, (e.g. the Service Chief is personally the subject of a review), the Service Chief's responsibilities shall be assumed by the Service Vice-Chief. If the Service Vice-Chief is unavailable, or may not appropriately participate in an activity for which the Service has or shares responsibility because of a conflict of interest, then the Service Chief role for this activity may be assumed by the most recent former Service Chief, or if not available, another current Service Chief, who is selected jointly by the Chief of Staff and the CMO.

9.10 SERVICE VICE-CHIEF

9.10.1 Qualifications and Appointment. Each Service Vice-Chief shall be appointed by the Service Chief with concurrence of the Chief of Staff.

9.10.2 Term of Office and Removal. A Service Vice-Chief shall serve a term commencing with office appointment, and continuing until a successor is appointed. Removal of a Service Vice-Chief from office may be made by the Service Chief or the MEC.

9.10.3 Vacancy. Upon a vacancy in the office of Service Vice-Chief, the Service Chief shall appoint a member of the Service to fill the vacancy. In the event the Service Chief position is also vacant, the MEC may appoint a Vice-Chief.

9.10.4 Duties. The Service Vice-Chief shall, in the absence of the Service Chief, carry out the duties of the Service Chief and perform such duties as may be assigned by the Service Chief.

9.11 STANDING COMMITTEE CHAIRS

As provided in Section 9.8.1, The Chief of Staff shall appoint and may, if necessary, remove, all Standing Committee Chairs, except as otherwise provided in the Medical Staff Documents. The term, duties and other responsibilities of Standing Committee Chairs shall be as provided in the Committee Protocol Appendix.

9.12 CHIEF EMERITUS

Each prior Chief of Staff who successfully completes, without removal or resignation, his/her term as Chief of Staff, shall be considered a Chief Emeritus, provided such individual continues to meet the qualifications provided in Section 9.1. Except otherwise provided in Section 11.5 for the Chief Emeritus who most recently served as Chief of Staff, a Chief Emeritus may attend as a guest, but not vote at, MEC meetings, provided the Chief Emeritus cooperates fully with the protocols in place and meaningfully contributes to the meeting. The MEC may, in its sole discretion, rescind Chief Emeritus status.

9.13 APP ADVISOR

The MEC may, in its discretion, appoint and, if necessary, remove, the APP Advisor. The term, duties and other responsibilities of APP Advisor shall be as determined by the MEC.

9.14 ADDITIONAL APPOINTMENT

The Board and/or CEO may, after considering the advice and recommendations of the MEC, appoint additional Health Professionals to medical administrative positions within the Hospital to perform such duties as are prescribed by the Board, or as defined by amendments to these Bylaws.

ARTICLE X: SERVICES OF THE MEDICAL STAFF

10.1 ORGANIZATION OF SERVICES OF THE MEDICAL STAFF

10.1.1 Service Establishment. Services are established for the purpose of efficiently maintaining and improving the competence and conduct of the Medical Staff, the quality of medical care, and promoting effective Medical Staff communication.

10.1.2 Organization. Each Service shall be organized as a separate part of the Medical Staff and shall have a Service Chief and a Vice-Chief.

10.1.3 Services. The current Services are Medicine, Surgery, Emergency, Anesthesia and Psychiatry. When deemed appropriate, the MEC, with the Approval of the Board, may create, eliminate, subdivide or combine any Services.

10.2 ASSIGNMENT TO SERVICE

10.2.1 Service Membership. Each Health Professional shall be assigned membership in at least one Service, in which the Health Professional has primary assignment. A Health Professional who truly practices within the area of two Services may request that a second assignment may be made to a second Service.

10.2.2 Privileges in more than One Service. A Member with Privileges in more than one Service shall vote in the Service in which the Member has primary assignment.

10.3 DESIGNATION OF CONTRACT AREA

The Hospital, after formal documented consultation with the Medical Staff, may conclude that an exclusive contractual arrangement between an individual Health Professional, group of Health Professionals or, in some instances, an entire Service, is the preferred way to deliver a service or accomplish a function (sometimes referred to as a "Contract Service", i.e., that is a Contract Area comprising an entire Service). In all instances, the Member, group or Service will be governed by all policies and obligations of Membership, as applicable, Practice Authority and Service assignment. The following requirements shall be met in connection with any such contractual arrangement with the Hospital:

10.3.1 Practice Authority. Each Health Professional who will furnish services at the Hospital pursuant to the contract must obtain and maintain Practice Authority and, unless otherwise exempted (e.g., Physicians providing temporary services), Medical Staff Membership.

10.3.2 Termination of Medical Staff Membership and Practice Authority. Unless the employment contract of a Health Professional of a Contract Service expressly states that the Health Professional shall retain Membership, as applicable, on the Medical Staff or Practice Authority after the end of his/her employment or other contract and such a provision is acceptable to the Hospital, then the expiration or the termination of a Health Professional's employment or other contract with the party that staffs the Contract Service, or expiration or termination of the contract with the Hospital, as applicable, shall be an automatic termination of the Health Professional's Practice Authority, and if applicable, Medical Staff Membership.

10.4 FUNCTIONS OF SERVICE

10.4.1 Services may:

- a. Conduct or participate in educational programs;
- b. Review clinical cases for educational purposes;
- c. Refer appropriate cases to the Medical Staff's peer professional review committees;
- d. Review policy and advise the MEC;
- e. Review Hospital staffing, Services, or equipment needs and advise the MEC or Hospital Administration;

- f. Develop recommendations for the Service Chief or the MEC.

10.4.2 The Service shall submit written minutes to the MEC or other reports concerning:

- a. Any recommendations for maintaining and improving the quality of care provided in the Service and the Hospital; and
- b. Other matters as may be requested from time to time by the MEC, other Services or committees.

10.5 SERVICE POLICIES AND PROCEDURES

There shall be no separate Service policies and procedures or rules.

ARTICLE XI: MEDICAL STAFF FUNCTIONS AND COMMITTEES

11.1 INTRODUCTION

Provision shall be made in these Bylaws, through policies and procedures, or by resolution of the MEC, for the effective performance of the staff functions specified in this Article and described in current Policy Manual, and if such other Medical Staff functions as the MEC or Board shall reasonably require. Such provision may include MEC assignment to Services, to Medical Staff committees, to Medical Staff Officers, to Officials, or to interdisciplinary Hospital committees.

11.2 FUNCTIONS OF THE MEDICAL STAFF

The Medical Staff shall:

11.2.1 Participate in and coordinate quality/performance improvement, utilization management and risk management activities at the Medical Staff level;

11.2.2 Review professional practices in an effort to reduce morbidity and mortality, and improve the care and treatment of patients in the Hospital's facilities. This will include monitoring Hospital policies and the Policy Manual, meeting requirements for alternate coverage and consultation, and recommending methods of change and enforcement, when appropriate;

11.2.3 Review complications and deaths occurring in the Hospital;

11.2.4 Review the credentials of Applicants for appointment and reappointment to the Medical Staff and the granting Practice Authority, assignment to Medical Staff category and specific Service, and make recommendations of such to the Board;

11.2.5 Facilitate education that is responsive to the needs of the Medical Staff;

11.2.6 Participate in the development of policies for and review of drug utilization, blood utilization, medical records policy compliance, pharmacy and therapeutics;

11.2.7 Participate in monitoring and investigating the Hospital's nosocomial infections and infection control program;

11.2.8 Ensure blood usage review is performed for evaluation of transfusion appropriateness, transfusion reactions, and policies and procedures related to use and administration of blood and blood components;

11.2.9 Conduct surgical case reviews and invasive procedure evaluations for appropriateness and opportunities for quality improvement activities;

11.2.10 Participate in other review functions such as: (1) monitoring and evaluating clinical functions performed in special care units; (2) internal and external disaster plans; (3) Hospital safety; (4) hazardous waste management activities; and (5) other functions reasonably requested by the Medical Executive Committee and/or the Board;

11.2.11 Ensure appropriate on call coverage for the Emergency Room and inpatient consults;

11.2.12 Where relevant, provide clinical oversight for participants in professional graduate education programs;

11.2.13 Participate with the Board and/or Hospital administration in planning for appropriate Hospital growth and development and further provision of services required to meet the needs of the community, including high technology equipment;

11.2.14 Direct Medical Staff organizational activities including Medical Staff Bylaws review and revision, Officer, Official and committee nominations, liaisons with the Board and Hospital administration;

11.2.15 Participate in Hospital efforts to meet accreditation requirements;

11.2.16 Coordinate the care provided by Health Professionals with the care provided by other Hospital staff;

11.2.17 Participate in activities to improve care and develop clinical policy for ambulatory care services, patient care support services, and special care areas;

11.2.18 Direct, order, and require the collection of records, data, and knowledge in furtherance of its duties; and

11.2.19 Comply with and enforce the Bylaws.

11.3 COMMUNICATION AND COORDINATION WITH GOVERNANCE AND ADMINISTRATION

The communication functions of the Medical Staff shall include the following:

11.3.1 Serve as the primary means for accountability to the Board for appropriateness of professional performance and ethical conduct of each Health Professional with Practice Authority.

11.3.2 Medical Staff Bylaws review and revision, Medical Staff Officer and committee nominations, liaison with the Board and Administration, and review and maintenance of Hospital accreditation.

11.3.3 Coordinate care provided by the Medical Staff with the care provided by other Hospital patient care and administrative services.

11.4 COMMITTEES

11.4.1 Committees. The Medical Staff shall have standing and special (ad hoc) committees that carry out the functions of the Medical Staff and fulfill regulatory and accreditation requirements. All data, knowledge, and records of these committees involving Peer-Professional Review Functions shall be kept in a confidential manner and shall not be subject to being subpoenaed or produced in legal proceedings consistent with the provisions of Michigan and Federal statutes (including, but not limited to, Michigan Public Health Code, MCL Sections 333.20175, 333.21513, 333.21515, and MCL Sections 331.531, 331.532, and 331.533).

11.4.2 Policies and Procedures. There will be policies and procedures delineating the standing committees of the Medical Staff.

11.4.3 A Member on any committee must be a Member in Good Standing and be eligible to serve on a committee. Information regarding an individual's level of participation in committee activities will be reviewed when determining continuing committee membership.

11.5 MEDICAL EXECUTIVE COMMITTEE

11.5.1 Composition.

a. Voting Members:

- i. Elected Officers of the Medical Staff;
- ii. The Chief Emeritus who most recently served as Chief of Staff (for a two-year period only, after which time, this position shall not be filled until the next change in the individual elected to Chief of Staff);
- iii. The Service Chiefs;
- iv. At-large Member(s) elected by the Medical Staff; and
- v. The CMO.

b. Non-voting (Ex-officio) members:

- i. Hospital CEO;
- ii. Chief Nursing Officer;
- iii. Board Chair or another lay Board member appointed by the Board Chair.

c. The MEC will include Physicians or other licensed independent practitioners on the Medical Staff; however, the majority of the voting members of

the Medical Executive Committee shall, at all times, be composed of Physician Members;

d. The Chief of Staff shall serve as chair of the Medical Executive Committee.

11.5.2 Duties. The MEC is empowered to act on the Medical Staff's behalf on issues delegated to the MEC by the Medical Staff. The duties delegated to the Medical Executive Committee shall be to:

a. Represent and act on behalf of the Medical Staff as a whole and be empowered to act for the organized Medical Staff between meetings of the organized Medical Staff;

b. Coordinate the activities and policies of the Medical Staff and Services;

c. Exercise full responsibility for the function of all standing and ad hoc committees of the Medical Staff; receiving and reviewing all reports and minutes from standing and ad hoc committees;

d. Formulate, approve and implement policies of the Medical Staff;

e. Serve a liaison function, in cooperation with the CMO, between the Medical Staff and the CEO;

f. Recommend directly to the Board, matters pertaining to all Applicants for Medical Staff appointment, reappointment, staff category, Service assignment and Privileges and all other Health Professionals applying for Practice Authority, and requests for change of staff category, or Practice Authority after receiving recommendations from the Credentials Committee or APP Credentials Subcommittee, and of the process used to review credentials and delineate Practice Authority;

g. Receive, review and, when needed, act upon reports received from Services;

h. Recommend action to the Board and/or CEO regarding Hospital management and medical-administrative matters that may affect the Medical Staff and/or patient care;

i. Monitor and oversee fulfillment of the Medical Staff's accountability to the Board for the medical care and the reduction of morbidity and mortality within the Hospital;

j. Conduct professional peer review and participate in performance improvement activities in furtherance of improving the quality of clinical care and reducing the morbidity and mortality within the Hospital, including action upon professional peer review recommendations of any Medical Staff committee;

k. Take action and/or make recommendations to the Board on concerns related to the clinical competence and professional conduct of Health

Professionals, including recommendations for corrective action measures as indicated;

- l. Take action and/or make recommendations directly to the Board on the review of and actions on report of Medical Staff committees, Services and other assigned activity groups;
- m. Advise the Hospital regarding strategic planning;
- n. Inform the Medical Staff of the accreditation program and the accreditation status of the Hospital at least triennially (every three years);
- o. Report through the Chief of Staff at each general Medical Staff meeting and Board meeting;
- p. Review Secretary's reports;
- q. Make recommendations directly to the Board, as indicated, regarding the structure of the Medical Staff;
- r. Conduct such other functions as are necessary for the effective operation of the Medical Staff.

11.5.3 Executive Session.

- a. The Chair may call an executive session of the MEC. This may be a special meeting, or may occur during or following a regular meeting of the MEC.
- b. Only members of the MEC may ordinarily attend. Others, including any Health Professional under review, shall attend only by special invitation of the Chair or the MEC. A Health Professional under review, even if a member of MEC, may not participate in the portion of the meeting devoted to deliberation of the Health Professional's review. The Medical Staff Coordinator or a secretary may be added to attend for record keeping at the prerogative of the Chair. Minutes shall be recorded, but shall be kept separately in the Office of Medical Affairs from the regular minutes of the MEC. Access to minutes of the Executive Sessions shall be obtained only with written approval of the Chief of Staff or the CMO as such access is subject to the Article on Confidentiality and the Policy Manual.

11.5.4 Removing Delegated Authority from the MEC. A Member may initiate removing part or all of its authority from the MEC by the same process used to amend the Bylaws (see Section 15.5).

11.6 PARTICIPATION ON OTHER COMMITTEES

11.6.1 Medical Staff Participation. In addition to the above, Health Professionals may serve on other Medical Staff committees as delineated in the Policy Manual.

11.6.2 Hospital/Board Medical Staff Participation. Health Professionals may also participate on Hospital, Board and Corporate Board committees.

11.7 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) WITHIN AN ESTABLISHED REVIEW COMMITTEE

11.7.1 Purpose. To provide for focused review of each Health Professional who has Practice Authority at the Hospital, the Medical Staff or its designee shall conduct a focused review of any Health Professional in the following circumstances: upon the initial grant of Practice Authority, upon the subsequent grant of any new or additional Practice Authority; and in the event of a single triggering incident or a pattern of care that meets or exceeds outlier criteria established by the Hospital or Medical Staff, when there is doubt regarding a practitioner's ability to competently perform his/her Practice Authority or upon other circumstances identified in the Medical Staff Documents or Policy Manual. FPPE shall be conducted in accordance with the Medical Staff Documents. Special Professional Review may be utilized to fulfill an in depth review process if desired or deemed required.

11.7.2 Participation by the Health Professional. Health Professionals shall participate in, and cooperate with, the FPPE process, as required by the Hospital or Medical Staff.

11.8 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) WITHIN AN ESTABLISHED REVIEW COMMITTEE

To provide for continuous concurrent monitoring of each Health Professional who has Practice Authority at the Hospital, the Medical Staff or its designee shall collect, verify and evaluate data on each such Health Professional with Practice Authority to analyze that individual's competence in his/her field(s) in accordance with the Hospital's OPPE policies. Monitoring will be performed on an ongoing basis and will be based on peer review activities, quality activities conducted by the Hospital and Medical Staff, medical record review, direct observation, monitoring of clinical practice patterns data from other institutions where the Health Professional is credentialed and other relevant information. The Medical Staff will evaluate the Health Professional based on generally recognized standards of care as well as established benchmarks or norms (when available), and other indicators determined by the Medical Staff. OPPE information will be used for consideration of requested Membership or Practice Authority at each reappointment or renewal cycle. Health Professionals shall participate in, and cooperate with, the OPPE process, as required by the Hospital or Medical Staff.

11.9 CONFLICT BETWEEN THE MEDICAL STAFF MEMBER(S) AND MEC

11.9.1 Collegial Discussion with Chief of Staff and/or CMO. Any Member(s) who disagree(s) with any decision of the MEC unrelated to Corrective Action involving a Member of the Medical Staff (pursuant to Medical Staff Bylaws and the Health Professional Evaluation Support and Intervention Appendix) will discuss their disagreement with the Chief of Staff and/or CMO.

11.9.2 MEC Appearance. If the conflict persists, the Member will request an audience with the MEC. At least one week prior to the meeting, the Member will provide the following in writing to the Chief of Staff who will forward it to the MEC:

- a. The decision of the MEC that the Member disagrees with,
- b. Relevant sections of the Medical Staff Bylaws, Hospital Bylaws and/or Medical Staff or Hospital policy, and

- c. The reasoning of the Member's disagreement with the decision.

11.9.3 Medical Staff Petition to the Board. If the Member is not able to resolve the issue working directly with the MEC, a petition requesting an in-person meeting may be submitted to the Board chair. The petition must be signed by at least five percent (5%) of the voting Members of the Medical Staff and will contain the content listed in Section 11.9.2.a-c above. In addition to the Board chair, copies of the petition will be provided to the Chief of Staff, CMO and CEO. At the discretion of the Board chair, in consultation with the Board Executive Committee (as needed), the petitioning Members may be granted an appearance before the full Board to present their issue.

11.9.4 For the procedure to manage conflicts specific to Corrective Action taken against a Member, refer to the Review Procedures Appendix.

11.9.5 For the procedure to address the concerns of a single Member specific to proposed amendments to Medical Staff Bylaws or policies, refer to Bylaws Article XV.

11.9.6 This process is not intended to prevent Members from communicating directly with the Board.

ARTICLE XII: MEETINGS

12.1 GENERAL MEDICAL STAFF MEETINGS

12.1.1 Regular Meetings. The Medical Staff shall hold regular meetings, at least biannually. One meeting each year shall constitute the annual meeting. The Chief of Staff shall designate the time and place of all meetings and distribute such to Members. The Chief of Staff will chair these meetings. Written minutes of each meeting shall be recorded and maintained in the Office of Medical Affairs.

12.1.2 Special Meetings. Special meetings of the Medical Staff may be called at any time by the Board, Chief of Staff, MEC, or shall be called by the Chief of Staff within fifteen (15) days after receipt of a written request for such a meeting signed by not less than five percent (5%) of the Members eligible to vote. Such request shall state the purpose of the meeting. A written notice will designate the time, place, and purpose of the meeting, and will be delivered to each Member, or the Member's office, entitled to be present by at least one of the following methodologies: (1) personal delivery, (2) registered or certified mail, return receipt requested; (3) mail by a nationally recognized overnight delivery service; (4) email to the email address then on file with the Hospital; or (5) secure messaging systems utilized by the Hospital (currently HALO). Such notice will be no less than 5 days before the meeting date unless there are special circumstances requiring a more emergent meeting date which does not permit such notice. No business shall be transacted at any special meeting except as stated in the meeting notice.

12.1.3 Agenda. The order of business at a regular meeting shall be determined by the Chief of Staff and shall include but not be limited to:

- a. Review and acceptance of the Minutes of the last regular, and of all special meetings, held since the last regular meeting;

- b. Reports from the Chief of Staff, CEO, including review of recent Board action; CMO; Service Chiefs and Committee Chairs;
- c. Election of Officers when required by these Bylaws;
- d. New business.

12.2 SERVICE MEETINGS

Members in each Service shall hold regular meetings at least biannually with the respective Service Chief acting as chair.

12.3 QUORUM

Except as otherwise provided in the Medical Staff Documents, the quorum for meetings shall be as follows:

12.3.1 Regular and Special Meetings of the General Medical Staff. Those Members present and eligible to vote, provided at least ten (10) Members eligible to vote are present.

12.3.2 Medical Executive Committee. Fifty percent (50%) of the committee members eligible to vote.

12.3.3 Service Meetings. Those Members present and eligible to vote, provided that at least 2 members eligible to vote are present.

12.4 MANNER OF ACTION

Actions shall be undertaken by the Medical Staff, Service, MEC, Nominating Committee or other body as follows:

12.4.1 Action During a Meeting. Except as otherwise specified in these Bylaws, in meetings where a quorum is established, the action of a Simple Majority Vote shall be the action of the group.

12.4.2 Actions Between Meetings. Except as provided below, action may be taken by a Service, MEC, or Nominating Committee between meetings when all voting members receive notice of a proposed action and when a minimum of two-thirds (2/3) of the vote-eligible members set forth the action

- a. via a personally signed document, or
- b. communicating via e-mail or telephone with the Office of Medical Affairs signifying their approval of the proposed action. At the next meeting of the committee, Members will sign an attestation of their vote on the action.

Actions between meetings will be reported by the Service Chief or committee chair at the next meeting of the committee.

12.4.3 Action may not be taken between meetings when a full meeting of the MEC is required to act upon a Category Two or Three application for Medical Staff Membership and Privileges or Category Two application for APP Privileges or when corrective action

or professional peer review action is being considered. Such action shall only take place at a committee meeting.

12.4.4 Medical Staff committee members who are not Members of the Medical Staff are not eligible to vote.

12.5 SPECIAL APPEARANCE REQUIREMENT

12.5.1 Educational Program. Whenever a Medical Staff or Service educational program is prompted by findings from quality improvement and/or risk management activities, the Health Professional whose performance prompted the program will be notified of the time, date, and place, the subject matter to be covered, and its special applicability to the Health Professional's practice. Except in unusual circumstances, the Health Professional shall be required to be present.

12.5.2 Clinical Course of Treatment Discussion. If a Health Professional is being requested to attend a regular Service meeting at which time the clinical course of management of one or more patients by the Health Professional is to be discussed, such Health Professional shall be given written notice of the matter and of the time and place of the meeting and the case(s) to be discussed at least ten (10) days prior to the meeting. Whenever an apparent, or suspected, difference from generally accepted clinical practice is involved, the Chief of Staff, CMO or MEC may require the Health Professional to confer with them or with a standing, or ad hoc committee considering the matter. Special notice shall be given to the Health Professional at least ten (10) days prior to the meeting including the date, time, and place of the meeting. Appearance is mandatory. Failure to appear at any meeting to which such special notice was given, unless excused by the person or group requesting the meeting, or MEC upon a showing of good cause, may result in an automatic withholding of all, or such portion of the Health Professional's Practice Authority, as the MEC may direct. Such action shall remain in effect until the matter is resolved by subsequent action of the MEC and the Board.

12.6 OTHER ATTENDANCE REQUIREMENTS

12.6.1 Service and General Medical Staff Meetings. Attendance at Service and general Medical Staff meetings is encouraged.

12.6.2 Medical Staff Committee Meetings. Members of MEC and Nominating Committee are expected to attend a minimum of fifty percent (50%) of their regularly scheduled meetings.

12.6.3 Attendance by Electronic Means. Participation in a meeting by electronic means is permissible if permitted in the Medical Staff Documents or Policy Manual. However, no Medical Staff, Service, or committee meetings will be concurrently electronically recorded or the electronic media stored without the written consent of the chair of the meeting after due consideration and discussion of confidentiality issues with the CMO.

12.7 RULES OF ORDER

Meetings of the Medical Staff, Committees and Services shall be conducted in accordance with procedures established by the Medical Staff, Committee or Service either in writing or through established practice acceptable to a majority of the meeting participants, which fairly allow each

individual participating in the meeting to review and consider relevant information, reasonably express his or her views, vote, and have his or her vote or dissent recorded. Notwithstanding the foregoing, if one third or more of the members at the meeting believe the procedures utilized do not meet the foregoing requirements or are unfair with respect to one or more matters, they may, by written notice signed by each of them, require that proceedings on such matter(s) be conducted in accord with the current edition of Robert's Rules of Order, Revised.

ARTICLE XIII: CONFIDENTIALITY, IMMUNITY, AND RELEASE

13.1 DEFINITIONS

For the purpose of this Article, the following special definitions shall apply:

13.1.1 Representative. A person, committee, medical staff organization, board or entity that has the obligation to: conduct professional/peer review, undertake professional/peer review actions, or collect, prepare, hold, or disclose professional/peer review information concerning a health care professional. Article XI delineates committees and Health Professionals assigned professional/peer review functions.

13.1.2 Facility. A healthcare facility or organization and includes the Hospital, other hospitals, clinics, universities, health maintenance organizations, prudent purchaser organizations, and independent practice associations.

13.1.3 Professional/Peer Review. Review of the health, clinical ability, ethics, education, conduct and/or judgment of a Health Professional or other health care provider. This includes, but is not limited to: morbidity and mortality review, quality improvement activities, utilization review, patient care and audits, performance reviews in an academic or practice setting, insurance underwriting and malpractice loss prevention reviews, credential investigations, appraisal for Medical Staff or APP appointment, reappointment of Practice Authority, review of applications for employment at a facility (as defined), or initiation of corrective action proceedings or appellate reviews in the course of a facility's medical staff or APP affairs.

13.1.4 Professional/Peer Review Function Information. Records, data, and knowledge developed or collected in connection with a Peer-Professional Review Function, and includes, but is not limited to: applications, reports, minutes, transcripts, recommendations, communications, and summaries respecting professional/peer review.

13.1.5 Professional/Peer Review Action. An action taken in the process of a Peer-Professional Review Function or an account of professional/peer review information. Professional/peer review actions include, but are not limited to: appointment, non-appointment, reappointment and non-reappointment to a medical staff, APP staff or a facility, corrective action proceedings or appeals in a facility, preparation of reports regarding the professional conduct or clinical competence of a Health Professional in a facility, and recommendations or imposition of discipline or restrictions upon the professional activities of a Health Professional.

13.1.6 Health Professional. A Health Professional, or other health care provider who has applied for or has Membership and/or, Practice Authority in the Hospital.

13.2 AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising Practice Authority within this Hospital, a Health Professional agrees to the following:

13.2.1 Professional/peer review. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon professional/peer review information bearing on the Health Professional's professional ability and other qualifications;

13.2.2 Legal Claims. Agrees to be bound by the provisions of this Article and to waive and release all legal claims against any representative who acts in accordance with the provisions of this Article; and

13.2.3 Conditions of Application. Acknowledges that the provisions of this Article are express conditions to the Health Professional's application for or acceptance of Membership, or the exercise of Practice Authority at the Hospital.

13.3 CONFIDENTIALITY OF INFORMATION

13.3.1 Medical Records. Patient charts and records are privileged and confidential and are to be used only for the purposes for which they are intended and in a manner consistent with Hospital policies and applicable law.

13.3.2 Professional/Peer Review Function Information. Professional/peer review information with respect to any Health Professional submitted, collected, prepared, or held by the Hospital for the purpose of achieving and maintaining quality patient care, shall to the fullest extent permitted by law, be confidential. In special circumstances, however, (e.g., a Health Professional under review publicly discloses confidential information) the Hospital may choose to explain inaccurate or incomplete information that has been communicated by the Health Professional regarding the review process and/or its findings.

13.3.3 Enforcement. The Board, CMO, Chief of Staff, and the CEO shall have the authority to enforce this section.

13.3.4 Court Subpoena. Pursuant to State and Federal laws pertaining to the professional/peer review functions of hospitals, especially as it relates to the purpose of reducing morbidity and mortality and improving the care provided for patients, all records, data, and knowledge collected for, or by, individuals or committees assigned a professional/peer review function or quality of patient care review function are explicitly not public records and are not subject to court subpoena.

13.3.5 National Practitioner Data Bank. The Hospital shall comply with State and Federal statutory reporting requirements in making reports when a professional/peer review action results in the reduction, restriction, suspension, revocation, or denial of Privileges. This will include that the Medical Staff and CEO shall report to the National Practitioner Data Bank and/or State of Michigan authorities consistent with applicable legal requirements, corrective and other professional/peer review actions taken with respect to a Health Professional.

13.3.6 Internal Reporting. Any action taken concerning a Health Professional's Membership or Health Professional, including at time of appointment or reappointment,

corrective or other action, shall be timely reported, if not already known, to the Chief of Staff, CMO, CEO, Board Chair, and on a need-to-know basis, to Health Professionals and Hospital employees (e.g. reduction in a Member's surgical Privileges would be reported to the Medical Director of the O.R. and the Surgery Service Nurse Manager). Further, any material change in a Health Professional's Practice Authority (increase or decrease; temporary or permanent) that could have an effect upon other Health Professional's decision to refer a patient for care shall be made available to all Health Professionals.

13.4 IMMUNITY FROM LIABILITY

13.4.1 Indemnity. Health Professionals who serve as Officers or Officials of the Medical Staff or Services, or on committees of the Hospital, Medical Staff, Board or Corporate Board, or act for, and on behalf of, the Hospital in discharging duties, functions, or responsibilities taken pursuant to these Board and Corporate Board-approved Medical Staff Bylaws, Board bylaws, and/or Medical Staff or Hospital policies and procedures, shall be indemnified by the Hospital, to the fullest extent permitted by law. The Health Professional shall have, and be entitled to, the same level of corporate indemnity protection that a Hospital or Board officer or Hospital employee would have under the articles and bylaws of the Hospital in similar circumstances.

