

St. Joseph Mercy Ann Arbor
St. Joseph Mercy Livingston



MEDICAL STAFF BYLAWS

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PREAMBLE

WHEREAS, the applicable Saint Joseph Mercy Health System hospital (Hospital) whose Medical Staff Bylaws these are, that is, St. Joseph Mercy Ann Arbor or St. Joseph Mercy Livingston, is a hospital component of Trinity Health-Michigan, a Michigan nonprofit corporation; 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 governing body for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the governing body, and that the cooperative efforts of the medical staff, hospital executives and the governing body are necessary to fulfill the hospital's obligations to its patients; and

NOW THEREFORE, the physicians, dentists and podiatrists practicing in Hospital hereby organize themselves into a medical staff ("Medical Staff") in conformity with these bylaws and the Department Rules and Regulations and the corporate bylaws and policies of Hospital and Trinity Health-Michigan.

DEFINITIONS

1. **Administration** means the officers and administrators involved in the management of St. Joseph Mercy Ann Arbor and/or St. Joseph Mercy Livingston hospitals.
2. **Applicable Hospital** refers to an individual Hospital in matters relating to a Local Department Chair at that Hospital, as further defined in Section 8.6.1.
3. **Approval of/Approved by the Board** means the initiation and completion of the approval process required by the Trinity Health-Michigan or Hospital bylaws, applicable policies and procedures, and the Medical Staff Bylaws.
4. **Advanced Practice Professional or APP** is a health care practitioner (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, and the Credentialing Policies and Procedures. APPs include both individuals who are employed by the Hospital and those who are not. APPs are not eligible for Medical Staff membership. The Board shall designate the categories of practitioners eligible for APP status. An APP shall provide direct patient care at the Hospital only within the scope of his or her Delineated Clinical Privileges.
5. **Board** means the Trinity Health-Michigan Board or the local board for the St. Joseph Mercy Ann Arbor/Livingston operating unit, as specified at the time in the Trinity Health-Michigan Authority Matrix.
6. **Chief Medical Officer or CMO** means the Physician designated by the President to work with Medical Staff leadership on matters of medical administration and quality oversight.
7. **Contract Department or Service** means a Hospital department or service staffed by means of an exclusive contract, as described in Section 8.2.
8. **Credentialing Policies and Procedures** means those policies and procedures relating to credentialing at the Hospitals that have been recommended by the Credentials Committee and the Medical Executive Committees, and approved by the Board.
9. **Delineated Clinical Privileges** means the permission granted to a Medical Staff member, an APP (acting under the supervision of an identified Supervising Member), a House Physician, or other authorization granted in accordance with these Bylaws to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services at the Hospital. Delineated Clinical Privileges are listed on the appropriate individual, Department or specialty Delineation of Clinical Privileges form for the individual's department or clinical specialty.
10. **Dentist** means a person licensed to practice dentistry in the State of Michigan.
11. **Department** means a clinical department of the Hospital Medical Staffs as further described in Article VIII.
12. **Due Process** means the right to utilize the hearing and appellate review procedures described in Article XVIII, to the extent applicable.
13. **Ex Officio** means service on a body by virtue of an office or position held. Unless otherwise expressly provided, an ex officio member of a body shall not be entitled to vote and shall not be counted in determining the existence of a quorum.
14. **Focused Professional Practice Evaluation or FPPE** means the time-limited evaluation of a practitioner's competence in performing specific Delineated Clinical Privilege(s) and professional behavior.
15. **Hospital** means St. Joseph Mercy Ann Arbor or St. Joseph Mercy Livingston hospital, as the context requires; these hospitals are referred to collectively as "**the Hospitals.**"

16. **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 a Hospital to provide services in the Hospital on a time-limited basis.
17. **Joint Conference** means a meeting between Medical Staff and Board representatives held in accordance with Section 17.1.
18. **Local Department Chair** means the individual selected to serve as Local Chair of a Department in accordance with Section 8.6.3.
19. **Medical Executive Committee or MEC** means the Hospital-specific Medical Executive Committee of a Medical Staff. The MECs at both Hospitals are referred to collectively as “**the Medical Executive Committees**” or “**MECs**.”
20. **Medical Staff** means the Physicians, Podiatrists and Dentists who are granted Delineated Clinical Privileges and admitted to the Medical Staff of a Hospital in accordance with these Bylaws.
21. **Medical Staff Hospital-Specific Policy** means a policy that is not included in the Credentialing Policies and Procedures, that affects the Medical Staff of one Hospital, but not both Hospitals, at large (rather than affecting only selected Departments(s)), and that is adopted in accordance with Article XIV of these Bylaws.
22. **Medical Staff Multi-Hospital Policy** means a policy that affects the Medical Staffs of both Hospitals at large (rather than affecting only selected Department(s)), and that is adopted in accordance with Article XIII of these Bylaws. Medical Staff Multi-Hospital Policies include the Credentialing Policies and Procedures.
23. **Medical Staff Policy** means the Medical Staff Multi-Hospital Policy(s) and Medical Staff Hospital-Specific Policy(s) relevant to a topic.
24. **Medical Staff Services** means the Hospital administrative department that provides support services to the Medical Staffs.
25. **Medical Staff Year** commences January 1 and ends December 31.
26. **Medical Staffs** or **Hospital Medical Staffs** means the Medical Staffs of the Hospitals.
27. **Ongoing Professional Practice Evaluation or OPPE** means ongoing collection, verification and evaluation of data relevant to a practitioner’s competence in performing specific Delineated Clinical Privileges and professional behavior.
28. **Oral Surgeon** means a person who has successfully completed a residency program in oral and maxillofacial surgery accredited by the American Dental Association’s Commission on Dental Accreditation, who is licensed in Michigan to practice dentistry, and who holds Michigan specialty certification in oral and maxillofacial surgery.
29. **Physician** means a person licensed to practice allopathic or osteopathic medicine and surgery in the State of Michigan.
30. **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. Physician Advisors are appointed and terminated by the Chair of the System Physician Leadership Council and shall report to the System Physician Leadership Council.
31. **Podiatrist** means a person licensed to practice podiatric medicine and surgery in the State of Michigan.
32. **President** means the President of the Hospital appointed by the Board and, unless specifically required otherwise, includes his or her designee; a “designee” of the President shall be a person the President

specifically designates to act in his or her place and stead, or a person within the Administration who is designated by means of a policy or organization chart approved by the President or Board.

33. **Saint Joseph Mercy Health System or SJMHS** is the unincorporated operating unit within Trinity Health-Michigan responsible for operational oversight of the assets of Trinity Health-Michigan located in Eastern Michigan. The provisions of these Bylaws apply only to the following SJMHS facilities: St. Joseph Mercy Ann Arbor and St. Joseph Mercy Livingston hospitals, and activities and subsidiaries related to those facilities.
34. **Special Notice** means written notice that is (a) delivered personally, (b) sent by registered or certified mail, return receipt requested, or (c) sent by overnight delivery service, to the person to whom the notice is directed.
35. **Supervising Member** is a Physician, Podiatrist or Oral Surgeon who is a member of the Active or Associate Medical Staff and who is approved pursuant to these Bylaws to supervise the exercise of Delineated Clinical Privileges by an Advanced Practice Professional.
36. **System Department Chair** means the individual selected to serve as the System Chair of a Department in accordance with Section 8.5.3.
37. **System Physician Leadership Council** means the Medical Staff leadership body for the Hospital Medical Staffs as further described in Section 10.4.
38. **Telemedicine Delineated Clinical Privileges** means Delineated Clinical Privileges that authorize provision of clinical services to Hospital patients by a Physician, Podiatrist or Dentist from a distance via electronic communications.
39. **Telemedicine Provider** means a Medicare-participating hospital or other Joint Commission accredited telemedicine entity that, pursuant to a written agreement with the Hospital which satisfies the requirements of the Medicare Hospital Conditions of Participation, furnishes to the Hospital the services of qualified Physician(s) who are granted Telemedicine Delineated Clinical Services by the Hospital.
40. **Temporary Absence** occurs when an individual is unavailable to perform his or her functions for a period of three (3) months or less.
41. **Designees**. Unless these Bylaws expressly require otherwise, references to the Chief of Staff, a System or Local Department Chair, a Section Head, 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 System Physician Leadership Council. Unless these Bylaws expressly require otherwise, references to the Chief Medical Officer include that individual's qualified designee who is selected and authorized to act in the Chief Medical Officer's place and stead in accordance with Hospital administrative policy.
42. **Disqualification**. An individual who holds a Medical Staff position, such as Medical Staff officer or committee member, shall not act in that capacity (including committee deliberations and voting) with respect to any matter of which the individual himself/herself is the subject, including applications for Medical Staff appointment or Delineated Clinical Privileges or action pursuant to Articles VII or XVIII of these Bylaws. The Medical Executive Committee shall resolve any questions regarding application of this standard.
43. **Construction**. Use of the word "including" in these Bylaws is not intended to be exclusive and means "including, but not limited to." The word "or" is not intended to be exclusive unless the context clearly requires otherwise.

ARTICLE I. NAME

- 1.1 The name of the organization shall be the Medical Staff of the Hospital.

ARTICLE II. PURPOSES

- 2.1 The purpose of this organization shall be to:
- a. Maintain a high standard of quality for the medical care received by all patients admitted to or treated in any of the facilities, departments, or services of the Hospital.
 - b. Be accountable to the Board for the quality of medical care delivered at the Hospital, through recommendations regarding appropriate Delineated Clinical Privileges, and through ongoing review and evaluation of the performance of each member of the Medical Staff and each Advanced Practice Professional and other practitioners who are credentialed and granted Delineated Clinical Privileges.
 - c. Provide mechanisms and opportunities for communication and understanding among members of the Medical Staff, the Administration, Hospital employees and the Board.
 - d. Initiate, implement and maintain methods and structures for self-government of the Medical Staff as reflected in the Medical Staff Bylaws and Department Rules and Regulations that adequately define responsibility, authority, and accountability for the defined roles of the Medical Staff.
 - e. Participate in and support, as appropriate, academic opportunities for medical students, individuals in a Graduate Medical Education program, and Advanced Practice Professionals, as well as provide continuing educational programs for the Medical Staff.
 - f. Promote and participate, as appropriate, in medical research.
 - g. 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. MEMBERSHIP**3.1 NATURE OF MEDICAL STAFF MEMBERSHIP**

Membership on the Medical Staff of the Hospital and Delineated Clinical Privileges granted by the Board, are considered a privilege and not a right. The Medical Staff through its designated organization shall make recommendations to the Board regarding the granting and continuation of Medical Staff membership and/or Delineated Clinical Privileges.

3.2 QUALIFICATIONS FOR MEMBERSHIP**3.2.1 Basic Qualifications.**

All candidates who seek or enjoy Medical Staff membership and Delineated Clinical Privileges must, at the time of appointment, and continuously thereafter, demonstrate (via the Credentials Committee), to the satisfaction of the Medical Staff (via the Medical Executive Committee) and the Board the following qualifications:

- a. Licensure. A current, valid unrestricted license issued by the State of Michigan to practice Medicine, Osteopathic Medicine and Surgery, Podiatric Medicine and Surgery, or Dentistry.
- b. Performance. Professional education, training, experience, background, judgment, individual character, adherence to the ethics of their profession, and clinical results documenting the continuing provision of high quality medical, podiatric, or dental care, including compliance with board certification requirements as outlined in Section 3.2.6 and the Credentialing Policies and Procedures. Performance review shall include initial and ongoing review of the following competencies:

1. Technical quality and fund of knowledge: Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted
 2. Service quality: Ability to meet the customer service needs of patients and other caregivers
 3. Patient safety/patient rights: Cooperation with patient safety and patient rights, rules, and procedures
 4. Resource use: Effective and efficient use of Hospital clinical resources
 5. Relations: Interpersonal interactions with colleagues, Hospital staff, and patients
 6. Citizenship: Participation in and cooperation with medical staff responsibilities
- c. Professionalism. A documented willingness and capability, based on present attitude and evidence of performance, to work with and relate to patients, other Medical Staff members, members of other health disciplines, Administration, volunteers, visitors and the community in general in a cooperative, professional manner that is supportive of an environment of high-quality patient care.

Denial of appointment or reappointment based on these defined qualifications may give rise to Due Process rights to the extent provided in Article XVIII.

3.2.2 Professional Liability Coverage.

To obtain and maintain Delineated Clinical Privileges, applicants to and members of the Medical Staff shall be required to maintain and provide evidence of professional liability insurance coverage with policy limits of no less than \$200,000 per occurrence and \$600,000 annual aggregate.

3.2.3 Nondiscrimination.

Medical Staff membership or Delineated Clinical Privileges will not be denied because of race, color, religion, gender, height, weight, national origin, age, marital or veteran status, the presence of any physical or mental impairment unrelated to ability to practice, or the presence of any physical or mental impairment that can be reasonably accommodated.

3.2.4 Effect of Other Affiliations.

No practitioner shall be automatically entitled to membership on the Medical Staff or to particular Delineated Clinical Privileges merely because he/she is licensed to practice in this or in any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had or presently has staff membership or privileges at another hospital, health care facility, or in another practice setting.

3.2.5 Application.

Every application for Medical Staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of every Medical Staff member's duties as outlined in these Medical Staff Bylaws, Departmental Rules and Regulations, and Medical Staff Policy.

3.2.6 Board Certification.

If the member fails to become board certified within five years after first becoming board eligible, the member shall resign from the Medical Staff or the member's privileges and membership shall automatically terminate at the end of said 5-year period, as further described in the Credentialing Policies and Procedures. If a board certified member fails to remain certified, the member shall resign from the Medical Staff or the member's privileges and membership shall automatically terminate upon loss of certification, as further described in the Credentialing Policies and Procedures.

3.3 GENERAL CONSIDERATIONS FOR MEMBERSHIP AND PRIVILEGING

The Board shall take into account, in determining membership and privileges, the needs and plans of the Hospitals to meet the present and future requirements of the community it serves, with input from the Medical Executive Committee:

- a. to maintain a continuity of service by the Medical Staff in light of projected resignations, transfers to inactive status and deaths of members of the Medical Staff;
- b. to provide new skills as they may be developed through the evolution of medical science and technology;
- c. to supply medical skills and experience necessary for the continued ability of the Hospitals, and the Medical Staff to carry out the programs and projects of the Hospitals and, including committee assignments and supervisory responsibilities;
- d. to support the Hospitals' ability to provide adequate facilities and supportive services for Medical Staff members, the applicant, and their patients.

Denial of appointment or reappointment or modification of Delineated Clinical Privileges by the Board for any of the reasons described in this Section 3.3 shall not be considered a determination regarding the applicant's qualifications, shall not give rise to any Due Process rights under these Bylaws, and shall be deemed solely an "inability to accommodate the applicant." Additionally, the limitations on reapplication described in Section 3.6.10 shall not apply to such denials.

3.4 DUTIES AND RESPONSIBILITIES OF MEMBERSHIP

3.4.1 Duties.

By accepting Medical Staff membership, a member agrees:

- a. To maintain a current, valid unrestricted license issued by the State of Michigan to practice Medicine, Osteopathic Medicine and Surgery, Podiatric Medicine and Surgery, or Dentistry and a DEA registration unless a waiver has been obtained.
- b. To comply with these Bylaws, Hospital and Department Rules and Regulations, and Credentialing Policies and Procedures, and with all Medical Staff, Administrative, Hospital/Clinical, and Department Policies and Procedures.
- c. To be responsible for providing continuous care for his/her patients that meets the prevailing standards of quality and efficiency, including:
 1. to exercise sound medical judgment commensurate with training and experience,
 2. to recognize and stay within one's limitations, and
 3. to seek consultation and advice from recognized sources of information when there is any indication of the need for such.
- d. To be available for emergency service care and inpatient consults, in accordance with Medical Staff Policy. The Medical Executive Committee will monitor emergency service coverage plans on a regular basis.
- e. To assume and carry out such Medical Staff, Department, Committee and Hospital duties for which the member is responsible by appointment, election or otherwise. This includes participation in Graduate Medical Education programs sponsored by the Hospital and supervision of medical students and residents, where applicable. To prepare in a timely, accurate and complete fashion, the medical and other required records for any patients admitted or in any way cared for by the member at the Hospital, including all affiliated facilities and services.