13.4.2 Good Faith Immunity. No Representative of the Hospital or Medical Staff shall be liable in any judicial proceeding for damages, or other relief, for any professional/peer review action taken, or statement of recommendation made, or for disclosure of professional/peer review information with respect to any Health Professional, within the scope of his duties as a representative. Regardless of any provisions of State law to the contrary, truth shall be an absolute defense in any legal proceeding charging a representative or facility for professional/peer review actions taken or professional/peer review information disclosed, in all circumstances.

13.4.3 Providing Information. No Representative shall be liable in any judicial proceeding for damages or other relief for any professional/peer review action taken, or the disclosure of professional/peer review information, to a representative of this Hospital or other facilities with respect to any Health Professional.

13.4.4 Total Immunity for Communication to Governmental Agencies or Compliance with Law or Court Proceedings. Neither a Representative of the Hospital, nor the Hospital itself, shall have any liability in damages or otherwise, to a Health Professional for:

- a. Any information communicated to a governmental agency under the assumption or belief that the representative of the Hospital had a legal or moral obligation to do so;
- b. Communication of any information in accordance with a court order and/or court subpoena, or in accordance with the directive, in any form, of a governmental agency. The provisions of this section, however, do not waive the rights of confidentiality of the Hospital or its representatives in Section 13.3 above: "Confidentiality of Information".

13.5 WAIVER OF PRIVILEGE BY HEALTH PROFESSIONAL

Any Health Professional who shall bring legal action against a facility or representative for a professional/peer review action or disclosure of professional/peer review information, shall by bringing such legal action, waive any legal confidentiality privilege respecting professional/peer review information concerning the affected Health Professional.

13.6 RELEASES AND AUTHORIZATIONS

Any Health Professional shall facilitate professional/peer review, execute written releases and/or authorizations consistent with this article upon request of the Hospital or a Hospital representative. However, execution of a release or authorization is not a prerequisite to the effectiveness of this article.

13.7 CUMULATIVE EFFECT

Provisions in these Bylaws, other Medical Staff Documents, Policy Manual, Hospital policies and procedures, and in application or reapplication 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 of such legal protections.

ARTICLE XIV: GENERAL PROVISIONS

14.1 PROFESSIONAL LIABILITY INSURANCE

14.1.1 Assurance of Financial Responsibility. Each Health Professional granted Practice Authority in the Hospital shall maintain professional liability insurance from an insurance company licensed to do business in the state of Michigan, or otherwise approved in writing by the Board as an approved insurance company and meet any other financial responsibility requirements as established by the Board after consultation with the MEC. Any bona fide questions as to whether a particular means of assurance of financial responsibility meets the requirements of the Hospital shall be approved by the Board after recommendation by the MEC.

14.1.2 Proof of Insurance/Financial Responsibility. For Health Professionals who are not Hospital employees, proof of the current status of professional liability insurance or other proof of financial responsibility shall be annually submitted to, and maintained by, the Office of Medical Affairs. Any change in the status of the professional liability insurance of a Health Professional, including the name of the professional liability carrier and the amount of coverage, shall be reported to the Office of Medical Affairs within fourteen (14) days after the change is effective.

14.2 PHYSICAL AND MENTAL HEALTH QUALIFICATIONS REVIEW

Each Health Professional may be requested by the Chief of Staff or CMO acting in consultation with the relevant Service Chief to voluntarily submit to, or may be required by the MEC or the Board, to receive physical or mental health examination(s) (which may include a screening or evaluation for substance abuse). The purpose of the examination(s) is to assist the Hospital in determining the ability of the Health Professional to continue to competently and safely exercise any Practice Authority that have been granted. If such examination(s) is required, the person requesting, or the body requiring the examination(s) shall select the Physician(s) to perform said

examination(s) after consulting with the Health Professional to try to reach mutual agreement on the choice of examining Physician. The expense for the examination(s) shall be the responsibility of the Hospital. The findings of the examination(s) shall be directly reported to the person requesting, or the chair of the body requiring, the examination(s). If health problems are identified, the report, or appropriate sections of the report, shall be made available to the Health Professional examined by the person requesting the examination or chair of the body requiring such, if the examiner does interpose a legitimate objection.

14.3 TIME LIMITS

The time limits for committee or administrative action delineated in all parts of these Bylaws may be extended by the MEC (at the Medical Staff level) or Board (all levels) for what is, in their discretion, good cause. In addition, the MEC may alter the scheduling for reappointment (i.e., the number of days prior to expiration of appointment by which time certain actions must be taken) provided persons subject to reappointment are given reasonable notice of the changes in scheduling.

14.4 TRANSMITTAL OF REPORTS

Reports and other information that these Bylaws require the MEC to transmit to the Board shall be deemed so transmitted when delivered, unless otherwise specified, to the CEO.

14.5 NOTICES

Routine notices from the Office of Medical Affairs or the Hospital, where such notice is being provided by mail or hand-delivery, shall be mailed or delivered to the Health Professional's office address on file in the Office of Medical Affairs. A Health Professional may, by written request, have such notices sent to another address or to a specifically designated person.

14.6 BOARD OBLIGATIONS

The Board will act in a manner that best harmonizes applicable law, accreditation requirements, Hospital Bylaws and these Bylaws. The Board will consider the Medical Staff Bylaws whenever making changes to the Hospital Bylaws in order to avoid conflict.

ARTICLE XV: ADOPTION, AMENDMENT, AND INTERPRETATION OF MEDICAL STAFF DOCUMENTS

15.1 NATURE OF BYLAWS AND OTHER MEDICAL STAFF DOCUMENTS

15.1.1 Contents of Medical Staff Bylaws. The Bylaws provide for the statement of objectives, organization, governance, and basic prerogatives and responsibilities of Membership to fulfill regulatory and accreditation requirements, and form the framework for other Medical Staff Documents and Policy Manual governing Member's and other Health Professional's conduct. However, the Bylaws, Rules, Appendices and Policy Manual, and any other documents issued thereunder (e.g., application forms), do not constitute a contract or an agreement upon which any individual or entity may claim contractual rights. The Medical Staff shall review these Bylaws at least every three (3) years.

15.1.2 Rules and Regulations Appendices. Medical Staff Rules shall, consistent with the applicable Medical Staff Bylaws, provide special methods and procedures related to patient care activity as well as performance affecting patient care. Medical Staff Rules may also clarify and/or provide detail necessary to effectively implement a specific Bylaws provision. The Appendices shall provide detail to supplement processes and functions described in the Medical Staff Bylaws. The Medical Staff shall review the Rules and Appendices at least every three (3) years.

15.1.3 Contents of the Policy Manual. The Policy Manual consists of policies and procedures, including associated details of The Joint Commission-required Elements of Performance, and are designated to clarify, amplify, or supplement general principles of the Bylaws and, as such, shall not be inconsistent with the Bylaws. The Policy Manual 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 Health Professional in the Hospital. Each policy and procedure will be reviewed at least every three (3) years.

15.2 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

15.2.1 Policy Manual. The Medical Staff delegates to the MEC the right to formulate, adopt, or repeal Medical Staff policies in the Policy Manual consistent with the Medical Staff Bylaws that are necessary to conduct the work of the Medical Staff.

15.2.2 Medical Staff Documents (Bylaws, Rules and Appendices). The Medical Staff shall have the responsibility and delegated authority to formulate, adopt, and recommend to the Board its Medical Staff Documents and amendments that will be effective when approved by the Board. Such responsibility and authority will be exercised in a reasonable, timely, and responsible manner to reflect the interests of providing quality patient care and maintaining harmony of purpose and effort with the Administration, Board, and the community, to provide a basis for acceptance by accreditation agencies, to comply with supervising authorities and to provide a system of ongoing effective peer-professional review.

15.3 ONGOING BYLAWS REVIEW PROCESS

As a permanent mechanism for ongoing review of the Medical Staff Documents, a Bylaws Committee composed of the CMO and other members appointed by the COS shall convene at least biennially. This committee shall make a written report to the MEC of the committee's recommendations for revision of the Medical Staff Documents, taking into account its observations, The Joint Commission (TJC) review suggestions, TJC policy changes, legal changes and the current needs of the Health Professional, Hospital staff, and the patients of the Hospital.

15.4 INTERPRETATION

15.4.1 Conformance with Law and State Code. The Medical Staff Documents shall be interpreted in a manner consistent with applicable law. In the event the provisions of these Medical Staff Documents promulgated hereunder shall not be in conformance with Michigan or Federal Law, they shall be deemed automatically amended to comply with such law. At or before their next scheduled meeting, the MEC shall meet and approve such Bylaws changes as are necessary in writing. A finding that any article, section, or subsection is legally invalid shall not invalidate the effectiveness of all other portions of the

Medical Staff Documents that are consistent with the law. Nothing contained in the Medical Staff Documents thereunder shall in any manner restrict or limit the authority of the Board to exercise its responsibilities as the governing body of the Hospital pursuant to the provisions of the Michigan Public Health Code.

15.4.2 Variation from Procedures. Minor variations from the procedures set forth in these Medical Staff Documents shall not be grounds for invalidating the action taken.

15.4.3 Headings. The captions or headings in these Bylaws are solely for convenience and are not to be considered in the interpretation of the Bylaws.

15.4.4 Language Variation. In the event of an apparent variation in language between the Bylaws and the other Medical Staff Documents, the policy and procedures and Bylaws will be interpreted as harmoniously as possible. In the event that there is an irreconcilable variation between the other Medical Staff Documents and Bylaws, the Bylaws shall prevail. Such variation shall not invalidate the remainder of said documents.

15.5 METHODOLOGY FOR ADOPTION AMENDMENT AND REPEAL

15.5.1 Policy Manual.

a. The Policy Manual may be adopted, amended or repealed by the Medical Staff. The MEC may, at any meeting at which a quorum is present, by a Simple Majority Vote of those present and eligible to vote, adopt, amend, or repeal the Policy Manual. The voting Members and the Board, through its Chair, shall be given notice that the MEC has taken action to adopt, amend, or repeal any Medical Staff policy in the Policy Manual. The text of the changes shall be available in the Office of Medical Affairs, or will be sent on request. Within the next sixty (60) days after such notice is sent to the Members and Board Chair, the Membership and Board shall have the opportunity, if they so choose, to rescind the change at a meeting of the body involved. Until and unless the Membership (by a Full Majority Vote of all Members eligible to vote) or the Board by a majority, votes to rescind the MEC action, in whole or in part, the policy and procedure remains in effect.

b. Certain policies related to Appointment and Reappointment will subsequently be reviewed and approved by the Board.

c. The Policy Manual may also be adopted, amended, or repealed in the same manner the Rules and Appendices, or the Bylaws may be amended.

15.5.2 Medical Staff Documents (Bylaws, Rules and Appendices)

a. Origination. Proposed amendments to the Medical Staff Documents that may include complete revisions of the Medical Staff Document(s), shall be directed to the Bylaws Committee and may originate from:

- i. The Medical Executive Committee;
- ii. The Board;

iii. The Chief of Staff, usually upon approval by Medical Executive Committee;

iv. The Bylaws Committee itself;

v. A Member, eligible to vote, who forwards to the Bylaws Committee, via the Office of Medical Affairs, a written request signed by ten (10) Members eligible to vote.

b. Review and Reporting by the Bylaws Committee. Proposed amendments shall be reviewed by the Bylaws Committee, which shall report the proposed change to the MEC with a recommendation to approve, approve with modifications, or reject the proposed amendment.

c. Action by the MEC. The MEC shall either, refer the proposal back to the Bylaws Committee for additional review, reject the proposal, or make its recommendations for a proposed amendment and distribute it to the Members.

d. Action by the Medical Staff.

i. After MEC review, the MEC may distribute or otherwise make available for review by all voting Members, an amendment proposed by the MEC, including a statement of the reason for the amendment. If any Member has comments or questions about the amendment, that Member will communicate with the Chief of Staff or the CMO so that those concerns can be considered and discussed by the MEC before the proposed amendment language is finalized for Medical Staff vote.

ii. The MEC will review all comments and questions from Members and will finally approve the amendment, approve with modifications, or reject the proposed amendment. Within one month, ballots identifying the proposed amendment, as approved by the MEC, will be sent to all Members eligible to vote.

iii. The ballot, to be returned within two months from the date of issuance, shall indicate the Member's vote for approval or disapproval of the proposed amendment. This time frame will allow for discussion among individual Members and for discussion as an agenda item at Service meetings if deemed necessary by the Service Chief.

iv. For the Bylaws, if a Full Majority Vote of the ballots issues to all voting Members recommends approval of the amendment, the amendment is adopted by the Medical Staff and shall be forwarded to the Board for action.

v. For the Rules or Appendices, if a Simple Majority Vote (by ballot or at a meeting) recommends approval of the amendment, the amendment is adopted by the Medical Staff and shall be forwarded to the Board for action, provided that the affirmative vote of at least twenty percent (20%) of the Medical Staff Members eligible to vote shall be required to constitute approval.

e. Action by the Board. Amendments approved by the Medical Staff shall be effective when approved by a majority vote of the Board. If Board refuses to act or does not act within ninety (90) days the MEC may call a Joint Conference Committee with the Board to discuss their reasons for refusal or inaction.

f. Corporate Board Ratification of Bylaws. For the Bylaws, upon approval by the Board, the Corporate Board shall ratify the Bylaws amendment. In the event the Corporate Board votes not to ratify the Bylaws amendment, a meeting of the Board and the MEC shall be called.

g. Independent Board Action. In the event that the Medical Staff shall fail to exercise its responsibility and authority as required above in paragraph 15.2, and after written notice from the Board to such effect including a period of sixty (60) days for response and a Joint Conference Committee with the MEC, the Board may initiate formulation or amendment of the Medical Staff Bylaws. In such event, the Board during its deliberations and in its actions shall carefully consider Medical Staff recommendations and views; however, the Board may not unilaterally amend Medical Staff Bylaws.

h. Emergency Action. In the event that there is a need for immediate action by the Medical Staff, any procedural rule or requirement in these Medical Staff Documents (e.g., a meeting notice requirement) may be modified by joint written action of the CEO, the Chief of Staff, and Board Chair (or authorized representative of the Board). In such case, the voting Members of the Medical Staff automatically delegate to the MEC the authority to provisionally approve an urgent amendment without prior notification of the Medical Staff. Such action shall be subject to prompt submission thereafter to the Medical Staff of a proposed amendment to the provision so modified. The Medical Staff would then have the opportunity for further review and comment on the provisional amendment. If the Medical Staff has significant disagreement with the amendment, the MEC may choose to review and revise it prior to Medical Staff vote. If the Medical Staff does not approve the provisional amendment in accordance with Sections 15.5.2.d.iv or 15.5.2.d.v, as applicable, there will be an opportunity for revision and resubmission to the Medical Staff, MEC and Board. Bylaws amendments made via emergency action shall be ratified by the Corporate Board.

i. Modification by formal agreement of the Medical Staff and Board. The provisions of the Medical Staff Documents may be modified or superseded by an agreement or policy adopted by the Medical Staff and approved by the Board in a manner which meets the voting requirements of an amendment to the Medical Staff Documents.

j. Attendance and Voting by Electronic Means. Where a meeting is called to approve amendments to the Medical Staff Documents, Members must attend the meeting in order to vote on the amendment. Members may attend and participate in meetings of the Medical Staff via electronic means, unless such remote participation is excluded by the meeting notice. Participation via approved electronic means will be considered attendance at the meeting. Voting may be conducted in person or remotely, as determined by the MEC.

15.5.3 Notice to Medical Staff.

- a. When Medical Staff Documents and/ or policies in the Policy Manual are adopted, materially amended or repealed, notice of the action shall be given and materially changed provisions shall be made available to all active Members for review.
- b. A current copy of Medical Staff Documents shall be maintained by the Office of Medical Affairs.
- c. Any Member may communicate with the Board regarding a Medical Staff or Hospital policy with the method of communication determined by the Board or its leadership.

ARTICLE XVI: PROCEDURES TO OPT-IN TO OR OUT OF UNIFIED MEDICAL STAFF

The Hospital is affiliated with two other health systems, SJMHS and the University of Michigan Health, but maintains a separate and independent Medical Staff. In the event the Medical Staff seeks to unify with another medical staff, or, after unifying, seeks to opt-out of a joint medical staff, such decisions shall be made in accordance with this Section, 42 CFR 482.22(b)(4) of the Medicare Conditions of Participation and TJC MS.01.01.01 EP 37.

16.1 UNIFICATION WITH OTHER MEDICAL STAFFS

The Medical Staff can be included in the unified medical staff of a health system in which the Medical Staff participates only after:

16.1.1 Three (3) months prior written notice to all Medical Staff Members describing the proposed unification, setting forth identified risks, benefits, and effects on the Medical Staff and its Members;

16.1.2 A Full Majority Vote in favor of unification. The MEC shall determine whether the Medical Staff votes:

- a. At a special meeting called for that purpose, or
- b. Via confidential mail or electronic balloting.

If all these requirements are not met, the Medical Staff shall remain separate from other medical staffs and shall continue as the independent Medical Staff of the Hospital. If the Medical Staff votes to accept unification, these Medical Staff Bylaws shall continue to remain in effect until and unless new Bylaws have been approved by the Medical Staff. The vote to unify with another medical staff shall be permitted no more than every two (2) years.

16.2 OPT-OUT FROM THE UNIFIED MEDICAL STAFF

16.2.1 The Medical Staff of the Hospital may request a vote to opt-out of the unified medical staff by obtaining signatures of at least twenty five percent (25%) of the voting Medical Staff Members on a petition requesting such a vote. Upon receipt of a petition signed by the requisite number of voting Medical Staff Members, a vote shall be held on the issue. In order to opt-out of a unified medical staff, a Full Majority Vote must vote in favor of opting out. In the event the Medical Staff opts out, it shall be the unique Medical Staff of the Hospital effective immediately. The Hospital shall call a special election to elect

Officers, Officials and other Medical Staff leadership immediately consistent with the Medical Staff Bylaws in effect immediately prior to dis-unification.

16.2.2 Upon dis-unification, the Medical Staff Bylaws in effect on the date of dis-unification shall continue to remain in effect until new Bylaws have been approved by the Hospital's distinct medical staff.

ARTICLE XVII: REVIEW PROCEDURES

Reviews and hearings will be conducted according to the provisions below, and in accordance with the Review Procedures for Members and Initial Applicants, which is Appendix I to these Bylaws. The following minimum requirements and further associated details in the Review Procedures Appendix for Medical Staff Members and Initial Applicants ("Review Procedures Appendix") are intended to be utilized with regard to certain types of disciplinary and administrative actions taken or about to be taken with regard to Members who make a timely request for same.

17.1 PROCESS FOR SCHEDULING HEARINGS

The following minimum procedural requirements shall apply when a recommendation is made or action taken by the MEC or the Board which, according to the Review Procedures Appendix, entitles an Affected Practitioner to a formal hearing (basic or special):

17.1.1 Special Notice. The Affected Practitioner shall be promptly given Special Notice by the CEO. The Affected Practitioner shall have thirty (30) calendar days from receipt of notice to request in writing a hearing.

17.1.2 Waiver. An Affected Practitioner who fails to request a formal hearing thirty (30) calendar days waives any right to such hearing and to any possible appellate review.

17.1.3 Hearing Date. Upon receipt of a timely request for hearing the CEO shall deliver such request to the Chief of Staff or the Board. The CEO, in coordination with the COS or Board Chair, shall promptly schedule and arrange for the hearing. At least seven (7) calendar days prior to the hearing date, the CEO shall notify the Affected Practitioner of the date, time and place of the commencement of the hearing by Special Notice. The hearing date should not ordinarily be more than forty-five (45) calendar days from the date of receipt of the request for a basic hearing, and shall not ordinarily be more than sixty (60) calendar days from the date of receipt of the request for a special hearing.

17.1.4 Release. By requesting a hearing or appellate review under these Bylaws or the Review Procedures Appendix, the Affected Practitioner agrees to be bound by the provisions of these Bylaws, Rules, Appendices and the Policy Manual in all matters relating thereto.

17.2 COMPOSITION OF HEARING COMMITTEE FOR BASIC HEARING

The composition of the hearing committee for a basic hearing, as defined in the Review Procedures, shall be:

17.2.1 By the MEC. A hearing occasioned by a proposed or actual adverse action of the MEC, shall be conducted by:

- a. A quorum of the MEC; or
- b. A subcommittee appointed by the Chief of Staff to conduct the hearing consisting of no less than three (3) Practitioners, at least one (1) of whom must be a member of the MEC.

The Chief of staff, who shall not be a member of the committee, shall appoint a member of the committee to serve as its chairperson or presiding officer.

17.2.2 By the Board. A hearing occasioned by a proposed or actual adverse action of the Board shall be conducted by a hearing committee appointed by the Board or its designee. This committee shall be composed of not less than three (3) persons, at least one (1) of whom shall be a Member. The Chairperson of the Board, who shall not be a member of the hearing committee, shall designate a member of the committee to serve as its chairperson and presiding officer.

17.3 COMPOSITION OF HEARING COMMITTEE FOR SPECIAL HEARING

The composition of the hearing committee for a special hearing, as defined in the Review Procedures Appendix, shall be:

17.3.1 By the MEC. A special hearing occasioned by recommendation or action of the MEC shall ordinarily be conducted by an ad hoc committee composed of no less than three (3) and no more than five (5) Practitioners appointed by the Chief of Staff in consultation with the CEO. The Chief of Staff, in consultation with the CEO, who shall not be a hearing committee member, shall appoint the presiding officer of the hearing committee who may, but need not be a Practitioner. An attorney may be appointed as a presiding officer, but if this is done, while the attorney may participate in committee deliberations and assist in the preparation of the hearing committee report, (s)he shall not have a vote for or against adoption of the final hearing committee report.

17.3.2 By the Board. A special hearing occasioned by a proposed or actual adverse action of the Board shall be conducted by a hearing committee of three (3) or more persons appointed by the Chairperson of the Board, at least One (1) of which must be a Practitioner, who may but is not required to be a Member and at least 1) of which must be a Board member. The Chairperson of the Board will designate one (1) of the appointees to the hearing committee as presiding officer.

17.4 PROCESS FOR CONDUCTING HEARINGS

The Medical Staff utilizes a three-tiered methodology for reviews to resolve disputed matters of concern involving Medical Staff Members and Applicants, which tailors the depth of the inquiry to reflect whether professional conduct or competence is at issue, the impact on the physician and involvement of patient, staff and community concerns. The lowest tier, informal review, dealing with non-substantive issues such as issuance of warning letter or letter of admonition does not require a hearing. Rather, the Affected Practitioner has the opportunity to submit a written statement to the MEC or Board, either of which may, in its discretion, grant a request to appear and talk in person. At the Basic Hearing (the middle tier of review dealing primarily with procedural requests or non-care issues like whether required insurance was purchased or a required document timely submitted), the Affected Practitioner shall have a reasonable opportunity to present relevant oral and documentary evidence and have their opinions fairly heard and

considered. Allowing the attendance of an attorney is discretionary by the hearing panel. The Presiding Officer shall determine the order of procedure and hearing rules and make all rulings on matters of law, procedure and the considerations of evidence. At a Special Hearing the highest tier of review designed for matters where the professional competence and/or conduct in the care of patients is involved, the Affected Practitioner shall have a reasonable opportunity to formally present relevant witnesses and documentary evidence and have their opinions fairly heard and considered in a process designed to be fully compliant with what is provided for hearings in the Health Care Quality Improvement Act of 1986. The Affected Practitioner shall have the right to have counsel present at the hearing and to cross-examine witnesses. The Presiding Officer shall determine the order of procedure and hearing rules and make all rulings on matters of law, procedure and the considerations of evidence. The decision will be rendered by a panel of uninvolved and fairly selected medical staff members or outside physicians. The details on the process for organizing and conducting reviews and hearings shall be provided in the Review Procedures Appendix.

17.5 RIGHT TO APPEAL

Affected Practitioners shall have the right to appeal a recommendation or action after a basic or special hearing in accordance with the Review Procedures Appendix

17.5.1 Written Request for Appeal After Basic Hearings. If, following a basic hearing pursuant to the Review Procedures Appendix, the Affected Practitioner believes that the hearing committee's recommendation was arbitrary, capricious, or lacks any evidence that justifies the decision, which shall be the sole grounds for appeal, (s)he may, within fifteen (15) calendar days of receipt of notice of the recommendation, submit a written appeal of the recommendation consisting of not more than ten (10) pages of text (not including exhibits) concisely stating the basis therefore to the CEO.

17.5.2 Written Request for Appeal After Special Hearings. After a special hearing, an Affected Practitioner shall have ten (10) calendar days following receipt of a notice pursuant as provided in the Review Procedures Appendix to file a written request for an appellate review. Such request shall be delivered to the CEO either in person or by certified mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, which was considered in making the actual or recommended adverse action or result.

17.5.3 Waiver. An Affected Practitioner who fails to request an appellate review within the applicable time and manner waives any right to such review.

17.6 PARALLEL EVENTS OR PROCEEDINGS

While a corrective action such as summary suspension is underway, a need for longer term action such as routine corrective action or reappointment may arise. Where longer term corrective action is required in addition to immediate corrective action, the MEC may initiate a parallel proceeding to address the longer term matter, with any hearings of both the more immediate and longer term issue being consolidated, as provided in the Review Procedures Appendix. To prevent a lapse of Privileges granted if the time of reappointment arises during the course of corrective action, the MEC, with Board consent, may extend the term of the existing appointment or recommend reappointment for a shorter period, with either such action subject to any limitation on exercise of such Privileges imposed as part of the more immediate action.

APPROVED by the MEC

Secretary Treasurer

ADOPTED by the Medical Staff

Chief of Staff

APPROVED by the Board

Chair, St. Joseph Mercy Chelsea Hospital Board

ST. JOSEPH MERCY CHELSEA

APPENDIX: 1. MEDICAL STAFF BYLAWS – COMMITTEE PROTOCOL (INCLUDING CONFIDENTIAL INFORMATION AND CONFLICT OF INTEREST POLICIES)

ARTICLE I: MEDICAL STAFF STANDING COMMITTEES

1.1 DESIGNATION

As provided in the Bylaws, there will be a Medical Executive Committee and other standing committees. The principles governing standing committees and the manner of and authority for the appointment of members and chairs of committees are set forth in this Protocol and other identified documents.

1.2 STANDING COMMITTEES ESTABLISHED BY MEDICAL STAFF DOCUMENTS AND OTHER POLICIES

The composition and duties of the:

- 1.2.1 MEC shall be as set forth in Section 11.5 of the Bylaws.
- 1.2.2 Nominating Committee shall be as set forth in Section 9.3 of the Bylaws.
- 1.2.3 Special Review Committees shall be as set forth in Article III of the Health Professional Evaluation Support and Intervention Appendix.
- 1.2.4 Alternative Action Committee shall be as set forth in Article VI of the Health Professional Evaluation Support and Intervention Appendix.
- 1.2.5 Professional Practice Evaluation Committee shall be as set forth in Article I of the Health Professional Evaluation Support and Intervention Appendix.

1.3 CREDENTIALS COMMITTEE

- 1.3.1 Composition. The Credentials Committee will be composed of the CMO and at least three other Members of the Medical Staff. Because continuity and seniority are important considerations for the committee, it is desirable that assignees serve for a minimum of five (5) years. The Credentials Committee may invite ad hoc members to attend Committee meetings, as appropriate, including, but not limited to, the APP Advisor.
- 1.3.2 Duties. The duties of the committee shall be to:
 - a. Review and evaluate the credentials, qualifications, and competence of all Applicants for appointment and reappointment to the Medical Staff and for all APPs seeking Authorized Functions to improve the quality of clinical care and to reduce morbidity and mortality in the Hospital;
 - b. Make recommendations to the MEC regarding:

- i. Applicants for Staff appointment and reappointment, Staff category and Service assignment and delineation of Privileges;
- ii. Requests for change of staff category or Privileges;
- iii. Delineation of Authorized Functions for APPs, as provided in the Policy Manual;
- iv. Policies and procedures regarding credentialing and Privileging functions.

1.3.3 Quorum. The quorum for meetings shall be fifty percent (50%) of the Committee members eligible to vote.

1.3.4 Electronic Participation. Committee members may attend and participate in meetings via conference telephone or other appropriate electronic means, unless such remote participation is prohibited by the meeting notice. Participation via electronic means will be considered attendance at the meeting.

1.3.5 Advisory Subcommittee. The Credentials Committee may, in its discretion, establish an advisory subcommittee to review and report on APP applications for appointment and reappointment of Authorized Functions.¹

1.4 BYLAWS COMMITTEE

1.4.1 Composition. The Vice Chief of Staff, CMO, and at least two (2) Primary Active Members. Ex-officio members include a representative of administration, and additional members as required.

1.4.2 Duties. To review and recommend to the MEC:

- a. Revisions of and new Bylaws of the Medical Staff.
- b. Revisions of and new Rules, Appendices and policies of the Medical Staff.
- c. Other revisions of and new Policies that require Medical Staff input.

1.4.3 Frequency. Meetings are scheduled four times per year and held at least twice per year, or as otherwise necessary to fulfill the committee's duties.

1.5 PHARMACY AND THERAPEUTIC LIAISON COMMITTEE (P&T)

1.5.1 Composition. The P&T Liaison Committee shall consist of the Chair of the Regional Pharmacy and Therapeutic Committee (or his/her designee) and an identified representative of the University of Michigan Health System Pharmacy Department, who shall serve as Liaison Members, ex officio with vote as well as at least four (4) appointed Medical Staff Members. Committee members shall also include a pharmacist, nursing administrator,

¹ The Bylaws Committee has established a proposed structure for such advisory subcommittee.

and representative of nursing service. Additional members and/or consultants may be appointed, as required.

1.5.2 Duties. The P&T Liaison Committee shall assist the Regional Pharmacy and Therapeutic Committee in the review and oversight of medications and medication-assisted devices at the Hospital, by:

- a. Recommending and developing policies and procedures concerning the evaluation, selection, proper use and safety of drugs.
- b. Recommending, developing and periodically reviewing a formulary for use in the Hospital.
- c. Establishing proposed guidelines concerning the use and control of investigational drugs and of research regarding the use of FDA-approved drugs.
- d. Recommending methods to improve the knowledge of Health Professionals and other staff in the proper and safe use of drugs.
- e. Conducting periodic reviews of the use of drugs in the Hospital.
- f. Performing other duties delegated by the Regional Pharmacy and Therapeutic Committee.

The P&T Liaison Committee shall, where applicable, report its findings and recommendations to the Regional Pharmacy and Therapeutic Committee.

1.5.3 Frequency. Meetings are scheduled quarterly, but additional meetings may be scheduled as necessary to fulfill the committee's duties.

1.5.4 Electronic Participation. Committee members may attend and participate in meetings via conference telephone or other appropriate electronic means, unless such remote participation is prohibited by the meeting notice. Participation via electronic means will be considered attendance at the meeting.

1.6 MEDICAL CARE REVIEW COMMITTEE (MCRC)

1.6.1 Composition. The MCRC shall consist of at least five (5) appointed Medical Staff Members chosen to represent a broad cross section of the Medicine Service, as well as certain ex-officio members. Ex-officio members include the Director of Nursing, the Medical Unit Nurse Director, the Director of Utilization Management, the Medicine Service Utilization Reviewer and additional members as required.

1.6.1 Duties.

- a. Identify and monitor key functions and services related to the health and safety of patients served by the Medical Staff, including legibility and clarity of clinical documentation by Health Professionals and other staff.

- b. Request and analyze data to assess the appropriateness, effectiveness and efficiency of care and service delivery by the Medical Staff. The foregoing notwithstanding, all questions related to surgical technique will be referred to the Surgical Case Review Committee, all questions related to psychiatry will be referred to the Psychiatry Care Review Committee, all questions related to emergency Physicians will be referred ER Physician Review Committee, and all questioned related to emergency services or intensive care shall be referred to the ICU/ER Committee. If more than one such committee may be implicated the committee chairs will decide which committees should be designated as a the primary reviewing committee
- c. Review all cases or issues consistent with the MCRC's scope of review as defined in Section 1.6.1(b) referred from a Service Chief, other Medical Staff Committees, the MEC, the Ethics Committee, the Hospital's Risk Manager or as identified by specific criteria when there are questions or potential concerns about the quality of medical care of an individual patient or patterns of care that prompt evaluation. MCRC assigns these cases to its members for independent review according to committee standards. When the reviewing member finds no concerns, the member may recommend committee approval. When the member identifies potential concerns, the case is discussed with the committee.
- d. Make recommendations to Health Professionals, the appropriate Service Chief, Chief of Staff or the MEC, as indicated, and establish mechanisms to follow-up on the recommendations.
- e. Identify, engage and oversee appropriate consultants as required to fulfill its duties. Advance written approval of the CMO is required before external consultants are engaged.
- f. Recommend and assist in the development and monitoring of clinical practice guidelines (clinical pathways and documentation tools) consistent with current knowledge and clinical experience to improve care by reducing medically unnecessary and/or unintended variations in care delivery.
- g. Review quality outcome findings related to clinical practice guideline improvement projects.
- h. Conduct quality of care reviews for Health Professionals, and provide Health Professional-specific and aggregate information to Medical Affairs for recredentialing purposes.
- i. Analyze the effectiveness of the committee's work by following up on the planned actions.
- j. Provide the Health Professionals and Hospital staff with information and support their efforts to improve the quality of medical care across the continuum.

1.6.3 Frequency. Meetings are scheduled monthly.

1.7 **SURGICAL CASE REVIEW COMMITTEE (SCRC)**

1.7.1 Composition. The SCRC shall consist of at least five (5) appointed Medical Staff Members chosen to represent a broad cross section of the Surgery Service, as well as certain ex-officio members. Ex-officio members include the Directors of Utilization Management and Medical Records (or their designee), the Nursing Manager of O.R., and additional members as required.

1.7.2 Duties.

- a. Identify and monitor the key functions related to the health and safety of patients with disorders that may, or have, required surgery, including legibility of clinical documentation by Health Professionals.
- b. Request and analyze data to assess the appropriateness, effectiveness and efficiency of care and service delivery for surgical cases. This may include patients whose attending Physicians are on the Medicine, Psychiatry or Surgery Services.
- c. Review all cases or issues referred from a Service Chief, other Medical Staff Committees, the MEC, Ethics Committee, the Hospital Risk Manager or identified by specific criteria when there are questions or potential concerns raised about the quality of surgical care. The issue may involve an isolated case or patterns of care.
- d. Make recommendations to individual Health Professionals, the appropriate Service Chief, Chief of Staff or the MEC, as appropriate, and establish mechanisms to follow-up the recommendations.
- e. Identify, engage and oversee appropriate consultants as required to fulfill the committee's duties. Advance written approval of the CMO are required before external consultants are engaged.
- f. Recommend and assist in the development and monitoring of clinical practice guidelines (clinical pathways and documentation tools) consistent with current knowledge and clinical experience to improve care by reducing medically unnecessary and/or unintended variations in care delivery.
- g. Analyze the effectiveness of the committee's actions including follow-up of the actions.
- h. Improve Medical Staff knowledge of important issues identified by the committee.
- i. Support the efforts of Health Professionals and other Hospital staff to improve the delivery of care across the entire continuum of care.

1.7.3 Frequency: Meetings are scheduled monthly (except August), but additional meetings may be scheduled as necessary to fulfill the committee's duties.

1.7.4 Subcommittee: General Surgery Forum

- a. This group of general surgeons will operate as an educational subcommittee of the Surgical Case Review Committee.
- b. In order to decrease morbidity and mortality in the Hospital and improve quality of care, the responsibilities of the General Surgery Forum are to:
 - i. Discuss various general surgery procedures and cases.
 - ii. Facilitate education responsive to the needs of the general surgeons and other Health Professionals at the Hospital.
 - iii. If requested to do so, make recommendations to the SCRC regarding general surgery issues.
 - iv. Discuss issues regarding procedures or protocols in general surgery as requested by other committees.
 - v. Report to the SCRC regarding topics discussed. Formal minutes are not required.

1.8 PSYCHIATRY CASE REVIEW COMMITTEE (PCRC)

1.8.1 Composition: The PCRC shall consist of at least three (3) appointed Medical Staff Members chosen to represent a broad cross section of the Psychiatry Service, as well as certain ex-officio members. Ex-officio members include a representative of Utilization Management, Psychiatry Unit Nursing Manager, a Psychiatric Social Worker and additional members as required.

1.8.2 Duties:

- a. Identify and monitor the key functions and services related to the health and safety of patients with psychiatric disorders, including legibility of clinical documentation by Health Professionals of the Psychiatry Service.
- b. Request and analyze data about the appropriateness, effectiveness and efficiency of care and service delivery for cases with psychiatric disorders. This may include patients whose attending Physicians are on the Medicine, Psychiatry or Surgery Services.
- c. Review all cases or issues referred from a Service Chief, other Medical Staff Committees, the MEC, Ethics Committee, the Hospital Risk Manager or identified by specific criteria when there are questions or potential concerns raised about the quality of psychiatric care. The issue may involve an isolated case or patterns of care.

- d. Make recommendations to individual Health Professionals and Hospital staff, the appropriate Service Chief, Chief of Staff or the MEC, as appropriate, and establish mechanisms to follow-up the recommendations.
- e. Identify, engage and oversee appropriate consultants as required to fulfill its duties. Advance written approval of the CMO is required before external consultants are engaged.
- f. Recommend and assist in the development and monitoring of clinical practice guidelines (clinical pathways and documentation tools) consistent with current knowledge and clinical experience to improve care by reducing medically unnecessary and/or unintended variations in care delivery.
- g. Analyze the effectiveness of the committee's actions including follow-up of the actions.
- h. Improve Health Professional and Hospital staff knowledge of important issues identified by the committee.
- i. Support the efforts of Health Professionals and Hospital staff to improve the delivery of care across the entire continuum of care.

1.8.3 Frequency: Meetings are scheduled at least quarterly, but additional meetings may be scheduled as necessary to fulfill the committee's duties.

1.9 ER PHYSICIAN REVIEW COMMITTEE (EPRC)

1.9.1 Composition: The EPRC shall consist of at least three (3) appointed Medical Staff Members chosen to represent Members with Privileges in the ER, as well as certain ex-officio members. Ex-officio members include the Nurse Manager of the ER, a representative of Utilization Management and additional members as required.

1.9.2 Duties:

- a. Review all cases or issues referred from a Service Chief, other Medical Staff Committees, the MEC, Ethics Committee, the Hospital Risk Manager, ER Director, other Medical Staff leaders or identified by specific criteria when there are questions or potential concerns raised about the quality of care of ER Physicians. The issue may involve an isolated case or patterns of care.
- b. Monitor legibility of clinical documentation by Privileged Physicians of the Emergency Service.
- c. Make recommendations to individual Members, the appropriate Service Chief, Director of the ER, Chief of Staff or the MEC, as appropriate, and establish mechanisms to follow-up the recommendations. Significant concerns regarding the competency or professional conduct of a Member with privileges to work in the ER will be referred to the ER Oversight Committee.

- d. Identify, engage and oversee appropriate consultants as required to fulfill its duties. Advance written approval of the CMO is required before external consultants are engaged.
- e. Recommend and assist in the development and monitoring of clinical practice guidelines (clinical pathways and documentation tools) consistent with current knowledge and clinical experience to improve care by reducing medically unnecessary and/or unintended variations in care delivery in the Emergency Room.
- f. Analyze the effectiveness of the committee's actions including follow-up of the actions.
- g. Improve Medical Staff and Privileged Physician knowledge of important issues identified by the committee.
- h. Support the efforts of Privileged Physicians to improve the delivery of care across the entire continuum of care.

1.9.3 Frequency: Meetings are scheduled at least quarterly, but additional meetings may be scheduled as necessary to fulfill the committee's duties.

1.10 ICU/ER COMMITTEE

1.10.1 Composition: The ICU-ER Committee shall consist of at least five (5) appointed Members chosen to represent Members with Privileges in the ICU and ER, as well as certain ex-officio members. Ex-officio members include the Nurse Managers of the ICU and ER, the Director of Nursing and additional members as required.

1.10.2 Duties:

- a. Identify and monitor the key functions and services related to the health and safety of patients requiring Emergency Services and/or Intensive care.
- b. Review all cases or issues referred from a Service Chief, other Medical Staff Committees, the MEC, Ethics Committee, the Hospital Risk Manager, ER Care Review Committee, other Medical Staff leaders or identified by specific criteria when there are questions or potential concerns raised about the quality of Intensive Care and/or Emergency Care. The issue may involve an isolated case or patterns of care.
- c. Make recommendations to individual Health Professionals and Hospital staff, the appropriate Service Chief, Chief of Staff or the MEC, as appropriate, and establish mechanisms to follow-up the recommendations
- d. Identify, engage and oversee appropriate consultants as required to fulfill its duties. Advance written approval of the CMO is required before external consultants are engaged.

- e. Recommend and assist in the development and monitoring of clinical practice guidelines (clinical pathways and documentation tools) consistent with current knowledge and clinical experience to improve care by reducing medically unnecessary and/or unintended variations in care delivery in the Emergency Room, Intensive Care Unit and acute care settings.
- f. Analyze the effectiveness of the committee's actions including follow-up of the actions.
- g. Improve Health Professional and Hospital staff knowledge of important issues identified by the committee.
- h. Support the efforts of Health Professionals and Hospital staff to improve the delivery of care across the entire continuum of care.
- i. Recommend and assist in developing policies and procedures related to the provision of cardiac care in the Emergency Services, Intensive Care Unit and Stress Testing/echocardiography in collaboration with the Director of Cardiology.

1.10.3 Frequency: Meetings are scheduled as necessary to fulfill the committee's duties.

1.11 INFECTION CONTROL LIAISON COMMITTEE

1.11.1 Composition. The Infection Control Liaison Committee shall consist of at least three (3) appointed Medical Staff Members, as well as the Chair of the Regional Infection Control Committee (or his/her designee), who shall serve as Liaison Members, ex officio with vote, and an identified representative of the University of Michigan Health System Department of Infection Control & Epidemiology. Members shall include a pharmacist, nursing administrator, and representative of nursing service. Additional members may be appointed, as required.

1.11.2 Duties. The Infection Control Liaison Committee shall assist the Infection Control Committee in the prevention of infection at the Hospital, by:

- a. Surveilling, on an ongoing basis, inadvertent institution infection potentials.
- b. Reviewing and analyzing actual infections.
- c. Promoting preventive and corrective programs designed to minimize infection hazards.
- d. Supervising infection control measures for activities.
- e. Recommending and developing policies and procedures concerning the types of surveillance carried out to monitor infections and the systems used to collect and analyze data and for assessing the effectiveness of surveillance, prevention, and control.

- f. Performing other duties delegated by the Regional Pharmacy and Therapeutic Committee.

The Infection Control Liaison Committee shall, where applicable, report its findings and recommendations to the Regional Infection Control Committee.

- 1.11.3 Frequency. The Infection Control Liaison Committee shall meet as necessary to fulfill the Committee's duties.

1.12 COMMITTEE CONSULTANTS

The COS or Chair of any Standing Committee, in conjunction with the CMO (or designee), may appoint one or more non-voting consultants to a Standing Committee.

ARTICLE II: SPECIAL AND AD HOC COMMITTEES

2.1 SPECIAL COMMITTEES

The Chief of Staff or the MEC may:

- 2.1.1 Establish special (ad hoc) committees of the Medical Staff and name their chairs, for the purpose of accomplishing specific objectives; and
- 2.1.2 Dissolve special committees of the Medical Staff when their charges have been completed.
- 2.1.3 Substitutes shall not attend the meeting or act in place of an absent Committee member.

2.2 JOINT CONFERENCE COMMITTEE

- 2.2.1 As provided in the Bylaws, a Joint Conference Committee is a joint meeting of an even number of representatives of the MEC and Board, which may be initiated on an ad hoc basis, by the MEC or Board, for the representatives of each body to discuss issues or disagreements and make reports and/or recommendations to the Board. The Board shall not be bound by the recommendations of the Joint Conference Committee.
- 2.2.2 Initiation. The Board and/or the MEC may initiate a Joint Conference Committee by providing written notice of the initiation to the other body. Once the Joint Conference Committee has been initiated, the bodies shall, at their earliest convenience, set a time for the meeting.
- 2.2.3 Composition. Unless otherwise agreed, the MEC's representatives at a Joint Conference Committee shall consist of the COS, Vice COS and a third Officer, Official or other person with special expertise selected by the COS and Vice COS. Unless otherwise agreed, the Board's representatives at a Joint Conference Committee shall consist of the CEO, Board Chair and Vice Chair.

ARTICLE III: HOSPITAL COMMITTEES WITH PROFESSIONAL REVIEW FUNCTION

The composition and duties of the:

- 3.1 Ethics Committee shall be as set forth in Appendix 1 of the Clinical Ethics Issues Policy.
- 3.2 Utilization Review Committee shall be as set forth in the Utilization Review Committee Monitoring Plan.
- 3.3 People Centered Care Committees shall be as set forth in the People Centered Care Committee Charter.

ARTICLE IV: REGIONAL COMMITTEES

The Hospital's parent-company health systems may establish, collectively or individually, regional committees overseeing certain aspects patient care, the provision of services and other functions of the Hospital. Hospital shall participate in such regional committees, as required, coordinate the activities of Hospital committees with overlapping regional committee, and shall cooperate with the recommendations and guidelines issues by such regional committees.

ARTICLE V: APPOINTMENT, TERM AND MEETING PROCEDURES

5.1 COMMITTEE APPOINTMENT AND TERM

- 5.1.1 Appointment. As provided in the Bylaws, unless otherwise specified for a particular committee, the Chief of Staff shall appoint the committee chairs, and shall recommend of appoint the other committee members.
- 5.1.2 Term. Unless otherwise specified for a particular committee, committee members shall serve on the committee until their successor has been approved, unless earlier resigns or is terminated. Ex officio members shall serve on a committee for as long as they serve in the position that supports their appointment ex officio.
- 5.1.3 Resignation. A committee member may resign upon written notice to the committee chair and COS.
- 5.1.4 Removal. The chair of a committee may be removed by the MEC, except that members of the MEC may be removed, as provided in the Bylaws. Committee members may be removed by the COS, with input from the committee chair, except that members of the MEC may be removed, as provided in the Bylaws.

5.2 NOTICE AND QUORUM OF MEETINGS

- 5.2.1 Notice. Except as otherwise provided, notice of committee meetings shall be given orally, by phone or in writing to each voting member of the body at least

three (3) days before the meeting, or in the case of emergencies, as soon as possible prior to the meeting. The attendance of a voting member at a meeting shall constitute his/her waiver of notice of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of or other proper advice of such meeting

- 5.2.2 Quorum. Unless a larger number is provided for a specific committee, then a quorum shall be the members present at the meeting and eligible to vote, provided that at least two members are present.

5.3 ATTENDANCE

- 5.3.1 Attendance. Members of Medical Staff committees are expected to attend a minimum of fifty percent (50%) of their regularly scheduled meetings.
- 5.3.2 Attendance by Electronic Means. As provided in the Bylaws, participation in a meeting by electronic means is permissible if permitted in the Policy Manual. However, no Medical Staff, Service, or committee meetings will be concurrently electronically recorded or the electronic media stored without the written consent of the chair of the meeting after due consideration and discussion of confidentiality issues with the CMO.
- 5.3.3 Special Meeting Attendance Requirements. If a Health Professional is being requested to attend a regular committee meeting at which time the clinical course of management of one or more patients by the Health Professional is to be discussed, such Health Professional shall be given written notice of the matter and of the time and place of the meeting and the case(s) to be discussed at least ten (10) days prior to the meeting. Whenever apparent, or suspected, difference from generally accepted clinical practice is involved, the Chief of Staff, CMO or MEC may require the Health Professional to confer with them or with a standing, or ad hoc committee considering the matter. Special notice shall be given to the Health Professional at least ten (10) days prior to the meeting including the date, time, and place of the meeting. Appearance is mandatory. Failure to appear at any meeting to which such special notice was given, unless excused by the person or group requesting the meeting, or MEC upon a showing of good cause, may result in an automatic withholding of all, or such portion of the Health Professional's Privileges, as the MEC may direct. Such action shall remain in effect until the matter is resolved by subsequent action of the MEC and the Board.

5.4 MEETINGS

Except as otherwise specified for a particular committee, committees shall meet as necessary to carry out the committee's functions. The Service Chief, Chief of Staff, or respective Committee chair may call a special meeting of any service or committee.

5.5 MANNER OF ACTION

- 5.5.1 Action During a Meeting. Except as otherwise specified in this Appendix, the Medical Staff Documents or Policy Manual, in meetings where a quorum is

established, the action of a majority of the vote-eligible members present and voting shall be the action of the group.

5.5.2 Actions Between Meetings. Action may be taken by a Service or committee without a meeting when all voting members receive notice of a proposed action and when a minimum of two-thirds (2/3) of the vote-eligible members set forth the action:

- a. via a personally signed document, or
- b. via e-mail or telephone communication with the Office of Medical Affairs signifying their approval of the proposed action. At the next meeting of the committee, members will sign an attestation of their vote on the action.

Actions between meetings will be reported by the committee chair at the next meeting of the committee. Action may not be taken between meetings when a full meeting of the Credentials Committee is required to act upon a Category Two or Three application for Medical Staff Membership and Privileges or a Category Two application for Authorized Functions, or when corrective action or professional peer review action is being considered. Such action shall only take place at a committee meeting.

5.5.3 Medical Staff committee members who are not Members of the Medical Staff are not eligible to vote.

5.6 MINUTES

Except as otherwise provided in this Appendix or the Medical Staff Documents and Policy Manual, a permanent record of proceedings and actions will be maintained and copies forwarded to the MEC.

5.7 PROCEDURAL RULES

As provided in the Bylaws, meetings of committees shall be conducted in accordance with procedures established by the committee either in writing or through established practice acceptable to a majority of the meeting participants, which fairly allow each individual participating in the meeting to review and consider relevant information, reasonably express his or her views, vote, and have his or her vote or dissent recorded. Notwithstanding the foregoing, if one third or more of the members at the meeting believe the procedures utilized do not meet the foregoing requirements or are unfair with respect to one or more matters, they may, by written notice signed by each of them, require that proceedings on such matter(s) be conducted in accord with the current edition of Robert's Rules of Order, Revised.

5.8 RIGHTS OF EX OFFICIO MEMBERS

Except as otherwise provided, persons serving as ex officio Members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote or be counted in determining the existence of a quorum.

5.9 PARTICIPATION BY PRESIDENT

The President or designee may attend any committee meetings of the Medical Staff.

ARTICLE VI: CONFIDENTIAL INFORMATION POLICY

6.1 PURPOSE

The Medical Staff of the Hospital is charged with many sensitive responsibilities, including oversight and/or directing of professional/peer review, risk and quality management, Medical Staff actions and many reviews of matters relating to, contracts, employment, and strategic planning of the Hospital. Confidentiality protection of the proceedings and deliberations of the Medical Staff and its Services and committees is vital to their ability to effectively carry out these responsibilities. This policy identifies matters that constitute Confidential Information and Sealed Information; delineates expectations for maintaining the confidentiality of Medical Staff proceedings and deliberations; and stipulates appropriate sanctions for unauthorized disclosure of Confidential or Sealed Information.

6.2 DEFINITIONS

- 6.2.1 **“Confidential Information”**. Consists of all information presented to, considered by or acted upon by the Medical Staff, its officers, its Services or its committees that is declared confidential by those bodies or is related to professional/peer review functions (Bylaws 13.1.3), except information: that is already known within the Hospital or in the public domain (provided it is not in the public domain because of prior, unauthorized disclosure); information which must be disclosed as a requirement of law, contract, financial reporting, or accreditation; and information designated by MEC, Board, or President, for general disclosure (e.g., a press release). In the event professional /peer review information or other Confidential Information must be reported or made available to external agencies, such information shall be maintained as confidential as reasonably possible, taking into account the need to externally report or grant access
- 6.2.2 **“Sealed Information”**. Consists of information that the Board or Medical Executive Committee specifically designates as “Under Seal” for the purpose of special confidentiality protection or reports the details of discussions or deliberations conducted during Executive Session of the MEC without such designation.
- 6.2.3 **“Covered Persons”**. This policy applies to all members of the Board of Trustees, Health Professionals, Hospital program medical directors, Hospital employees who are privy to the proceedings of the Medical Staff, and those other persons who are not Health Professionals or Hospital employees but are present at or have access to information considered or acted upon at Medical Staff committee and Service meetings.

6.3 APPLICABILITY OF THIS POLICY GENERALLY

This Policy applies to all Covered Persons with respect to Confidential Information and Sealed Information.

6.4 CONFIDENTIAL COMMITTEE PROFESSIONAL REVIEW FUNCTIONS

An essential purpose of all the committees which have clinical or professional review functions is to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency available by the state of the healing arts and the resources locally available. The duties of Medical Staff committees shall include, but are not necessarily limited to:

- 6.4.1 Review of professional practices of the Hospital in an effort to reduce morbidity and mortality;
- 6.4.2 Review of professional practices in an effort to improve the care and treatment provided patients in the Hospital, which shall include monitoring Hospital and Medical Staff policies and procedures, requirements for alternate coverage and consultations, and recommending methods of enforcement and changes when appropriate;
- 6.4.3 Review of quality and necessity of care provided to patients in the Hospital;
- 6.4.4 Review of preventability of complications and deaths occurring in the Hospital;
- 6.4.5 Directing, ordering and requiring the collection of records, data and knowledge in furtherance of its duties; and
- 6.4.6 Submittal of reports to the MEC concerning:
 - a. Findings of the committee's review and evaluation activities, actions taken thereon, and the results of such action;
 - b. Recommendations for maintaining and improving the quality of care provided in the Hospital; and
 - c. Such other matters as may be requested from time to time by the MEC.

6.5 CUSTODY AND MANAGEMENT OF CONFIDENTIAL INFORMATION AND SEALED INFORMATION

- 6.5.1 Custody. The minutes and records of the Medical Staff and the Board of Trustees will be maintained in a secure manner. Medical Staff minutes and records are maintained in the Office of Medical Affairs. Except as otherwise provided below, the minutes and records of the Board of Trustees, which may contain Medical Staff Confidential Information related to credentialing and professional/peer review information, are maintained by the office of the President. The Chief Medical Officer or his/her designee will have custody of all writings of Medical Staff bodies containing Sealed Information.
- 6.5.2 Professional/peer review Header. All professional/peer review documents will be labeled with the following legend:

This is a confidential professional/peer review and quality improvement document of the hospital and the Trinity Health system of providers. It is

protected from disclosure pursuant to the provisions of MCL 333.20175, 333.21513, MCL 333.21515, MCL 333.16222, MCL 331.531, MCL 331.533, MCL 330.1748, MCL 330.1143a, and other state laws as well as the federal Patient Safety and Quality Improvement Act, 42 U.S.C. 299b-21-b-26 and other federal laws. Unauthorized disclosure or duplication is absolutely prohibited.

- 6.5.3 Identification Numbers. As needed, Health Professionals are assigned an identification number by the Office of Medical Affairs for specific use in Professional/peer review documents. In some instances, it may be necessary for a reviewer to assign a Physician or group an alternate confidential number. Patients will be identified only by medical record number, or, if necessary, a professional/peer reviewer may assign an alternate confidential number.
- 6.5.4 Committee Member Responsibility. If Confidential or Sealed Information, including any document with the professional/peer review statement, is distributed prior to a Medical Staff, Hospital or Board meeting, committee members will take appropriate measures to maintain confidentiality of the documents.
- 6.5.5 Committee Coordinator Responsibility. Confidential and Sealed Information, including documents with the professional/peer review statement, will be collected at the end of the meeting where they have been discussed and either disposed of or stored in a secure manner. If documents were distributed prior to the meeting, committee members who were not present at the meeting are required to destroy or return the materials to the committee coordinator. All Confidential and Sealed Information, including documents containing professional/peer review information for use by Medical Staff Committees, shall be kept in a secure location by the OMA.
- 6.5.6 Permitted Disclosures of Confidential and Sealed Information.
- a. Confidential Information. Confidential Information may be disclosed with Covered Persons, providing that there is a need to know the information in order to carry out the his/her duties on behalf of the Medical Staff, e.g., as a Medical Staff committee member, and that the Covered Person does not have a personal conflict of interest in the matter. It shall be generally presumed that a committee or Service member (whether voting or non-voting), without conflict of interest, has a need to know Confidential Information which generally came before a committee or Service meeting, whether or not (s)he was present.
 - b. Sealed information. Disclosing Sealed Information is generally only permitted: (1) among those who were present when the information was originally disclosed, (2) to those individuals who must carry out any conditions specified by the information, and (3) those Health Professionals not present (unrelated to any conflict of interest) who require the information to carry out their committee or Service membership responsibilities.

- c. Confidential and Sealed Information may be disclosed beyond the above limitations only with the authorization of the Chief Medical Officer or Chief of Staff or if legal interests of the Hospital are involved, the President or Board Chair may authorize such release.

6.5.7 Separation from Credentials Files. Professional/peer review information will be kept in a separate folder within the Physician's credentials file. Professional/peer review information will not be released as a part of a Physician's credentials file.

6.5.8 Presumption of Confidentiality. Any doubt as to whether or not information is Confidential or Sealed Information shall be resolved by presuming it is Confidential or Sealed Information until the MEC, President or Board can act to clarify the matter.

6.5.10 Continuing Obligations. The obligations imposed by this policy survive the termination of a covered person's relationship with the Hospital, and Covered Persons acknowledge a continuing obligation to adhere to this policy despite the termination of that relationship. Covered Persons also acknowledge that a failure to adhere to this Policy after termination of the relationship may result in the Hospital's pursuit of legal and equitable remedies.

6.6 REQUESTING CONFIDENTIAL AND SEALED INFORMATION

6.6.1 By a Member, APP. Members, APPs will not have access to their own professional/peer review information, e.g., documents, minutes, etc., until such time, if ever, that disciplinary action is instituted, at which time access may be granted pursuant to Bylaws. It is understood that a Member, APP under review may be asked to leave the room during discussion of such information.

6.6.2 By a non-Committee Member. Requests by a Health Professional or other staff members for committee or service meeting minutes who is not an active member of the committee or service will be made to the Office of Medical Affairs and will include the reason beneficial to the Medical Staff and/or Hospital for such request. The CMO will review such requests, consult with the Chief of Staff, and decide whether the request will be granted and so inform the individual.

6.6.3 Subpoenas and other legal efforts. Subpoenas, orders and other legal efforts to obtain Confidential or Sealed Information will be referred to and processed by Hospital Counsel in consultation with the Chief Medical Officer and Chief of Staff. Until action can be taken, any Hospital executive shall be empowered and may authorize legal counsel to take such steps as are reasonably necessary and advisable to lawfully resist document production of the information. No release of Confidential or Sealed Information shall be made without the concurrence of or the Hospital executive responsible for legal affairs and risk management, or his/her superior, acting in consultation with legal counsel whenever appropriate, absent other instructions from the Board.