- f. Not to receive from or pay to another Physician, Podiatrist or Dentist either directly or indirectly, any part of a fee received for professional services, except in case where a partnership or an employee relationship exists.
- g. To pay annual Medical Staff dues and special assessments as established by the System Physician Leadership Council. Dues may be waived in accordance with Medical Staff Policy.
- h. To treat employees, patients, volunteers, visitors, and other practitioners at the Hospital in a dignified and courteous manner and to avoid impairment of the community's confidence in the Hospital.
- i. Report any of the following events in writing to the Chief of Staff within fifteen (15) days after it occurs with respect to the Medical Staff member: (1) the member is convicted of (or pleads guilty or no contest to) a felony, (2) disciplinary action is imposed on the member by a licensed health facility, (3) the member resigns or limits clinical privileges at a licensed health facility while under investigation or in order to avoid an investigation or proceedings; or (4) the member's license to practice a health profession or to prescribe drugs in any jurisdiction is terminated, limited, placed on probation, relinquished, or lapses.

3.4.2 Requirements for Completing Histories and Physicals (H&Ps).

The medical history and physical examination shall be completed and documented by a Physician, Oral Surgeon, advanced practice nurse, physician assistant or appropriately trained Podiatrist. The history and physical must be completed in accordance with Medical Staff Policy and shall include, at a minimum, the following:

- a. For inpatient admissions and certain outpatient procedures: Completion and documentation of the H&P no more than 30 days before or 24 hours after inpatient admission and in any event before inpatient or outpatient surgery or procedure requiring anesthesia (other than local). If the H&P is within 30 days prior to admission and/or surgery/anesthesia, a legible copy may be placed in the patient's hospital record, provided the H&P was performed and recorded by one of the types of licensed practitioners listed above, and an updated H&P that includes all additions to the history and any subsequent changes in the physical findings is performed and recorded by a practitioner whose Delineated Clinical Privileges permit them to do so, no later than 24 hours after admission and prior to surgery or a procedure requiring anesthesia. Additional requirements regarding histories and physicals are defined in Medical Staff Policies.
- b. For other outpatients: A brief H&P is required for all outpatients that includes the elements defined in Medical Staff Policy.

3.4.3 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 Hospital Code of Conduct shall govern the professional conduct of all members of the Medical Staff. Furthermore, it is understood that any Medical Staff member who violates the provisions of any applicable code of ethics enumerated above shall be subject to reduction or loss of Delineated Clinical Privileges or Medical Staff membership, in accordance with the procedures provided in these Bylaws. A copy of the current Ethical and Religious Directives for Catholic Health Care Services will be provided to each applicant during the initial appointment process and to all Medical Staff members at reappointment. In addition, updated copies of Ethical and Religious Directives for Catholic Health Care Services shall be made available to the Medical Staff members as changes in the document occur.

3.5 CONDITIONS AND DURATION OF APPOINTMENT

- 3.5.1** All initial appointments to the Medical Staff and initial Delineated Clinical Privileges shall be granted in accordance with the Credentialing Policies and Procedures and with applicable Medical Staff Policies and Department Rules and Regulations as they may be amended from time to time. Each applicant and Medical Staff member shall acknowledge that he or she is familiar with and will be

bound by such documents, as well as these Bylaws, in the appointment and delineation of privileges processes.

- 3.5.2** Appointment to the Medical Staff shall confer on the appointee only such Delineated Clinical Privileges as have been granted by the Board, in accordance with these Bylaws.
- 3.5.3** As part of the Hospital's performance improvement activities, membership on the Medical Staff and Delineated Clinical Privileges shall be reviewed at least biennially for each member of the Medical Staff for the purpose of determining recommendations to the Board for reappointment, Medical Staff category, and scope of Delineated Clinical Privileges for the ensuing reappointment period, in accordance with these Bylaws and the relevant Medical Staff and/or Credentialing Policies and Procedures.
- 3.5.4** Initial appointments and all reappointments to the Medical Staff will be for no more than 24 calendar months.
- 3.5.5 Leave of Absence.**

Members of the Medical Staff wishing to apply for a Leave of Absence must submit an application explaining precisely the purpose and proposed duration of the leave. The leave may not be less than 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 Staff member. The Credentials Committee shall consult with the relevant Local Department Chair 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 Credentialing Policies and Procedures. Members on Leave of Absence who seek reinstatement of their Delineated Clinical Privileges shall apply for reinstatement in the circumstances and according to the procedure described in the Credentialing Policies and Procedures. Denial of a request for a Leave of Absence or the imposition of conditions on a Leave of Absence does not entitle the Medical Staff member to Due Process.

3.5.6 Resignation.

A member who intends to resign from the Medical Staff shall notify his/her Local Department Chair in writing. The Local Department Chair shall recommend approval or denial of such request to the Credentials Committee. The request shall be deemed accepted once approved by the Credentials Committee, the Medical Executive Committee and the Board.

3.6 INITIAL APPLICATION FOR APPOINTMENT

3.6.1 Application Form.

Each application for appointment to the Medical Staff shall be submitted on the form approved by the Credentials Committee and signed by the applicant. The application will elicit information relevant to the qualifications described in Section 3.2 and shall indicate the Medical Staff category and Delineated Clinical Privileges requested.

3.6.2 Applicant's Responsibilities.

The applicant is responsible for producing adequate information for a proper evaluation of his/her qualifications and for resolution of any doubts about those qualifications. The applicant shall notify Medical Staff Services' Credentialing Department immediately in writing of any change to information contained in the application that occurs while the application is pending. The applicant may be required by the Credentials Committee, Medical Executive Committee or Board to appear for an interview regarding the application or related matters and/or to submit answers to written questions posed by those bodies.

3.6.3 Credentials Verification.

An application is complete when Medical Staff Services' Credentialing Department has received and verified all information specified in the Credentialing Policies and Procedures. A complete application shall

be referred to the local chair of the Department in which the applicant seeks Medical Staff membership and/or Delineated Clinical Privileges. If an applicant requests Telemedicine Delineated Clinical Privileges, the Medical Staff may rely upon credential verification performed by a Telemedicine Provider or other telemedicine entity, to the extent permitted by the Credentialing Policies and Procedures.

3.6.4 Material Omission or Misrepresentation.

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

3.6.5 Department Chair Action.

The Local Department Chair shall review the applicant's qualifications and may interview the applicant. The Local Department Chair shall submit a written report and recommendation (as defined in Section 3.6.11) to the Credentials Committee.

3.6.6 Credentials Committee Action.

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

3.6.7 Medical Executive Committee Action.

Upon receipt of the report of the Credentials Committee, the Medical Executive Committee shall review the reports of the Credentials Committee and Local Department Chair and other relevant information. The MEC shall submit its written report and recommendation to the Board.

3.6.8 Board Action.

The Board has final authority for all appointments to the Medical Staff and for granting Delineated Clinical Privileges. Delineated Clinical Privileges are determined in accordance with Article V. The Board shall either (a) adopt the recommendation of the Medical Executive Committee, or (b) refer it back to the Medical Executive Committee for further consideration with a statement of the reason(s) for such action. If an application is referred back, the Medical Executive Committee shall again make a written report and recommendation to the Board, which shall consider the recommendation before taking final action on the application.

3.6.9 Adverse Recommendations.

If the Medical Executive Committee makes an adverse recommendation or the Board makes a preliminary adverse decision with respect to an application, the applicant may request a hearing to the extent available under Section 18.2.1. If an applicant who is the subject of an adverse preliminary decision does not make a request for a hearing by the deadline stated in Section 18.3.1 or is not entitled to a hearing, the application is considered to have been withdrawn and shall not receive further consideration. If a decision is unfavorable with respect to scope of Delineated Clinical Privileges only, an applicant who either does not timely request a hearing or is not entitled to a hearing, will be deemed to have requested only those Delineated Clinical Privileges the Board is willing to grant.

3.6.10 Reapplication.

A practitioner whose application for Medical Staff membership or privileges is deemed withdrawn pursuant to Section 3.6.4 or 3.6.9 or whose application is denied by the Board shall not be eligible to reapply to the Medical Staff for a period of two years from the date of withdrawal or final adverse decision denying Medical Staff membership or privileges, as applicable, unless the Board specifies otherwise.

3.6.11 Reports and Recommendations.

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

3.7 PROCEDURE FOR REAPPOINTMENT

3.7.1 Reappointment Application.

Each member who desires reappointment to the Medical Staff shall submit a timely, signed and complete reappointment application to Medical Staff Services' Credentialing Department in accordance with the Credentialing Policies and Procedures on a form approved by the Credentials Committee. The application will indicate the Medical Staff category and Delineated Clinical Privileges requested. If a reappointment application is not submitted in a timely and complete manner (as specified in the Credentialing Policies and Procedures), the member's Medical Staff membership and Delineated Clinical Privileges will expire at the end of the current term of appointment. The deadline to submit a reappointment application shall continue to apply when a Medical Staff member is on a Leave of Absence. The reappointment application will require submission of information that will allow a determination of whether the member meets the ongoing qualifications for Medical Staff membership and for requested Delineated Clinical Privileges, including providing reasonable evidence of current ability to perform capably the Delineated Clinical Privileges requested and information concerning any changes in the member's qualifications since his/her last (re)appointment. The results of Ongoing Professional Practice Evaluation shall be considered in acting on reappointment applications.

3.7.2 Processing Reappointment Applications.

Applications for reappointment shall be processed in the same manner as initial applications, using the procedures described in relevant portions of Section 3.6 of these Bylaws.

3.7.3 Medical Executive Committee Input Required.

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

3.7.4 Board Action.

The Board shall take final action on applications for reappointment and renewal of Delineated Clinical Privileges, except that no final action may be taken with respect to any member as to whom an adverse recommendation or decision has been made who has not either waived or completed the Due Process provided for in Section 18.2.1, if applicable.

ARTICLE IV. CATEGORIES OF MEDICAL STAFF MEMBERSHIP

Staff category will be assigned, based on the qualifications outlined below, by the respective Local Department Chair based on a review of the practice plan submitted by initial applicants and for existing members at time of reappointment, the patient care volumes and level of participation in appropriate Medical Staff affairs, and community need.

4.1 ACTIVE STAFF

4.1.1 Qualifications.

The Active Staff shall consist of qualified Physicians, Dentists and Podiatrists who:

- a. Have served on the Medical Staff for at least one (1) year and has either:
 1. Had at least fifty (50) patient contacts per two (2) years (i.e., a patient contact is defined as an inpatient admission, consultation, an inpatient or outpatient surgical procedure, shifts performed by

an emergency department practitioner, hospitalist, pathologist, radiologist, anesthesiologist, or practitioner in a provider-based clinic), or

2. Attended at least ten (10) Medical Staff or hospital meetings in the hospital over the past two (2) years
- b. is appointed to a medical leadership role (i.e., Department Chair, or another key role identified and approved by the MEC).

In the event that a member of the Active category does not meet the qualifications for reappointment to the Active category, and if the member is otherwise abiding by the Bylaws, rules, regulations, and policies of the Medical Staff and Hospital, the Medical Staff member may be appointed to another Medical Staff category if s/he meets the eligibility requirements for such category.

4.1.2 Responsibilities.

Active Staff members:

- a. Shall contribute to the organizational and administrative affairs of the Medical Staff; and
- b. Shall actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion and in the discharge of other staff functions as may be required; and
- c. Shall fulfill or comply with any applicable Medical Staff or hospital policies or procedures and must assume all the functions and responsibilities of membership on the Active Medical Staff, including emergency service care and consultation assignments (as defined in Medical Staff Policy and monitored by the Medical Executive Committee), medical education, response time, teaching assignments, and clinic and staff service assignments (where applicable); and
- d. Are encouraged, but not required, to attend Medical Staff meetings, and shall attend applicable Medical Staff committee meetings and participate in Department activities, as required by these Bylaws or applicable Department Rules and Regulations; and
- e. Must serve on Medical Staff committees and/or as a Physician Advisor, as assigned; and
- f. Must faithfully perform the duties of any office or position to which elected or assigned; and
- g. Must pay all applicable dues and other special assessments as determined by the System Physician Leadership Council.

4.1.3 Prerogatives.

Active Staff members may:

- a. Attend Medical Staff, Department, and Section meetings of which s/he is a member and any Medical Staff or hospital education programs;
- b. Vote on all matters presented by the Medical Staff, Department, Section, and committee(s) to which the member is assigned; and
- c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws or Medical Staff policies and serve as Physician Advisory for certain function of the Medical Staff.

4.2 ASSOCIATE STAFF

4.2.1 Qualifications.

The Associate Staff shall consist of qualified Physicians, Dentists and Podiatrists with Delineated Clinical Privileges who do not meet the eligibility requirements for the Active category.

4.2.2 Responsibilities.

Associate Staff members shall have the same responsibilities as Active Category members.

4.2.3 Prerogatives.

Associate Staff members may:

- a. Attend Medical Staff, Department, and Section meetings of which s/he is a member and any Medical Staff or hospital education programs;
- b. Not vote on matters presented by the entire Medical Staff, Department, or Section or be an officer of the Medical Staff; and
- c. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.

4.3 AFFILIATE STAFF

4.3.1 Qualifications.

The Affiliate Medical Staff is reserved for qualified Physicians, Dentists and Podiatrists who do not have Delineated Clinical Privileges and who do not meet the meeting requirements for eligibility for the Active Staff category. Affiliate Medical Staff may not admit or treat patients at the Hospital but may refer patients to other members of the Medical Staff for admission, evaluation and/or care and treatment.

4.3.2 Responsibilities.

Affiliate Staff members shall have the same responsibilities as Active Staff category members, except for those responsibilities related to the possession of Delineated Clinical Privileges.

4.3.3 Prerogatives.

Affiliate Staff members may:

- a. Attend Medical Staff, Department, and Section meetings of which s/he is a member and any Medical Staff or hospital education programs;
- b. Not vote on matters presented by the entire Medical Staff, Department, or Section or be an officer of the Medical Staff; and
- c. Serve on Medical Staff committees, other than the MEC, and may vote on matters that come before such committees.

4.4 HONORARY RECOGNITION

Members of the Medical Staff who retire may be transferred to Honorary status upon request to the Local Chair of their Department and with the approval of that Department, the Medical Executive Committee, and the Board. This recognition is entirely discretionary and may be rescinded at any time. Members granted Honorary Recognition shall be those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff and Department meetings, continuing medical education activities, and may be appointed to committees but may not chair a standing committee or Department. They shall not hold Delineated Clinical Privileges, hold office or be eligible to vote on Medical Staff or Department matters although they may vote on matters in committees to which they are assigned, or pay dues. Honorary recognition does not require recredentialing.

ARTICLE V. PRIVILEGES**5.1 DELINEATED CLINICAL PRIVILEGES****5.1.1 Nature of Delineated Clinical Privileges.**

A practitioner who provides clinical services at the Hospital by virtue of Medical Staff membership, APP status or as otherwise permitted by Section 5.1.4 may exercise only those Delineated Clinical Privileges specifically granted to him/her by the Board. Regardless of the level of privileges granted, each practitioner must obtain consultation when necessary for the safety of his/her patient or when required by the Rules and Regulations of the Department, Medical Staff Policy, or Hospital or Department policy.

5.1.2 Determination of Delineated Clinical Privileges.

Delineated Clinical Privileges are granted by the Board, based upon the practitioner's education, training, experience and demonstrated current competence and judgment, as documented and verified in each practitioner's credentials file, and in accordance with the Credentialing Policies and Procedures. Privilege determinations shall take into account pertinent information concerning clinical performance obtained from other sources, especially from other institutions and health care settings where the practitioner has exercised clinical privileges. The practitioner has the burden of establishing his/her qualifications and competency in the Delineated Clinical Privileges requested. The various levels of Delineated Clinical Privileges, the specific qualification(s) for the exercise of the same at each level and additional details regarding the procedures by which requests for Delineated Clinical Privileges are processed are addressed in the Rules and Regulations of the various Departments.

5.1.3 Dentists and Podiatrists.

Delineated Clinical Privileges granted to Dentists and Podiatrists shall be based on their education, training, experience, and demonstrated current competence and judgment. The scope and extent of surgical procedures that each Podiatrist or Dentist may perform shall be specifically reviewed and delineated in the same manner as all other surgical privileges. Only a Physician or Oral Surgeon member of the Medical Staff may be the Admitting Physician, and such Physician or Oral Surgeon shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization.