6.7 UNAUTHORIZED DISCLOSURE AND SANCTIONS

Unofficial use of committee minutes and other written documents generated by official Medical Staff activities is not permitted. Unauthorized disclosure of Confidential or Sealed Information should be promptly reported to Medical Staff leadership and may result in the following actions:

- a. For Medical Staff Members: discipline, including loss of committee membership, Medical Director position, or termination of Privileges and/or Medical Staff Membership;
- b. For other Health Professionals: discipline, including loss of committee membership, appointed offices or positions, or termination of Practice Authority;
- c. For Board members: reprimand, loss of committee membership, or removal from the Board; and
- d. For other Hospital employees: discipline, including reprimand or termination of employment.

In determining the appropriate sanction, Medical Staff leadership will the degree of willfulness of the disclosure, the manner of disclosure, the likelihood of recurrence and the magnitude of harm done by the disclosure to the Hospital, its Medical Staff, patients and/or staff members.

6.8 ASSIGNED PROFESSIONAL/PEER REVIEW FUNCTIONS

At the time this Appendix is adopted (and subject to change by the MEC and Board) the following committees and their members are assigned professional/peer review functions by the Board of Trustees and the Medical Staff: MEC, Credentials Committee, Medical Care Review Committee, Surgical Case Review Committee, Psychiatry Care Review Committee, ER Physician Review Committee, Emergency Care Review Committee, Laboratory Committee, ICU-ER Committee, all Special Professional Review Committees, Alternative Action Committees, Hearing Committees or Alternative Hearing Committees, the Board of Trustees, all officers of the Medical Staff and Service officers, and other Members or Hospital Administrators delegated to and in such roles.

6.11 COORDINATION WITH OTHER POLICIES

This Policy should be read consistent with any other Hospital or Medical Staff confidentiality and conflict of interest policies. However, in the event another more specific policy covering similar subject matter is more restrictive and protective of confidentiality, that policy's more restrictive requirements shall supersede.

ARTICLE VII: MANAGEMENT OF CONFLICTS OF INTERESTS

7.1 PURPOSE

Free flow of communication and sound decision making requires Health Professionals and other Hospital staff who serve as Medical Staff officers or committee members or staff disclose any duality of interest on matters under consideration by them in those capacities and, where personal economic or other interest could influence fair decision making concerning fellow Health Professionals and applicants, or Hospital related-business issues, to refrain from participation and voting in such matters.

7.2 POLICY

- 7.2.1 Good Faith. Health Professionals, and other Hospital employees and Hospital-retained independent contractors involved in Medical Staff decision making roles or processes, all exercise the utmost good faith in all transactions touching upon their respective duties on behalf of the Medical Staff and the Hospital. The use of position, or knowledge gained therefrom, in such a way that a conflict may arise between his/her interest and the interest of the Medical Staff as a whole, the Hospital, or other Health Professionals, including improper personal gain, shall not be permitted. Moreover, acceptance of gifts, favors, hospitality or consulting fees which may influence decisions or actions affecting the best interest of Medical Staff, Hospital, or Hospital patients may constitute a potential or actual conflict of interest.
- 7.2.2 Disclosure of Actual or Potential Conflicts. Each Health Professional or other Hospital employee holding an Officer or Official position or serving on a committee (as member or staff) should be alert for potential or actual conflicts of interest and should express any concern or possible conflict prior to discussion of the matter. The OMA shall distribute conflict of interest forms upon appointment, reappointment and at the Medical Staff annual meeting. All actual or potential conflicts of interest should be identified and explained in the disclosure form. If any information on the form changes, or another conflict arises after the form is submitted, the Health Professional shall report the change or new actual or potential conflict to OMA.
- 7.2.3 Financial Conflicts. Where OMA becomes aware of an actual or potential conflict of interest that is financial in nature, such conflict shall be reported to the SJMHS Compliance Officer, who shall evaluate the conflict and make a determination on how the actual or potential conflict will be handled. The SJMHS Compliance Officer may designate the Hospital's MEC or other body to assist in the evaluation of the conflict.
- 7.2.4 Other Conflicts. Where OMA becomes aware of an actual or potential conflict of interest that is not financial in nature (e.g., interpersonal conflicts, familial relationships), the conflict may be evaluated in accordance with this Section 7.2.4. However, nothing in this Section shall prevent OMA from submitting the conflict to the SJMHS Compliance Officer for evaluation and resolution. Potential or actual conflicts involving an action or decision should be evaluated by COS (or designee), in conjunction with legal counsel and, if applicable, the SJMHS Compliance Officer. Where it is determined a potential conflict of interest exists but is minor, irrelevant, or is in the best interests of the Medical Staff, Hospital, and patients are not at risk based upon a weighing of the advantages and disadvantages accompanying the conflict, the COS may resolve and conclude a conflict does not exist. Upon such a finding, the individual whose potential conflict of interest or actual conflict of interest was under consideration, shall be permitted to freely participate and vote or take action on the matter, as appropriate. A finding that a conflict does not exist or is waived, should be reflected in the pertinent body's minutes and/or records.

- 7.2.5 Limited Participation Upon Disclosure. Unless otherwise provided by the SJMHS Compliance Officer or the Hospital, the foregoing requirements should not be construed to prevent any such person from disclosing any reason known by him/her why a contract, transaction or other matter is not in the best interests of the Medical Staff or Hospital. Upon proper identification and explanation of potential or actual conflict of interest, such person may answer pertinent questions stating his/her position on the issue especially where such person possesses relevant special knowledge, education, or training and where permitted by affirmative majority vote of the remaining members of a body or committee, or where action is to be taken by another person, the permission of such other person. All decisions to permit participation by a person with a potential or actual conflict of interest shall be evaluated in accordance with the following sections of this Appendix.
- 7.2.6 Other Policies. This Appendix should be read consistent with any other Hospital or Medical Staff confidentiality and conflict of interest policies. However, in the event another more specific policy covering similar subject matter is more restrictive and protective against conflicts, that policy's more restrictive requirements shall supersede.

ST. JOSEPH MERCY CHELSEA

MEDICAL STAFF BYLAWS APPENDIX: 2. HEALTH PROFESSIONAL EVALUATION SUPPORT AND INTERVENTION

ARTICLE I: PROFESSIONAL PRACTICE EVALUATION POLICY

1.1 PROFESSIONAL PRACTICE EVALUATION COMMITTEE ("PPEC")

The PPEC is the multi-specialty committee that oversees the administration and implementation of the Hospital's several professional practice evaluation and intervention processes. The PPEC shall review all issues referred by the Service Chief and determine when further review or action is required in accordance with the PPE Algorithm and PPE Process Map.

1.2 COMPOSITION OF THE PPEC

The PPEC shall consist of the Vice Chief of Staff, who shall serve as the chair of the Committee, the CMO, who shall serve as the vice chair of the committee, and the Hospital's Vice Service Chiefs, each of whom shall be voting members. The PPEC may invite other individuals who have knowledge relevant to the Committee's purpose and/or duties to serve as ad hoc members and attend Committee meetings, as appropriate, without vote.

1.3 DUTIES OF THE PPEC

1.3.1 Receive, from the MEC, the Board, CEO, Officers or Officials or other persons, referrals for follow up of Health Professionals, who, in the opinion of the referring party, exhibit personal or professional issues that require evaluation or intervention beyond a single in-person meeting.

1.3.2 Review and evaluate the cases referred to the PPEC to identify the evaluation or intervention process that is most appropriate to address the subject Health Professional's issue(s), including but not limited to, Special Committee Professional Review, the Disruptive Behavior process, Impaired Health Professional process, Alternative Action process, and Administrative, Corrective and Summary Action, and provide necessary follow up.

1.3.3 Provide input and oversight concerning the professional practice evaluation processes.

1.3.4 Approve all forms to be used in the professional practice evaluation process to ensure standardization.

1.3.5 Identify system issues and refer them to the Chief Quality Office and escalate to CMO, MEC, or Board when appropriate (e.g., service disruption).

1.3.6 The PPEC shall prepare annual reports for the MEC and the Board, including:

- a. Individual Health Professional history report, including all referrals reviewed by the PPEC within the past two years and the disposition;

- b. Aggregate number of referrals reviewed through the PPE process and the dispositions of those matters; and
- c. Reports upon request by the MEC, Hospital leadership or the Board.

1.3.7 The PPEC will receive and review annual professional practice evaluation activity.

1.4 ELEVATION TO OR PREEMPTION BY MEC OR BOARD

The MEC and/or the Board may, in their sole discretion, preempt the Committee's evaluation of a referral. Further, either the Chair or Vice Chair of the Committee may, in his/her sole discretion, elevate any referral to the MEC or Board to review.

1.5 QUORUM

The quorum for meetings shall be fifty percent (50%) of the Committee members eligible to vote.

1.6 PPEC ACTION

The action of a majority of the voting members present at a meeting at which a quorum is present shall be deemed to be the action of the PPEC. The PPEC shall report matters to MEC, Chief of Staff, CMO and/or CEO as warranted, for review and consideration when circumstances warrant further review or action. In and of itself, PPEC review under this Article shall not be considered as disciplinary action relating to patient care reportable to the State of Michigan licensing authorities or an investigation triggering reporting to the National Practitioner Data Bank.

1.7 FREQUENCY

Meetings are scheduled as necessary to fulfill the committee's duties.

ARTICLE II: HEALTH PROFESSIONAL ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE") AND FOCUSED PROFESSIONAL PRACTICE EVALUATION ("FPPE")

2.1 ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE")

The purpose of OPPE is to provide for continuous concurrent monitoring for the competency of each Health Professional who has been granted Practice Authority to provide inpatient care to patients. Effective continuous monitoring of competencies for these Health Professionals leads to increased patient safety and quality of care by identifying and resolving potential professional practice trends and performance issues as soon as possible. This will provide for an evidence-based Practice Authority renewal process for Health Professionals. OPPE shall be carried out in accordance with the Practice Evaluation for Medical Staff and Advanced Practice Professionals (APPs) Policy, which is attached to this Appendix, as such policy may be amended from time to time.

2.2 FOCUSED PROFESSIONAL PRACTICE EVALUATION (“FPPE”)

The Focused Professional Practice Evaluation process is designed to be a fair, balanced, and educational approach to ensure the competency of the Health Professionals who have or seek Practice Authority. FPPE is to be consistently implemented in accordance with the criteria and requirements defined by the Medical Staff in the Practice Evaluation for Medical Staff and Advanced Practice Professionals (APPs) Policy, which is attached to this Appendix, as such policy may be amended from time to time.

ARTICLE III: SPECIAL COMMITTEE PROFESSIONAL REVIEW FOR HEALTH PROFESSIONALS

3.1 PURPOSE OF SPECIAL PROFESSIONAL REVIEW

A confidential special professional peer review, study or investigation of the practice of one or more Health Professionals, may be initiated on a Hospital or Service basis for the purpose of reducing morbidity and mortality in the Hospital, formulating policy or resolving concerns regarding patient care, cooperation, and collegiality among the Medical Staff and/or with Hospital staff, or the reputation of the Hospital and/or its Medical Staff. As such, it shall be considered a review matter and not an adversarial proceeding. The provisions of the Review Procedures Appendix shall not apply. A Member shall not be entitled to have legal counsel present during any meetings or discussions between such Member and the individual reviewer or members of the committee. Examples of events triggering review under this section include, but are not limited to: an unanticipated patient death or major injury; recurrent unexpected patient morbidity; events for which a claim or licensure report is threatened by patient; circumstances where state reporting by colleagues is required.

3.2 SPECIAL PROFESSIONAL REVIEW INITIATION

A professional review, or study at the Service or Medical Staff level may be initiated by:

3.2.1 A finding by a review committee that there was a single triggering episode or a pattern or care by a Health Professional that met or exceeded outlier criteria established by or for such committee and the committee or MEC determines that a separate review independent of the committee is needed; or

3.2.2 A special professional review process is recommended by one of the following due to a single incident or trend in clinical practice or professional conduct:

- a. Joint request of the Chief of Staff and CMO (or CEO); or
- b. Request of the PPEC; or
- c. Request of the MEC; or
- d. Request of a Service Chief with the concurrence of the CMO and notice to the Chief of Staff; or
- e. Request of the Board.

3.3 SPECIAL PROFESSIONAL REVIEW SCOPE AND PROCESS

- 3.3.1 The scope and time frame of the special professional review shall be specified in a written review process agreed upon by those initiating the review, or if these individuals do not agree, by the Chief of Staff with input from the Service Chief. The process may direct that Members, Hospital staff, and others be interviewed in the process if so specified. All those from whom an interview is requested shall comply. The MEC or Chief of Staff may modify the process as appropriate, with input from the Service Chief.
- 3.3.2 When performance monitoring is recommended, the monitoring process will be clearly defined and include: criteria for conducting performance monitoring, the method for establishing a monitoring plan specific to the requested Privilege(s), and the method for determining the duration of performance monitoring.

3.4 SPECIAL REVIEW COMMITTEE COMPOSITION

The review committee composition shall be specified in the written review process. The committee may be an existing Medical Staff committee, the Board or composed of any person(s) who are determined by those initiating the review to be the best to carry out the review or study (e.g., legal counsel, independent physician consultant, etc.), provided that there must always be at least one Member on the review committee, unless so doing would result in a serious irreconcilable conflict of interest.

3.5 PARTICIPATION OF HEALTH PROFESSIONAL

If the review focuses upon a specific Health Professional, that Health Professional shall be given the opportunity to meet and discuss the issues involved in the review with the reviewing committee.

3.6 EXTERNAL REVIEWERS

When, in the judgment of the review committee or those appointing it, there are no Health Professionals with the necessary expertise who are willing to meaningfully participate in the review, or the participation of such individual may give rise to an irreconcilable conflict of interest, or an independent review would be the most effective alternative, the committee shall utilize an independent review procedure. The selection of the external reviewer shall be made by the committee and, especially if payment of a fee by the Hospital may be involved, the CEO (or designee).

3.7 REPORTING

Upon completion of its study or investigation (but not later than ninety days after establishment of the committee), the reviewing committee shall report its findings to the applicable Service Chief and MEC through the CMO and provide a summary of its findings to the Health Professional being reviewed. Such report and summary shall include any committee recommendations of action to be taken to improve performance. Confidentiality shall be maintained consistent with Medical Staff Documents and Policy Manual as well as Hospital policies made known the Medical Staff.

ARTICLE IV: DISRUPTIVE BEHAVIOR POLICY

4.1 STATEMENT OF ACCEPTABLE AND UNACCEPTABLE HEALTH PROFESSIONAL CONDUCT

4.1.1 A working environment in the Hospital with excellent collegial interactions among and between Members, patients and families, Hospital employees, Administration, and the Board of Trustees contributes to excellent patient care. It is expected by the Medical Staff that all individuals within its facilities be treated courteously, respectfully, and with dignity. To that end, the Medical Staff and Board require that all Health Professionals conduct themselves in a professional and cooperative manner while in the Hospital or while involved in patient care.

4.1.2 Disruptive behavior consists of a broad array of actions and may take many forms. For the purposes of this policy, behavior and conduct are used synonymously. "Disruptive behavior" is defined as behavior that is: detrimental to the best interest of the Hospital and/or Medical Staff; detrimental to the good practice of medicine; unprofessional; vulgar; rude; degrading; demeaning; demoralizing; argumentative; insulting; intimidating; profane; harassing and/or abusive. Such behavior undermines the culture of safety and may disrupt the operation of the Hospital, affect the abilities of others to perform their jobs, create a hostile work environment for Hospital employees or other Members, or interfere with the Member's own ability to practice competently. Unusual, unorthodox or different behavior alone is not sufficient to justify corrective or rehabilitative action. If, however, the conduct significantly interferes with the effective operation of the Hospital or poses a threat to patient care, Hospital personnel or Member(s), an effective process must be put in place to address it.

4.1.3 The Medical Staff considers the following behaviors representative of (but not limiting to) acts which violate Medical Staff and Hospital policy:

- a. Verbal attacks toward Hospital employees and/or Members that are personal, unwarranted, inappropriate, and/or go beyond the bounds of fair professional comments.
- b. Comments that intimidate, undermine confidence, belittle, berate, threaten, and/or imply stupidity or incompetence, including in situations where legitimate concerns about judgment or attitude are brought to the commenter's attention.
- c. Inappropriate written comments (or illustrations) in patient medical records, or other official documents, or verbalized to patients or the public, that impugn the quality of care in the Hospital or attack or demean a Health Professional, Hospital staff member or Hospital policy.
- d. Angry outbursts directed at patients, family members or Hospital employees that are not reasonably justified by the circumstances.
- e. Public criticism of a Member or Hospital employee or the Hospital that is destructive or malicious. Constructive criticism made through appropriate Hospital or Medical Staff channels or lawful reporting to appropriately address regulatory compliance concerns would not be considered disruptive conduct.

- f. Any form of sexual harassment directed at employees or Health Professionals (see Sexual Harassment section below for further clarification).
- g. Verbal or physical threats, assaults, or abuse directed at patients, families, employees, or Health Professionals.
- h. Participation in practical jokes, horseplay, harassing, abusive, or similar behavior which interferes with work, creates risk of injury, or is unduly offensive to other(s).
- i. Refusing to accept Medical Staff assignments (rotational call, unassigned patient call, completion of medical records, committee assignments), or participate in committee or Service affairs on anything but one's own terms, or to participate in a disruptive manner.
- j. Persistent tardiness in responding to on-call duties or arriving in a scheduled environment (e.g., clinics, operating rooms or required meetings).
- k. Throwing or propelling objects in anger or to intimidate.
- l. Imposing idiosyncratic requirements on staff that have nothing to do with better patient care or represent bizarre or impertinent requirements contrary to Medical Staff or Hospital policy, common sense or recognized procedure in a hospital setting.
- m. Retaliation, such as disciplining, changing work assignments of, providing inaccurate work information to, or refusing to cooperate or discuss work-related matters with, any employee or other staff because that employee or staff member has complained about the Health Professional or others for conduct such employee/staff member reasonably considered to be unacceptable in accordance with this Policy or other Medical Staff or Hospital policy.
- n. Any other behaviors in contradiction to the expectations set forth in the Trinity Health-Michigan Code of Conduct Supplement for Medical Staff.

4.1.4 Health Professionals who engage in disruptive behavior will be dealt with in accordance with this policy. Health Professionals who are Hospital employees may also be dealt with in accordance with Hospital policy.

4.1.5 This policy outlines a number of steps that may be taken to resolve complaints about disruptive behavior by Health Professionals. This policy notwithstanding, prior to or following use of some or all of these procedures, at times a single incident of disruptive behavior or a series of incidents may be of such concern as that immediate disciplinary action is indicated prior to initiation or completion of these steps. Nothing in this policy precludes the immediate initiation of formal corrective action including summary action and suspension, pursuant to this Appendix, or immediate referral to the MEC (or the Board) or the elimination of any particular step in this policy in dealing with a complaint about disruptive conduct.

4.2 SEXUAL HARASSMENT

4.2.1 When a Health Professional's behavior affects the ability of others to get their job done, it creates a "hostile" environment, or interferes with the Health Professional's own ability to practice competently, it is the Medical Staff's and Hospital's duty to take action.

4.2.2 Sexual harassment by a Health Professional of any patient, visitor, Health Professional or other staff member, will not be tolerated by the Hospital and the Medical Staff. Reported allegations of such behavior are considered matters of concern and are addressed as outlined in Section 4.3 of this Policy.

4.2.3 Sexual harassment of a Health Professional or Hospital staff member creates a hostile working environment for that individual and for the co-workers of that person, and violates the law. The following list serves to identify and establish specific examples of behavior that can be considered sexual harassment:

- a. Physical assaults of a sexual nature, such as:
 - i. Rape, sexual battery, molestation or attempts to commit these assaults; or
 - ii. Intentional physical conduct which is sexual in nature, such as touching, pinching, patting, grabbing, intentional brushing against another's body, or poking another's body.
- b. Unwanted sexual advances or statements, including propositions or other sexual comments such as:
 - i. Sexually-oriented gestures, noises, remarks, jokes or comments about a person's sexuality or sexual experience directed at or made in the presence of any employee who indicates or has indicated in any way that such conduct in his or her presence is unwelcome;
 - ii. Preferential treatment or promises of preferential treatment to an employee or other Health Professional for submitting to sexual conduct, including soliciting or attempting to solicit any other Health Professional or Hospital staff member to engage in sexual activity for compensation or reward; or
 - iii. Subjecting, or threats of subjecting, an employee to unwelcome sexual attention or conduct or intentionally making performance of the person's job more difficult because of that person's gender or sexual preference.
- c. Sexual or discriminatory displays or publications anywhere in the Hospital's workplace by a Health Professional, such as:
 - i. Displaying pictures, posters, computer screens (e.g., "wallpaper"), calendars, graffiti, objects, promotional materials, reading materials or other materials that are sexually suggestive, sexually demeaning, or pornographic, or bringing into the work environment or possessing any

such material to read, display or view at work. A picture will be presumed to be sexually suggestive if it depicts a person of either sex who is not fully clothed or in clothes that are not suited to or ordinarily accepted for the accomplishment of routine work in and around the Hospital and who is posed for the obvious purpose of displaying or drawing attention to private portions of his or her body.

iii. Reading or otherwise publicizing in the work environment materials that are in any way sexually revealing, sexually suggestive, sexually demeaning or pornographic; or

iii. Displaying signs or other materials purporting to segregate an employee by sex in any area of the workplace (other than restrooms and similar semi-private lockers/changing rooms).

d. Retaliation for sexual harassment complaints, such as disciplining, changing work assignments of, providing inaccurate work information to, or refusing to cooperate or discuss work-related matters with any employee because that employee has complained about or resisted harassment, discrimination or retaliation.

4.3 PROCEDURE

4.3.1 Preparing a report. Documentation of disruptive conduct is critical since it is often not one incident that justifies disciplinary action, but rather a pattern of conduct or two or more separate incidents. If any individual working at the Hospital (including a Health Professional) observes a Health Professional's significant disruptive behavior or becomes aware of an apparent pattern of disruptive behavior, the individual (the "Reporter") shall make a written report. The report shall include:

a. The date and time of the behavior(s);

b. The patient(s), patient family member(s), Health Professional(s) or Hospital employee(s) involved in or witnessing the incident;

c. The circumstances that precipitated the incident, if known;

d. A description of the behavior(s) observed including observations and any/all pertinent objective facts to the extent possible, including:

i. Any actual observed consequences, if any, of the disruptive behavior related to patient care or the reporter's expectations of such future consequences, e.g., how do you expect it to affect patient care?

ii. Actual or anticipated consequences, if any, of the disruptive behavior on Hospital operations.

iii. Any action taken to intervene or remedy the situation including date, time, place, action, and name(s) of those intervening and the observed response of the Health Professional.

- e. The name of the Reporter and the date of the report;
- f. Additionally, the name(s), if any, of other individuals who observed the behavior and discussed it with the Reporter and all others present who are believed by the reporter to have observed the behavior.

4.3.2 Submitting a report. The report shall be submitted to the appropriate Service Chief and CMO. If the report is submitted to another Health Professional, Hospital Department Director, or Hospital Administration, it shall be forwarded immediately to the appropriate Service Chief and CMO. For informational purposes, the report will also be shared with the Chief of Staff.

4.3.3 Initial Report Review. The Service Chief and CMO will review and discuss the report. One or both (or their designees) will discuss the contents of the report with the Reporter and, as deemed appropriate by the Service Chief and CMO, with others present as well. The two will summarize the information and plan the appropriate next steps. If the Service Chief and CMO determine that the conduct is so egregious that it may justify formal corrective action, the matter shall be processed in accordance with Articles VII, VIII, X and/or XI. If, in the joint judgment of the Service Chief and CMO, the report is unwarranted and no action is justified, they shall so notify the Reporter. Otherwise, the following procedure will be followed.

4.3.4 Informal meeting not saved in permanent file. If the Service Chief and CMO determine that a single incident warrants a discussion with the affected Health Professional but does not, at that time, warrant stronger action, the Service Chief, with support of the CMO, shall initiate the discussion as a collegial intervention (or they may agree that the CMO or other Health Professional shall have this discussion). The foregoing notwithstanding, if a single event of disruptive behavior is of more concern, but is not believed to warrant corrective action, then the process for a formal meeting with the Health Professional outlined in 4.3.5 will be followed.

- a. The purpose of the discussion is to help the affected Health Professional understand that certain conduct is inappropriate and unacceptable.
- b. If the affected Health Professional raises other concerns, such Health Professional will be informed of the administrative channels for reporting such concerns, if appropriate.
- c. In each individual case, the Chief of Staff will determine whether the identity of the Reporter will be kept confidential.
- d. The affected Health Professional will be informed that any retaliation or retribution against the Reporter or anyone involved in reporting the incident will not be tolerated by the Medical Staff, and may be grounds for summary action.
- e. Legal counsel shall not be present at this informal meeting.
- f. The Service Chief (or other Officer, Official or representative of Administration present) shall document the meeting. This will be sent to and saved in the Office of Medical Affairs, but not placed at this time in the Health Professional's permanent credentials file. Pursuant to this Appendix, the Service

Chief may write the Health Professional a Letter of Concern, which will not be placed in the Health Professional's permanent credentials file. The Health Professional may also submit a written response to the concerns raised about his/her conduct, a copy of which shall be sent to and maintained by the Office of Medical Affairs.

4.3.5 Additional Intervention. If it appears to either the CMO or Service Chief that a single incident requires a more formal meeting, that a pattern of disruptive behavior is developing, or this is the second or more separate incident to have occurred within any 12-month period that after review is deemed to warrant a formal discussion with the involved Health Professional, then the CMO or Service Chief shall present the case to the PPEC for direction on how to proceed.

4.3.6 In the event the PPEC determines that the Disruptive Behavior process is the appropriate means of continued intervention, then a second meeting shall be arranged with the affected Health Professional. The CMO and Service Chief will determine who will attend the meeting representing the Medical Staff, provided that there shall be no less than two people representing the Medical Staff in addition to the CMO and/or the Service Chief. Other Officers or Officials of the Medical Staff, another Medical Staff leader or the CEO may be included, if appropriate.¹

- a. Preparation for and conduct of the 2nd meeting:
 - i. Notice to the affected Health Professional will usually be twenty four to forty eight (24-48) hours, but may be shorter at the discretion of the participants representing the Medical Staff.
 - ii. It will be emphasized that if the behavior continues, more formal action will be taken to stop it.
- b. The initial approach will ordinarily be collegial and designed to be helpful to the Health Professional. The meeting should give the Health Professional an opportunity to discuss the conduct in question. Emphasis shall be given to the premise that, if the behavior continues, more formal action will be taken to stop it.
- c. Following the 2nd Meeting:
 - i. If appropriate, a follow-up letter of expectation will be sent to the Health Professional and shall include a statement that the Health Professional is required to behave professionally and cooperatively.
 - ii. As a means to minimize the likelihood of future issues, at the Health Professional's request, a plan for mutually acceptable corrective action, which includes a monitoring requirement, in the form of a Memorandum of Understanding, may also be developed and implemented.

¹ Additional participants representing the Medical Staff may be considered if a strong response is anticipated or if there is any anticipation that Federal discrimination issues will be raised.

iii. The documentation of the meeting with a copy of any prior complaints about the Health Professional's behavior and the documentation of any previous meetings and/or communications with the Health Professional regarding behavior shall be sent to the CMO to be maintained in the Office of Medical Affairs professional review files.

4.3.7 Subsequent Reports of Disruptive Behavior

a. Review. All subsequent reports of disruptive behavior by the Health Professional shall be reviewed and discussed by the Service Chief and CMO. The Service Chief and CMO will then discuss the situation with the Chief of Staff (and usually the MEC, if summary action is not required) to plan future steps.

b. Additional meeting. If it has been determined that the expectations for resolution of the disruptive behavior have not been met and that further action is indicated, an additional meeting with the Health Professional will be arranged, if corrective action has not already been taken.

c. Participants. Participants representing the Medical Staff at such meeting will include at least two members of the MEC. The Board Chair and/or CEO and/or other Health Professionals may also be invited to attend as deemed appropriate.

d. Final Warning. This meeting is not a discussion, but rather constitutes the Health Professional's final warning that the disruptive behavior will not be tolerated.

e. Follow-up letter. The meeting shall be followed with a letter reiterating the warning. This letter will include a description of the disruptive conduct, outline the steps already taken to correct it, and detail the behavior that is acceptable and unacceptable. Additionally, the letter may confirm the consequences of an additional incident of disruptive behavior, including but not limited to temporary or permanent loss of Practice Authority and/or a request for a formal investigation, pursuant to Bylaws. A copy of the letter shall be provided to the CEO and the Service Chief. The MEC shall be informed.

f. If, at any point, a determination is made that the conduct is so egregious that it may justify formal corrective action, the matter shall be processed in accordance with Articles VII, VIII, X and/or XI.

4.3.8 Permanent Record. Once it has been decided that a pattern of disruptive behavior exists, the file will be referred to the MEC. If the MEC agrees with the determination, all the information pertaining to such behavior will be saved in the Health Professional's permanent credentials file, and shall be a factor considered at the time of reappointment

4.3.9 Further behavior after final warning

a. If after final warning the behavior continues, and if summary action is not required, the Chief of Staff or CEO shall refer the matter to the MEC with a request for formal corrective action, pursuant to this Appendix.

b. At any point in the process, the MEC may refer the matter to the Board with a full description of the behavioral concern, with or without a recommendation. Once the Board is informed, any further action, including any hearing or appeal shall then be conducted under the direction of the Board.

4.3.10 The failure of any person (Reporter) to make a written report or documentation as required by this policy shall not excuse a Health Professional who acts in a disruptive manner from any of the procedures and actions outlined in this policy.

4.3.11 Legal counsel for either side shall not attend any of the meetings described above, unless otherwise determined by the Chief of Staff and CEO, jointly.