5.1.4 Non-Members.

Delineated Clinical Privileges may be granted to qualified Physicians, Podiatrists, Dentists and APPs, who are not Medical Staff members, pursuant to Article VI. Non-members may not be granted admitting privileges, except as otherwise permitted by Sections 6.1 and 6.2. A non-member of the Medical Staff may participate in the care of patients, including performance of histories and physicals, only in accordance with the scope of Delineated Clinical Privileges granted to the non-member. Non-members are not entitled to vote on Medical Staff or department matters.

5.2 MODIFICATIONS TO PRIVILEGES

A member or APP may request an increase in Delineated Clinical Privileges during the term of an appointment by submitting a written request in accordance with the Credentialing Policies and Procedures. Any such request will be processed using substantially the same procedures as for a request for reappointment. A member or APP may request a decrease in Delineated Clinical 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 Delineated Clinical Privilege reduction request that it approves.

5.3 FOCUSED PROFESSIONAL PRACTICE EVALUATION

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

ARTICLE VI. PROVISION OF PATIENT CARE BY NON-MEDICAL STAFF MEMBERS

6.1 PRACTITIONERS WITH TEMPORARY PRIVILEGES

In situations where professional skills are to be exercised for a limited time only, a Physician, Podiatrist, Dentist or a practitioner licensed in a category eligible for APP status may be granted specific temporary privileges in accordance with the Credentialing Policies and Procedures. However, rights of Medical Staff membership or APP status are not conferred by temporary privileges. Such privileges shall be Department-specific and may be granted in the categories specified in this Section 6.1.

6.1.1 Application in Process.

The President, on behalf of the Board and upon recommendation of the Chief of Staff, the Chair of the Credentials Committee, and Local Chair of the Department in which temporary clinical privileges are requested, may grant temporary clinical privileges to (a) a Physician, Dentist or Podiatrist who has submitted an initial application for Medical Staff membership, (b) a Physician, Podiatrist or Dentist, as applicable, who has submitted an initial application for Delineated Clinical Privileges pursuant to Section 6.4 or 6.5, or (c) a qualified practitioner who has submitted an initial application for APP status, and in each case 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 Credentialing Policies and Procedures. Temporary clinical privileges shall be granted for a limited time only, not to exceed the shorter of 120 days or pending action by the Medical Staff and Board on a Medical Staff membership or Delineated Clinical Privileges application, but always subject to revocation or suspension as provided in Section 6.1.3.

6.1.2 Locum Tenens, House Physicians or Visiting Practitioners.

Temporary clinical privileges for the care and treatment of a specific identified patient or patients may be granted to a Physician, Dentist, or Podiatrist to fulfill an important patient care need; temporary clinical privileges shall automatically expire on the earlier of the date specified in the privileging request, or with the discharge of the identified hospitalized patient(s). Temporary privileges may also be granted for up to 120 days to a practitioner who substitutes for a member of the Medical Staff during an illness or Leave of Absence, and to a Physician who is engaged by the Hospital as a House Physician. All temporary privileges granted pursuant to this Section 6.1.2 shall be: preceded by verification of the practitioner's licensure and current competence; granted by the President, on behalf of the Board and upon recommendation from the Chief of Staff, the Chair of the Credentials Committee, and the Local Chair of the Department in which temporary clinical privileges are requested; and subject to revocation and suspension as provided in Section 6.1.3.

6.1.3 Supervision and Revocation.

Each practitioner who performs services in the Hospital pursuant to temporary clinical privileges granted in accord with Section 6.1 shall be under the supervision of the Local Chair of the Department in which privileges are exercised and, in the case of an APP, shall also be under the supervision of a designated Supervising Member. Practitioners granted temporary privileges shall comply with the requirements imposed by these Bylaws on Medical Staff members unless exempted by the MEC. The Chief of Staff may summarily suspend or revoke temporary privileges when in his or her sole discretion such suspension or revocation is in the best interests of the Hospital. Upon such suspension or termination, the patients then in the Hospital under the practitioner's care shall be assigned to a Medical Staff member by the Local Department Chair. The wishes of the patients shall be considered, as feasible, in choosing a substitute Medical Staff member. Denial or termination of temporary privileges does not trigger Due Process rights.

6.2 DISASTER PRIVILEGES

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

6.3 ADVANCED PRACTICE PROFESSIONALS

6.3.1 Assignment, Supervision and Compliance.

Although responsible to the Medical Staff and the Board, Advanced Practice Professionals are not members of the Medical Staff. Each APP may furnish patient care at the Hospital only within the limits of the Delineated Clinical Privileges granted in accordance with these Bylaws, except as otherwise permitted by Sections 6.1 and 6.2. Each APP acts under the overall supervision of an identified Supervising Member approved by the Board, acting on the recommendation of the Medical Executive Committee. Each APP shall be assigned to a Department. The APP shall immediately notify the applicable Local Department Chair in writing if the APP's supervisory arrangement with the Supervising Member ends. An APP may not be granted a Delineated Clinical Privilege that exceeds the Delineated Clinical Privileges of the APP's Supervising Member. The Hospital may grant Delineated Clinical Privileges that are less extensive than the scope of activities an APP is licensed to perform. APPs shall comply with the requirements imposed by these Bylaws on Medical Staff members (including Section 3.4) unless exempted by the MEC.

6.3.2 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 Delineated Clinical Privileges will be processed using the procedures and criteria set forth in Articles III and V to the extent applicable to the practitioner's profession, subject to the Credentialing Policies and Procedures, including alternative APP investigative process rights that replace Article XVIII with respect to APPs.

6.3.3 Suspension and Termination.

An APP's Delineated Clinical Privilege may be suspended, revoked, or not renewed (including action pursuant to Article VII) in the same manner as a member of the Medical Staff (subject, however, to the alternative APP investigative process set forth in the Credentialing Policies and Procedures), 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. If (a) the Supervising Member ceases to be a member of the Medical Staff, (b) the supervising arrangement (such as, collaboration agreement or employment) between the APP and the Supervising Member terminates, or (c) the APP ceases to be an employee of the Hospital, if applicable, then the APP's Delineated Clinical Privilege shall terminate automatically, without an investigative process. The events described in (a) and (b) will not result in automatic termination of the APP's Delineated Clinical Privilege if the applicable Local Department Chair immediately approves a substitute Supervising Member.

6.4 HOUSE PHYSICIANS

6.4.1 Assignment, Supervision and Compliance.

Although responsible to the Medical Staff and the Board, House Physicians are not members of the Medical Staff. Each House Physician may furnish patient care at the Hospital only within the limits of the Delineated Clinical Privileges granted to him/her in accordance with these Bylaws, except as otherwise permitted by Sections 6.1 and 6.2. Each House Physician acts under the overall supervision of the Local Chair of the Department to which assigned. When participating in the care of a patient admitted to the Hospital, the House Physician shall work under the supervision of the attending Medical Staff member. House Physicians shall comply with the requirements imposed by these Bylaws, on Medical Staff members unless exempted by the MEC, Medical Staff Policy, and any Hospital policy intended to govern their activities.

6.4.2 Qualifications.

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

6.4.3 Suspension and Termination.

A House Physician's Delineated Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Article VII) in the same manner as a member of the Medical Staff, as well as in accordance with the terms of the contract governing the House Physician's services to the Hospital and, in the case of a Hospital-employed House Physician, in accordance with any applicable Hospital policy.

6.5 TELEMEDICINE AND OTHER SELECT DELINEATED CLINICAL PRIVILEGES

6.5.1 Assignment, Supervision and Compliance.

Qualified Physicians, Podiatrists and Dentists who are not members of the Medical Staff (a) may be granted Telemedicine Delineated Clinical Privileges, or (b) may be granted Delineated Clinical Privileges to satisfy a need for specialized services identified by the Medical Executive Committee which need cannot effectively be met by Medical Staff members. Practitioners granted Delineated Clinical Privileges pursuant to this Section 6.5 are responsible to the Medical Staff and the Board. They may furnish patient care at the Hospital only within the limits of the Delineated Clinical Privileges granted to him/her in accordance with the Bylaws, except as otherwise permitted by Sections 6.1 and 6.2. Practitioners granted Delineated Clinical Privileges pursuant to this Section 6.5 act under the overall supervision of the Local Chair of the Department to which assigned and shall comply with the requirements imposed by these Bylaws on Medical Staff members unless exempted by the MEC.

6.5.2 Qualifications.

Applications for initial and renewed Delineated Clinical Privileges pursuant to this Section 6.5 will be processed using the procedures and criteria set forth in Articles III and V.

6.5.3 Suspension and Termination.

Delineated Clinical Privileges granted pursuant to this Section 6.5 may be suspended, revoked, or not renewed (including action pursuant to Article VII) in the same manner as a member of the Medical Staff, as well as in accordance with the terms of any employment or contractual relationship the practitioner may have with the Hospital and, in the case of any Hospital-employed practitioner, any applicable Hospital policy.

ARTICLE VII. CORRECTIVE ACTION, SUSPENSION AND TERMINATION

The Credentialing Policies and Procedures contains additional details regarding disciplinary action, automatic suspension/termination, and investigative procedures with respect to APPs.

7.1 CORRECTIVE ACTION

7.1.1 Grounds For Request.

Any of the following may request corrective action with respect to Medical Staff members: (a) Chief of Staff; (b) System Department Chair; (c) Local Department Chair; or (d) the President, the Board, or the Chief Medical Officer, after consultation, if feasible, with the Chief of Staff or System or Local Department Chair. A request for corrective action shall be based on reasonable grounds including any of the following:

- a. It appears the practitioner no longer possesses the qualifications for Medical Staff membership or for the Delineated Clinical Privileges held.
- b. Personal activity or professional conduct that is, or is likely to be, detrimental to patient safety or to delivery of patient care, or disruptive to Hospital operations.
- c. Unethical professional practice in or outside of the Hospital.

- d. Conduct that constitutes sexual harassment or morally offensive conduct toward, or that creates a hostile work environment for, any Medical Staff member, APP, Hospital personnel, patient, or Hospital visitor.
- e. Violation of these Bylaws or Medical Staff Policy.
- f. Conduct that indicates unwillingness or inability to work harmoniously with Medical Staff members, APPs, Hospital personnel, or patients.

7.1.2 Form Of Request.

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

7.1.3 Notice Of Request.

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

7.1.4 Investigation.

The Chief of Staff, in consultation with the System/Local Department Chair, may designate an individual or an ad hoc committee (from among its members or not) to investigate the grounds for a request for corrective action, if deemed necessary or appropriate by the Chief of Staff. The designated person or committee shall promptly investigate the matter (which shall include an interview with the affected Medical Staff member or an opportunity for the affected Medical Staff member to respond in writing, as selected by the investigator) and, within 30 days after receipt of the assignment, shall forward a written report of their findings to the Chief of Staff. If the affected Medical Staff member is interviewed pursuant to this Section 7.1.4 and/or Section 7.1.5, the interview shall be informal; such an interview does not constitute a hearing and therefore none of the procedural rules relating to Due Process (including presence of an attorney) shall apply.

7.1.5 Medical Executive Committee's Action On Request.

As soon as practical after receiving the corrective action request or, if an investigation was performed, after receipt of the investigating party's report, the Chief of Staff shall inform the Medical Executive Committee of the request and recommend a response. The Medical Executive Committee may, but is not required, to interview the affected Medical Staff member. As described in Section 7.1.4, any such interview does not constitute a hearing (and hence there is no right to presence of an attorney). The Medical Executive Committee's response to a corrective action request may include, without limitation:

- a. Reject the request for corrective action.
- b. Issue a written warning that future corrective action will be taken if the Medical Staff member's behavior does not conform to the standards stated in the warning.
- c. Issue a written reprimand stating the MEC's disapproval of the Medical Staff member's behavior and directing that the behavior ceases immediately.
- d. Require proctoring or consultation (the Medical Staff member is not required to obtain consent of the consultant or proctor before the Medical Staff member may provide patient care).
- e. Require education to improve the Medical Staff member's knowledge, skills, or ability in clinical subjects or in non-clinical subjects (such as anger management), that does not affect current Delineated Clinical Privileges.
- f. Require a health assessment of the Medical Staff member by a health professional or at a facility selected by the Medical Executive Committee and under such conditions (including reports to the MEC or its designee) as the MEC may establish, and/or require the Medical Staff member to undergo appropriate treatment.

- g. Recommend to the Board:
1. Reduction, limitation, suspension, or revocation of Delineated Clinical Privileges;
 2. Suspension or revocation of Medical Staff appointment;
 3. Any other form of discipline that materially limits the Medical Staff member's right to provide direct patient care as previously authorized (such as proctoring or consultation in which consent of the proctor or consultant is required before patient care may be provided).

7.1.6 Report To The Board.

- a. All Medical Executive Committee actions relating to a corrective action request shall be reported promptly to the Board.
- b. If the Medical Executive Committee recommends any of the actions specified in Section 7.1.5(g), the Board will not act on the recommendation until the affected Medical Staff member has either waived or exhausted Due Process (if applicable). The Board may then adopt, modify, or reject the Medical Executive Committee's recommendation.
- c. In addition to considering and acting upon recommendations of the Medical Executive Committee regarding corrective action, the Board may, at any time, respond to a corrective action request by imposing corrective action against the Medical Staff member, subject to the member's right, if applicable, to Due Process.

7.1.7 Monitoring Practitioner's Compliance.

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

7.1.8 Professional Practice Evaluations.

The Department Chairs shall have the power to conduct an informal professional practice evaluation of a Medical Staff member in accordance with the Medical Staff Professional Practice Evaluation policy. This Section 7.1.8 shall not be construed to require that an informal professional practice evaluation be conducted before action is taken pursuant to Sections 7.1, 7.2 or 7.3.

7.2 SUMMARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

7.2.1 Imposition.

The following individuals and bodies have the authority to suspend or restrict (referred to collectively as a "suspension") summarily all or any portion of the Clinical Privileges of a Medical Staff member whenever they determine failure to take immediate action may result in an imminent danger to the mental or physical health of any individual: (a) Chief of Staff, (b) System Department Chair, (c) Local Department Chair, or (d) President, Board, or Chief Medical Officer, after consultation with the Chief of Staff or System or Local Department Chair. Summary suspension is effective immediately upon imposition. The Chief of Staff shall promptly notify the suspended practitioner of the suspension by Special Notice.

7.2.2 Medical Executive Committee Review.

Within ten (10) days after the suspension is effective, the Medical Executive Committee will hold a special meeting to review the suspension. The Medical Executive Committee's review of the suspension shall be an informal proceeding and shall not be deemed a hearing and therefore none of the procedural rules relating to Due Process (including presence of an attorney) shall apply. The suspended member will be invited to present his or her point of view to the Medical Executive Committee at the meeting provided for in this Section 7.2.2. The Medical Executive Committee may recommend modification, continuation or

termination of the summary suspension and shall recommend the future status of the practitioner's Medical Staff membership/Delineated Clinical Privileges (for example, reinstate after suspension of a specified duration, or terminate Medical Staff membership/Delineated Clinical Privileges). The Medical Executive Committee shall act by majority vote of those present at this meeting, regardless of whether a quorum is present.

7.2.3 Favorable Recommendation.

- a. If the Medical Executive Committee, acting pursuant to Section 7.2.2, recommends termination of the suspension and a disposition of the matter that does not trigger Due Process, the suspension is terminated, unless the suspension was imposed by the President, Board, or CMO, in which case Section 7.2.3(b) applies.
- b. In the case of suspensions imposed by the Board, President, or CMO, the Medical Executive Committee's recommendation to terminate the suspension and to take no action that triggers that Due Process shall be transmitted immediately, together with all supporting documentation, to the Board. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision by the Board, except a suspension imposed by the President or the CMO shall be terminated if the individual who imposed that suspension concurs with the Medical Executive Committee's recommendation to terminate the suspension.

7.2.4 Unfavorable Recommendation.

If the Medical Executive Committee, acting pursuant to Section 7.2.2, recommends continuation of the suspension and/or a disposition of the matter that triggers Due Process, the practitioner shall be entitled to Due Process. The terms of the summary suspension shall remain in effect pending a final decision by the Board regarding the suspension and the future status of the practitioner's Medical Staff membership/Delineated Clinical Privileges.

7.2.5 Care Of Patients.

Upon imposition of a summary suspension, the patients then in the Hospital under the practitioner's care shall be assigned to a Medical Staff member by the Local Department Chair. The wishes of the patients shall be considered, as feasible, in choosing a substitute Medical Staff member.

7.3 INVESTIGATIVE SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

7.3.1 Imposition.

The following individuals have the authority to suspend or restrict all or any portion of the Delineated Clinical Privileges of a practitioner for up to fourteen (14) days pursuant to this Section 7.3: (a) any two of the following individuals: Chief of Staff, System Department Chair or Local Department Chair, President, or (b) President or Chief Medical Officer, after consultation with the Chief of Staff or System or Local Department Chair. An investigative suspension may be imposed if authorized individual(s) listed in this Section conclude that grounds may exist for imposing summary suspension under Section 7.2, but additional time and investigation is needed to determine the relevant facts (for example, to reconcile conflicting accounts of a key event) or to obtain access to the expertise needed to determine whether summary suspension is warranted. An investigative suspension is effective immediately upon imposition. The Chief of Staff shall promptly notify the suspended practitioner of the suspension by Special Notice.

7.3.2 Interim Nature.

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

7.3.3 Care of Patients.

Upon imposition of an investigative suspension, the procedures described in Section 7.2.5 shall be used to arrange for care of patients.

7.4 AUTOMATIC SUSPENSION/TERMINATION OF DELINEATED CLINICAL PRIVILEGES/MEMBERSHIP

7.4.1 Process.

The events described in this Section 7.4 shall result in automatic suspension or termination of a Medical Staff member's Medical Staff membership or Delineated Clinical Privileges, as specified, without right to Due Process. If a Medical Staff member's Medical Staff membership or Delineated Clinical Privileges are automatically suspended or terminated, Medical Staff Services shall notify the member of the suspension or termination in writing, after notifying the Chief of Staff. The procedures described in Section 7.2.5 shall be used to arrange for care of patients.

7.4.2 Professional License.

A Medical Staff member whose license to practice a health profession in the State of Michigan is suspended, restricted or lapsed shall automatically be suspended from practicing in the Hospital. If a Medical Staff member's license is reinstated while his/her ability to practice in the Hospital is suspended pursuant to this Section 7.4, the Local Department Chair shall either (a) determine that reinstatement of Delineated Clinical Privileges is appropriate or (b) request corrective action pursuant to Section 7.1.1 in which case the suspension from practicing in the Hospital remains in effect pending the final outcome of the corrective action process. If a Medical Staff member's Michigan health profession license is revoked or otherwise terminated, or is suspended, restricted, or lapsed for more than sixty (60) consecutive days, the practitioner's Medical Staff membership and Delineated Clinical Privileges shall terminate automatically.

7.4.3 Drug Enforcement Administration (DEA) Registration Or State Controlled Substances License.

A Medical Staff member whose DEA registration or Michigan Controlled Substances license is suspended, restricted or lapsed shall automatically be suspended from practicing in the Hospital, unless the Medical Staff member is exempt from the requirement to maintain a DEA registration/controlled substance license pursuant to the Credentialing Policies and Procedures. If a Medical Staff member's DEA registration or Michigan Controlled Substance license is reinstated while his/her ability to practice in the Hospital is suspended pursuant to this Section 7.4, the Local Department Chair shall either (a) determine that reinstatement of Delineated Clinical Privileges is appropriate or (b) request corrective action pursuant to Section 7.1.1 in which case the suspension from practicing in the Hospital remains in effect pending the final outcome of the corrective action process. If a Medical Staff member's DEA registration or Michigan Controlled Substance license is revoked or otherwise terminated, or is suspended, restricted, or lapsed for more than sixty (60) consecutive days, the practitioner's Medical Staff membership and Delineated Clinical Privileges shall terminate automatically, unless the Medical Staff member is exempt from maintaining a DEA registration/controlled substances license by the Credentialing Policies and Procedures.

7.4.4 Medical Records.

A Medical Staff member who fails to complete medical records within the periods prescribed in Medical Staff Policy shall automatically be suspended from practicing in the Hospital in accordance with Medical Staff Policy.

7.4.5 Malpractice Insurance.

A Medical Staff member who fails to provide the Hospital with adequate evidence of the professional liability insurance required by Section 3.2.2 shall be automatically suspended from practicing in the Hospital. If the Medical Staff member fails to provide the Hospital with adequate evidence of the required insurance within sixty (60) days after being suspended, the Medical Staff member's Medical Staff membership and Delineated Clinical Privileges shall terminate automatically.

7.4.6 Federal Program Exclusion.

Exclusion of a Medical Staff member from a federal health care program shall cause an automatic termination of the practitioner's Medical Staff membership and Delineated Clinical Privileges. (The terms of this Section 7.4.6 do not apply to a voluntary decision by a Medical Staff member not to participate in federal health care program(s).)

7.4.7 Dues.

A Medical Staff member who fails to pay Medical Staff dues within thirty (30) days after the due date shall automatically be suspended from practicing in the Hospital until dues are paid in full. If a member fails to pay Medical Staff dues for more than ninety (90) days after the original due date, the member's Medical Staff membership and Delineated Clinical Privileges shall terminate automatically.

7.4.8 Leave Of Absence.

Failure to submit a request for reinstatement from a leave of absence by the deadline stated in the Credentialing Policies and Procedures or failure to provide a summary of activities during a leave of absence or other information requested or required pursuant to the Credentialing Policies and Procedures will result in automatic termination of Medical Staff membership and Delineated Clinical Privileges.

7.4.9 Reappointment.

A Medical Staff member who fails to file an application for reappointment to the Medical Staff or for renewal of Delineated Clinical Privileges by the deadline stated in the Credentialing Policies and Procedures shall automatically cease to be a Medical Staff member and cease to hold Delineated Clinical Privileges upon expiration of the practitioner's term of appointment.

7.4.10 Board Certification.

A Medical Staff member's Medical Staff membership or affected Delineated Clinical Privileges, as applicable, shall terminate automatically upon failure to obtain board certification or recertification by the deadline stated in Section 3.2.6.

7.4.11 Contractual Practitioners.

Expiration or termination of a Medical Staff member's contractual relationship relating to a Contract Department/Service shall result in automatic termination of Medical Staff membership and Delineated Clinical Privileges, except as otherwise provided in Section 8.2. A Medical Staff member who practices at the Hospital pursuant to a contract with the Hospital that provides for automatic termination of Medical Staff membership and/or Delineated Clinical Privileges is subject to automatic termination in accordance with the terms of that contract.

7.4.12 Health Evaluation.

A Medical Staff member who fails to submit to a physical or mental health evaluation (which may include evaluation for substance abuse) within sixty (60) days of a written request therefor by the Board based on evidence of need for the evaluation supplied to the Board by the Medical Executive Committee, shall automatically be suspended from practicing at the Hospital until the evaluation occurs. If the Medical Staff member fails to submit to the evaluation and furnish the Hospital with the results thereof within ninety (90) days after being suspended, the Medical Staff member's Medical Staff membership and Delineated Clinical Privileges shall terminate automatically.

7.4.13 Communicable Disease Test Results/and Vaccination.

A Medical Staff member 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 be suspended from practicing at the Hospital until the required documentation is furnished. If the Medical Staff member fails to provide the Hospital the required

documentation within ninety (90) days after being suspended, the Medical Staff member's Medical Staff membership and Delineated Clinical Privileges shall terminate automatically.

7.4.14 Action At Another Trinity Health-Michigan Hospital.

- a. If a Medical Staff member's Delineated Clinical Privileges are summarily suspended or restricted at another hospital operated by Trinity Health - Michigan (including but not limited to another Hospital, as defined above in Definition 15), the member's Delineated Clinical Privileges at this Hospital shall automatically be subject to the same restriction or suspension, at such time as the suspension or restriction is affirmed by the MEC at the other Trinity Health – Michigan hospital. If the summary restriction or suspension is lifted at the other Trinity Health - Michigan hospital, the restriction or suspension is automatically lifted at this Hospital as well, subject to the Medical Staff's/Hospital's right to take any appropriate action provided for in these Bylaws.
- b. If a Medical Staff member's medical staff membership or Delineated Clinical Privileges at another hospital operated by Trinity Health - Michigan is/are terminated, restricted, or subject to conditions, the Medical Staff member's status at this Hospital shall automatically be subject to the same action or restrictions at such time as the final adverse decision of the Board at the other Trinity Health – Michigan hospital is made.
- c. This Section 7.4.14 shall not be triggered by action at another Trinity Health - Michigan hospital that is based solely on the grounds described in Section 7.4.4, 7.4.7, 7.4.8, 7.4.9 or 7.4.13 of these Bylaws which occur at that other hospital.

7.4.15 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 practitioner who performs the covered service in the Hospital perform a minimum volume of the service annually. If a Medical Staff member fails to satisfy this State-imposed minimum volume requirement, the relevant Delineated Clinical Privilege may be terminated without Due Process.

7.4.16 Michigan "Criminal Background Check" Statutes.

Michigan law prohibits hospitals with a psychiatric unit from granting or continuing clinical privileges in such unit to a practitioner convicted of certain crimes or found to have engaged in specific prohibited behavior (such as abuse or neglect). The same Michigan statute requires individuals who hold clinical privileges in a psychiatric unit to notify the hospital immediately of certain arraignments, convictions, and other governmental actions taken against the practitioner. The Hospital may terminate Delineated Clinical Privileges without Due Process if Michigan law requires termination, or if a Medical Staff member fails to make such a statutorily required report to the Hospital.

ARTICLE VIII. DEPARTMENTS

8.1 ORGANIZATION OF DEPARTMENTS

- 8.1.1** Each member of the Medical Staff shall hold membership in a clinical Department. A clinical department is defined as all Medical Staff members at the Hospitals who: (a) practice the same specialty or subspecialty, (b) choose to be identified as a department, (c) fulfill the responsibilities of a department, and (d) are designated a Department by the System Physician Leadership Council and the Board. A minimum of five (5) such voting members who practice at a single Hospital is required to constitute a Department. Those specialty or subspecialty areas not meeting all of these criteria may be organized as sections within a Department, with the approval of the System Physician Leadership Council. An up-to-date list of Departments and Sections will be kept in the Medical Staff Services' office.
- 8.1.2** When deemed appropriate, the System Physician Leadership Council, subject to approval by the Board, may eliminate, subdivide, further subdivide or combine Departments. Any such changes shall be reflected on the List of Departments and Sections.

- 8.1.3** Any requested exceptions to the requirements of this Section 8.1 shall be reviewed and approved by the System Physician Leadership Council with final approved by the Board.
- 8.1.4** The System Physician Leadership Council shall provide the Medical Executive Committees with an opportunity to comment before the Council makes decisions pursuant to Sections 8.1.1 through 8.1.3.
- 8.1.5** Each Department and Section shall encompass both Hospitals. Each Department will have a single System Department Chair, and a single set of Department Rules and Regulations, and consistent Delineated Clinical Privilege forms that apply at both Hospitals. Section Heads, if any, shall report to the System Department Chair.
- 8.1.6** Each individual is entitled to no more than one vote even if he/she is a voting member of the Medical Staff of more than one Hospital. Unless otherwise expressly noted in these Bylaws, all voting members of a department, regardless of Hospital affiliation, shall vote on all matters put to a vote of the department.

8.2 CONTRACT DEPARTMENTS/SERVICES

The Hospital, after formal documented consultation with the Medical Staff, may conclude that an exclusive contractual arrangement between an individual Medical Staff member, group of members or, in some instances, an entire Department, is the preferred way to deliver a service or accomplish a function (sometimes referred to as a "Contract Department/Service"). In all instances, the Medical Staff member, group or Department will be governed by all rules and obligations of Medical Staff and Departmental membership. The following requirements shall be met in connection with any such contractual arrangement with the Hospital:

8.2.1 Medical Staff Membership.

Each practitioner who will furnish services at the Hospital pursuant to the contract must obtain and maintain membership on the Medical Staff and appropriate Delineated Clinical Privileges, in accordance with Article III of these Bylaws.

8.2.2 Selection of Department Chairs.

The System Department Chair and the Local Department Chair(s) of a Contract Department must be acceptable to the Department, the System Physician Leadership Council, the Board, and (in the case of Local Department Chair) to the Medical Executive Committee of the Applicable Hospital, according to the provisions of Sections 8.5.3 and 8.6.3.

8.2.3 Termination of Medical Staff Membership and Privileges.

Unless the employment contract of a member of a Contract Department/Service expressly states that the member shall retain membership on the Medical Staff 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 member's employment or other contract with the party that staffs the Contract Department/Service or expiration or termination of the contract with the Hospital, as applicable, shall constitute an automatic termination of the member's Medical Staff membership under Section 7.4.11.

8.3 ASSIGNMENT TO DEPARTMENTS

Each member of the Medical Staff shall be assigned membership in only one Department by the Medical Executive Committee and the Board, but may be granted Delineated Clinical Privileges and attendant responsibilities in one or more Departments. Assignment of an individual Medical Staff member to a department will typically be based on the practitioner's primary board certification. Responsibility for determining qualifications belongs within the Department(s) deemed most expert in these Delineated Clinical Privileges. The exercise of Delineated Clinical Privileges within any Department shall be subject to the Rules and Regulations of that Department.

8.4 FUNCTIONS OF DEPARTMENTS

- 8.4.1 Each Department will assure adequate physician representation in the clinical workings of the Hospital in its primary goal of achieving the best possible patient care.
- 8.4.2 Each Department shall function as the peer review and quality assessment body for all its members with the goal of delivering high quality, cost effective, safe patient care consistent with the standards of practice and achieving positive patient outcomes.
- 8.4.3 Each Department, through the actions of the System Department Chair in collaboration with the Local Department Chairs, shall recommend to the Credentials Committee criteria for the granting of Delineated Clinical Privileges in the Department that are consistent with the policies of the Medical Staff and of the Board, and consistent with recognized standards of medical practice.
- 8.4.4 Departments will conduct meetings and clinical/quality of care activities in accordance with Article XI of these Bylaws.
- 8.4.5 Each Department shall schedule and conduct educational programs as needs are identified/indicated within the Department.
- 8.4.6 Each Department shall review, evaluate and direct all aspects of patient care which fall within the Delineated Clinical Privileges defined by those Departments. Questions falling in areas that overlap between or among Departments should be resolved by the Departments involved, subject to approval by the Medical Executive Committees.
- 8.4.7 Each Department shall adopt guidelines, requirements and policies identifying the specific expectations of its members.
- 8.4.8 Each Department shall monitor the volume threshold for Medical Staff members in the Associate category, above which such members are eligible to be appointed to the Active Staff.

8.5 SYSTEM DEPARTMENT CHAIR

8.5.1 Functions of the System Department Chair.

Each Department of the Medical Staff shall have a System Chair whose responsibilities extend to Department members at both Hospitals and include:

- a. Accountability for all clinically-related activities within his/her Department;
- b. Accountability for all administratively-related activities of the Department unless otherwise provided by the Hospital;
- c. Recommending to the Credentials Committee (which will in turn recommend to the Medical Executive Committees) the criteria for Delineated Clinical Privileges that are relevant to the care provided in the Department;
- d. Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care services not provided by the Department or the Hospital;
- e. Participation in the planning and administration of his/her Department through cooperation with the Nursing Service and the Administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;
- f. Continuous assessment and improvement of the quality of care and services provided, including arranging and conducting educational programs as needs are identified/indicated within the Department;
- g. Integration of the Department into the primary functions of the Hospital;

- h. Development of Department policies and procedures that guide and support the provision of services, and that are consistent with regulatory requirements and standards of care;
- i. Development of Department Rules and Regulations in accordance with Section 8.7;
- j. Maintenance of quality improvement programs as appropriate; and
- k. Recommendations for space and other resources needed by the Department.

Additional specific duties for System Department Chairs may be assigned by the System Physician Leadership Council. A System Department Chair shall designate a Local Department Chair or other qualified member of the Department to perform the System Chair's functions during a Temporary Absence of the System Chair.

8.5.2 Qualifications of System Department Chair.

The System Department Chair shall be board certified, be an Active Staff member in good standing at each Hospital, have actively participated in QA/peer review activities of the Department, and demonstrated a willingness and ability to work with others (e.g., Hospital employees, other departments, Administration) to provide high quality patient care consistent with recognized standards of care. In addition, the System Department Chair shall indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or Delineated Clinical Privileges, and be in compliance with the professional conduct policies of the Hospital. It is preferential that System Department Chairs have previous leadership experience or be willing to participate in leadership training. System Department Chairs may not simultaneously hold a leadership position (any position in which the individual serves on the MEC or the Board) on another unaffiliated hospital's medical staff or in a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in the System Department Chair being automatically removed from office. Additional qualifications may be specified by the individual Medical Staff Departments in their Rules and Regulations. System Department Chairs must remain members in good standing of the Medical Staff of each Hospital during the tenure of their office.