4.3.12 Status as a Health Professional. The one year period following a warning under 4.3.5 or 4.3.7, or referral for corrective action, which did not involve termination of Medical Staff Membership or Practice Authority, is considered a "Critical Period". During a Critical Period, a Health Professional not considered to be fully in Good Standing and may not serve as a Medical Staff Officer or Official, unless a waiver is granted by the Board Executive Committee.

ARTICLE V: HEALTH PROFESSIONAL HEALTH AND IMPAIRMENT POLICY

5.1 DEFINITIONS

5.1.1 "Impaired", for the purposes of this Policy, means the diminished capacity of an individual to perform his/her duties while in the Hospital, including when treating a patient, offering treatment advice for a patient in the Hospital, or when on call. This may occur while acting in the scope of employment or professional responsibilities. Such diminished capacity may have resulted from aging, physical illness, mental illness, alcohol abuse, drug abuse, or other conditions causing impairment. A person who is impaired for this purpose may or may not be "legally impaired" (see definition below).

5.1.2 "Legally Impaired", for the purposes of this Policy, means the inability or immediately impending inability of a Health Professional to practice his or her profession in a manner which conforms to minimum standards of acceptable and prevailing practice of that health profession due to the Health Professional's substance abuse, chemical dependency, or mental illness, or the Health Professional's use of drugs or alcohol that does not constitute substance abuse or chemical dependency. (See MCL 333.16106a)

5.1.3 "Chemical dependency" means: "A group of cognitive, behavioral and physiological symptoms that indicate that an individual has a substantial lack of or no control over his or her use of psychoactive substances." (MCL 333.16106a)

5.1.4 "Substance abuse" means: "The taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof." (MCL 333.1100d)

5.1.5 “Mental illness” means: “A substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality or ability to cope with the ordinary demands of life.” (MCL 330.2001a)

5.2 HEALTH PROFESSIONAL WELL-BEING

In order to carry out the obligation of protecting patients from harm, the Hospital and the Medical Staff recognize the importance of identifying and managing matters of individual Health Professional’s health separate from the Medical Staff or Hospital disciplinary function. Accordingly, the MEC, PPEC and/or relevant peer review committee(s), with the assistance of the CEO, shall implement a process that provides education about Health Professional health, addresses prevention of physical, psychiatric or emotional illness, and facilitates confidential diagnosis, treatment and rehabilitation of Health Professionals who suffer from a potentially impairing condition. The purpose of the process is assistance and rehabilitation, rather than discipline, in order to aid Health Professionals in retaining or regaining optimal professional functioning, consistent with the protection of patients. If the Medical Staff identifies a need to educate Health Professionals and other staff about issues related to health and impairment, e.g., at-risk criteria, this education will be provided as follows: a) during a regular meeting of the Medical Staff, or b) at special meeting organized for this purpose, or c) via another mechanism of the MEC’s choosing.

5.3 REPORTING OF IMPAIRMENT

- 5.3.1 By Others. If an individual working at the Hospital, including a Member, has a reasonable suspicion that a Health Professional is impaired, that individual shall prepare a written report to the Chief of Staff. The report shall include a description of the incident(s) that led to the belief that the Health Professional may be impaired. The report must be factual. The individual making the report does not need to have proof of the impairment, but must state the facts including observations and descriptions of behavior leading to the suspicion. The individual making the report must have a reasonable suspicion that the Health Professional is impaired based upon specific, objective facts and reasonable inferences drawn from such facts in light of experience. If an oral report is made to the Chief of Staff, other Medical Staff Officer, Service Chief, or the CEO, that officer shall assist the reporter in making a written report.
- 5.3.2 Self-Report. Any Health Professional who believes he/she may be impaired or is subject to a rehabilitation contract through a program with the Michigan Health Professional Recovery Program (MHPRP) or has had his/her privileges (or their equivalent) or employment duties limited by any healthcare organization shall report that circumstance to the Chief of Staff or CMO.
- 5.3.3 Confidentiality. The identity of the reporter will be kept confidential if requested by the reporter, except when prevented by the circumstances as determined by the Chief of Staff. Additionally, the affected Health Professional will be advised that the Medical Staff will not tolerate any retribution regarding this report.
- 5.3.4 Report to MHPRP. If a Health Professional has self-reported their impairment to the Chief of Staff or CMO but has not yet reported to the MHPRP, contact with the MHPRP must be initiated. The Health Professional will have the choice of initiating such report or the Chief of Staff or CMO will do so. Report and

evaluation by the MHPRP will not substitute for the Medical Staff process described in this policy.

5.4 ACTION ON REPORT

The CMO (or designee) shall discuss the objective facts and reasonable inferences reported with the individual who submitted the report. The affected Health Professional will meet with the Chief of Staff to discuss his/her condition, if so requested. In the event additional intervention is required, the CMO (or designee) shall refer the case to the PPEC for further direction. The PPEC shall generally refer impaired Health Professionals for Alternative Action in accordance with Article VI. However, nothing in this Article, Article 1 or Article VI precludes the immediate initiation of formal corrective action, including summary action and suspension, pursuant to this Appendix, immediate referral to the MEC (or the Board), or request for a physical or mental health evaluation.

5.5 MONITORING WHILE TREATMENT IS IN PROGRESS

In addition to any other requirements of Alternative Action or in any other written agreement with the Medical Staff and the Hospital, a Health Professional subject to impairment monitoring shall be subject to all of the following requirements:

- 5.5.1 The Health Professional must inform the PPEC (or Alternative Action Committee, if the Health Professional is in Alternative Action) of the name and address of his/her physicians and other health care providers overseeing or providing his/her clinical care for the impairment, and must authorize all such health care providers to provide the PPEC (or Alternative Action Committee) (in writing, by phone, or in person) with information regarding the precise nature of the Health Professional's condition, and the clinical course, the current course of treatment that the Health Professional is receiving, if any, level of participation in the program and mental, physical and emotional assessments of the Health Professional's ability to safely exercise Practice Authority.
- 5.5.2 Furthermore, the PPEC (or Alternative Action Committee, if the Health Professional is in Alternative Action) has the right to require an opinion(s) from other consultant(s) to evaluate and examine the Health Professional if the PPEC (or Alternative Action Committee) believes such an additional opinion(s) is warranted.
- 5.5.3 The subject Health Professional shall identify at least one other Health Professional on the Hospital's Medical Staff who is willing and able to assume responsibility for the care of the Health Professional's patients in the event of his/her inability or unavailability to render appropriate and safe care and treatment to the patients and obtain that Health Professional's written agreement to do so.
- 5.5.4 The subject Health Professional shall be required to have reports provided to the Hospital and Medical Staff leadership (or Alternative Action Committee, if the Health Professional is in Alternative Action) for a period of time specified by the Chief of Staff and CEO (or Alternative Action Committee). The report shall indicate the precise nature of the Health Professional's condition, the clinical course, the current course of treatment that the Health Professional is receiving,

if any, and level of participation in the program, and mental, physical and emotional assessments of the Health Professional's ability to safely exercise Practice Authority.

- 5.5.5 In the event the Health Professional resumes clinical practice while still in treatment, the Health Professional's performance in exercising Privileges in the Hospital shall be monitored by the Service Chief or by another Health Professional appointed by the Service Chief, unless the PPEC appoints a different Member to assume this role, or by the Alternative Action Committee, if the Health Professional is in Alternative Action. If the Service Chief or member of the Alternative Action Committee is the Health Professional in question with impairment, then the CMO or CEO shall substitute.
- 5.5.6 While the Health Professional is subject to monitoring, at the request of the Committee, Service Chief, CMO or CEO (or Alternative Action Committee, if the Health Professional is in Alternative Action), the subject Health Professional shall agree to immediately submit him/herself to a physical examination, including blood, breath, saliva, urine and other testing, in order to rule out the presence of drugs or alcohol or any other physical examination to rule out any other impairment. In addition, a system may be developed for the Hospital to randomly conduct, with or without cause, blood, breath, saliva, urine and/or other testing upon the Health Professional in order to rule out the presence of drugs or alcohol whenever the Health Professional is on duty for clinical issues at any location, including on-call responsibilities. Should the Health Professional in question decline to submit to such an exam or testing within a reasonable period of time (and no more than 4 hours) after the request is made and/or should the exam/testing reveal the presence of alcohol, illicit drugs, prescription drugs that the Health Professional had agreed not to take, or lack of sobriety, the Alternative Action Committee, if applicable, shall notify the PPEC of such refusal, and the PPEC or other appropriate party may initiate corrective action as outlined in this Appendix. The PPEC or Board, after considering the various aspects of the subject Health Professional's case, may elect to treat the refusal to submit to an exam or testing as a resignation of the subject Health Professional's Membership on the Medical Staff, if applicable, or Practice Authority.
- 5.5.7 In advance, as part of his/her agreement with the PPEC or Alternative Action Committee, the subject Health Professional shall sign a Recovery Contract that will include an acknowledgement that he/she shall resign immediately from the Medical Staff and relinquish all Practice Authority should such a request for exam or testing be made and should the Health Professional deny the request or take action that would render the test invalid. If the exam/testing reveal the presence of alcohol, illicit drugs or other lack of sobriety, such a positive test shall be considered a violation of the agreement with the Committee and the Medical Staff, may, in its discretion, pursue additional action in accordance with the Medical Staff Documents.

5.6 MONITORING OF THE HEALTH PROFESSIONAL AFTER SUCCESSFUL COMPLETION OF AGREEMENT OR ALTERNATIVE ACTION

- 5.6.1 The Health Professional's clinical use of Practice Authority in the Hospital shall be monitored by the Service Chief or by another Health Professional appointed

by the Service Chief in the event the Health Professional resumes clinical practice after completion of the agreement with the PPEC or Alternative Action. If the Service Chief is the Health Professional in question with an impairment, then the CMO or CEO shall substitute. All aspects of the monitoring shall be determined by the PPEC or Alternative Action Committee, as applicable, in coordination with the recommended requirement(s) of the State of Michigan Health Professional Recovery Program, if either is involved. However, the PPEC will monitor a recovering Health Professional for at least three years, given that the Health Professional has been compliant with their monitoring program and have remained in recovery for that same period. Cessation of monitoring will be recommended by the PPEC, or by the Alternative Action Committee and subject to approval by the PPEC.

- 5.6.2 While the Health Professional is subject to monitoring after successful completion of treatment or Alternative Action, the Health Professional will be subject to the same procedures for random testing as delineated in Section 5.5.6.

5.7 APPROPRIATE AUTHORITIES

At all times, the Administration will be kept appropriately advised of all information that would affect the delivery of patient care or safety of clinical staff.

ARTICLE VI: ALTERNATIVE ACTION PROCEDURE FOR HEALTH PROFESSIONALS

6.1 DEFINITION AND BASIS

- 6.1.1 Alternative Action Defined. Alternative Action is an alternative means of remedying a problem of a Health Professional for which corrective action or other traditional means of behavioral modification are either not feasible or not as appropriate. Although others may request or suggest it, Alternative Action is voluntary and may be used only if accepted by the Health Professional.
- 6.1.2 Basis for Alternative Action. As provided in this Appendix, the basis for considering Alternative Action shall be a Health Professional's state of mind, course of conduct, or condition (physical, mental or emotional) that may potentially impair the ability of a Health Professional to safely and skillfully practice his/her profession. By way of example and not in limitation, circumstances that indicate Alternative Action include substance abuse, impairment, unusual behavior, inability to interpersonally relate to patients, their family, other Health Professionals and/or Hospital staff, or onset of a debilitating illness or condition. Manifestations of the foregoing justifying Alternative Action need not be observed on Hospital premises, but rather can be based on reasonably supportable observations of the Health Professional at any time. This may include conditions considered under the Articles IV and V.

6.2 ALTERNATIVE ACTION COMMITTEE COMPOSITION

- 6.2.1 Purpose. The Alternative Action Committee shall oversee the Alternative Action process. For impaired Health Professionals in Alternative Action, the Alternative

Action Committee shall also perform the role of a local health and wellness committee.

- 6.2.1 Standing Members. Standing members of the Alternative Action Committee will be a member of Administration selected by the CEO after consultation with the CMO and a Member selected by the MEC who is not then a member of the MEC. The Administration member shall be the Committee's secretary and custodian of records.
- 6.2.2 Special Members. The standing members of the Committee shall appoint for each particular case a third special member who is a Health Professional in the same field or with a substantial knowledge of the specialty of the involved Health Professional, e.g., if the Health Professional involved is a surgeon, another surgeon would generally be appointed. The special committee member will ordinarily (but is not required to) be affiliated with the Hospital.
- 6.2.3 Adjunct Members. The Committee may, as circumstances require, appoint one or more adjunct members during the process if the Committee believes this will aid its work. Adjunct members shall be persons having particular knowledge of the problem of the involved Health Professional. The adjunct members may provide guidance on managing particular problems in their area. Adjunct members may participate in person or their participation may be limited to telephone or written communications. By way of example and not in limitation, an appropriate adjunct member might be a psychiatrist, a general practitioner, an internist, a social worker, a clinical psychologist, or an experienced representative of an appropriate substance abuse treatment program. The adjunct members may not be affiliated with the Hospital, the Medical Staff or Board. If the adjunct members require payment for participation on the Committee and/or services rendered on the Committee's behalf, such fees will be the responsibility of the Health Professional who is the subject of Alternative Action.
- 6.2.4 Regional Health and Wellness Committee. The Chair of the Alternative Action Committee or his/her designee, shall be the representative of the Trinity Regional Health and Wellness Committee.

6.3 INITIATION OF ALTERNATIVE ACTION

- 6.3.1 Alternative Action may be initiated in any of the following ways for a Health Professional:
 - a. By a Health Professional volunteering for Alternative Action at any point before a corrective action process is instituted or adverse action on an application (initial or renewal) is taken; and the PPEC agrees;
 - b. At any time after corrective action is instituted or adverse action has been taken on an application (initial or renewal), but before hearing, when the Member or Initial Applicant requests approval of acceptance for Alternative Action and the PPEC agrees;

- c. In lieu of corrective action, at the request of MEC or PPEC and with the consent of the involved Member, where corrective action would otherwise be warranted and the Member agrees to proceed in good faith with Alternative Action;
- d. Where an initial applicant for Practice Authority or a Health Professional seeking renewal of Practice Authority has, in the judgment of MEC or PPEC a personal problem which is appropriate for Alternative Action but if not evaluated and/or acted upon would require denial or non-renewal of Practice Authority, and the Health Professional or applicant agrees to proceed in good faith with Alternative Action;
- e. At the request of the PPEC or Board with the consent of the subject non-Member Health Professional, at any point before the subject non-Member Health Professional's Practice Authority, if any, is terminated by the Hospital; and
- f. According to the procedures of the Health Professional Health and Impairment procedures in Article V.

6.3.2 In the event that one (1) of the criteria set forth in Sections 6.3.1 above are met, the matter will be referred to the Alternative Action Committee.

6.4 PROCESS FOR ALTERNATIVE ACTION

- 6.4.1 Requests. The Committee will begin its activities when a request is received for Alternative Action. All requests will be signed by the subject Health Professional and Chief of Staff. The request form will include a brief summary of the nature of the problem for which Alternative Action is sought and whether termination or other corrective action procedures have been initiated. Additionally, for a Member or initial applicant where adverse action is contemplated, the acknowledgment of the subject Health Professional that the subject Health Professional will be responsible for payment of fees of adjunct members appointed to the Committee.
- 6.4.2 Regional Health and Wellness Committee Support. The Alternative Action Committee, may, in its sole discretion, consult with the Trinity Regional Health and Wellness Committee at any time to assist in its evaluation of the Health Professional.
- 6.4.3 Initial Interview. After receiving the request, the standing members of the Committee will then informally meet with the subject Health Professional and discuss the problem, including its history, the reasons for the initiation of the Alternative Action, and the expectations of the subject Health Professional.
- 6.4.4 Appointment of Additional Members. Following the initial interview, the standing members of the Committee will meet privately and discuss the Committee's future course of action. A determination will then be made as to who should be appointed as a special Committee member, and whether to seek additional adjunct member (and if so, the type of individual being sought for such

position(s)). The Secretary will contact and be responsible for making arrangements for the special and adjunct members joining the Committee.

6.4.5 Plan of Activity, Diagnostic Interview(s)/Examination(s), Preliminary Findings.

Once the special and adjunct Committee members have been selected and agree to participate, the Committee will meet and establish a written plan for further activity. The Committee will consult the CMO. Where the Health Professional is impaired, as defined in Article V, such plan shall incorporate the monitoring requirements outlined in Section 5.5. The plan may include designations of diagnostic interviews and/or examinations of the subject Health Professional by an adjunct Committee member(s) or an external consultant and reports of same which will be utilized in formulating preliminary findings. An adjunct member may utilize the services of an APP or AHP in carrying out the adjunct member's aspect of an evaluation, e.g., a psychiatrist having a clinical psychologist do testing. The plan shall be provided to the CMO and the applicable peer review committee for review prior to the informal hearing in Section 6.4.6. The CMO and the applicable peer review committee shall promptly provide any comments or suggestions to the Committee after receipt of the plan. The Committee will consider, but is not required to incorporate such comments and suggestions into the plan.

6.4.6 Informal Hearing. The Committee will formulate its preliminary findings and prepare to meet the subject Health Professional for an informal hearing. The subject Health Professional will be expected to be prepared to openly discuss the problem with the Committee and participate in consideration of a final report. Others with knowledge of the Health Professional's background may appear and speak to pertinent issues at the informal hearing either upon request of the subject Health Professional or the Committee. These other Health Professional and Hospital employees shall be obliged to appear if so requested.

6.4.7 Final Report and Course of Action. Following the informal hearing, the Committee will deliberate in private and formulate, in writing, a Formal Report and Course of Action. The Formal Report and Course of Action shall be provided to the CMO and the applicable peer review committee for review after the informal hearing in Section 6.4.6. The CMO and the applicable peer review committee shall promptly provide any comments or suggestions to the Committee after receipt of the Formal Report and Course of Action. The Committee will consider, but is not required to incorporate such comments and suggestions into the Formal Report and Course of Action. As soon as practical after completion, the Final Report and Course of Action will be made available for review to the subject Health Professional, who shall either approve it, or, if the subject Health Professional does not approve it, promptly provide written comments, which shall be made a part of the permanent record of the Committee. After review of such comments, the Committee may modify its Final Report or Course of Action with notice of any changes to the subject Health Professional. Once the Final Report and Course of Action are approved by the subject Health Professional or the opportunity for the Health Professional to comment has been exhausted, the COS, Board, and, except as hereinafter provided, give notice of the Course(s) of Action selected and information needed

to protect the safety of patients and staff and to carry out their part of any course of action selected.

6.5 COURSE OF ACTION

6.5.1 Alternatives. Course of Action alternatives that may be selected by the Committee include, but are not limited to:

- a. A determination that there is no reason for (or to continue) Alternative Action;
- b. A determination that the Health Professional involved, by reason of attitude, nature of problem or similar reason is not a candidate for Alternative Action (if corrective action was initiated with respect to the Health Professional, the matter would be referred back for completion of formal corrective action);
- c. Leave of absence in coordination with Medical Staff policy delineating the procedures to apply for leave of absence;
- d. Imposition of a course of therapy requirement;
- e. Imposition of periodic mental and/or physical health examinations by a health care professional selected by the Committee (who may be 1 of the adjunct members) with reports to the Committee;
- f. Voluntary or other restrictions or limitations on practice and/or Practice Authority at the Hospital and/or other practice settings, including a consultation or proctoring requirement;
- g. Recommendation of resignation from the Medical Staff (which the Member would implement by formal resignation), or termination of all or selected Practice Authority;
- h. If at reappointment, recommendation that some or all Practice Authority not be reapplied for; and
- i. Recommendation of denial of appointment (if an initial Applicant to the Medical Staff).

6.5.2 If alternatives in Section 6.5.1(b), (g), (h), or (i) are selected, the determination or recommendation shall be forwarded along with a report supporting the recommendation to the PPEC, MEC or other appropriate Medical Staff, Administration and Board entities for follow-up.

6.5.3 If the alternatives in Section 6.5.1(b), (g), (h) or (i) are not selected, the determination or recommendation shall be forwarded along with a report supporting the recommendation to the PPEC, MEC or other appropriate Medical Staff entity for follow-up.

- 6.5.4 When not inconsistent, two (2) or more of the above alternatives may be utilized simultaneously. Further, nothing shall prevent the Committee from applying any two or more alternatives in serial fashion, e.g., leave of absence with a prescribed course of therapy, a return to the Hospital and required periodic health examinations, followed by a determination that there is no longer a need for Alternative Action.
- 6.5.5 Appointment and Function of Monitor. To implement alternatives (c), (d), (e) and/or (f) of Section 6.5.1, the Committee shall appoint one of its standing members as a Monitor. The Monitor will be responsible for making sure the Course(s) of Action determined by the Committee are carried out, with respect to reporting, preceptorship, or consultations. If a leave of absence is decided upon and undertaken by the subject Health Professional, the Monitor will maintain a line of communication with the subject Health Professional and will be responsible for reconvening the Committee when a return of the subject Health Professional to practice at a Hospital facility is contemplated. The Monitor may also reconvene the Committee at any time the Monitor feels same is indicated, at which time the Committee may modify, change, or rescind the alternative(s) selected. The Committee will retain jurisdiction over the subject Health Professional's case until such time as alternatives (a), (b), (g), (h), and/or (i) of Section 6.5.1 are determined to be applicable. Impaired Health Professionals in Alternative Action shall also be subject to the monitoring described in Section 5.5.

6.6 CONFIDENTIALITY

- 6.6.1 Records are Confidential. Inasmuch as the Committee's function is professional/peer review, the records, data and knowledge collected by the Committee in any form shall be maintained at all times in a confidential manner, consistent with the Medical Staff's Policy on Confidentiality and provisions of Michigan and Federal statutes, including but not limited to MCL 331.531, MCL 331.533, MCL 333.20175, MCL 330.1143a, MCL 333.21513 and MCL 333.21515.
- 6.6.2 Disclosure and Reporting to Leadership. When a Health Professional is in the Alternative Action Program, the Committee shall notify the CEO, COS and relevant Service Chief as needed, but at least every 90 days of the following: the current course of the action alternatives applied to the Health Professional; the continued participation and cooperation of the Health Professional in the Alternative Action process. The Committee will immediately notify the CEO and Chief of Staff if there is any indication from any source that the Health Professional represents a hazard to the safety of patients, Hospital employees or Medical Staff, or if the Health Professional is uncooperative or not participating as required.
- a. Entities/Persons Entitled To Disclosure. Except for the reporting of its selected Course(s) of Action according to Article V (Course of Action), and the regular reporting in the paragraph above, the records, data and knowledge of the Committee may be disclosed only to other entities

having a professional review function and only under the following circumstances:

- i. The Committee selects any Course of Action alternative except for alternative (a) of Section 6.5.1, and reaches the opinion that patient and staff welfare and/or safety require that some or all of the records, data and knowledge accumulated by the Committee be provided to the COS, the CMO, a review committee of the Medical Staff, the Board or a corrective action entity of the Hospital, or another hospital where the subject Health Professional has or is seeking privileges or the equivalent;
- ii. The COS, Board, and MEC or the Credentials Committee believe in good faith that some or all of the records, data and knowledge accumulated by the Committee are required for their meaningful evaluation of an initial Applicant, reappointment of a Health Professional or delineation of Practice Authority. A request under these circumstances will be honored by the Committee after consultation with the requesting entity to narrow the scope of disclosure to the minimum needed; or
- iii. The Committee is required by law to respond to State licensing authorities or report, as required, to the NPDB.

Notwithstanding the above, if the Board chair, CEO, CMO or Chief of Staff after raising concerns and discussing them with the MEC, believe that the course of action chosen represents a hazard to the safety of patients, Hospital employees or Medical Staff, and after the Board chair, CMO and Chief of Staff discuss the issue, the person with the issue may bring that issue to a meeting of the Executive Committee of the Board for discussion and consideration of further action. The MEC will be notified of the plan to bring the issue to the Executive Committee of the Board.

- b. Alternatives to Release. With respect to 6.6.2(a) above, the Committee will notify the subject Health Professional of its intentions and/or the request of the COS, Board, or review committee. Except to the extent necessary to fulfill legal reporting requirements (if any are applicable), the subject Health Professional may, in lieu of the information being provided (where release is not required by law):
 - i. If non-Member Health Professional, resign his/her Practice Authority, if any; or
 - ii. If a Member or Applicant:
 - 1. Withdraw his/her application, if an initial application is involved;
 - 2. Withdraw his/her request for reappointment, if the matters are required in order to assess reappointment;

3. Withdraw his/her request for Privileges, if the request stems from a request for renewal or additional Privileges; or
4. Resign from the Medical Staff if the request stems from corrective action.

In the event of application withdrawal, request withdrawal, or resignation in accordance with the above, the material requested above will not be provided by the Committee.

- 6.6.3 Disclosure to Replacement Committee Members. In the event a Committee member must be replaced, the Committee member's replacement is entitled to review all records, data and knowledge of the Committee.

ARTICLE VII: AUTOMATIC ACTION

7.1 Automatic action will occur and a Health Professional's Membership, if applicable, and Practice Authority shall terminate and the Health Professional shall be immediately and automatically suspended from practicing in the Hospital without notice for any of the following:

- 7.1.1 A Health Professional whose license authorizing practice in the State is voluntarily or involuntarily relinquished, restricted, revoked or suspended or that expires without renewal;
- 7.1.2 A Health Professional is convicted for a crime, which in the judgment of the CEO and COS, involves clinical practice or Hospital facilities, or is convicted of any felony;
- 7.1.3 A Health Professional is sanctioned, barred, or excluded from Medicare, Medicaid, Tricare or any other federal program participation.

Action may be requested from any source with action taken by the CEO acting alone or the CMO and Chief of Staff acting together. Action will be taken only after primary source verification of the court or governmental action that triggered the automatic action. A Special Notice will be sent to the Health Professional notifying them of the action.

7.2 REINSTATEMENT AFTER LICENSURE SANCTION OF ONE YEAR OR MORE OR CRIMINAL CONVICTION

If the matter involves conviction of a crime or if the license relinquishment, restriction, revocation, suspension or expiration is for one year or more, then the application process for reinstatement will be handled the same as an application of a new applicant.

7.3 REINSTATEMENT AFTER LICENSURE SANCTION OF LESS THAN ONE YEAR

If the license relinquishment, restriction, revocation, suspension or expiration is for less than one year, then the appointment shall be deemed to have lapsed. The application process for reinstatement will be the same as for reappointment, if the Health Professional applies within

thirty (30) days of the expiration or completion of the process that led to the automatic action. However, if the Member does not timely apply, any subsequent application will be as a new applicant. The final action of the Board may deny, grant, or limit reappointment and/or Practice Authority. Such action shall not be exclusive of any other corrective action that may be imposed.

ARTICLE VIII: ADMINISTRATIVE ACTION

8.1 CIRCUMSTANCES

Administrative action shall be automatically imposed for any of the reasons enumerated under the provisions of this section, which are not based on the professional competence or conduct of a Health Professional does not necessarily constitute a reportable Medical Staff action in accordance with State and Federal reporting requirements, as it is considered to be non-disciplinary and non-professional review action for purposes of those reporting requirements. Administrative action shall not, however, preclude corrective action or other forms of discipline being imposed simultaneously or sequentially, when same is also warranted. Because administrative action taken pursuant to this Section is not disciplinary, it is not subject to the Special Hearing procedures under the Review Procedures Appendix.

8.2 PRESCRIBING AUTHORITY

A Health Professional whose DEA registration, State Board of Pharmacy license or other authority to prescribe and administer is revoked, suspended or relinquished shall immediately and automatically be divested of the right to prescribe medications at the Hospital as covered by such authority. After such administrative action, the MEC, at its next regularly scheduled meeting, shall review and consider the facts under which the authority was revoked, suspended or relinquished. The MEC may then take corrective action as is appropriate to the facts disclosed in its review.

8.3 MEDICAL RECORDS

Health Professionals who do not complete their medical documents or records may have all admitting, consulting, and operative Practice Authority withheld in accordance with the Medical Record Delinquency Policy in Article IX.

8.4 ADMINISTRATIVE CONSULTATIONS AND LIMITATIONS

8.4.1 Patient Care.

a. The CEO, Chief of Staff, CMO, Service Chief or PPEC may initiate an administrative consultation requirement or limitation for a particular patient, certain particular patients, or all patients of a Health Professional, when it is determined that the welfare of a patient or patients of a Health Professional or the interests of the Hospital require such action. Such consultation requirement may include proctoring, retrospective or concurrent review or joint management of the case, or other conditions or limitations upon the Health Professional's practice.

b. Initiation of a patient care-based administrative consultation or limitation will ordinarily be preceded by the concurrence of:

- i. the CEO or CMO, and
- ii. Chief of Staff or Service Chief.

Where obtaining such prior concurrence is not possible due to the matter requiring that immediate action be taken, concurrence should be obtained as soon as reasonably possible thereafter. Those taking the action will inform the CEO, Chief of Staff, CMO, Service Chief or PPEC, if not already informed, as soon as is reasonably possible.

8.4.2 In the event a Health Professional is suspended at another licensed health facility (as defined in the Public Health Code) an administrative consultation or limitation may be imposed. In this respect, the Health Professional's Practice Authority may be administratively withheld, in whole or in part, and/or a consultation requirement including proctoring, retrospective or concurrent review or joint management of cases, may be imposed.