8.5.3 Selection and Term of Office of System Department Chair.

System Department Chairs (including System Chairs of Contract Departments) shall be nominated by an Ad Hoc Search Committee appointed by the Chiefs of Staff of the Hospitals, as outlined by Medical Staff Policy (which search committee shall at a minimum have representation from the involved department, at least one other department and Administration). The System Department Chair must be (a) elected by a simple majority of the Active members who vote on the matter, (b) approved by the Medical Executive Committee of each Hospital at which one or more Department members (other than the nominee for System Department Chair) holds Medical Staff membership and Delineated Clinical Privileges, and (c) ratified by the Board. If the Board fails to ratify an elected System Department Chair, the Medical Staff shall be entitled to a Joint Conference pursuant to Section 17.1. Each System Department Chair shall be elected to serve an initial term of three (3) years and may thereafter be reaffirmed for up to two (2) successive terms for a total of nine (9) years. A System Department Chair may be reaffirmed to serve additional terms only if elected by a two-thirds (2/3rds) supermajority vote. All Active members of the Department must have the opportunity to vote. Failure to reaffirm activates a new System Department Chair selection process.

8.5.4 Removal of System Department Chair.

A System Department Chair shall be automatically removed if he or she ceases to be a member in good standing of the Active Staff of each Hospital. In addition, a System Department Chair may be removed by action by the relevant Department or by the Board as outlined below:

- a. The members of the Department may request removal (1) for breach of responsibilities outlined in Section 8.5.1, or (2) by vote of no confidence, utilizing the following process:

Removal of a System Department Chair during his/her term of office may be proposed by a petition that states the ground(s) for removal, bears the signatures of at least 25% of the voting members of the Department, and is filed with the System Physician Leadership Council. The System Physician

Leadership Council shall verify the signatures and the requisite number. If the petition complies with this Section 8.5.4, the issue shall be placed on the agenda for the next regular meeting of the Department when approval of the request for removal will require a two-thirds majority of the voting members of the Department, provided that at least one week prior to the vote all voting members of the Department shall have been notified in writing of the pending petition to remove the System Chair including the stated ground(s) for removal. Removal of the System Department Chair, upon such vote, shall be effective upon notification by the System Physician Leadership Council to the System Department Chair that he/she has been removed by a vote of the Department.

- b. The Board may at any time, provided it has first held a Joint Conference with the Medical Staff Executive Committees of the Hospitals, remove any System Department Chair if the Board determines such System Chair is not satisfactorily performing his/her obligations under these Bylaws, applicable Medical Staff Policy, or the Department Rules and Regulations.

If a System Department Chair also performs the functions of a local department chair, his or her removal as System Department Chair shall automatically terminate his or her functions as local department chair.

8.6 LOCAL DEPARTMENT CHAIR

8.6.1 Functions of the Local Department Chair.

Each Local Department Chair selected in accordance with Section 8.6.3 shall fulfill the following responsibilities, which are delegated to the Local Department Chair by the System Department Chair. Each Local Department Chair shall perform the following functions with respect to the specific Hospital for which he/she is responsible (referred to as the "Applicable Hospital").

- a. Membership on the Medical Executive Committee of the Applicable Hospital, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his/her own Department in order to assure quality patient care;
- b. Continuing surveillance of the professional performance of all individuals in the Department who have Delineated Clinical Privileges;
- c. Recommending Delineated Clinical Privileges for each member of the Department; Responsibility for enforcement of the Hospital Bylaws and of the Medical Staff Bylaws, Medical Staff Policies, and the Department's Rules and Regulations and policies;
- d. Coordination and integration of interdepartmental and intradepartmental services;
- e. Implementation of Department policies and procedures that guide and support the provision of services, and that are consistent with regulatory requirements and standards of care;
- f. Recommendations for a sufficient number of qualified and competent persons to provide care or services in the department;
- g. Determination of the qualifications and competence of Department personnel who are not licensed independent practitioners and who provide patient care services as further described in the Credentialing Policies and Procedures;
- h. Orientation and education of all persons in the Department; and
- i. Responsibilities assigned by the System Department Chair.

Additional specific duties for each Local Department Chair shall address all applicable accreditation requirements and be delineated in the Rules and Regulations for that Department.

8.6.2 Qualifications of Local Department Chair.

The Local Department Chair shall be board certified, be an Active Staff member in good standing at the Applicable Hospital, have actively participated in QA/peer review activities of the Department, and demonstrated a willingness and ability to work with others (e.g., Hospital employees, other departments, Administration) to provide high quality patient care consistent with recognized standards of care. Additional

qualifications may be specified by the individual Medical Staff Departments in their Rules and Regulations. Local Department Chairs must remain members in good standing of the Medical Staff of the Applicable Hospital during the tenure of their office.

8.6.3 Selection and Term of Office of Local Department Chair.

If five (5) or more voting members of a Department are members of the Medical Staff at a Hospital, the System Chair shall determine, in consultation with the Department members at that Hospital, whether a local department chair is needed at that Hospital. The System Department Chair shall perform the functions of the local department chair with respect to the Hospital (a) if the System Department Chair determines that a local department chair is not needed, or (b) if fewer than five (5) members of the Department are voting members of the Medical Staff at the Hospital. Local Department Chairs (including Local Chairs of Contract Departments) shall be nominated by an Ad Hoc Search Committee appointed by the Chief of Staff of the Applicable Hospital, as outlined by Medical Staff Policy (which search committee shall at a minimum include the applicable System Department Chair, and shall have other representation from the involved department and from at least one other department and Administration). He/she must be elected by a simple majority of the Active members of the Department who are members of the Medical Staff of the Applicable Hospital and who vote on the matter, and be approved by the Applicable Hospital's Medical Executive Committee and ratified by the Board. If the Board fails to ratify an elected Local Department Chair, the Medical Staff of the Applicable Hospital shall be entitled to a Joint Conference pursuant to Section 17.1. Each Local Department Chair shall be elected to serve an initial term of three (3) years and may thereafter be reaffirmed for up to two (2) successive terms for a total of nine (9) years. A Local Department Chair may be reaffirmed to serve additional terms only if elected by a two-thirds (2/3rds) supermajority vote. All Active members of the Department must have the opportunity to vote. Failure to reaffirm activates a new Local Department Chair selection process.

8.6.4 Removal of Local Department Chair.

A Local Department Chair shall be automatically removed if he or she ceases to be a member in good standing on the Active Staff of the Applicable Hospital. In addition, a Local Department Chair may be removed by action by the relevant Department or by the Board as outlined below:

- a. The members of the Department at the Applicable Hospital may request removal (1) for breach of responsibilities outlined in Section 8.6.1, or (2) by vote of no confidence, utilizing the following process:

Removal of a Local Department Chair during his/her term of office may be proposed by a petition that states the ground(s) for removal, bears the signatures of at least 25% of the voting members of the Department at the Applicable Hospital, and is filed with the Medical Executive Committee of the Applicable Hospital. The Medical Executive Committee shall verify the signatures and the requisite number. If the petition complies with this Section 8.6.4, the issue shall be placed on the agenda for a meeting of the members of the Department at the Applicable Hospital, at which approval of the request for removal will require a two-thirds majority of the voting members of the Department at the Applicable Hospital. At least one week prior to the vote all voting members of the Department at the Applicable Hospital shall be notified in writing of the pending petition to remove the Local Chair including the stated ground(s) for removal. Removal of the Local Department Chair, upon such vote, shall be effective upon notification by the Chief of Staff to the Local Department Chair that he/she has been removed by a vote of the Department.

- b. The Board may at any time, provided it has first held a Joint Conference with the Medical Executive Committee of the Applicable Hospital, remove any Local Department Chair if the Board determines such Local Chair is not satisfactorily performing his/her obligations under these Bylaws, applicable Medical Staff Policy, or the Department Rules and Regulations.

8.6.5 Department Local Vice Chairs.

If the Local Department Chair determines a Local Vice Chair is needed, the members of the Department at the Applicable Hospital will elect or appoint a Local Vice Chair (who may also be referred to as a Local Associate Chair) per a process described in the Department Rules and Regulations. The Local Vice Chair qualifications shall be consistent with those of the Local Department Chair identified in Section 8.6.2. The Local Vice Chair shall assume the duties of the Local Chair during a Temporary Absence of the Local Chair. The Department may assign other duties to the Local Vice Chair that are consistent with these

Bylaws. The term of office of a Local Vice Chair shall be defined in the Department Rules and Regulations. These individuals must be members in good standing of the Medical Staff of the Applicable Hospital during the tenure of their office. If there is no Local Vice Chair, the Local Department Chair shall designate a qualified Department member at the Applicable Hospital to perform the Local Chair's functions during a Temporary Absence of the Local Chair.

8.7 DEPARTMENT RULES AND REGULATIONS

- 8.7.1** Each Department shall draft and maintain appropriate Rules and Regulations for the Department. Department Rules and Regulations shall govern the conduct of Department functions and affect only that Department. Department Rules and Regulations shall not duplicate or contradict the Medical Staff Bylaws. In matters of interpretation, the Medical Staff Bylaws shall be given precedence over Department Rules and Regulations.
- 8.7.2** Each Department shall maintain a manual of its Rules and Regulations, which shall be open for inspection by any member of the Medical Staff.
- 8.7.3 Preparation, Approval and Review of Department Rules and Regulations.**
- a. Each System Department Chair will submit all new Rules and Regulations, amendments to Rules and Regulations, and deletions of Rules and Regulations, approved by his or her Department and reviewed/supported as necessary by legal counsel, to each Medical Executive Committee for consideration and recommendation.
 - b. After appropriate consideration of a proposed Rule or Regulation, which may include time for research and discussion into the need for the Rule and Regulation and its effect on the Hospitals, the Medical Executive Committees shall recommend that the Board either accept, reject, or return the proposed Rule or Regulation to the Department for further consideration and/or modification.
 - c. Department Rules and Regulations shall become effective following approval by each of the Medical Executive Committees and the Board.

ARTICLE IX. OFFICERS

9.1 OFFICERS

The officers of the Medical Staff shall be:

- a. Chief of Staff
- b. Vice-Chief of Staff
- c. Secretary/Treasurer

The Medical Executive Committee may also recognize the office of Member-at-Large. Should the Medical Executive Committee elect to recognize the office of Member-at-Large, the Medical Executive Committee shall designate the number (between 1 and 3) of Members-at-Large who shall be elected. As officers of the Medical Staff, Members-at-Large shall be subject to the terms of this Article IX.

9.2 QUALIFICATIONS

Officers must be Active Staff members at the time of nomination and election and must remain members in good standing of the Active Staff during their terms of office. Chief of Staff and Vice Chief of Staff positions must have been members of the Active category at any combination of the Medical Staffs for a minimum of five (5) consecutive years immediately preceding election as an officer. Chief of Staff and Vice Chief of Staff positions require demonstrated medico-administrative experience, as may be evidenced by membership on a standing committee, or holding departmental office or other leadership position within the Medical Staff. For all other positions, officers must have been members of the Active category at any combination of the Medical Staffs for a minimum of three (3) consecutive years immediately preceding election as an officer.

9.3 ELECTION OF OFFICERS

An ad hoc nominating committee, appointed by the Chief of Staff and approved by the Medical Executive Committee, shall offer one or more nominees for each office. The nominating committee shall consist of at least three (3) Active members and may also include the CMO. Nominees will be announced to the Medical Staff via regular Medical Staff communication channels. Additional nominations will be accepted by written petition submitted to the Chief of Staff by a specified date, no later than two weeks prior to the election, signed by 5% of the voting members of the Medical Staff. These names will then appear on the official ballot.

Officers shall be elected by confidential ballots, distributed by direct mailing or electronically, to all voting members of the Medical Staff with return date as specified on the ballot. The nominee with the highest number of affirmative cast votes is elected to office. Results of the elections will be announced subsequently, and officers will take office on January 1.

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 shall be entitled to a Joint Conference pursuant to Section 17.1.

9.4 ROLES AND RESPONSIBILITIES OF OFFICERS

9.4.1 Chief of Staff.

Role.

- a. Ensure that the Medical Staff carries out its responsibility for the quality and safety of the medical care delivered to the patients of the Hospital.
- b. Serve as primary liaison officer between the Medical Staff, the Administration and the Board and be responsible for the organization and conduct of the Medical Staff.

Responsibilities.

- a. Call and preside at all meetings of the Medical Executive Committee and general meetings of the Medical Staff.
- b. Subject to approval of the Medical Executive Committee, create and appoint the members and chair of non-standing committees of the Medical Staff to accomplish specific tasks, after which the committee shall disband automatically.
- c. Carry out Medical Executive Committee assignments.
- d. Report relevant actions of the Medical Executive Committee to the Medical Staff.
- e. Serve as ex officio member of all Medical Staff committees of which not a voting member.
- f. Be responsible for the enforcement of Medical Staff Bylaws, Department Rules and Regulations, and Medical Staff Policies.
- g. Serve as a voting member of the System Physician Leadership Council and the Medical Executive Committee.

9.4.2 Vice-Chief of Staff.

The Vice-Chief of Staff shall:

- a. Assume all of the duties of the Chief of Staff in the Temporary Absence of the Chief of Staff.
- b. Fill a vacancy in the office of Chief of Staff as provided in Section 9.7.
- c. Assume those duties and responsibilities delegated by the Chief of Staff.

- d. Be a voting member of the Medical Executive Committee and of the System Physician Leadership Council.

9.4.3 Secretary/Treasurer of the Medical Staff.

The Secretary/Treasurer of the Medical Staff shall:

- a. Record or cause to be recorded complete and accurate minutes of all general meetings of the Medical Staff and the Medical Executive Committee.
- b. Oversee collection of annual dues as described in Medical Staff Policies.
- c. Oversee the keeping of accurate accounts of Medical Staff funds.
- d. Oversee payment of the financial obligations of the Medical Staff after approval of the Medical Executive Committee or as directed by Medical Staff Policy.
- e. See that the books of the Medical Staff are submitted for accounting review and/or audit as directed by the Medical Executive Committee.
- f. Assume the duties and responsibilities of the Chief of Staff during the simultaneous Temporary Absence of the Chief of Staff and Vice-Chief of Staff.
- g. Be a voting member of the Medical Executive Committee.

9.4.4 Member(s)-at-Large.

Each Member-at-Large, if any, shall:

- a. Provide advice and counsel, upon request, to the other Medical Staff officers.
- b. Be a voting member of the Medical Executive Committee.

9.5 TENURE OF OFFICERS

The term for each officer shall be two (2) years. Each officer shall assume office on January 1. The Chief of Staff and Vice-Chief of Staff may not be reelected to a successive term unless it occurs by a two-thirds (2/3rds) supermajority vote. The Chief of Staff and Vice-Chief of Staff may only be elected to one (1) successive term. The Secretary/Treasurer and Member(s)-at-Large may be elected to two (2) successive terms, for a total of six (6) years. Any officer may run again for the same position after having not been an officer for one two-year cycle. An officer seeking to run for a different position may do so immediately. Each officer shall serve in office until the end of their term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

9.6 REMOVAL OF OFFICERS

9.6.1 The Medical Staff may recall any officer of the Medical Staff under either of the following conditions:

- a. If the officer ceases to be a member of an appropriate Medical Staff category specified in Section 9.2, then he/she shall be deemed to be automatically removed from office. A successor shall be identified as provided in Section 9.7.
- b. The members of the Medical Staff may request removal (1) for breach of responsibilities outlined in Section 9.4, or (2) by vote of no confidence, utilizing the following procedure:

Removal of an officer during his/her term of office may be proposed by a petition that states the ground(s) for removal, bears the signatures of at least 25 percent of the voting members of the Medical Staff, and is filed with the Medical Executive Committee. The petition shall be presented to the next meeting of the Medical Executive Committee, which shall verify the signatures and the requisite number. If the petition complies with this Section 9.6.1, the Medical Executive Committee shall instruct the Secretary to send a mail or electronic ballot to each voting member of the Medical Staff, which ballot shall be returnable to the

Chief of Staff (or to the Vice Chief of Staff, if the Chief of Staff is the subject of the petition) not more than 20 days after the date of issuance. The ballot shall be in the following form:

“A petition has been received to recall Dr. _____ as _____ of the Medical Staff due to _____. Shall Dr. _____ be recalled as _____ of the Medical Staff:

Yes ___ No _____. Vote, and return this ballot to the Chief of Staff [or Vice Chief of Staff, if applicable] on or before _____.”

The Chief of Staff shall present the ballots to the Medical Executive Committee at its next meeting following the date of the recall election and they shall be counted by two tellers appointed by the Medical Executive Committee. If more than 50% percent of the total number of members of the Medical Staff who are eligible to vote, vote for the recall, such officer shall be deemed as recalled and relieved of his/her duties as of the date of such Medical Executive Committee meeting. Medical Staff members shall be notified of this action. A successor shall be identified as provided in Section 9.7.

9.6.2 The Board may, at any time, provided it has first held a Joint Conference pursuant to Section 17.1 with the Medical Executive Committee, remove any officer of the Medical Staff if the Board determines such officer is not satisfactorily performing his/her obligations under these Bylaws, applicable Medical Staff Policy, or Department Rules and Regulations.

9.7 VACANCIES

In the event of the death, resignation, recall or disqualification of the Chief of Staff, the Vice Chief of Staff shall assume the Chief of Staff role. If the Vice Chief of Staff replaces the Chief of Staff, the MEC will determine whether to appoint or hold elections to fill the Vice Chief position. In the event of the death, resignation, recall or disqualification of an officer other than the Chief of Staff, the remaining Medical Staff officers will make recommendations to the Medical Executive Committee and the Medical Executive Committee shall appoint an interim successor who will serve until an individual is duly nominated and elected at the time of the next regular election.

9.8 ABSENCES OF MEDICAL STAFF OFFICERS

In the event of a simultaneous Temporary Absence of the Chief of Staff, Vice-Chief of Staff and Secretary/Treasurer, the Chief of Staff will designate a member of the MEC to assume the appropriate duties.

ARTICLE X. MEDICAL STAFF FUNCTIONS AND COMMITTEES

10.1 MEDICAL STAFF FUNCTIONS

Required functions of the Medical Staff may, subject to approval by the System Physician Leadership Council (with respect to multi-Hospital matters), the Medical Executive Committee (with respect to single-Hospital matters), or the Board, be carried out through assignment to the Departments, Medical Staff committees, interdisciplinary Hospital committees, multi-Hospital committees, Physician Advisors, or other Medical Staff members who have been delegated such responsibility. Medical Staff functions include:

10.1.1 Quality.

The quality review and improvement functions of the Medical Staff shall include the following:

- a. Conduct or coordinate evaluations and investigations relating to (1) Medical Staff initial appointments, reappointments and (2) Delineated Clinical Privileges.
- b. Review and evaluate medical records for appropriate medical record practices.
- c. Develop and maintain surveillance over drug utilization policies and practices.
- d. Investigate and control nosocomial infections and monitor the Hospital's infection control program.

- e. Conduct blood usage review for evaluation of transfusion appropriateness, transfusion reactions, and policies and procedures related to use and administration of blood and blood components.
- f. Conduct surgical case reviews and invasive procedure evaluations for appropriateness and opportunities for quality improvement activities.
- g. Conduct or coordinate utilization review activities.
- h. Where relevant, provide clinical oversight for participants in professional graduate education programs.
- i. 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 System Physician Leadership Council, Medical Executive Committee and/or the Board.
- j. Ensure appropriate on call coverage for the Emergency Department and inpatient consults.

10.1.2 Communication & Coordination with Governance and Administration.

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

- a. Serve as primary means for accountability to the Board for appropriateness of professional performance and ethical conduct of each member of the Medical Staff and each Advanced Practice Professional and other practitioners who are credentialed and granted Delineated Clinical Privileges.
- b. Direct Medical Staff organizational activities, including 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.
- c. Coordinate care provided by the Medical Staff with the care provided by other Hospital patient care and administrative services.

10.2 APPOINTMENT AND TERMINATION OF COMMITTEES AND PHYSICIAN ADVISORS

- 10.2.1** Medical Staff members shall be appointed to Medical Staff committees in accordance with these Bylaws. Any Medical Staff committee appointment not expressly addressed in these Bylaws shall be made (a) by the System Physician Leadership Council (if the committee performs a multi-Hospital function) or (b) by the Chief of Staff, in consultation with the System Physician Leadership Council Chair (if the committee performs a single-Hospital function). Physician Advisors are appointed and terminated by the Chair of the System Physician Leadership Council and shall report to the System Physician Leadership Council.
- 10.2.2** Medical Staff members of all committees must remain members in good standing of a Medical Staff category whose members are 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.
- 10.2.3** The Medical Staff members of committees with joint responsibility to both the Medical Staff and Administration shall be appointed by the System Physician Leadership Council (if the committee performs a multi-Hospital function), or by the Chief of Staff, in consultation with the System Physician Leadership Council Chair (if the committee performs a single-Hospital function), and in all cases in consultation with the President. These committees will have reporting responsibility to both the Medical Staff and Administration.

10.3 REQUIRED COMMITTEES

The required Medical Staff committees are:

- a. System Physician Leadership Council
- b. Medical Executive Committee

- c. Credentials Committee
- d. Physicians Provider Assistance Committee
- e. Bylaws Committee
- f. Professional Practice Evaluation Committee

10.4 SYSTEM PHYSICIAN LEADERSHIP COUNCIL

10.4.1 Composition.

The System Physician Leadership Council shall be composed of:

Voting Members:

- a. Chief of Staff of each Hospital
- b. Vice-Chief of Staff of each Hospital
- c. System Department Chairs

Ex-officio (Non-Voting) Members:

- a. President
- b. Chief Medical Officer
- c. Chair, Credentials Committee
- d. Administrator designated by St. Joseph Mercy Ann Arbor Hospital
- e. Administrator designated by St. Joseph Mercy Livingston Hospital
- f. Chief, Clinical Decision Services.

Ad Hoc Members:

The voting members listed above may, from time to time, appoint one or more non-voting members to serve for a time-limited period.

10.4.2 Chair.

The voting members of the System Physician Leadership Council shall elect a chair of the Council from among the Chiefs of Staff who serve on the System Physician Leadership Council. The Chair shall be elected for a one-year term. An individual may be elected as chair of the Council for more than one consecutive term.

10.4.3 Purpose and Function.

The Council shall promote consistency of standards within the Hospitals and reduce duplication of effort by the individual Medical Staffs. The function of the System Physician Leadership Council shall be to provide a forum for elected physician leadership to discuss and resolve multi-Hospital integration issues relating to quality of patient care, credentialing, policies and procedures and the Medical Staff Bylaws. The Council's main responsibilities include:

- a. Strive to promote consistency and improve the quality of patient care delivered at the Hospitals;
- b. Develop and oversee the organization of Departments, as further described in Article VIII of these Bylaws;
- c. Establish Medical Staff dues and other special assessments; and

- d. Resolve any disagreements or discrepancies between the Medical Executive Committees. This includes issues regarding but not limited to:
 1. DOP forms and criteria for granting Delineated Clinical Privileges, and Credentialing Policies and Procedures.
 2. Activities of multi-Hospital Medical Staff committees and task forces, including the Credentials Committee.
 3. Medical Staff Multi-Hospital Policies.

10.4.4 Voting.

The vote of two-thirds of all voting members of the System Physician Leadership Council, with a minimum of two voting members from each Hospital, is required to take action. If the Medical Executive Committee of a Hospital disagrees with an action of the System Physician Leadership Council, the issue will be reexamined by the System Physician Leadership Council if a simple majority of the System Physician Leadership Council's voting members vote to reexamine the issue. If the System Physician Leadership Council declines to reexamine an issue or a Medical Executive Committee continues to disagree with the System Physician Leadership Council's final decision on the matter after reexamination, the Medical Executive Committee may request a joint conference, in which case a procedure comparable to that described in Section 17.1 of these Bylaws will be utilized except the participants shall be the System Physician Leadership Council and applicable MEC(s).

10.4.5 Meetings.

The System Physician Leadership Council shall meet as needed, and shall maintain a record of its proceedings and actions.

10.5 HOSPITAL MEDICAL EXECUTIVE COMMITTEE

10.5.1 Composition.

The Medical Executive Committee shall be composed of:

Voting Members:

- a. Chief of Staff (serves as Chair)
- b. Immediate-Past Chief of Staff (for one year for continuity)
- c. Vice-Chief of Staff
- d. Secretary/Treasurer of the Medical Staff
- e. Member(s)-at-Large (where applicable)
- f. Local Chairs of the Medical Staff Departments
- g. Others as approved by the Medical Executive Committee

Members serving in more than one capacity shall have a single vote only.

Ex-Officio (non-voting) Members:

- a. President

- b. System Department Chairs.¹

Guests (non-voting):

Other individuals serving in specific roles may be invited to attend Medical Executive Committee meetings with approval of the Committee.

10.5.2 Function.

The Medical Executive Committee shall fulfill the following Hospital-specific duties and responsibilities (the duties delegated to the Medical Executive Committee pursuant to these Bylaws may be modified by amending these Bylaws in accordance with Article XVI):

- a. Represent and act on behalf of the Medical Staff;
- b. Coordinate activities and general policies of the Medical Staff;
- c. Receive and act upon reports from committees, Physician Advisors, and others assigned specific function(s), including reports from the Designated Institutional Officer regarding GME activities;
- d. Evaluate and recommend proposed Medical Staff Policies and implement adopted Medical Staff Policies to the Board
- e. Review and recommend Department Rules and Regulations, DOP forms and criteria for granting Delineated Clinical Privileges to the Board;
- f. Ensure that each Department regularly reviews the medical care rendered by its members and by APPs assigned to the Department;
- g. Provide communication between the Medical Staff and the President;
- h. Recommend action to the President on medico-administrative matters;
- i. Ensure the Medical Staff is informed of the accreditation program and accreditation status of the Hospital;
- j. Fulfill the Medical Staff organization's accountability to the Board for the medical care rendered to patients in the Hospital, including receiving reports from the Credentials Committee and other committees regarding Medical Staff credentialing, FPPE, OPPE, and disciplinary proceedings and make recommendations to the Board regarding appointment, reappointment, and Delineated Clinical Privileges and disciplinary actions;
- k. Ensure ethical conduct and competent clinical performance of each member of the Medical Staff and each Advanced Practice Professional and other practitioners who are credentialed and granted Delineated Clinical Privileges, and initiate or participate in disciplinary measures as warranted;
- l. Conduct other functions necessary for the effective operation of the Medical Staff;
- m. Where applicable, report to the Medical Staff any recommendations made by the Medical Executive Committee;
- n. Receive regular communication about the safety and quality of care provided by, and supervisory needs of, the participants in accredited professional graduate education programs and communicate periodically to the Board about educational needs and performance of participants in these programs; and
- o. Ensure appropriate on-call coverage for the Emergency Department and inpatient consults.

¹ If (a) a System Department Chair performs the functions of local department chair at the Hospital and (b) five (5) or more members of the Department are voting members of the Medical Staff at the Hospital, the System Department Chair shall serve on the MEC with vote; otherwise, the System Department Chair is a non-voting member of the MEC.

Subcommittees may be appointed to carry out functions (excluding credentialing and privileging) on behalf of the MEC as deemed appropriate by the MEC.

10.5.3 Meetings.

The Medical Executive Committee shall meet monthly or less frequently as needed, shall maintain a record of its proceedings and actions, and shall make available a copy of the record of all its meetings to the Chair of the System Physician Leadership Council.

10.6 CREDENTIALS COMMITTEE

The Credentials Committee is the multi-Hospital body to which Medical Staff and APP credentialing functions are delegated as specified in these Bylaws and in the Credentialing Policies and Procedures.

10.6.1 Composition.

Unless otherwise determined by the Board, the Credentials Committee shall be composed of no less than five (5) and no more than eleven (11) Physicians, each of whom is a member of the Medical Staff of at least one Hospital, and four (4) APPs. Members of the Committee serve a three-year term. At a minimum, the composition of the Committee shall include the following:

- a. One (1) Physician recommended by the St. Joseph Mercy Livingston Medical Executive Committee and appointed by the Board.
- b. Three (3) Physicians recommended by the St. Joseph Mercy Ann Arbor Medical Executive Committee and appointed by the Board.
- c. One (1) Physician, who shall serve as Chair, recommended by the System Physician Leadership Council in collaboration with other members of the Credentials Committee, then recommended by the Medical Executive Committee at each Hospital and approved by the Board.
- d. Four (4) APPs recommended by the Director of Mid-Level Providers and approved by the MEC and Board.

Each Committee member has one vote. A majority of the members of the Committee constitutes a quorum. The affirmative vote of a majority of the members present at a meeting at which a quorum is present is required for Committee action.

10.6.2 Functions.

The main responsibilities of the Credentials Committee include:

- a. Review the completed application file for each applicant to determine eligibility for Medical Staff membership and/or Delineated Clinical Privileges, as applicable;
- b. Recommend to the Medical Executive Committee action on all requests for Medical Staff membership and/or Delineated Clinical Privileges;
- c. Process and make recommendations regarding Leaves of Absence and resignations;
- d. Periodically review and make recommendations to the Medical Executive Committees regarding criteria for the evaluation of applicants for Medical Staff membership and/or for Delineated Clinical Privileges, and regarding Delineation of Privileges ("DOP") forms used by the Departments; receive recommendations from Medical Executive Committee on these matters;
- e. Review and make recommendations to the Medical Executive Committees regarding all Credentialing Policies and Procedures and forms for the credentialing process; and
- f. Perform such other functions as specified in the Credentialing Policies and Procedures or Medical Staff Policies and approved by the Medical Executive Committees.

10.7 PHYSICIANS PROVIDER ASSISTANCE COMMITTEE

10.7.1 Composition.

The Physicians Provider Assistance Committee shall be composed of Physicians and other categories of health care professionals from Trinity Health- Michigan hospitals and shall include at least one Medical Staff member from each Hospital. The Medical Staff members and individual Committee members shall be appointed by the Chiefs of Staff of the Hospitals with concurrence of the System Physician Leadership Council. The number of members and length of time in office are unlimited. Appointed members may be removed and vacancies filled by the relevant Chief of Staff with concurrence of the System Physician Leadership Council.

10.7.2 Function.

The Committee shall serve as an ongoing peer review entity and provide a confidential, voluntary mechanism for identification, confrontation, recommendation for rehabilitation, and coaching and monitoring of Medical Staff members and Advanced Practice Professionals who may come under the Committee's jurisdiction consistent with Medical Staff and Hospital policy and procedures. The specific duties of the Committee are to (1) support provider health/wellness, (2) support safe patient and community medical care in the Hospital, (3) develop and support policies applicable to the Medical Staff and/or Hospital for ongoing wellness and patient safety, and (4) adherence with current State of Michigan and Federal regulatory requirements involving issues of impairment or behavior.

The Committee shall not serve as an investigative or disciplinary body. Nothing precludes this Committee from making a referral to another Medical Staff committee or the MEC for review. Any request for investigation or action with respect to any Medical Staff member or APP will be referred to the MEC in accordance with Article VII of the Medical Staff Bylaws.

10.7.3 Meetings.

The Committee shall meet as necessary and report directly to the Chiefs of Staff. The Committee shall provide an annual summary report to the MEC that does not include any provider specific data.

10.8 BYLAWS COMMITTEE

10.8.1 Composition.

The Bylaws Committee shall be composed of Active members of each of the Medical Staffs and others as may be deemed appropriate by the System Physician Leadership Council and appointed by the Medical Executive Committees. There shall be a minimum of 5 members and length of time in office is unlimited. Appointed members may be removed and vacancies filled by the relevant Medical Executive Committee.

10.8.2 Function.

The Committee shall review the Medical Staff Bylaws periodically, but not less often than every two years, and recommend appropriately worded amendments to the Medical Staff through each of the Medical Executive Committees. Any change to the Medical Staff Bylaws must be approved by vote of the Medical Staffs, as described in Section 16.2.2, in order for such change to be effective. As stated in Section 16.2.1, requests for such action may originate in a variety of ways. The Bylaws Committee may also consider questions of interpretation and application of the Bylaws and will function, with the System Physician Leadership Council, as the conference committee should there be differences in the bylaw language desired by Hospitals.

10.8.3 Meetings.

The Bylaws Committee shall meet as necessary, but no less than biennially, and shall provide written reports of each meeting to the Hospital Medical Executive Committees.