8.4.3 The administrative consultation requirement or limitation imposed may stay in effect, without institution of corrective action for thirty (30) days, or if corrective action proceedings are in process, for the duration of those proceedings. Imposition of an administrative consultation requirement or limitation in accordance with this provision shall be communicated by the CEO, CMO, Chief of Staff, Service Chief or PPEC to the affected Health Professional immediately via written notification. The result of the administrative consultation or limitation shall be reported back to the Chief of Staff, CMO, Service Chief, PPEC and CEO. This information will be addressed by the PPEC at its next regularly scheduled meeting for determination of an appropriate course of action, which may include continuation of the consultation requirement and/or corrective action pursuant to Article X.

8.5 PROFESSIONAL LIABILITY INSURANCE

In the event that a Member with Privileges fails to:

- a. Maintain in force required professional liability insurance in prescribed amounts or maintain other proof of financial responsibility, in accordance with current requirements of the Board; or
- b. Secure a special exemption from those requirements from the MEC and the Board; or
- c. Report any change in the status of professional liability insurance to the Office of Medical Affairs within seven (7) days subsequent to the change,

then the Privileges of such Member shall be withheld upon Special Notice to the Member until the requirement is met. While Privileges are withheld, the Member may not practice in any

Medical Staff capacity on or in Hospital property or facilities, including but not limited to, admitting, seeing, treating, or consulting on patients at the Hospital. If the Member fails to provide the Hospital with adequate evidence of the required insurance within sixty (60) days after Privileges being withheld, the Member's Medical Staff Membership and Privileges shall be deemed to have been resigned without expression upon the Member's professional competence or professional conduct.

8.6 MEDICAL STAFF DOCUMENTS, POLICY MANUAL, OR OTHER HOSPITAL POLICIES

In the event a Member is found to have violated a provision of the Medical Staff Documents, Policy Manual, or other Hospital policy (written or unwritten) which does not involve competence or conduct or does not directly and immediately impact patient care, the CEO or CMO, after consultation with the MEC or the Board, is empowered to issue a letter to the Member giving Notice of Non-Compliance and advising the Member of the importance of future compliance. The Member involved shall be required, within thirty (30) days after a receipt of such notice, to acknowledge in writing its receipt, and to pledge to heretofore comply with the policy involved, and provide any mitigating considerations felt warranted. A copy of such Notice of Non-Compliance and the Member's response shall be placed in the Member's Medical Staff Credentials file. Such notice may be considered at reappointment and in any corrective action proceedings that involve the Member occurring during the current appointment and next two full reappointment periods. If no further Notices of Non-Compliance are issued within two full reappointment cycles for similar infractions, it will, at the request of the Member, be permanently expunged from the Member's Medical Staff review file. Nothing in this Section shall prevent the Hospital from considering the underlying disruptive or non-compliant behavior in accordance with the Medical Staff Documents. The issuance of a notice of non-compliance, by itself, does not constitute a request for corrective action if it would not trigger an investigation or action under that Appendix.

8.7 FAILURE TO COMPLY WITH SPECIAL ATTENDANCE REQUIREMENT

A Health Professional who fails to attend a meeting of the Medical Staff, Service, or committee, as required by Medical Staff Documents, without advance permission by the chair or the body involved, after having been given written notice that special appearance is mandatory, may, upon written notice by the CEO, have all Practice Authority to practice at the Hospital withheld until the matter is resolved by MEC review. Such review shall be done in a timely manner not to exceed ten (10) working days, and will include the individual Health Professional, MEC members, and invited individuals as deemed appropriate by the MEC.

8.8 SUSPENSION OR TERMINATION BY OR LEAVE OF ABSENCE FROM EDUCATIONAL OR HEALTH ORGANIZATION EMPLOYER

8.8.1 If the employment or authority to practice of a Health Professional are suspended or terminated by the Health Professional's educational or other health care organization employer, or a leave of absence is taken from practice, for reasons that, in the judgment of the CEO, after consultation with the Chief of Staff, are related to the quality of patient care, competence, conduct or ethics, the affected Health Professional shall be automatically placed on leave of absence as a Health Professional at the Hospital. Before the Health Professional can be

considered for reinstatement to the Medical Staff or APP staff, the Hospital and/or its Medical Staff shall complete a review or investigation of the reasons for the suspension, termination or leave of absence from practice. If deemed appropriate, corrective action procedures may be instituted by the Hospital and/or Medical Staff based upon those other facts.

- 8.8.2 If employment or privileges are terminated by the educational or health care organization employer and employment by the other organization is a contractual condition of Membership, if applicable, or the Practice Authority in the Hospital, then the Membership, if applicable, or Practice Authority (as the contract provides) of the Health Professional shall likewise be terminated. If that applies, Membership at the Hospital, if thereafter desired, may be obtained only by submitting an application, which is then processed in the manner specified for application for initial appointments, unless, in their sole discretion, the Board and MEC authorize a different procedure.
- 8.8.3 If so specified in a written contract between the Hospital and either the Health Professional or the person or entity which employs or subcontracts him/her, the Membership, if applicable, and/or Practice Authority of the Health Professional held in accordance with such a contract, will terminate automatically in the event of expiration (without renewal) or termination of the contract, without regard to the professional competence of the Health Professional and, for Members, without recourse to a formal hearing of the Review Procedures Appendix. A Health Professional whose Medical Staff Membership, if applicable, and/or Practice Authority are terminated solely by reason of contract expiration or termination shall be entitled upon request to receive a written statement to that effect, a copy of which shall be maintained on file with the Office of Medical Affairs. Authorization to reapply to the Medical Staff or APP staff following termination based on this section shall be subject to the determination of the Board, after recommendation of the MEC, that the services of an individual in the former Health Professional's specialty are needed by the Hospital and its patients, the former Health Professional can capably provide such services, and that such services do not violate the agreement between the Hospital and a group having a contract to provide such services.

8.9 UNAVAILABILITY/RESIGNATION

A Health Professional with Practice Authority, unless exempted in advance by the MEC or on an authorized leave of absence, who is not practicing in the geographic area of the Hospital, as defined by the Board, for more than 90 days or who removes his/her office address and phone number from the usual manner of publication, shall be notified by Special Notice to last known address and attempt made to contact by telephone, that resignation will be automatic if response is not received within thirty (30) days. If there is still no authorized leave of absence, the Health Professional shall be automatically deemed to have resigned his/her Medical Staff Membership, if applicable, and Practice Authority without expression upon his/her professional conduct or competence or professional conduct.

8.10 DUES

If a Health Professional fails to pay required dues for more than ninety (90) days after the original due date, the Health Professional shall be automatically deemed to have resigned his/her Medical Staff Membership, if applicable and Practice Authority without expression upon the Health Professional's professional competence or professional conduct.

8.11 REAPPOINTMENT

A Health Professional who fails to file an application for reappointment to the Medical Staff or APP staff or for renewal of Practice Authority by the deadline stated in the Policy Manual shall automatically cease to be a Health Professional and cease to hold Practice Authority upon expiration of the Health Professional's term of appointment.

8.12 BOARD CERTIFICATION

A Health Professional who fails to comply with the Hospital board certification requirements applicable to his/her specialty or area of practice by the deadline stated in Medical Staff Documents or the Policy Manual shall be deemed to have automatically resigned his/her Medical Staff Membership, if applicable, and Practice Authority.

8.13 MICHIGAN CERTIFICATE OF NEED STANDARDS

The State of Michigan requires, as a condition to granting a certificate of need to furnish certain types of services, that each Member who performs the covered service in the Hospital perform a minimum volume of the service annually. If a Member fails to satisfy this State-imposed minimum volume requirement, the relevant Privileges will be withheld until a satisfactory plan for meeting them is in place or the Member's Privileges expire without renewal.

8.14 FAILURE TO MEET MINIMUM ACTIVITY REQUIREMENTS – RESIGNATION

A Member, not on an authorized leave of absence or whose activity requirements have not otherwise been waived who fails to meet minimum activity requirements established pursuant to Section 3.2 of the Medical Staff Bylaws for any one (1) year may be deemed to have resigned from the Medical Staff without reflection upon his/her professional conduct or competence.

8.15 HEALTH EVALUATION

Unless otherwise acted upon by the Board, a Health Professional who fails to submit to a physical or mental health evaluation (which may include a screening or evaluation for substance abuse) within fourteen (14) calendar days of a written request made in accordance with the Bylaws, Articles V or VI of this Appendix, shall have his/her Practice Authority at the Hospital withheld until the evaluation occurs. If the Health Professional fails to submit to the evaluation and furnish the Hospital with the results thereof within thirty (30) days after Practice Authority is withheld, the Health Professional's Medical Staff Membership, if applicable, and Practice Authority shall be deemed to have voluntarily resigned without expression upon the Health Professional's professional competence or professional conduct. Nothing in the section shall prevent the Board or MEC from initiating or requiring other corrective or Alternative Action relating to a Health Professional who fails to timely submit to a physical or mental health examination when an official request is made.

8.16 COMMUNICABLE DISEASE TEST RESULTS/AND VACCINATION

A Health Professional who fails to provide satisfactory evidence of communicable disease test results as required by Hospital policy or who fails to comply with Hospital policy regarding proof of immunity/vaccination, shall automatically have his/her Practice Authority withheld at the Hospital until the required documentation is furnished. If the Health Professional fails to provide the Hospital the required documentation within ninety (90) days after Practice Authority is withheld, the Health Professional's Medical Staff Membership, if applicable, and Practice Authority shall be deemed to have voluntarily resigned without expression upon the Health Professional's professional competence or professional conduct.

8.17 FAILURE TO MEET CONTINUING EDUCATION REQUIREMENTS

A Health Professional, who has failed to complete required continuing education hours in a given period required by law may be deemed to have resigned from the Medical Staff without reflection upon his/her professional conduct or competence.

8.18 FAILURE TO EXECUTE RELEASE AND/OR PROVIDE DOCUMENTS

A Health Professional who fails to execute a general or specific release and/or provide documents when requested by the COS or designee to evaluate the competency and credentialing/privileging qualifications of the Health Professional shall have all Practice Authority withheld until the requirement is met. If the release is not thereafter executed and/or documents provided within thirty (30) calendar days of notice of an MEC or Board directive to do so, the Health Professional will be deemed to have resigned voluntarily from the Medical Staff.

8.19 FAILURE TO COMPLY WITH REPORTING REQUIREMENT

A Health Professional who is determined by the MEC to have failed to comply with the reporting requirements under the Medical Staff Documents, shall, upon written notice by the CEO, have all Practice Authority withheld until the non-compliance is explained at a meeting with the MEC; if the MEC concludes that the failure to report was a knowing violation of the Medical Staff Documents or other Medical Staff requirements, the matter shall be considered by the MEC for potential corrective action.

8.20 FAILURE TO MEANINGFULLY PARTICIPATE IN A MANDATORY REVIEW PROCESS

A Health Professional who fails to meaningfully participate in a review of his/her qualifications for Membership and/or Practice Authority as required under these Medical Staff Documents shall have all Practice Authority withheld until the Health Professional complies with the requirement for a meaningful participation. Failure to meaningfully comply within thirty (30) calendar days after being given notice of an MEC or Board directive to do so, without good cause not do so, will be considered a voluntary resignation from the Medical Staff and/or Practice Authority.

ARTICLE IX: DELINQUENT MEDICAL RECORDS POLICY

9.1 DEFINITION

- 9.1.1 “Delinquent Documents” means a Health Professional who is at or above ten percent (10%) non-compliance, as determined by the Medical Records Department, with the time standards for completion of the operative note, discharge summary, history and physical, and responses to queries related to documentation, clarification, or coding, as provided in the Hospital’s Policy Manual.
- 9.1.2 “Delinquent Medical Records” means a medical record that has not been completed within thirty (30) days of the patient’s discharge.

9.2 DELINQUENT DOCUMENTS

- 9.2.1 When a Health Professional has Delinquent Documents, Medical Records will send a letter to the Health Professional (with a copy to the appropriate Service Chief and the PPEC) notifying them of their delinquency. If a Health Professional continues to have Delinquent Documents during the following thirty (30) days, another similar letter will be sent.
- 9.2.2 Upon the third consecutive month of Delinquent Documents, or if the Service Chief or the PPEC finds a pattern of Delinquent Documents for three (3) out of six (6) months, the Health Professional will be notified of the time and date to appear at the PPEC to explain their reason(s) for delinquency. The PPEC may impose a deadline for completion of specified Delinquent Document, or make recommendations, which may include, but not be limited to, suspension of Practice Authority or termination of Practice Authority and/or Membership, if applicable, after this appearance.
- 9.2.3 If such Delinquent Documents continue to remain incomplete for seven (7) days following the deadline imposed, then the Medical Records Department shall notify the CEO and MEC. For a Member such notice shall be considered the same as an MEC recommendation to revoke the Medical Staff Membership and/or Privileges made pursuant to Section 10.6 reported to the Board, and entitle the Member to such procedures as are applicable in the Review Procedures Appendix For a Privileged Practitioner who is not a Member, such notice shall be considered a notice of revocation of Privileges. For an APP, such notice shall be considered a recommendation to revoke the Authorized Function pursuant to Article VI of the APP Governance Policy.
- 9.2.3 The foregoing notwithstanding, nothing in this Section will prevent the Hospital from taking action under Section 9.3, as applicable, or pursuing other disciplinary action in accordance with this Appendix.

9.3 DELINQUENT MEDICAL RECORDS

- 9.3.1 Delinquent Medical Records will result in an automatic suspension of Practice Authority that shall remain in effect until all medical records in the Health

Professional's incomplete file are completed. Reasonable justifications for delay in completing medical records and avoidance of automatic suspension shall be determined by the Medical Records Department and may include but are not limited to the following: That the Health Professional or any other individual contributing to the record is ill, on vacation or otherwise unavailable for a period of time.

- 9.3.2 A copy of the suspension letter will be sent to the Medical Staff Office and the appropriate Service Chief, which will be provided according to established Medical Records Department procedures for Notification to Health Professional of Incomplete Medical Records.
- 9.3.3 If the medical records remain incomplete forty-five (45) days after patient discharge, or if there is a pattern of noncompliance at thirty (30) days as determined by the Service Chief, the Health Professional will be notified of the time and date to appear at the Medical Executive Committee (MEC) to explain their reason(s) for non-compliance. The MEC may impose a deadline for completion of specified Delinquent Medical Records, or make recommendations, which may include, but not be limited to, continued suspension of Practice Authority or termination of Practice Authority and/or Membership, if applicable, after this appearance.
- 9.3.4 If such Delinquent Medical Records continue to remain incomplete for seven (7) days following the deadline imposed, then the Medical Records Department shall notify the CEO and MEC. For a Member, such notice shall be considered the same as an MEC recommendation to revoke the Medical Staff Membership and/or Privileges made pursuant to Section 10.6 reported to the Board, and entitle the Member to such procedures as are applicable in the Review Procedures Appendix. For a Privileged Practitioner who is not a Member, such notice shall be considered a notice of revocation of Privileges. For an APP, such notice shall be considered a recommendation to revoke the Authorized Function pursuant to Article VI of the APP Governance Policy.

9.4 SPECIAL LIMITED WAIVER

In the event a Health Professional is going on vacation or leave of absence, or that, at discharge, information material to making a final diagnosis (e.g., autopsy results, important lab cultures, or necessary imaging) has not been completed through no fault of the Health Professional responsible for recording that diagnosis, the PPEC, CMO, COS, or Director of Medical Records Department may waive completion of the element of the record that is dependent up that material information.

9.5 REPORTING

In and of itself, automatic resignation under this Section 9.5 shall not be considered as disciplinary action relating to patient care reportable to the State of Michigan licensing authorities or the National Practitioner Data Bank. However, if a record is Delinquent on account of a matter that could affect subsequent patient care (e.g., no final diagnosis) as opposed to a technical issue (e.g., missing signature), any resulting automatic resignation may be reportable to such agencies in the judgment of the COS or CMO.

ARTICLE X: CORRECTIVE ACTION

10.1 CRITERIA FOR INITIATION

Any Officer of the Medical Staff, Service Chief, CMO, CEO or PPEC may initiate requests for corrective action based on, but not limited to, the following grounds:

- 10.1.1 The activities or professional conduct of any Health Professional are, or are reasonably probable, of being:
 - a. Detrimental to the safety of patient(s) or others;
 - b. Detrimental to effective delivery of patient care;
 - c. Disruptive to Hospital operations.
- 10.1.2 Unethical conduct or professional practice in or outside the Hospital including willful dishonesty in communications with the Medical Staff, recurrently false or wrongly coded billings and records or a finding by any local, state or national professional organization that a Health Professional committed unethical acts;
- 10.1.3 Institution of formal charges (e.g., indictment) for any felony or any other crime involving or affecting professional practice or Hospital activities (for this purpose, an indictment or other formal charge will be grounds to trigger corrective action investigation processes but the charge without more is not enough to require actual institution of corrective action);
- 10.1.4 Commission or conviction of any felony or any other crime involving or affecting professional practice or Hospital activities;
- 10.1.5 The pendency of prosecutorial or regulatory investigation, which has the potential to result in a Member's failure to maintain the qualifications and responsibilities for Membership in Section 3.2 of the Medical Staff Bylaws or a Health Professional's failure to maintain qualifications required in the Medical Staff Documents or Policy Manual (for this purpose, formal notice of an investigation by regulators would be grounds to trigger corrective action investigation processes, but the fact of the investigation without evidence of such failure to maintain the qualifications and responsibilities, act or omission does not require actual institution of corrective action);
- 10.1.6 Total or partial incapacitation or incompetence (which includes mental, judgmental, and physical);
- 10.1.7 Conduct that constitutes sexual harassment or morally offensive conduct toward, or that creates a hostile work environment for, any Health Professional, Hospital personnel, patient, or Hospital visitor;

- 10.1.8 Conduct that indicates unwillingness or inability to work harmoniously with Health Professionals, AHPs, Hospital personnel, or patients;
- 10.1.9 Violation of the Medical Staff Documents, Policy Manual or the policies and procedures of the Hospital (including but not limited to, falsification of application or credential documents and/or failure to report a change in professional liability insurance within seven (7) days of notice that such change will occur;
- 10.1.10 Failure of a Member to continuously discharge basic responsibilities of Medical Staff Membership as provided in Article III of the Medical Staff Bylaws;
- 10.1.11 Unauthorized disclosure of confidential Hospital or Medical Staff information relating to patient care, professional peer review, Hospital business or the knowing submission of false information in the course of professional review and corrective action processes; or
- 10.1.12 Failure or inability to comply with an agreement between the Hospital or Medical Staff and the Health Professional established in accordance with Medical Staff procedures intended to modify unacceptable behavior or practices of the Health Professional;
- 10.1.13 Failure to comply, in good faith, with a course of therapy, Alternative Action Program, precondition to Practice Authority or practice quality improvement protocol which has been agreed upon by the Health Professional; or
- 10.1.14 Any circumstance which formed the basis of a summary action; or
- 10.1.15 A finding by any professional licensing board that a Health Professional violated licensing statutes or administrative rules; or
- 10.1.16 A finding by any local, state or national professional organization that a Health Professional committed unethical acts; or
- 10.1.17 Repeated over-utilization of Hospital services and/or facilities, or
- 10.1.18 Willful disregard of utilization review findings and requirements; or
- 10.1.19 Any conduct that constitutes one of the grounds for state agency action as listed in Section 16221 of the Michigan Public Health Code, codified as MCL 333.16221.

10.2 REPORTING OF CORRECTIVE ACTION EVENTS AND SUBSEQUENT PROCESSING

10.2.1 Reporting. If a Health Professional or Hospital employee believes that corrective action of a Member may be indicated, that person will contact the Chief of Staff directly or the Office of Medical Affairs for review by the COS or CMO.

10.2.2 Initiation and Processing. The occurrence of an act, omission or other event that can give rise to corrective action for APPs shall be processed in accordance with the APP Governance Policy. For Members, the processes set forth below in Section 10.3 through 10.10 and in the Review Procedures Appendix shall govern. For Privileged Practitioners who are not Members, corrective action shall be carried out in accordance with the terms of their written contract, if any, or in accordance with Article VII of the Bylaws; provided however, the MEC or Board, in the discretion of either, may authorize the use of other procedures in the Review Procedures Appendix and/or this Section 10 to address implementation of corrective action procedures.

10.3 REQUESTS AND NOTICES FOR MEMBERS

All requests for corrective action shall be in writing, submitted to the MEC and supported by reference to the specific activities or conduct that constitute the grounds for the request. Unless corrective action was instituted by such individual, the COS, CMO and CEO shall be promptly and fully informed of all requests for corrective action received by the MEC and shall, in any event, be kept fully informed of all action taken in conjunction herewith that they are not personally managing.

10.4 INVESTIGATION OF MEMBERS WHEN APPROPRIATE AND REPORT

The MEC may, by issuing a formal resolution, designate a person or an ad hoc committee to investigate, if an investigation is deemed necessary and/or appropriate. When so designated, the investigator (person or committee) shall promptly investigate the matter on his or her own or using the assistance of one or more internal or external independent reviewer(s) and, ordinarily within forty-five (45) days after the receipt of the designation, forward a written report of the investigation to the MEC. The time for reporting may be extended for good reasons, including dependence upon an external third-party reviewer over whom the investigator or MEC lacks meaningful control. If the corrective action request was preceded by an investigation or Special Professional Review, a report of that investigation or Special Professional Review (including a description of the investigative or review process) may be used in lieu of a subsequent investigation. The Member subject to the investigation will be advised.

10.5 INTERVIEW OF SUBJECT MEMBER

The Member subject to a corrective action request shall submit to an interview, upon the request of the MEC, Service Chief or an investigator (person or committee) at any point after the corrective action request is made. At such interview, the Member shall be informed of the general nature of the basis for the request against him/her and shall be invited to discuss, explain or refute such basis. Any such appearance shall be a preliminary, informal meeting between professionals; it shall not constitute a hearing, attorneys shall not be present and none of the procedural steps of the Review Procedures Appendix shall apply. A record of such appearance shall be made.

10.6 MEC ACTION

The MEC shall take action within forty-five (45) days following receipt of a request or, if an investigation is requested, within forty-five (45) days following receipt of the investigation report. Action taken by the MEC may include without limitation:

- 10.6.1 Rejecting the request for corrective action with or without a Letter of Concern or suggestion or requirement for education that does not affect Privileges;
- 10.6.2 Recommending collegial intervention;
- 10.6.3 Requiring a health assessment of the Member by a health provider or at a facility selected by the MEC and under such conditions (including reports to the MEC or its designee) as the MEC may establish, and/or require the Member to undergo appropriate treatment;
- 10.6.4 Issuing a Letter of Reprimand;
- 10.6.5 Recommending to the Board a probation without limitation of Privileges;
- 10.6.6 Recommending to the Board requirements of consultation, other than administrative consultations or limitations (as specified in Section 8.4) or consultation required for Members;
- 10.6.7 Recommending to the Board reduction of Medical Staff category or limitation of any prerogatives directly related to patient care;
- 10.6.8 Recommending to the Board reduction, limitation, suspension, or revocation of Privileges;
- 10.6.9 Recommending to the Board suspension or revocation of Membership;
- 10.6.10 Recommending to the Board that other action be taken.

10.7 NON-PARTICIPATION OF SUBJECT MEMBER

A Member who is subject to corrective action may attend the MEC meeting to express his/her views or answer questions, but be excluded by the Chief of Staff or the MEC from participating in those aspects of the meetings of the MEC which involve deliberations, and may not vote on action to be taken concerning him/her (including the committee's communication with its legal counsel).

10.8 EXERCISE OR WAIVER OF MEMBER'S PROCEDURAL RIGHTS

Any recommendation or action taken pursuant to Section 10.6.3 through 10.6.10 (but not Articles VII, VIII, IX and XI) will ordinarily be held in abeyance for a period of thirty (30) days, or during the timely and effective exercise of procedural rights applicable in the Review Procedures Appendix, whichever is longer. However, during such a period, other actions including those described in Articles VII, VIII, IX and XI, may still be taken as appropriate. The MEC may, based on the outcome of any informal review or formal hearing, revise its action or recommendation, and if it has the effect of reducing the adversity of the action or recommendation, no further review at the Medical Staff level may be requested. Failure of the subject Member to timely request and pursue procedural rights shall constitute acquiescence to an Adverse Action or recommendation as provided in the Review Procedures Appendix.

10.9 REPORT TO THE BOARD AND BOARD ACTION

All MEC actions and recommendations regarding a corrective action request shall be reported promptly to the Board. A rejection of a request for corrective action or the taking of actions specified in Section 10.6.4 through 10.6.10 shall not be final until affirmatively approved by the Board. If not approved by the Board, the Board may, after due consultation with the MEC take any other action specified in Section 10.6. For any corrective action taken or recommended by the MEC for which a Member has timely and effectively pursued a formal hearing (basic or special), if applicable, Board notice and action will await the outcome or waiver of the Member's appeal. For any corrective action taken or recommended by the MEC for which the Member is not entitled to, or has waived, a formal hearing, the Board may expressly affirm, or after consultation with the MEC, reject or rescind the action or recommendation with special directives to Administration and/or the MEC as it deems appropriate. Silence or non-action by the Board for 60 days after the receipt of notice of an MEC recommendation regarding corrective action where a hearing or appeal proceedings are not pending, shall constitute the Board's implied approval of the recommended action.

10.10 MONITORING MEMBER'S COMPLIANCE

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

ARTICLE XI: SUMMARY CORRECTIVE ACTION

11.1 CRITERIA AND INITIATION

Any two of the Chief of Staff, CEO, CMO, or the appropriate Service Chief, acting jointly, or the MEC or Board, acting alone, shall have the authority to summarily (immediately) suspend or place conditions upon the exercise of all or any portion of the Practice Authority of a Health Professional whenever there is reasonable belief:

11.1.1 The Health Professional's temporary or permanent mental or physical state is such that one or more patients under the Health Professional's care would be subject to imminent danger to their health as a result of the Health Professional's action or inaction if permitted to continue to exercise Practice Authority; or

11.1.3 There is substantial evidence that the Health Professional has committed acts of an illegal or unethical nature, while in the Hospital or other setting, which are of such gravity that, if proven, would justify revocation or permanent suspension of Membership, if applicable, Practice Authority, professional licensure and/or prescribing authority; or

11.1.3 There is substantial evidence of a gross dereliction of duty which relates to the assurance of a patient's well-being, or the management of one or more patients, that, in the judgment of those having the authority to summarily act, indicates one or more patients under the present and/or future care of the Health Professional involved would

be subject to imminent danger to their health, if the Health Professional is permitted to continue to exercise Practice Authority. (A pattern of unusually high frequencies of unexpected deaths or morbidity shall constitute sufficient grounds to invoke the provision);

11.1.4 There is substantial evidence of an act, omission, or pattern by the Health Professional which has the potential of materially damaging the Hospital's reputation, licensure status, or the ability to effectively function as a provider of services;

11.1.5 Of non-compliance with an agreement between the Health Professional and the MEC or Board, where the agreement specifies non-compliance will result in suspension or the acts of non-compliance places patient, staff of Health Professional welfare at significant risk.

11.2 NOTICE OF SUSPENSION AND SUBSEQUENT PROCESSING

11.2.1 Notice. Such summary action shall become effective immediately upon imposition, and the CEO shall promptly give written notice of the suspension to the Member.

11.2.2 Initiation and Processing. The occurrence of an act, omission or other event that can give rise to summary action for APPs shall be processed in accordance with the APP Governance Policy. For Members, the processes set forth below in Section 11.3 through 11.5 and in the Review Procedures Appendix shall govern. For Privileged Practitioners who are not Members, summary action shall be carried out in accordance with the terms of their written contract, if any, or in accordance with Article VII of the Bylaws; provided however, the MEC or Board, in the discretion of either, may authorize the use of other procedures in the Review Procedures Appendix and/or this Section 11 to address implementation of summary action procedures.

11.3 MEDICAL EXECUTIVE COMMITTEE MEETING

The Chief of Staff and CEO, unless involved in the summary action, will be notified as soon as possible. Either or both shall then call an emergency meeting of the Medical Executive Committee within twelve (12) days after the suspension takes effect to review said action. The CEO will endeavor to give notice of the MEC meeting to the subject Member by the most expeditious means possible. The MEC shall have the right but not the obligation to have the subject Member appear before the MEC and review the situation before it votes. The meeting may be delayed at the request of the subject Member. For the purposes of this section only, the presence of a simple majority of the voting members of the MEC shall constitute a quorum for conducting a review of said action. If the subject Member is also an MEC member, he/she may not be present during deliberations and may not vote.

11.4 MEC ACTION

The MEC may recommend that the Member's Privileges be reinstated, or curtailed to a lesser or greater extent than provided in the original action, or keep the summary action in place, with or without modification, while corrective action proceedings are pending. If an MEC decision is other than to rescind the action in total within twelve (12) days of imposition, the subject Practitioner may make a request to pursue the procedures applicable in the Review Procedures Appendix. If the MEC should rescind the summary action, but refer the matter for routine corrective action as an alternative, any request for the procedures of the Review Procedures Appendix, other than informal review, shall be pursued under Section 10.8 of the routine corrective action section only after MEC has taken action under paragraph 10.6 of that same section. In the event that the MEC should recommend routine correction action concurrent with summary action for the same Member, then any review procedures for both actions shall be consolidated in accordance with the provisions of the Review Procedures Appendix. The terms of the summary action shall remain in effect until terminated or modified by the MEC or the Board.

11.5 PATIENT CARE RESPONSIBILITIES

The medical coverage for the inpatients in the Hospital of the Member subject to summary suspension shall be selected by the Service Chief to which said Member is assigned and/or the service in which the patient is primarily receiving care, or the Chief of Staff. As much as possible, the wishes of the respective patient(s) shall be considered in the selection but may not ultimately determine the medical coverage.

APPENDIX 3: REVIEW PROCEDURES, PLAN FOR HEARING, APPEALS AND OTHER TYPES OF REVIEW FOR MEDICAL STAFF MEMBERS AND INITIAL APPLICANTS

ARTICLE I: APPLICATION OF REVIEW PROCEDURES

1.1 DEFINITIONS

The following definitions shall apply to this Appendix, in addition to those set forth in the "Definitions and Interpretation" section of the Medical Staff Bylaws, which are incorporated by reference:

Affected Practitioner: means a Member or Initial Applicant as to whom a Medical Staff or Board recommendation was made or action taken.

CEO means the Chief Executive Officer of St. Joseph Mercy Chelsea (Hospital). The Chief Medical Officer (CMO) is an authorized designee of the CEO for all purposes under this Appendix.

Initial Applicant: means a Physician, Dentist, or Podiatrist making application for initial appointment to the Medical Staff.

Presiding Officer means a person, who if not the hearing committee chair, is appointed to assist the hearing committee before and during the hearing and who presides at the hearing, but does not participate in the committee's deliberation.

1.2 GENERAL APPLICATION

The procedures set forth in this Appendix are intended to be utilized for Affected Persons who make a timely request for an informal review or hearing with regard to certain types of disciplinary and administrative actions taken or about to be taken with regard to Members and Initial Applicants who make a timely request for same.

1.3 INFORMAL REVIEW AND NON-APPLICATION OF FORMAL (BASIC AND SPECIAL) HEARING PROCEDURES

The informal review procedures shall apply (and the basic and special hearing procedures specified in Articles III through V of this Appendix and/or in Medical Staff Policy or Procedures do not apply) to any of the following recommendations or actions:

- a. Removal from any committee for failure to fulfill the responsibilities of Membership;
- b. Issuance of a written warning letter or letter of admonition or requirement of additional education without material limitation of prerogatives (e.g., being on the on-call list) or Privileges;
- c. Continuation of provisional status when Membership has been no more than two (2) years;
- d. Summary action when rescinded within fourteen (14) calendar days;

- e. Withholding of Privileges on account of late filing of a Reappointment Form;
- f. Non-reappointment for failure to file a completed and signed recredentialing form and any other requirements for reappointment including other requested recredentialing requirements or materials;
- g. A reduction of Privileges which applies equally and generally to all of a class of Members of like or similar training, experience, and Medical Staff Membership duration;
- h. Imposition of a consultation requirement of fourteen (14) calendar days or less without a hearing or appeal proceedings pending, or for the duration of hearing and appeal proceedings regarding Membership or Privileges, or during provisional status monitoring period, whichever is longer;
- i. Involuntary resignation of Membership as a result of a failure to timely request reinstatement while on leave of absence;
- j. Termination of Membership or Privileges according to the terms of a written contract;
- k. Removal or mandatory leave of absence from a medical-administrative capacity (i.e., Medical-Administrative Officer or Medical Staff Officer) by virtue of action by the Administrator, President, Medical Staff or Board or by contract operation or expiration;
- l. Denial of an initial application to the Medical Staff for any reason unrelated to professional competence or professional conduct of the Initial Applicant, such as, but not limited to, material inaccuracies in the application; failure to submit a complete and accurate initial application (including all required attachments); failure to meet the minimal objective requirements for appointment as set forth in these Bylaws, other the Medical Staff Documents, and the Policy Manual (including threshold Board Certification requirements); failure to timely cure deficiencies in the information received by the Hospital from external sources; the inability of the Hospital to accommodate the Applicant; and failure to demonstrate a history of behavior consistent with the basic responsibilities and requirements for Membership.
- m. Denial of transfer to a Medical Staff category that has fewer prerogatives and responsibilities than that to which an Affected Practitioner is appointed;
- n. Revocation or withdrawal of the Membership and Privileges of a Member on Provisional Status by reason of insufficient activity upon which to base an evaluation of such individual's ability;
- o. Appointment or reappointment for less than the maximum appointment term;
- p. Denial, expiration or revocation of temporary Privileges;
- q. Denial of request for waiver of required minimal requirements for liability insurance coverage as required by the Board;

- r. Withholding of Privileges on account of violation of medical record completion requirements;
- s. The appointment of a reviewer, investigator, ad hoc review committee or investigation committee or the conduct of an informal review or investigation;
- t. When the Initial Applicant or Member is requesting Privileges for procedure(s) or Membership in a specialty that is closed or where the number of Members is limited by Board action;
- u. Any recommendation or action not “adversely affecting” (as defined by the Health Care Quality Improvement Act; see Section 4.30) an Initial Applicant or a Member or, except as otherwise covered in Sections 1.4 or 1.5, that is not based on a subjective determination of the Affected Practitioner’s professional conduct or competency in the care of patients.

When the formal (basic or special) hearing procedures delineated in this Appendix do not apply to a recommendation or action, any Affected Practitioner who believes he/she is aggrieved by any such action or recommendation of the MEC or Board may seek review of the action or recommendation by submitting a written statement taking exception to such action or recommendation and specifying the reasons therefor. The statement shall be read or furnished to whichever body made the recommendation or took the action, and made a part of the Affected Practitioner's permanent file. The statement may also request an opportunity to appear before the MEC or Board to informally discuss his/her position on the action, which request may be granted in the discretion of the MEC or Board. After review the Board may also, in its sole discretion, direct a basic or special hearing be held (although one is not required), to review and make recommendations concerning the underlying matter at issue.

1.4 APPLICATION OF BASIC HEARING PROCEDURES

The basic hearing procedures as set forth in Article III of this Appendix shall apply only to the following recommendations or actions:

- a. Automatic suspension of Membership or Privileges due to suspension or loss of licensure; suspension or loss of Federal DEA Registration Certificate or Michigan Board of Pharmacy Controlled Substance license or other governmentally authorized prescribing authority; the temporary or permanent exclusion from Medicare, Medicaid or other federal or state health care programs; or conviction of any felony or any crime arising out of professional practice or involving fraud, theft, embezzlement or other financial misconduct, the abuse or neglect of patients, the unlawful manufacture, distribution, prescription or dispensing of a controlled substance or Medicare, Medicaid or other federal or state healthcare program. However, a hearing based on the actions in this 1.4(b) shall be limited to the issue of whether the event triggering the automatic suspension occurred;
- b. Denial of a request to increase Privileges which are not ordinarily possessed by Practitioners of like training, experience, Board Certification status, Medical Staff category and Membership duration;
- c. Denial of a requested change in Medical Staff category to one that has more Privileges or prerogatives than that to which a Member is appointed when level of

practice requirements for the requested category (e.g., patient encounters and admissions) are met, except as provided in Section 1.3(s);

- d. Issuance of a formal Letter of Reprimand without any reduction or limitation on the exercise of Privileges;
- e. Non-reappointment, suspension, or termination of Membership or Privileges by reason of failure to comply with Board Certification requirements. However, a hearing based on this action shall be limited to the issue of whether Board Certification compliance has been documented by the Member;
- f. Non-reappointment, suspension or termination of Membership or Privileges by reason of failure to document financial responsibility/professional liability insurance requirement compliance. However, a hearing based on this action shall be limited to the issue of whether financial responsibility/professional liability coverage compliance has been documented by the Member;
- g. Involuntary resignation of Privileges or Membership, or non-reappointment, on account of violation of medical records completion requirements;
- h. Suspension, termination of Privileges, termination of Membership or non-reappointment for failure to comply with a written agreement between the Member and the MEC or Board used in lieu of corrective action or alternative action which provides for such suspension, termination of Membership, and/or non-reappointment in the event of non-compliance. However, a hearing based on this action shall be limited to the issue of whether compliance with the agreement has been established by the Member;
- i. Suspension, termination of Privileges, termination of Membership or non-reappointment for recurrent failure to work cooperatively with others after disruptive Practitioner or alternative action procedures have been undertaken and professional conduct or competence in the care of patients is not involved;
- j. Denial, non-reappointment, involuntary reduction or suspension of a Member's Privileges for more than fifteen (15) calendar days for reasons unrelated to the professional competence or professional conduct of the Member;
- k. A recommendation that the Member be directed to obtain retraining, additional training, or continued education for a Member which immediately limits prerogatives (e.g., being on the on-call list) but does not materially limit exercise of Privileges;
- l. Requirement of corrective counseling without limitation of Privileges;
- m. Imposition of a probationary or a special retrospective review process without limiting Privileges; and
- n. Imposition of a consultation requirement for fifteen (15) calendar days or more for reasons unrelated to professional competence or conduct unless the Member is on provisional status or hearing and appeal proceedings are in progress;

- o. Such other recommendations or actions as the MEC or Board may direct, in its discretion, after consultation with the other body.

1.5 APPLICATION OF SPECIAL HEARING PROCEDURES

The special hearing procedures as set forth in Article IV of this Appendix shall apply to the following recommendations or actions:

- a. Non-reappointment, for reasons relating to professional competence or professional conduct affecting the care of patients, not including administrative-type issues such as: failure to timely submit a recredentialing form; failure to document professional liability coverage; failure to meet Board certification requirements; failure to timely request reinstatement following an expiration of leave of absence; termination of a written contract with the Member and/or his/her employer, recurrent non-compliance with medical records requirements; failure to comply with a written agreement between the MEC or Board and the Member which provides for non-reappointment for failure to comply; and recurrent failure to work cooperatively with others after disruptive Practitioner or alternative action procedures have been undertaken;
- b. Denial, involuntary reduction or suspension of Privileges of a Member which are ordinarily possessed by a Member of like or similar training or Medical Staff duration, for fifteen (15) calendar days or more for reasons related to professional competence or professional conduct in the care of patients, except for failure to comply with a written agreement between the MEC or Board and the Member which provides for denial, involuntary reduction or suspension of Privileges for failure to comply;
- c. Revocation or suspension of Membership or Privileges for fifteen (15) calendar days or more, for reasons relating to professional competence or professional conduct affecting the care of patients, not including the following: failure to meet Board certification requirements; failure to timely submit a recredentialing form; failure to document professional liability coverage; or timely request reinstatement following a leave of absence; resignation due to insufficient activity as a Member on Provisional Status; denial of an initial application for appointment to the Medical Staff except for reasons unrelated to the professional competence or conduct of the Applicant such as failure to meet minimal objective requirements for appointment, the application being incomplete or the application containing material inaccuracies or omissions; expiration or termination of a written contract with the Member and/or his/her employer; failure to comply with a written agreement between the MEC or Board and the Member which provides for revocation or suspension for failure to comply; and recurrent failure to work cooperatively with others after disruptive Practitioner or alternative action procedures have been undertaken;
- d. Denial of an initial application for appointment to the Medical Staff for reasons related to the professional competence or professional conduct of the initial Applicant, not including: the application being incomplete; the application containing material inaccuracies or omissions; absence or termination of a written contract with the Member and/or his/her employer where required for

Privileges; or any reason unrelated to the professional competence or professional conduct in the care of patients of the Initial Applicant;

- e. Imposition of a consultation requirement for fifteen (15) calendar days or more based on professional conduct or competence, unless the Member is on Provisional Status or hearing and appeal proceedings are already in progress;
- f. Such other recommendations or actions as the Board may direct, in its sole discretion, after consultation with the MEC.

ARTICLE II: ADVERSE RECOMMENDATION OR ACTION

2.1 NOTICE OF RECOMMENDATION OF ACTION

When a proposed or actual Adverse Action taken by the MEC or the Board which, according to this Appendix, entitles an Affected Practitioner to a basic hearing (Section 3.1) or special hearing (Section 4.1), prior to a final decision of the Board on that recommendation or action, the Affected Practitioner shall be promptly given Special Notice by the President. The Special Notice shall contain:

- a. A statement of the proposed or actual Adverse Action and the general reasons for it;
- b. A statement that the Affected Practitioner has the right to request in writing a hearing on the proposed or actual Adverse Action within thirty (30) calendar days of his/her receipt of the notice;
- c. A statement of the kind of hearing (basic or special) to which the Affected Practitioner is entitled; and
- d. A copy of this Appendix, unless it has already been provided to the Affected Practitioner.

2.2 REQUEST FOR ORIGINAL HEARING

The Affected Practitioner shall have thirty (30) calendar days following receipt of the Special Notice according to Section 2.1 to file a written request for a hearing. The request shall be made by a writing delivered in person or by Special Notice to the President. This request shall include a written response to the statement of reasons for the adverse action that concisely explains any disagreement with the statement and a list of individuals, if any, who the Affected Person believes have information that would support the Affected Person's position and meet the burden of proof as delineated in Section 3.6 or 4.10. The request will not be deemed complete unless it includes the required written response and a list of individuals, if any, with such information.

2.3 WAIVER BY FAILURE TO TIMELY REQUEST A HEARING

An Affected Practitioner who fails to request a formal hearing within the time and in the manner specified in Section 2.2 waives any right to such hearing and to any possible appellate review. When such waiver is in connection with:

- a. A proposed or actual Adverse Action by the Board, it shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board;
- b. A proposed or actual Adverse Action by the MEC, it shall constitute acceptance of that action which shall thereupon become and remain effective pending the final decision of the Board. In this event, the Board shall consider the MEC's proposed or actual Adverse Action at its next regular meeting following waiver. In its deliberations, the Board shall review and consider the Adverse Action proposed or taken and supporting documentation of the MEC and may consider any other relevant information received from any source. The Board's action on the matter shall constitute the final decision of the Board.

The CEO shall promptly send the Affected Practitioner notice of each official action taken after a failure to request a Hearing conforming to this Section 2.3 and shall notify the Chief of Staff (COS) and the CMO if the CMO is not acting as designee of the CEO and the Chairperson of the Board of each such action.

ARTICLE III: BASIC HEARING PROCEDURES

3.1 NOTICE OF TIME AND PLACE FOR HEARING

Upon receipt of a timely request for hearing, the CEO shall deliver such request to the COS or the Board, depending on the body whose recommendation or action prompted the request for hearing. The CEO, in coordination with the COS or Board Chair, as appropriate shall promptly schedule and arrange for a basic hearing. Within thirty (30) calendar days following the receipt of the Special Notice and at least seven (7) calendar days prior to the hearing date, the CEO, by Special Notice, shall notify the Affected Practitioner of the date, time and place of the commencement of the hearing. The hearing date should generally not be more than forty-five (45) calendar days from the date of receipt of the request for hearing. For an Affected Practitioner who is under suspension or a substantial restriction of Privileges then in effect, a hearing shall ordinarily be held as soon as the arrangements and preparations for it may be reasonably made and requirements for same are met and no change of date or extension is requested. The notice may also furnish hearing rules, including time limits, prepared by the CEO or COS, that take into account the anticipated nature and scope of the hearing, as well as the interests of both parties and the hearing committee.

3.2 SUPPLEMENTAL STATEMENT OF REASON(S)

If the reason(s) for the action or recommendation has not already been stated to the Affected Practitioner seeking a hearing, the Affected Practitioner's request for hearing may include a request that such reasons be provided. Such a request for reasons shall be responded to by letter from the CEO or COS; alternatively the MEC or the Advocate, on its/his/her own initiative, may issue a more detailed statement of reasons. Ordinarily any such supplemental letter must be delivered to the Affected Practitioner at least three (3) calendar days before the scheduled date for the hearing. The statement of reasons may be amended at any time, provided the Affected Practitioner is given a reasonably sufficient opportunity to prepare to meet any added reasons.

3.3 APPOINTMENTS OF HEARING COMMITTEE FOR BASIC HEARING

- 3.3.1 By the MEC. A hearing occasioned by a proposed or actual Adverse Action of the MEC shall, in the MEC's discretion, be conducted by:
- a. a quorum of the MEC; or
 - (b) a subcommittee appointed by the COS to conduct the hearing consisting of no less than three (3) Practitioners, who may or may not be Members, but at least one (1) of whom must be a member of the MEC.

The COS, who shall not be a member of the committee, shall appoint a member of the committee to serve as its chair and Presiding Officer.

- 3.3.2 By the Board. A hearing occasioned by a proposed or actual Adverse Action of the Board shall be conducted by a hearing committee appointed by the Board or its designee. This committee shall be composed of not less than three (3) persons, at least one (1) of whom shall be a Member of the Medical Staff. The Board Chair, who shall not be a member of the hearing committee, shall designate a member of the committee to serve as its chair and Presiding Officer.
- 3.3.3 Service on Hearing Committee. A Member or Board Trustee shall not be disqualified from serving on a hearing committee merely because of prior participation in the review or investigation of the underlying matter at issue or because of knowledge of facts involved. Individuals involved in Peer Review activities shall be impartial peers and shall not have an economic interest in and/or a conflict of interest with the subject of the Peer Review activity. Impartial peers would also exclude individuals with blood relationships, employer/employee relationships, or other potential conflicts that might prevent the individual from giving an impartial assessment, or give the appearance for the potential of bias for or against the subject of the Peer Review. In any event, all members of a hearing committee shall be required to consider and decide the case with good faith objectivity.

3.4 APPEARANCE AND REPRESENTATION

- 3.4.1 Appearance of Affected Practitioner. The Affected Practitioner requesting the hearing must be present for the hearing; the Affected Practitioner's failure to appear at the date and time set forth in the notice shall constitute a waiver of the right to a hearing.
- 3.4.2 Representation. At any Basic Hearing:
- a. An Affected Practitioner shall represent himself/herself, except as otherwise decided according to Section 5.1.1(a).
 - b. If the hearing committee is the MEC or a subcommittee thereof, the COS may, in his/her discretion, appoint the COS or another Member to present the position adverse to the Affected Practitioner. This person shall be called the "Advocate."

- c. If the hearing committee is a committee appointed by the Board, the Board Chair may, in his/her discretion, appoint a Member or other person to present the position adverse to the Affected Practitioner. This person shall be called the "Advocate."
- d. Neither the Affected Practitioner nor the Advocate may participate in deliberations of the hearing committee.

3.5 HEARING CONDUCT AND EVIDENCE

3.5.1 Hearing Conduct and the Presiding Officer. The chairperson of the hearing committee shall be the Presiding Officer, appointed in accordance with Section 3.3. The Presiding Officer shall act to maintain decorum and to assure that the hearing shall be conducted in such a manner that both the Affected Practitioner and the Advocate (if any) have a reasonable opportunity to present relevant oral and documentary evidence and have their positions fairly heard and considered. The Presiding Officer shall determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the considerations of evidence. The Presiding Officer may also promulgate hearing rules, including reasonable time limits, according to Section 5.4 of this Appendix, which may modify any rules provided by the CEO or COS under Section 3.1. Members of the hearing committee may ask questions of the Affected Practitioner and the Advocate (if any). Neither legal rules of procedure or evidence, nor specified rules of order used for other Bylaws purposes shall apply to a hearing under this Article.

3.5.2 Evidence. The Affected Practitioner and the Advocate (if any) may submit to the hearing committee for consideration:

- a. Written statements, letters and documents that are relevant to the subject matter of the hearing, including relevant portions of the Affected Practitioner's Credentials File maintained by the Hospital;
- b. Oral statements by the Affected Practitioner and the Advocate (if any);
- c. Only when deemed essential to a meaningful hearing, the Presiding Officer may, in his/her discretion, authorize the appearance, examination and cross-examination of witnesses, consistent with supplemental hearing rules. Unless so authorized, neither the Affected Practitioner nor the Advocate (if any) shall have a right to present witnesses, or cross-examine in person.
- d. Evidence admitted in the hearing need not strictly meet the requirements of admissibility of a court of law, and the hearing committee may consider any evidence customarily relied upon by responsible persons in the conduct of serious affairs.

3.6 BURDEN OF PROOF

The body whose adverse recommendation or action occasioned the hearing shall have the burden to present evidence sufficient to show its recommendation or action has justification. If such justification is presented in support of the recommendation or action, the Affected

Practitioner shall have the burden of proof and must demonstrate that the action or recommendation is:

- a. Arbitrary;
- b. Capricious; and/or
- c. Based on inaccurate or insufficient information through no fault of the Affected Practitioner.

3.7 RECORDING OF HEARING

The hearing shall be recorded by minutes prepared by a recording secretary selected by the CEO. Such minutes shall be subject to approval and amendment by the hearing committee. Other means of recording (e.g., electronic tape or court stenographer) shall be used only at the request, or with the consent, of the hearing committee. If the Affected Practitioner elects such an alternate method of recording that is approved by the hearing committee, the Affected Practitioner shall bear the primary cost thereof.

3.8 RECOMMENDATION

3.8.1 Notice. Within thirty (30) calendar days after completion of the hearing, the hearing committee shall meet, deliberate, and then issue its report in writing to the CEO. The report shall then be submitted by the CEO to the COS or Board, as appropriate. The CEO shall also send notice of the recommendation to the Affected Practitioner (by Special Notice) as provided in Section 3.9.

3.8.2 Action on Recommendation.

- a. If the hearing committee was a subcommittee of the MEC, its report shall be submitted to the MEC for consideration. Thereafter, the MEC shall make its final recommendation, subject to approval by the Board.
- b. If the hearing committee was the MEC, its report shall become the final recommendation of the MEC, subject to Board action.
- c. If the hearing committee was a committee appointed on behalf of the Board, its report shall become the committee's final recommendation, subject to Board action. Prior to final Board action, the MEC may submit to the Board its comments on such hearing committee report. If an appeal is timely requested, final Board action may be subject to reconsideration on appeal that is timely requested. Final Board action shall be deferred until the opportunity for appeal is waived or, if requested, the appeal process is concluded.

3.9 NOTICE OF AFFECTED PRACTITIONER

Within seven (7) calendar days after the Hearing Committee's recommendation, the CEO shall send written Special Notice to the Affected Practitioner regarding the notice of recommendation.

3.10 APPEAL

If, following a basic hearing pursuant to this Article, the Affected Practitioner believes that the hearing committee's recommendation was arbitrary, capricious, or lacks any evidence in

support, which shall be the sole grounds for appeal, the Affected Person may, within fifteen (15) calendar days of receipt of notice of the recommendation, submit a written appeal of the recommendation consisting of not more than ten (10) pages of text (not including exhibits) concisely stating the basis therefore to the CEO. If such an appeal is filed, the hearing committee or a representative thereof may submit a written response in opposition within fifteen (15) calendar days after the appeal is received.

- 3.10.1 Presiding Officer. The chairperson of the appellate review proceedings shall be Presiding Officer for any appellate hearing and shall determine the order of procedure during the review, make all required rulings, and maintain decorum.
- 3.10.2 Oral Statements. The Board, in its sole discretion, may allow the parties or their representatives to personally appear 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 Board.
- 3.10.3 Recess, Closing and Deliberation. The Board 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 proceedings shall be closed. The Board 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 adjourned.
- 3.10.4 The appeal shall be considered by the Board which shall, within 45 days after receipt of the appeal, take one of the following actions:
 - a. Refer the matter back to the hearing committee for further review or supplemental findings. If this is done, the hearing committee shall respond in writing to the Board request within forty-five (45) calendar days of request, and the Board shall then take the actions in (b), (c) or (d) below within fifteen (15) calendar days after receipt of the response; or
 - b. Uphold the recommendation of the hearing committee and take final action accordingly; or
 - c. Reverse the recommendation of the hearing committee, with or without the requirement that further hearings be conducted by the hearing committee; or
 - d. Reverse the recommendation of the hearing committee and require a special hearing be held in accordance with the provisions of Article IV of this Appendix.

The CEO shall advise the Affected Practitioner, by Special Notice, of the outcome of the appeal within seven (7) calendar days of the final action.

3.11 RELEASE

By requesting an informal hearing or appellate review under this Appendix, the Affected Practitioner agrees to be bound by the provisions of the Medical Staff Documents, including this Appendix and the Policy Manual in all matters relating thereto.

ARTICLE IV: SPECIAL HEARING PROCEDURES

4.1 NOTICE OF TIME AND PLACE FOR HEARING

- 4.1.1 Scheduling of Hearing. Upon the CEO's receipt of a timely and proper request for a special hearing, the CEO shall promptly schedule and arrange for the hearing. The initial hearing date shall ordinarily be scheduled not less than thirty (30) calendar days nor more than sixty (60) calendar days from the date of receipt of the request for hearing.
- 4.1.2 Shortened Time Limit for Hearing. A hearing for a Member who is under suspension then in effect may be held in less than thirty (30) calendar days after the request is made, provided such Member's request for the hearing includes a specific request that the hearing be held in less than thirty (30) calendar days and it is feasible to do so considering the complexity of the issues involved; in the event such a special request for a shorter period is made by a Member who is under suspension, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and requirements for same met, subject to Section 4.1.3 below.
- 4.1.3 Lengthened Time Limit for Hearing. Pursuant to Section 4.3, if the Affected Practitioner submits questions to one (1) or more committee members, objects to the composition of an ad hoc hearing committee, or a determination is made that a hearing officer who is not a Member shall conduct the hearing, the usual sixty (60) calendar day maximum limitation shall be deemed waived by the Affected Practitioner. In such event, the hearing shall be held as soon as the arrangements and preparations for it may reasonably be made and the requirements for same met. The CEO shall give written notice of the new scheduled date, time, and place of the hearing to the Affected Practitioner, hearing committee or officer, and the COS or Board, once the questioning and objection processes are complete and the hearing committee or officer has been finally selected.

4.2 HEARING NOTICE, RESPONSE AND WITNESS LISTS

- 4.2.1 Hearing Notice. The CEO shall issue a notice of hearing by Special Notice to the Affected Practitioner, and by any suitable means of notice to others involved in the hearing process. The notice of hearing shall specify:
- a. Time, Location and Hearing Committee Members. The scheduled date, time and location of the hearing, and list of such individuals who have been appointed to the hearing committee, if determined. Except as provided in Section 4.1.2 or 4.1.3, such date shall be at least thirty (30) calendar days out from notice.
 - b. Statement of Reasons. As applicable, a statement of the alleged acts or omissions of a Member, a list identifying the medical record numbers of the specific or representative patient charts in question, and/or other

reasons or subject matter forming the basis for the adverse recommendation or action that is the subject of the hearing.

- c. List of Witnesses. A list of witnesses, if any, that the body which took or proposed adverse action (or its designated representative) believes will be called as witnesses to testify in support of the recommendation or action at the time of the hearing.

4.2.2 Response and List of Witnesses of Affected Practitioner. Within fourteen (14) calendar days after receipt of the notice of hearing (but no less than seven (7) days before the hearing if the Affected Practitioner has requested and been granted an expedited hearing), the Affected Practitioner shall furnish a written response to the Statement of Reasons to the CEO and a list of the individuals (including their addresses and phone numbers, if not Members or Hospital employees, their phone numbers and email address) who may or will be called as witnesses in support of the Affected Practitioner's position at the time of the hearing.

4.2.3 Amendments. The statement of reasons, the response, or the list of witnesses of either party may be amended at any time by the party furnishing them, provided that the opposite party is given a reasonable period in which to prepare to meet the amended statement of reasons or substance of the testimony of any additional witnesses. For the purpose of this provision, a time period of five (5) business days or more shall be presumed to be a "reasonable period." The permissibility of a shorter period of notice shall be subject to the discretion of the Presiding Officer for the hearing.

4.3 APPOINTMENTS OF HEARING COMMITTEE FOR SPECIAL HEARING

4.3.1 By the MEC. A special hearing occasioned by recommendation of the MEC according to Sections 1.5 and 2.1 shall ordinarily be conducted by an ad hoc committee. This hearing committee shall be appointed by the COS, and composed of no less than 3 and no more than 5 Practitioners, who may or may not also be Members or on the MEC. The COS in consultation with the CEO, who shall not be a hearing committee member, shall appoint the Presiding Officer of the hearing committee who may, but need not be a Practitioner. An attorney may be appointed as a Presiding Officer, but if this is done, while the attorney may participate in committee deliberations and assist in the preparation of the hearing committee report, (s)he shall not have a vote for or against adoption of the final hearing committee report. The appointments are subject to the procedures of Sections 4.3.3, 4.3.4, 4.3.5 and 4.3.6.

4.3.2 By the Board. A hearing occasioned by adverse action of the Board pursuant to Section 2.1 shall be conducted by a hearing committee of three (3) or more persons appointed by the Board Chair, at least one (1) of which must be a Practitioner, who may, but is not required to be a Member and at least one (1) of which must be a Board member. The Board Chair will designate one (1) of the appointees to the hearing committee as Presiding Officer. The appointments are subject to the procedures of Sections 4.3.3, 4.3.4, 4.3.5 and 4.3.6.

4.3.3 Service on Hearing Committee. A Member or other person appointed to serve on an ad hoc hearing committee shall not be disqualified from serving on a

hearing committee merely because of knowledge of the facts involved due to prior participation in the investigation of the underlying matter and issue because of knowledge of the facts involved, or because of participation in an earlier disciplinary hearing involving the Affected Practitioner, unless a determination to disqualify is made in accordance with Section 4.3.5.