10.9 PROFESSIONAL PRACTICE EVALUATION COMMITTEE**10.9.1 Composition.**

The Professional Practice Evaluation Committee shall be composed of

Voting Members:

- a. Co-Chair: Chief of Staff Ann Arbor
- b. Co-Chair: Chief of Staff Livingston
- c. Vice Chair Surgery
- d. Vice Chair Medicine
- e. Vice Chair Emergency Medicine
- f. Credentials Chair
- g. Director Quality Safety and Risk
- h. Director Medical Staff Services
- i. Department Representatives - Ann Arbor & Livingston (rotation of 3)

Non-Voting Members:

- a. Chief Quality Officer
- b. Ad hoc when clinical or other specialized expertise is required

10.9.2 Function.

The Committee oversees the professional practice evaluation process, conducts case reviews, and develops performance improvement plans. The Committee shall review all issues referred by the Department Chair and determine when further review or action is required in accordance with the Medical Staff Policies.

10.9.3 Meetings.

The Committee shall meet as necessary and report directly to the Chiefs of Staff.

10.9.4 Voting.

A quorum shall be defined as 50% of the voting members of the Committee. 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 Committee. The Committee shall report matters to MEC, Chief of Staff, Chief Medical Officer and/or CEO as warranted, for review and consideration when circumstances warrant further review or action. Any request for corrective action, suspension or restriction of a Practitioner's clinical privileges shall be conducted in accordance with Article VII of the Medical Staff Bylaws.

ARTICLE XI. MEETINGS**11.1 REGULAR MEDICAL STAFF MEETINGS**

A general meeting of the Medical Staff shall be held at least once annually. A notice of the annual meeting and of other general meetings of the Medical Staff, if any, shall be provided to the Medical Staff via the regular channels of communication.

11.2 SPECIAL MEDICAL STAFF MEETINGS

The Chief of Staff, Medical Executive Committee or System Physician Leadership Council may call a special meeting of the Medical Staff at any time. Additionally, the Chief of Staff shall call a special meeting upon receipt of a written request for such a meeting by 5% of the voting members of the Medical Staff. Such request shall state the purpose of the meeting. The agenda and purpose for any special meeting shall be included in notices provided to the Medical Staff via the regular channels of communication. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

11.3 DEPARTMENT MEETINGS AND ACTIVITIES

Departments or sections of a department shall conduct clinical quality of care meetings and/or activities, the format and frequency of which shall be specified in the Department Rules and Regulations. Departmental business meetings may be held as defined in Department Rules and Regulations. Complete and accurate documentation shall be kept of both business and quality meetings/activities.

11.4 CALLING MEDICAL STAFF COMMITTEE MEETINGS AND DEPARTMENT/SECTION MEETINGS

Committees, Departments and Sections may, by resolution, establish the time for holding regular meetings without additional notice other than such a resolution. A special meeting of any Department, Section or Committee may be called by the chair of the body (the System Chair in the case of an entire Department, and the Local Chair in the case of the Department members at the Applicable Hospital for a purpose provided in Section 8.6), and shall be called by the chair at the request of not less than 10% of the voting members of said body.

11.5 ATTENDANCE

11.5.1 All Medical Staff members are encouraged, but not required, to attend meetings of the Medical Staff.

11.5.2 All members of a Medical Staff Committee are expected to participate in at least 50% of the Committee's meetings and other activities.

11.5.3 Active members of a Department or Section are expected to comply with any participation and meeting attendance requirements stated in the Department Rules and Regulations. Information regarding individual Medical Staff member attendance at Department meetings and participation in Department activities will be reviewed by the Local Department Chair for information during reappointment, if applicable.

11.5.4 Further details of these participation and attendance expectations and requirements may be described in the Medical Staff Policies and Department Rules and Regulations.

11.6 QUORUM AND MANNER OF ACTION**11.6.1 Meetings of the Medical Staff.**

A quorum shall be defined as 25% of the Active members of the Medical Staff. 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 Medical Staff, unless otherwise expressly stated in these Bylaws.

11.6.2 Medical Staff Committees.

A quorum shall be defined as 50% of the voting members of a Committee. 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 Committee, unless otherwise expressly stated in these Bylaws.

11.6.3 Departments.

The quorum and voting standards for Departments and Sections shall be defined in the Department's Rules and Regulations.

11.7 RECORDS

Records of the proceedings and actions taken at each meeting of the Medical Staff, as well as at Medical Staff Committee and Department/Section meetings, shall be maintained by the respective body and shall include a record of the attendance of members and the votes taken on each matter.

11.8 RULES OF ORDER

The latest edition of "Rules of Order" by James E. Davis, M.D. shall prevail at all meetings of the Medical Staff, Committees, Departments and Sections unless waived, except:

- 11.8.1** the chairperson of any meeting may vote;
- 11.8.2** in the case of a tie vote in a Medical Staff election, a second ballot shall be taken and if said ballot does not break the tie, then the matter shall be forwarded to the Medical Executive Committee for final resolution; and
- 11.8.3** these Bylaws shall control over any contrary provision of said Rules of Order.

ARTICLE XII. MEDICAL STAFF BILL OF RIGHTS

- 12.1** Every member of the Medical Staff has the right to meet with the Medical Staff officers. An issue that is not resolved by such a meeting will be brought to the Medical Executive Committee at the request of the Medical Staff member who raised the issue.
- 12.2** Any voting member of the Medical Staff has the right to initiate a recall of an officer of the Medical Staff in accordance with Section 9.6, recall of a System Department Chair in accordance with Section 8.5.4, or recall of a Local Department Chair in accordance with Section 8.6.4.
- 12.3** Any voting member of the Medical Staff has the right to call for a special Medical Staff meeting in accordance with Section 11.2, or a Department meeting in accordance with Section 11.4. Special meetings may be called, among other purposes, as a forum in which the Medical Staff and the MEC may discuss and attempt in good faith to resolve, differences of opinion regarding issues such as Medical Staff Policies.
- 12.4** Voting members of the Medical Staff may pursue amendment or repeal of a Medical Staff Policy or these Bylaws in accordance with Article XIII, XIV or XVI, as applicable.
- 12.5** Any Medical Staff member has the right to Due Process in all circumstances outlined in Section 18.2.1. Sections 12.1, 12.2, 12.3, and 12.4 do not pertain to the rights and issues covered in Section 3.4.3 (Ethical and Religious Directives and Ethical Relationships) and the protections therein will not be employed to address matters described in Section 3.4.3.

ARTICLE XIII. MEDICAL STAFF MULTI-HOSPITAL POLICIES

- 13.1** The Medical Staff delegates to the Medical Executive Committees the right to formulate Medical Staff Multi-Hospital Policies consistent with the Medical Staff Bylaws, that are necessary for the conduct of the work of the Medical Staff.
- 13.2** Either the Medical Staff (by means of a petition signed by 5% of the aggregated voting members of the Medical Staffs) or the Medical Executive Committee may propose adoption, change or repeal of Medical Staff Multi-Hospital Policies that are consistent with these Bylaws. Administration may also submit proposed Medical Staff Multi-Hospital Policies to the Medical Executive Committees for approval that are deemed necessary to meet requirements of regulatory agencies or to comply with federal or state law. Medical Staff Multi-Hospital Policies provide additional detail and procedures relating to subjects addressed in these Bylaws and are effective upon Board approval. Neither the Medical Executive Committees,

System Physician Leadership Council, the Medical Staffs, nor the Board may unilaterally adopt or amend a Medical Staff Multi-Hospital Policy.

- 13.3** Any proposed Medical Staff Multi-Hospital Policies, including Credentialing Policies and Procedures, shall be introduced at a meeting of the Medical Executive Committee, along with any relevant documentation. A copy of all such proposals shall be provided to the other Medical Executive Committee for consideration. The proposal shall be voted upon at the next regularly scheduled meeting by each Medical Executive Committee. Any disagreements or discrepancies between the Medical Executive Committees regarding a proposed Medical Staff Multi-Hospital Policy, which remain unresolved after two regularly scheduled meetings of each MEC, shall be referred to the System Physician Leadership Council for resolution. Any Medical Staff Multi-Hospital Policy approved by the Board shall be communicated by the Medical Executive Committees to the Medical Staffs via regular channels of communication.
- 13.4** If the Medical Staffs (by means of a petition signed by 5% of the aggregated voting members of the Medical Staffs) propose adoption, amendment or repeal of a Medical Staff Multi-Hospital Policy, the proposal shall be submitted, in writing, to Medical Staff Services which will promptly review the proposal and initiate any applicable research, meetings, gathering of data and/or legal opinions deemed reasonable and necessary. Medical Staff Services will typically complete this process and forward the proposed policy to the Medical Executive Committees within sixty days after Medical Staff Services receives a proposal. Each Medical Executive Committee shall review the proposal and any comments received and recommend its adoption or rejection. Each Medical Executive Committee will typically make its recommendation within thirty days after receiving the proposal from Medical Staff Services. Medical Staff Services shall distribute the proposed policy and relevant documentation (including the Medical Executive Committees' recommendation) to the voting members of the Medical Staffs by direct mailing or electronically for a vote. Included with the proposed policy shall be a ballot to be returned within two months from the date of issuance which shall indicate the Medical Staff member's recommendation for approval or disapproval of the proposal. If a simple majority of the completed ballots recommend approval of the policy proposal, this shall be forwarded, as the Medical Staffs' recommendation, to the Board for final approval. If a simple majority of the completed ballots are not in favor of the proposal, the proposal expires. Any such policy proposal that is adopted by the Medical Staffs shall be submitted to the Board for approval.

ARTICLE XIV. MEDICAL STAFF HOSPITAL-SPECIFIC POLICIES

- 14.1** The Medical Staff delegates to the Medical Executive Committee the right to formulate and approve Medical Staff Hospital-Specific Policies, consistent with the Medical Staff Bylaws, that are necessary for the conduct of the work of the Medical Staff.
- 14.2** Either the Medical Staff (by means of a petition signed by 5% of the voting members of Medical Staff) or the Medical Executive Committee may propose adoption, change or repeal of Medical Staff Hospital-Specific Policies that are consistent with these Bylaws. Administration may also submit proposed Medical Staff Hospital-Specific Policies to the Medical Executive Committee for approval that are deemed necessary to meet requirements of regulatory agencies or to comply with federal or state law. Medical Staff Hospital-Specific Policies provide additional detail and procedures relating to subjects addressed in these Bylaws and are effective upon Board approval. Neither the System Physician Leadership Council, Medical Executive Committee, Medical Staff, nor the Board may unilaterally adopt or amend a Medical Staff Hospital-Specific Policy.
- 14.3** Medical Staff Hospital-Specific Policies proposed by or to the Medical Executive Committee shall be introduced at one meeting of the Medical Executive Committee, along with any relevant documentation, and voted upon at the next regularly scheduled Medical Executive Committee meeting. Any Medical Staff Hospital-Specific Policy approved by the Medical Executive Committee shall be communicated by the Medical Executive Committee to the Medical Staff via regular channels of communication.
- 14.4** If the Medical Staff (by means of a petition signed by 5% of the voting members of the Medical Staff) proposes adoption, amendment or repeal of a Medical Staff Hospital-Specific Policy, the proposal shall be submitted, in writing, to Medical Staff Services which will promptly review the proposal and initiate any applicable research, meetings, gathering of data and/or legal opinions deemed reasonable and necessary. Medical Staff Services will typically complete this process and forward the proposed policy to the Medical Executive Committees within sixty days after Medical Staff Services receives a proposal. The Medical

Executive Committee shall review the proposal and recommend its adoption or rejection. Each Medical Executive Committee will typically make their recommendations within thirty days after receiving the proposal from Medical Staff Services. Medical Staff Services shall distribute the proposed policy and relevant documentation (including the Medical Executive Committee's recommendation) to the voting members of the Medical Staff by direct mailing or electronically for a vote. Included with the proposed policy shall be a ballot to be returned within two months from the date of issuance which shall indicate the Medical Staff member's recommendation for approval or disapproval of the proposal. If a simple majority of the completed ballots recommend approval of the policy proposal, this shall be forwarded, as the Medical Staff's recommendation, to the Board for final approval. If a simple majority of the completed ballots are not in favor of the proposal, the proposal expires. Any such policy proposal that is adopted by the Medical Staff shall be submitted to the Board for approval.

ARTICLE XV. CONFIDENTIALITY, IMMUNITY AND RELEASES

15.1 CONFIDENTIALITY OF MEDICAL RECORDS AND PEER REVIEW COMMITTEE MATERIALS

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. Records, data and knowledge collected by or for Medical Staff departments, sections and committees, by joint Hospital-Medical Staff, Hospital, or multi-Hospital committees, by Medical Staff Officers, System or Local Department Chairs, or Section Chairs, according to the Credentialing Policies and Procedures, or otherwise by individuals or committees assigned a quality assurance or professional practice function in the Hospital(s) for the purpose of reducing morbidity or improving the care provided to patients, are privileged and confidential and are to be used only for the purpose for which they are intended. The use of such information by Medical Staff members for any purpose other than those stated in these Bylaws, shall be grounds for discipline by the Medical Staff and may include expulsion from the Medical Staff.

Pursuant to the provisions of State law, the records, data, and knowledge collected for or by individuals or committees assigned such review function are confidential, shall not be made public records, and shall not be available for court subpoena.

15.2 RELEASE OF INFORMATION

All applicants, as well as members of the Medical Staff, and practitioners who seek or obtain Delineated Clinical Privileges consent to the release of information for any purpose set forth in these Bylaws, in the Credentialing Policies and Procedures, in other Medical Staff Policy or in the application form. All applicants and members absolutely release from liability and agree to hold harmless any person or entity furnishing or releasing such information concerning his/her application or Medical Staff status or exchanging such information as allowed by the documents referred to in this Section 15.2.

Any report, information, or accusation filed, or any action recommended by any agent or committee of the Medical Staff or the Board shall be deemed a privileged communication. Each applicant for membership on the Medical Staff or for Delineated Clinical Privileges and each member of the Medical Staff and other practitioner granted Delineated Clinical Privileges absolutely waives any right of personal redress against any individual member of the Medical Staff, the Medical Executive Committee, any Hearing Committee, the System Physician Leadership Council, the Board, any Hearing Officer or Appeals Officer, or any other agent or committee of the Board or Medical Staff, for any communication, and any participation in any action or recommendation that is adverse to said individual.

15.3 CONTRACTUAL LIABILITY

Neither these Bylaws, nor rules, regulations and policies promulgated pursuant to these Bylaws constitute a contract; therefore they do not entitle any individual to claim contract rights.

ARTICLE XVI. AMENDMENT AND ADOPTION

16.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staffs have the responsibility to formulate, adopt and recommend their Bylaws and amendments which will be effective when approved by vote of the Medical Staffs and the Board. Such responsibility and authority will be exercised in good faith and in a reasonable, timely and responsible manner reflecting the interests of providing quality patient care and of maintaining a harmony of purpose and effort with the Administration, Board and community. These Bylaws shall be reviewed by the Bylaws Committee for compliance with applicable regulatory and accreditation standards and Medical Staff practices, at the intervals stated in Section 10.5.2 or at any time that recommended revisions are warranted; in addition, proposed Bylaw amendments may originate from the other sources described in Section 16.2.1.

16.2 AMENDMENT PROCEDURE

These Bylaws may be amended in the manner described below.

16.2.1 Origination.

Proposed changes shall be directed to the Bylaws Committee. They may originate by one of the following means:

- a. From any of the Medical Executive Committees.
- b. From the Board.
- c. From any of the Chiefs of Staff.
- d. From the Bylaws Committee itself.
- e. From the System Physician Leadership Council.
- f. By a written petition forwarded to the Bylaws Committee signed by 5% of the aggregated voting members of the Medical Staffs.

The Bylaws Committee shall promptly review all proposed Bylaw amendments and shall forward the proposal, as well as the Committee's comments regarding the proposal, to the Medical Executive Committees, typically within sixty days after the Bylaws Committee receives the proposal.