- 4.3.4 Notice of Appointment to Hearing Committee. Within seven (7) calendar days after the Affected Practitioner is given notice of those who are proposed to serve on the hearing committee, the Affected Practitioner shall be entitled to submit reasonable written questions (except in extraordinary circumstances only of the "short answer" type) of not more than ten (10) in number limited to the issues of direct economic competition or bias to all or any one (1) or more of the proposed hearing committee members through the CEO. The CEO shall, after consultation with the COS, in his/her good faith discretion, determine whether questions are unreasonable or irrelevant to the issues of direct economic competition or bias, and shall strike such questions which are unreasonable or irrelevant. The questions, except those which are deemed by the CEO to be unreasonable or irrelevant, will then be submitted to the proposed hearing committee member(s) to whom directed, who shall then each submit his/her response(s) within thirty (30) calendar days to the CEO. The CEO shall in turn forward the answers on a prompt basis to the Affected Practitioner and the COS or Board Chair, depending upon the body that took the Adverse Action or made the recommendation, which is the subject of the hearing.
- 4.3.5 Objections to Proposed Hearing Committee Members. Within seven (7) calendar days after receipt of notice of the proposed hearing committee membership or, if the procedure set forth in Section 4.3.4 was elected by the Affected Practitioner, seven (7) calendar days after his/her receipt of the responses to the written questions, the Affected Practitioner shall be entitled to submit his/her written objections, if any, to those proposed members of the hearing committee which the Affected Person believes are in direct economic competition with him/her or are so biased against the Affected Practitioner as to prevent a fair hearing if they serve as a hearing committee member. Such objections, if any, will be reviewed by the CEO who shall determine in his/her good faith discretion as to whether or not the objections are meritorious.
- a. If none of the objections are deemed to be meritorious by the CEO, (s)he shall so advise the Affected Practitioner who requested the hearing, in writing, and the hearing committee shall be constituted in the manner proposed.
 - b. If the CEO determines that the objections to any or all of the hearing committee membership have substance, (s)he shall confer with the COS or the Chairperson of the Board, depending upon the body whose recommendation or action is the subject of the hearing, as to possible alternative proposed members of the hearing committee.
 - i. If the COS or Chairperson of the Board believes that there are other alternative persons who may satisfactorily meet the requirements of membership on the hearing committee, the process set forth in Section 4.3.4 and this 4.3.5 regarding written

questions and objections shall be repeated as necessary until an appropriate hearing committee can be constituted.

- ii. If, however, the COS or Chairperson of the Board believe that there is no person available at the Hospital or in the community, who meets the committee membership requirements for participation on a hearing committee, the requirements of Section 4.3.1 and 4.3.2 shall not then apply, and the COS or the Chairperson of the Board, depending upon the body whose recommendation or action is the subject of the hearing, shall choose such alternative persons who, in the COS or Chairperson's reasonable discretion, are qualified to serve as committee members, subject to the process set forth in section 4.3.4 and this 4.3.5. If deemed necessary to broaden the pool of candidates as hearing committee member, medical staff members from other SJMHS-affiliated hospitals may be selected as committee members.

4.3.6 Alternative Hearing Officer. If, by reason of objections to proposed membership that are determined to be valid by the CEO, a hearing committee of at least 3 volunteer persons as provided in Section 4.3 cannot be constituted, the CEO shall be empowered to appoint a single person to serve as hearing officer (who may, but need not be, a Member) where:

- a. In the good faith discretion of the CEO, such person is not in direct economic competition with, and has no known bias towards the Affected Practitioner; and
- b. The CEO has consulted with the Affected Practitioner and the COS or Board Chairperson (depending upon which body prompted the hearing) regarding the appointment of such person and the CEO has, in good faith and discretion, taken into account the legitimate objections of the Affected Practitioner and the COS or Board Chair as well as the availability of a qualified person to serve as hearing officer.
- c. As a part of the appointment process, in lieu of consultation provided in (b) above, the CEO may, in his/her sole discretion, provide the Affected Practitioner and the COS or Board Chair with a list, identifying by name two (2) or more prospective hearing committee members from which one (1) may be appointed by the CEO to serve as the alternative hearing officer. If such list is submitted, the Affected Practitioner and the COS or Board Chair, may submit objections and the reasons in writing to the CEO within seven (7) days of receiving the list. If objections are timely made and meritorious in the judgment of the CEO, this process may be repeated until a mutually satisfactory hearing officer can be selected by the CEO or the procedures of (b) above utilized.

4.3.7 Notice of Appointment of a Hearing Officer. Notice of the appointment of a hearing officer shall be promptly given to the Affected Practitioner. Such notice shall include the estimated fee and expenses of the hearing officer, if any.

- a. If a fee and expenses are required by the hearing officer their services as such, the cost will be equally borne by the Hospital and the Affected

Practitioner and an advance of one-half the estimated costs shall be sent to the hearing officer by the Affected Practitioner within fourteen (14) days from notice of the hearing officer's appointment.

- b. If, and only if, the Affected Practitioner who requested the hearing can demonstrate such poverty that the Affected Practitioner is unable to pay his/her portion of the hearing officer's fee, if any, the entire fee for the hearing officer shall be borne by the Hospital. However, in order to establish this poverty sufficient to relieve the Affected Practitioner of the obligation to pay half the fee and expenses for such hearing officer, the Affected Practitioner must provide, upon request, financial information which the CEO deems necessary to make the determination including personal and business income tax returns for the preceding two (2) years, financial statement regarding the Affected Practitioner's practice (including any professional corporation or partnership owned in whole or in part by the Affected Practitioner) and a statement of assets under oath.

4.3.8 Substituted Reference to Alternative Hearing Officer. In the event a hearing officer is appointed instead of a "hearing committee" or "Presiding Officer", all references in this Article to the "hearing committee" shall be deemed to refer instead to the hearing officer, unless the context would clearly indicate otherwise.

4.3.9 Waiver of Rights. In the event the Affected Practitioner who requested the hearing fails, within seven (7) calendar days, to timely submit written questions or raise written objections to proposed members of the hearing committee, the Affected Practitioner shall be deemed to have waived his/her right to submit such questions and/or make objections to the composition of the hearing committee. Further, a failure of the Affected Practitioner to timely submit financial information upon request to the CEO necessary to establish a claim of poverty with regard to payment of the hearing officer, shall constitute a waiver of any right to have the Hospital pay the full amount of a hearing officer's fee. The failure to timely submit one-half of the estimated fees and expenses of a hearing officer, if one is appointed, shall be deemed to be a waiver of the right to any hearing, unless an exception based on poverty is granted. In addition, the failure of the Affected Practitioner to pay the Affected Practitioner's share of the finally determined fees of the hearing officer, after the hearing, shall result in the withholding of any Privileges the Affected Practitioner holds, until such obligation is paid.

4.4 PERSONAL PRESENCE

The personal presence of the Affected Practitioner who requested the hearing shall be required. An Affected Practitioner who fails without good cause to appear and to proceed at such hearing shall be deemed to have waived such rights or review in the same manner and with the same consequences as provided in Sections 2.3 and 5.2.

4.5 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 appropriate oral and documentary evidence. The Presiding Officer shall determine the order of procedure during the hearing and shall make all rulings on the matters of law, procedure, and the considerations of evidence. If the hearing is

conducted by a single hearing officer, as provided in Section 4.3.6, then the hearing officer shall serve as the presiding officer.

4.6 REPRESENTATION

The Affected Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a Member in good standing or by a member of the Affected Person's local professional society. The MEC or Board, as may be applicable, shall appoint a person to present the facts in support of its adverse recommendation or action who shall be referred to as the "Advocate." The Advocate may present evidence but, even if an MEC or Board member, shall not participate in deliberations nor vote on the matter at issue. Representation of either party by an attorney at law shall be governed by the provisions of Section 5.1.

4.7 RIGHTS OF PARTIES

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

- a. Call and examine witnesses and cross-examine witnesses called by the other party;
- b. Introduce exhibits;
- c. Question witnesses on matters relevant to the issues; and
- d. Rebut any evidence.

within the scope of supplemental hearing rules, including time limits, established pursuant to Sections 4.5 and 5.4.

If the Affected Practitioner does not testify, (s)he may be called and examined as if under cross-examination. However, as provided in 5.4, the Presiding Officer may impose time limits and may permit or require testimony to be taken by deposition-like process outside the presence of the hearing committee and condensed (by use of mutually-agreed abstract or editing) before presentation takes place.

4.8 PROCEDURE AND EVIDENCE

- 4.8-1 Evidence. The hearing will not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. In this respect, reports and affidavits of expert witnesses are admissible provided the party offering them offers a reasonable means to test the veracity of its content (e.g., deposition-like cross-examination). All Medical Staff and Board documents, including meeting minutes and transcripts, shall be admissible consistent with Section 5.4.
- 4.8.2 Memoranda. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, during, at the close of or if specifically requested and authorized by the Presiding Officer,

within seven (7) calendar days after the hearing, be entitled to submit memoranda concerning any issue of procedure, fact, or conclusions drawn from fact, and such memoranda shall become part of the hearing record. The Presiding Officer may, but shall not be required, to order that oral evidence be taken only upon oath or affirmation.

4.9 MATTERS CONSIDERED

In addition to relevant evidence formally presented at the hearing, the hearing committee shall be entitled to consider any pertinent material contained on file in the Hospital and all other information that can be considered in connection with an application for appointment or reappointment to the Medical Staff and a request for Privileges. In this respect, to facilitate the hearing efficiency, subject medical charts, investigative reports, pertinent correspondence, committee minutes, and the statement of reasons may be furnished by the CEO, at the CEO's discretion, to the hearing committee, provided the Affected Practitioner is advised that the same have been furnished to the hearing committee and Affected Practitioner may challenge its relevancy at the hearing. The hearing committee shall be entitled to conduct independent review, research and interviews, or retain an independent consultant to do so, but may utilize the products of such in its decision, only if the Affected Practitioner and the Advocate are aware of such, and have an opportunity to rebut any information so gathered.

4.10 BURDEN OF PROOF

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its position. The Affected Practitioner shall thereafter have the burden of supporting a challenge to the adverse recommendation or action by evidence that the grounds therefor are not supported by the evidence or the conclusions drawn therefrom are arbitrary or capricious.

4.11 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any person or group that may later be called upon to review the record and render a recommendation or decision in the matter. If the CEO and the Affected Practitioner cannot agree on method, the Presiding Officer shall select the method to be used for making the record such as a court reporter, electronic recording unit or detailed transcription. The Affected Practitioner who requested the hearing shall be entitled to obtain a copy of the record upon payment of the reasonable charges associated with the preparation of same. If the Affected Practitioner who requested the hearing elects an alternate method of recording, (s)he shall bear the primary cost thereof.

4.12 POSTPONEMENT

Requests for postponements of a hearing shall be granted by the Presiding Officer only upon a showing of good cause.

4.13 RECESSES AND ADJOURNMENT

The hearing committee or hearing officer 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 evidence or consultation. If a hearing committee member is called away from the hearing for patient medical care reasons, the Presiding Officer shall determine if the hearing

should be continued, recessed or adjourned. The hearing may be continued in the absence of one (1) or more hearing committee members as long as a verbatim transcript of the continued hearing is taken and any absent hearing committee members who participate in the final determination of the committee review the transcript before deliberations are conducted.

4.14 DELIBERATIONS AND RECOMMENDATION OF THE HEARING COMMITTEE OR HEARING OFFICER

- 4.14.1 Deliberations. Upon conclusion of the presentation of evidence, the hearing shall be closed. Within thirty (30) calendar days after the conclusion, the hearing committee, outside the presence of any other person, shall conduct deliberations and consider the admitted evidence.
- 4.14.2 Contents of Report. The hearing committee shall prepare a report which shall contain a concise statement of recommendations and the reasons justifying the recommendations made. This report shall be delivered to the CEO.

4.15 DISPOSITION OF HEARING COMMITTEE REPORTS

Upon receipt, the CEO shall forward the hearing committee report and recommendation, along with all supporting documentation, to the COS and Board for further action. The CEO shall also send a copy of the report and recommendation by Special Notice to the Affected Practitioner. A copy of the report of the hearing shall be delivered by the CEO to anybody other than the Board that made the adverse recommendation for informational purposes.

4.16 NOTICE AND EFFECT OF RESULTS

- 4.16-1 Effect of and Action Upon Favorable Hearing Committee Report. If the hearing committee's report pursuant to Section 4.14 is favorable to the Affected Practitioner, the CEO shall promptly forward it, together with all supporting documentation, to the Board for its final action.
- a. The Board may, before taking final action thereon, refer the matter back to the hearing committee or the MEC for further consideration or information. Any such referral back shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing or other review be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action.
 - b. If the Board's action on the matter is favorable to the Affected Practitioner, it shall become the final decision of the Board, and the matter shall be closed.
 - c. If the Board's action would result in any of the recommendations or actions listed in Sections 1.4 or 1.5, the Special Notice shall inform the Affected Practitioner of a right to request an appellate review by the Board as provided in Section 4.17 of this Appendix, as if the hearing committee's report had been adverse. In such circumstances, the Board's tentative position adverse to the Affected Practitioner shall be represented by a person, selected by the Board

Chair for appellate review. All references in Sections 4.14 through 4.26 of this Plan to the “hearing committee” would instead refer to the Board, as the context requires.

4.16-2 Effect of Adverse Hearing Committee Report. If the report and recommendation of hearing committee pursuant to Section 4.14 is adverse to the Affected Practitioner in any of the respects listed in Sections 1.4 or 1.5, Special Notice shall be given of the report and recommendation and the Affected Person’s right to request appellate review by the Board as provided in Section 4.17 of this Appendix.

4.17 REQUEST FOR APPELLATE REVIEW

An Affected Practitioner shall have ten (10) calendar days following receipt of a notice pursuant to sections 4.16.1(c) or 4.16.2 to file a written request for an appellate review. Such request shall be delivered to the CEO either in person or by certified mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, which was considered in making the adverse action or result.

4.18 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

An Affected Practitioner who fails to request an appellate review within the time and in the manner specified in Section 4.17 waives any right to such review. Such waiver shall have the same force and effect as that provided in Sections 2.3 and 5.2 of this Appendix.

4.19 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the CEO shall deliver such request to the Board. The Board shall schedule and arrange for an appellate review which shall be not more than forty-five (45) calendar days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Member who is under a suspension then in effect shall be held as soon as the arrangements and preparations for it may reasonably be made. The CEO shall send the Affected Practitioner notice of the time, place and date of the review. The Board, for good cause, may extend the time for the appellate review.

4.20 APPELLATE REVIEW BODY

The Board shall be the appellate review body; one (1) Board member shall be designated as chairperson of the appellate review proceedings.

4.21 NATURE OF APPELLATE REVIEW PROCEEDINGS

The appellate review proceedings of the Board shall be an appellate review based solely upon the record of the hearing before the hearing committee, that committee’s report, and all subsequent results and actions thereon. The Board shall also consider the written statements as may be presented and accepted under this Article.

4.22 WRITTEN STATEMENTS

The Affected Practitioner shall submit a written statement detailing those findings of fact, conclusions and procedural matters with which (s)he disagrees, and the reason for such disagreement. This written statement may cover any matters raised at any step in the hearing

process. The statement shall be submitted to the Board through the CEO at least five (5) business days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the MEC, or if Board action is being appealed, the person selected by the Board to take the position adverse to the Affected Practitioner. If submitted, the CEO shall provide a copy thereof to the Affected Practitioner at least two (2) business days prior to the scheduled date of the appellate review.

4.23 PRESIDING OFFICER

The chairperson of the appellate review proceedings shall be Presiding Officer for any appellate hearing and shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

4.24 ORAL STATEMENT

The Board, in its sole discretion, may allow the parties or their representatives to personally appear 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 Board.

4.25 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

Subject to Section 5.3 below, new or additional matters, or evidence 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 Board, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

4.26 RECESSES AND ADJOURNMENT

The Board 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 proceedings shall be closed. The Board 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 adjourned.

4.27 ACTION TAKEN BY BOARD ON APPEAL

The Board may affirm, modify or reverse the adverse result or action taken by the hearing committee or hearing officer pursuant to Section 4.14 or, in its discretion, or may refer the matter back to the hearing committee or hearing officer for further review and recommendation to be returned to it within forty-five (45) calendar days and in accordance with its instructions. Within fifteen (15) calendar days after receipt of such recommendation after referral, the Board shall ordinarily make its final decision.

4.28 FINAL BOARD ACTION AFTER APPELLATE REVIEW

Unless the matter is referred back to a hearing committee or officer pursuant to Section 4.27, within fifteen (15) calendar days after the conclusion of the appellate review, including referrals back to the hearing committee or officer, the Board shall render its decision in the matter in writing and shall send notice thereof to the Affected Practitioner by Special Notice, to the COS, and to the MEC.

4.29 HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

Those actions or recommendations which entitle an Affected Practitioner to a special hearing pursuant to Article IV are those matters the Hospital and Medical Staff reasonably believe represent "professional review action" and "professional review activity" which may "adversely affect" a "physician" pursuant to the Health Care Quality Improvement Act of 1986. In this respect, it is the intent and purpose of this Appendix that the initiation and conduct of professional review actions hereunder comply with all the material aspects with the provisions of §412 of the Act.

ARTICLE V: GENERAL PROVISIONS APPLICABLE TO BASIC AND SPECIAL HEARINGS

5.1 ATTORNEYS

5.1.1 The Parties

- a. Basic Hearings. If the Affected Practitioner who requests a hearing desires to be represented by an attorney at any basic hearing or at any appellate review pursuant to the provisions of Article III of this Appendix, the request for such hearing or appellate review must so state. The hearing committee or appellate review body shall, in its sole discretion, determine whether to permit such representation at the hearings. If and only if it allows the Affected Practitioner to be so represented, the MEC or the Board may also be represented by an attorney at the hearing.
- b. Special Hearings If the Affected Practitioner desires to be represented by an attorney at any special hearing or at any appellate review appearance pursuant to the provisions of Article IV of this Appendix, the request for such hearing or appellate review must so state. The Affected Practitioner shall have a generally unqualified right to be represented by an attorney at any such special hearing or appellate review appearance. If the Affected Practitioner chooses to be so represented, the MEC or the Board may also be represented by an attorney at the hearing.
- c. Consultation

Notwithstanding the foregoing, however, an attorney may be contacted at appropriate times during the proceedings by any party for advice, provided such contact does not unduly interfere with the conduct of a hearing as determined by the Presiding Officer.

- 5.1.2 The Hearing Committee, Appellate Review Body, or CEO. A hearing committee, appellate review body, or the CEO may, in its discretion, consult with legal counsel at any stage of the proceedings for advice on appropriate hearing conduct or the drafting of its report(s). Hospital counsel may serve as counsel to Hospital, the hearing committee and the Advocate in the same proceeding.

5.2 WAIVER

If at any time after receipt of Special Notice of an adverse recommendation, action or result, an Affected Practitioner fails to make a required request or appearance or otherwise fails to comply with this Appendix, the Affected Practitioner shall be deemed to have consented to such

adverse recommendation, action or result and to have voluntarily waived all rights under the Medical Staff Documents then in effect or under this Appendix with respect to the matter involved.

5.3 INDEPENDENT CONSULTANTS

At any stage of hearing proceedings, a hearing committee or the Board may retain an independent consultant, who may or may not be a Member. The consultant may be provided with copies of medical records, films, slides, reports, or such other materials the consultant and the requesting body may deem appropriate for review by the consultant. The consultant shall present a written and/or oral report to the requesting body that shall be made available to the parties. A consultant so elected shall not be deemed a witness for any of the parties, but an independent advisor whose opinions represent evidence that may be considered.

5.4 SUPPLEMENTAL HEARING RULES

5.4.1 Hearing Rules. The Presiding Officer of any hearing or appellate review body may promulgate, with or without the advice of legal counsel, hearing rules to supplement those contained in this Appendix. Such rules shall be fundamentally fair to all parties and generally consistent with the provisions of this Appendix. The supplemental rules may set forth the order of presenting evidence and oral statements as well as time limits for presentations for the in-person aspects of the hearing. In this respect, the hearing rules may require that certain testimony be taken in deposition format and submitted to the hearing committee in the form of transcript, videotape, and/or abstracts of relevant testimony. When feasible, the Presiding Officer may in his/her discretion arrange a pre-meeting with the parties (or their representatives) to decide upon such rules or ask the parties (or their representatives) to meet and propose rules subject to the Presiding Officer's approval. When such rules are promulgated by the Presiding Officer, they shall be furnished to the parties before the hearing. Written objections by any of the parties shall be considered, and when deemed meritorious, amendments shall be made in the rules by the hearing committee or its designee to address the objections.

5.4.2 Special Rules for Lengthy Hearings

Because it is not expected that any Member or other individual who serves on a hearing committee should have to devote more than three (3) full days (i.e., 24 hours) to hearing attendance and deliberations (excluding time to independently review hearing matters in one's own office or home), the hearing shall not, without the consent of the hearing committee or unless required by the COS or Board, in consultation with the CEO, for good cause shown, extend beyond twelve (12) hours of in person hearing and presentation (six (6) hours allocated to each party). The hearing committee chair is expected to exercise the prerogative to make the hearing presentation more compact, if the time of taking testimony, presenting exhibits, and making arguments before the hearing panel are likely to exceed twelve (12) hours. If there is a perceived need to present more than can reasonably be presented within the allotted time, the matter shall be submitted to the Presiding Officer prior to the issuance of hearing rules so that alternative procedures (e.g., depositions and abstracts) can be authorized and timely used.

5.5 PRESENCE OF HEARING COMMITTEE MEMBERS

In a hearing before a hearing committee, the presence of a majority of members shall constitute a quorum, which shall be present at all times during the hearing. Hearing committee members are encouraged to arrange for clinical coverage during the time of the hearing; however, if the hearing will extend beyond a total of four (4) hours, committee members may, in their discretion, leave the hearing room to attend to patient care responsibilities without the hearing being adjourned so long as such committee members who leave and participate in the final determination commit to reviewing the transcript or other record of those parts of the hearing they did not attend.

5.6 NUMBER OF REVIEWS

Notwithstanding any other provision of the Bylaws or other Medical Staff Documents, no Affected Practitioner shall ever be entitled as a right to more than one (1) hearing and appellate review with respect to an adverse recommendation or action. Further, the MEC and the Board need not conduct additional hearings or reviews upon reapplication or request for reconsideration by the Affected Practitioner, absent, in the MEC's or Board's sole determination, a clear and convincing indication of new or additional information which has a substantial probability of changing the outcome of the previous hearing or appeal.

5.7 RELEASE

By requesting a hearing or appellate review under this Appendix, an Affected Practitioner agrees to be bound by the provisions of the Bylaws, or other Medical Staff Documents, including this Appendix, and the rules established for a hearing, in all matters relating thereto.

5.8 TIME LIMIT OR OTHER PROCEDURAL RULE MODIFICATION

Any procedural rule or time limit specified in this Appendix may be modified or waived by agreement between the Presiding Officer of the hearing committee, and the Affected Practitioner, or the duly authorized designate of any of them. The Board or the Presiding Officer at a hearing may, in its/his/her discretion, grant an extension of any time limits when required for fundamental fairness to any party. A request by an Affected Practitioner for an extension of any time limits, which is granted, waives any right to insist on the time limits specified herein being complied with. Nothing in this section shall require the consent the Authorized Practitioner's agreement to waive time limits on the hearing imposed under Section 5.4.

5.9 MEC REVIEW

If at any time during the Board's consideration and review of a recommendation or action with respect to an Affected Practitioner, the Board deems it necessary or advisable, the Board may refer the matter to the MEC. Within fifteen (15) calendar days of its receipt of a matter referred to it by the Board pursuant to the provisions of this Appendix, the MEC shall convene and consider this matter and submit its written recommendations to the Board for final action. The Board shall issue its final decision on the matter within the period of time generally prescribed under this Appendix, or within fifteen (15) calendar days after receipt of the MEC's written recommendation, whichever is later.

5.10 GOOD FAITH ALTERNATIVE SPECIAL NOTICE

- 5.10.1 Good Faith. In addition to those duties imposed in the Bylaws, it shall be the duty of each Affected Practitioner who requests a formal hearing to act with utmost good faith before and during the hearing process. Such good faith shall include, but not be limited to, timely compliance with requirements, cooperation in the receipt of required notices, and the exercise of procedures in this Appendix without intent to cause undue delay. In addition to other automatic hearing and appeal right waivers for non-compliance with time limits or appearance requirements, upon a finding by a hearing committee, hearing officer, or the Board that an Affected Practitioner is not acting or has not acted in good faith with regard to the hearing process of this Appendix, the hearing committee, hearing officer or Board may limit or deem waived the Affected Practitioner's rights to hearing, appeal, or use of particular procedures in a hearing or appeal.
- 5.10.2 Alternative Mailing. If, in attempting to give Special Notice, despite reasonable efforts, either postal or other delivery agencies are unable to deliver or obtain signature on a return receipt mail to the Affected Practitioner, or a representative of the Hospital is unable to make personal delivery, at the designated place of mail delivery for the Affected Practitioner, such Special Notice may alternatively be given by regular mail that is mailed to the last home address and last office address provided by the Affected Practitioner to Administration at least five (5) business days before any deadline for the Affected Practitioner to act.
- 5.10.3 Time Limits Constructive Receipt. For the purpose of time limits of this Appendix, if the alternative mailing procedure of Section 5.10.2 is used, the document mailed shall be deemed to have been received at the time the first attempt at registered or certified mail by postal authority or other nationally recognized delivery agencies or personal delivery by Hospital personnel was attempted, as documented by the written statement of either. This presumption of receipt shall be binding on the Affected Practitioner, even if it means rights to hearing, appeal, or objection are waived by failure to comply with time limits. This presumption may be overcome only by a clear and convincing showing to the Presiding Officer that the failure to make delivery or sign a receipt, was due to error, neglect, or unreasonable delay, of the postal authorities or Hospital representatives, and not the Affected Practitioner.
- 5.10.4 Designated Place of Mail Delivery. The designated place of mail delivery shall be the office and home address last provided by the Affected Practitioner to Administration. Any employee or relative of the Affected Person who signs a receipt for mail at such location shall be deemed as authorized by the Affected Practitioner to do so. In the event of the Affected Person's absence from the office or home, each Affected Practitioner shall either:
- (a) authorize his/her office staff to receive and sign receipts for mail on his/her behalf; or alternatively
 - (b) if his/her office shall be closed for more than two (2) successive business days or the Affected Person does not wish his/her office staff authorized to receive and sign a receipt for mail on his/her behalf, the Affected Person must, in a writing sent by certified mail or by recognized national overnight mail service to the CEO, designate the name and address of

an alternate designated place of delivery (e.g., a law or accounting firm) and provide a statement that any person who receives and signs for mail there is authorized to do so on his/her behalf. In addition, an Affected Practitioner or his/her officially designated attorney may authorize the use of electronic mail to specified email addresses in lieu of Special Notice.

5.10.5 Purpose-Good Faith. The purpose of the foregoing provisions of Sections 5.10.2, 5.10.3 and 5.10.4 are to assure that reasonable efforts to give required notices and proceed forward with requested hearings are not thwarted or delayed by avoidance of or refusal to accept delivery, refusal to sign receipts, office closure, absence from the community, or the bad faith on the part of an Affected Practitioner.

5.11 CONSOLIDATION

If two (2) or more hearings and/or appeals with respect to the same Member are proceeding simultaneously (e.g., summary suspension and non-reappointment), the Board, at the request of the Affected Practitioner, the COS, the CEO or the MEC, may order the proceedings be consolidated into a single hearing or appeal. In this respect, the Board shall have the authority to suspend or modify time limits and take whatever action most reasonably and fairly to all concerned to accommodate the consolidation.

ARTICLE VI: AMENDMENT AND APPLICATION

6.1 AMENDMENT

This Appendix may be amended or repealed, in whole or in part, according to Medical Staff Bylaws, and are subject always to the Bylaws of the Medical Staff, MEC and Hospital.

6.2 APPLICATION

Any matter subject to review or hearing pursuant to the Medical Staff Bylaws after adoption of this Appendix by the Medical Staff shall be governed by its terms; the prior review and hearing procedures shall be deemed superseded by the terms of this Appendix.

The foregoing Appendix to the Bylaws of the Medical Staff was APPROVED by the Medical Staff on the ___ day of _____, 20__

Chief of Staff

Secretary/Treasurer of the Medical Staff

**TABLE OF CONTENTS
REVIEW PROCEDURES APPENDIX
FOR MEDICAL STAFF MEMBERS AND APPLICANTS**

ARTICLE I.	APPLICATION OF REVIEW PROCEDURES	
1.1	Definitions	1
1.2	General Application.....	1
1.3	Informal Review and Non-Application of Formal (Basic and Special) Hearing Procedures.....	1
1.4	Application of Basic Hearing Procedures.....	3
1.5	Application of Special Hearing Procedures.....	5
ARTICLE II.	ADVERSE RECOMMENDATION OR ACTION	
2.1	Notice of Recommendation or Action	6
2.2	Request for Original Hearing	6
2.3	Waiver by Failure to Request Timely Hearing.....	6
ARTICLE III.	BASIC HEARING PROCEDURES	
3.1	Notice of Time and Place For Hearing.....	7
3.2	Supplemental Statement of Reason	7
3.3	Appointments of Hearing Committee	8
3.4	Appearance and Representation	8
3.5	Hearing Conduct and Evidence	9
3.6	Burden of Proof	9
3.7	Recording of Hearing	10
3.8	Recommendation	10
3.9	Notice of Affected Practitioner	10
3.10	Appeal.....	10
3.11	Release.....	11
ARTICLE IV.	SPECIAL HEARING PROCEDURES	
4.1	Notice of Time and Place For Hearing.....	12
4.2	Hearing Notice, Response and Witness Lists	12
4.3	Appointments of Hearing Committee for Special Hearing	13
4.4	Personal Presence	16
4.5	Presiding Officer.....	16
4.6	Representation.....	17
4.7	Rights of Parties.....	17
4.8	Procedure and Evidence	17
4.9	Matters Considered.....	18
4.10	Burden of Proof	18
4.11	Record of Hearing	18
4.12	Postponement	18
4.13	Recesses and Adjournment	18
4.14	Deliberations and Recommendation of the Hearing Committee or Hearing Officer	19
4.15	Disposition of Hearing Committee Reports	19
4.16	Notice and Effect of Results	19