16.2.2 Review and Action on Proposed Bylaw Amendments.

- a. All proposed amendments shall be reviewed by the Medical Executive Committees, which shall recommend that the proposed amendment be adopted or rejected. The Medical Executive Committees will typically act on a proposed Bylaw amendment within thirty days after receiving the proposal from the Bylaws Committee.
- b. If voted down by any of the Medical Executive Committees, the proposed amendment expires unless (1) the amendment was proposed by the System Physician Leadership Council pursuant to 16.2.1.e, or (2) the amendment was proposed by voting members of the Medical Staffs pursuant to Section 16.2.1.f.
- c. If (1) the Medical Executive Committees recommend approval of a proposed Bylaw amendment, or (2) the amendment was proposed by the System Physician Leadership Council or by voting members of the Medical Staffs pursuant to Section 16.2.1(e) or (f), then the proposed amendment, including a statement of the reason for the amendment, shall be distributed by direct mailing or electronically to all voting members of the Medical Staffs for their review.
- d. Included with the proposed amendment shall be a ballot to be returned within two months from the date of issuance which shall indicate the Medical Staff member's recommendation for approval or disapproval of the proposed amendment. This time frame will allow for discussion among individual members and for placement as an agenda item for discussion at Departmental meetings if deemed necessary by the System Department Chair.

- e. If a simple majority of the completed ballots recommend approval of the amendment, this shall be forwarded, as the Medical Staffs' recommendation, to the Board for final approval. If a simple majority of the completed ballots are not in favor of the proposed amendment, the proposal expires.

16.2.3 Action by the Board.

Amendments so recommended shall be effective when approved by the Board.

16.3 APPROVAL

These Bylaws shall replace any previous Medical Staff Bylaws and shall become effective when approved by vote of the Medical Staffs and the Board. They shall, when adopted and approved, be equally binding on the Board and the Medical Staffs.

ARTICLE XVII. JOINT CONFERENCE

- 17.1** If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee (relating to a matter within the MEC's jurisdiction) or by the System Physician Leadership Council, the Medical Executive Committee or System Physician Leadership Council, as applicable, is entitled to a Joint Conference between the officers of the Medical Staff and/or their designees and the Board. Such Joint Conference shall be for purposes of further communicating the Board's rationale for its contemplated action and to permit Medical Staff leaders to articulate fully the rationale for the Medical Executive Committee's or System Physician Leadership Council's recommendation. Such Joint Conference will be scheduled by the President within four weeks after receipt of a written request for same submitted by the Chief of Staff (in the case of a Medical Executive Committee request) or by the Chair of the System Physician Leadership Council (in the case of a System Physician Leadership Council request). The Board will furnish the other party to the Joint Conference with written notice of the Board's final decision.

ARTICLE XVIII. HEARING AND APPELLATE REVIEW PROCESS

18.1 DUE PROCESS

The Due Process rights of Medical Staff Members and of applicants for Medical Staff membership are governed by this Article XVIII. The hearing and appeal rights of APPs are governed by the Credentialing Policies and Procedures.

18.2 RIGHT TO A HEARING

18.2.1 Appealable Matters.

The affected Medical Staff member or applicant will be entitled to a hearing if (a) the Medical Executive Committee recommends any of the following actions or (b) the Board decides to take any of the following actions (and the Board's action was not preceded by a recommendation by the Medical Executive Committee to take one of the following actions):

- a. denial of Medical Staff membership;
- b. denial of Medical Staff reappointment;
- c. denial of requested initial or renewed Delineated Clinical Privileges;
- d. denial of requested increased Delineated Clinical Privileges;
- e. suspension or revocation of Medical Staff membership; reduction, limitation, suspension or revocation of Delineated Clinical Privileges;
- f. denial of a complete request for reinstatement from a leave of absence submitted by the deadline stated in Medical Staff Policy;

- g. an involuntary reduction in Medical Staff category or denial of a request to change Medical Staff category; or
- h. other material limitation of the right to provide direct patient care as previously authorized (such as requiring proctoring or consultation if the affected Medical Staff member is required to obtain consent of the proctor or consultant before patient care may be provided).

18.2.2 Non-Appealable Matters.

The affected Medical Staff member or applicant will not be entitled to a hearing as a result of a recommendation or action that is not listed in Section 18.2.1, including the following matters:

- a. voluntary resignation of Delineated Clinical Privilege(s) or Medical Staff membership, including expiration and failure to file an application for reappointment/renewal of Delineated Clinical Privileges by the deadline stated in the Credentialing Policies and Procedures, which shall continue to apply when a Medical Staff member is on a Leave of Absence;
- b. issuance of a written warning or a letter of reprimand;
- c. imposition of a consultation or proctoring requirement, if the affected Medical Staff member is not required to obtain consent of the consultant/proctor before patient care may be provided;
- d. imposition of an automatic suspension or termination pursuant to Section 7.4 of these Bylaws;
- e. imposition of a suspension or restriction of Delineated Clinical Privileges for a period no longer than fourteen (14) days pursuant to Section 7.2;
- f. imposition of an investigative suspension or restriction of Delineated Clinical Privileges pursuant to Section 7.3;
- g. denial of a request for, or termination of, temporary Delineated Clinical Privileges;
- h. denial of a request for a leave of absence (initial or extension), or imposition of conditions or limitations on a leave of absence;
- i. mandated education, that does not affect current Delineated Clinical Privileges;
- j. any action or recommendation (including those listed in Section 18.2.1) based on (1) the practitioner's failure to meet the written minimum objective criteria for the Delineated Clinical Privileges or Medical Staff status at issue, including failure to be involved in the care and treatment of the applicable threshold number of patients, or failure to obtain or maintain board certification; or (2) closure or limitation of a department or service by action of the Board, including the award of an exclusive contract;
- k. requiring a health assessment, report and/or treatment, as described in Section 7.1.5(d);
- l. a suspension due to violation of the Hospital's substance abuse policy unless the challenge to the suspension is based solely on the source of the specimen tested and/or to the accuracy of the test results based upon how (not why) the specimen was processed;
- m. any recommendation or action not "adversely affecting" (as such term is defined in the Health Care Quality Improvement Act) the applicant or Medical Staff member, or that is not based upon a subjective determination of the professional competence or conduct of the applicant or member; or
- n. appointment or reappointment, or the granting of Delineated Clinical Privileges, for a period less than twenty-four (24) months.

18.3 PRE-HEARING PHASE

18.3.1 Notice of Hearing Rights.

The Chief of Staff shall notify the practitioner by Special Notice of a recommendation or action that entitles the practitioner to a hearing. The notice shall state the following:

- a. The adverse recommendation or action.
- b. The reason(s) for the adverse recommendation or action.
- c. The practitioner's right to request a hearing.
- d. A summary of the practitioner's hearing rights.
- e. A time limit of thirty (30) days from the date of the practitioner's receipt of the notice within which the practitioner may submit a written request for a hearing to the Chief of Staff. The practitioner's request for a hearing shall state whether the practitioner will be represented at the hearing by either a member of the Medical Staff or an attorney. A practitioner who is subject to a summary suspension or whose term of appointment is likely to expire during Due Process, may request an early hearing as described in Section 18.3.2(a). Upon recommendation of the Medical Executive Committee, the Board may also approve a short-term reappointment for the practitioner subject to a final decision being rendered in the pending hearing process, not to exceed a period of ninety (90) days.

If the Chief of Staff does not receive a written request for a hearing from the practitioner within the 30-day deadline, the practitioner waives all right to such a hearing and appellate review. Copies of the Special Notice shall be sent to the President and to the Chief Operating Officer or designated administrator of each Hospital where the applicant or member holds or has applied for Delineated Clinical Privileges, the Chief of Staff of each Hospital where the individual holds or has applied for Delineated Clinical Privileges, the appropriate System Department Chair, and the appropriate Local Department Chair at each Hospital where the individual holds or has applied for Delineated Clinical Privileges, and the Chair of the Credentials Committee.

18.3.2 Notice of Scheduled Hearing; Witness Lists.

- a. Within sixty (60) days after receipt of a timely request for a hearing, the Chief of Staff shall notify the Appellant by Special Notice of the date, time and place of the hearing. Best efforts will be made to issue this notice of a scheduled hearing in fewer than sixty (60) days if the Appellant requested an early hearing pursuant to Section 18.3.1.
- b. The notice of the hearing shall be delivered at least thirty (30) days in advance of the scheduled hearing date (unless this time limit is mutually waived) and shall include a list of the witnesses, if any, expected to testify at the hearing on behalf of the Hospital; the Hospital shall supplement the list with a written list of the names of additional witnesses as they are determined.
- c. Not less than fourteen (14) days before the hearing, the Appellant shall furnish to the Chief of Staff a written list of the names of the individuals expected to testify at the hearing on behalf of the Appellant; the Appellant shall supplement the list with a written list of the names of additional witnesses as they are determined.
- d. Any witness who was not identified in writing to the other party at least ten (10) days before the date of testimony may testify only if the presiding officer determines there was good cause for not furnishing earlier notice.

18.3.3 Composition and Appointment of Hearing Committee.

- a. When a hearing is triggered by an adverse recommendation of the Medical Executive Committee, the Chief of Staff, acting on behalf of the Hospital, shall appoint a Hearing Committee of not fewer than three (3) members of the Medical Staff. One of the members shall be designated as chair.
- b. When a hearing is triggered by an adverse decision of the Board, the Board Chair shall appoint a Hearing Committee of not fewer than three (3) members. One of the members shall be designated as chair.
- c. The Hearing Committee shall not include an individual who (1) actively participated in consideration of the matter at issue at any previous level, (2) is in direct economic competition with the Appellant, or (3)

is a professional or business associate or family member of the Appellant. The Medical Executive Committee is authorized to determine eligibility for membership on a Hearing Committee under the standard stated in this Section 18.3.3.

18.3.4 Hearing Officer.

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

18.3.5 Pre-Hearing Conference.

Prior to or at the beginning of any hearing the presiding officer may, in his or her discretion, convene a conference to consider:

- a. The framing and simplification of issues to be presented at the hearing;
- b. Admission of facts or documents that will avoid unnecessary hearing testimony and proof;
- c. Limitation by the presiding officer of the number of witnesses to be called by the parties in order to reduce repetitive or irrelevant testimony;
- d. Such other matters as the presiding officer determines may aid in the expeditious disposition of the matters before the Hearing Committee.

The representative of the Medical Executive Committee or Board, as applicable, and the Appellant (or the Appellant's representative, if the Appellant will be represented at the hearing) shall participate in the pre-hearing conference. Members of the Hearing Committee shall not participate in the conference, with the exception of the Chair of the Hearing Committee if the Chair serves as presiding officer. The pre-hearing conference may be held by phone. The presiding officer may submit a summary of the decisions reached at the conference to the Hearing Committee and such summary will be used to control the subsequent course of the hearing.

18.3.6 Documents.

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

18.4 HEARING PHASE

18.4.1 Preliminary Rules.

- a. At least a majority of the members of the Hearing Committee shall be present when the hearing takes place.
- b. An accurate record of the hearing shall be kept by means of a court reporter or an electronic recording unit, as selected by the Hearing Committee. Upon request, the Appellant shall be entitled to a copy of the hearing record upon payment of any reasonable charge for preparation thereof.
- c. Postponement of a hearing beyond the time set forth in these Bylaws may be granted by the Hearing Committee, but only for a good reason, and in the sole discretion of the Hearing Committee.

18.4.2 Presence of Appellant.

The personal presence of the Appellant shall be required. An Appellant who fails, without good cause (as determined by the Hearing Committee), to appear at a hearing waives his or her rights to a hearing and to appellate review.

18.4.3 Representation.

- a. If the hearing is triggered by an adverse recommendation of the Medical Executive Committee, the Chief of Staff shall appoint a Medical Staff Member or an attorney to represent the Medical Executive Committee at the hearing.
- b. If the hearing is triggered by an adverse decision of the Board, the Board Chair shall appoint one of its members and/or an attorney to represent the Board at the hearing.
- c. The Appellant shall be entitled to be represented at the hearing by a member of the Medical Staff or an attorney, if the Appellant stated his or her intent to be so represented in the request for a hearing.

18.4.4 Conduct of Hearing.

- a. The presiding officer shall preside over the hearing, determine the order of procedure during the hearing, determine what evidence is admissible, ensure that all participants in the hearing have a reasonable opportunity to present oral and documentary evidence, rule on any issues that arise, set deadlines for the submission of briefs or other documentation, maintain decorum, ensure that all parties present their positions without delay, and ensure that no party abuses its privileges under this Article. The presiding officer may limit the number of witnesses and/or duration of testimony, especially character witnesses or evidence that is repetitive.
- b. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make the evidence inadmissible over objection in a civil or criminal action.
- c. The parties to the hearing shall have the following rights:
 1. To call and examine witnesses; however, neither party has the authority to compel witnesses to appear;
 2. To introduce written evidence;
 3. To cross-examine any witness on any relevant matter;
 4. To challenge any witness and to rebut any evidence.
 5. If the Appellant does not otherwise testify, the Appellant may be called and examined as if under cross-examination.
 6. Upon the request of either of the parties, the presiding officer shall order that oral evidence be taken only on oath or affirmation administered by any person designated by the presiding officer and entitled to notarize documents in the State of Michigan.
 7. Members of the Hearing Committee may question witnesses. Witnesses may volunteer information that the Hearing Committee determines to be relevant, even if not elicited by a specific question posed by the Hearing Committee or by a party.
 8. Each party shall present any objections to procedures to the presiding officer as soon as possible, so that they may be timely addressed.
 9. The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its action. The Appellant shall have the burden of proving that there was no reasonable basis for the adverse recommendation/action.

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

18.4.5 Recess of Hearing.

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

18.5 POST-HEARING PHASE

18.5.1 Decision of Hearing Committee.

- a. The Hearing Committee shall deliberate outside the presence of the parties to the hearing. No member of the Hearing Committee may vote by proxy. Within thirty (30) days after the later of (1) the closing of the hearing or (2) the deadline for filing post-hearing statements, if applicable, the Hearing Committee shall make a written report containing its recommendations and the basis therefor, and shall forward the report, together with the complete hearing record and all written evidence and exhibits, to the body whose action triggered the hearing (either the Medical Executive Committee or the Board). The Chief of Staff shall send a copy of the Hearing Committee's report to the Appellant by Special Notice.
- b. The Hearing Committee's report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or adverse decision of the Board.
- c. At its next regularly scheduled meeting, after receiving the Hearing Committee's written report, the Medical Executive Committee or the Board, whichever initiated the hearing, shall affirm, modify or reverse its original recommendation/action.

18.5.2 Notice of Post-Hearing Recommendation.

- a. Medical Executive Committee-Initiated Hearing.
 1. Within seven (7) days after the Medical Executive Committee makes its post-hearing recommendation, the Chief of Staff shall forward the recommendation, together with all supporting documentation, to the Board for its decision and shall send a copy of the post-hearing recommendation to the Appellant by Special Notice.
 2. If the Medical Executive Committee's recommendation is unfavorable, the Chief of Staff shall promptly notify the Appellant by Special Notice of the Appellant's right to request an Appellate Review.
 3. If the Medical Executive Committee's recommendation is favorable, the Board may (i) concur with the recommendation, in which case the Board's decision is final, or (ii) overrule the recommendation, in which case the Appellant has the right to request Appellate Review.
- b. Board-Initiated Hearing.
 1. When the Board's post-hearing decision is favorable to the Appellant, the Board's decision is final. The President shall promptly notify the Appellant of the favorable decision by Special Notice.
 2. When the Board's post-hearing decision is unfavorable to the Appellant, the President shall promptly notify the Appellant by Special Notice of the adverse decision and the Appellant's right to request an Appellate Review.
- c. "Favorable/Unfavorable." For purposes of this Section 18.5.2, a recommendation or action is "unfavorable" if it entails any of the appealable matters listed in Section 18.2.1, and is "favorable" if it does not entail any of the appealable matters listed in Section 18.2.1.

18.6 APPELLATE REVIEW

18.6.1 Appeal to the Board.

- a. An Appellant who is entitled to an Appellate Review shall have fifteen (15) days following receipt of the Special Notice sent pursuant to Section 18.5.2(a)(2) or 18.5.2(b)(2) in which to submit a written request for Appellate Review to the President by means of Special Notice. To be complete, the request must be accompanied by a written statement of the reasons for the Appellant's contention there is no reasonable basis for the unfavorable recommendation/action that is the subject of the Appellant Review. The written request shall not be deemed to be complete unless it includes such as a written statement. If the Appellant wishes to make an oral statement to the Appellate Review Committee, the Appellant's request for Appellate Review must include a request to make an oral statement.
- b. If the President does not receive a complete written request for Appellate Review from the Appellant within the 15-day deadline, the Appellant waives the right to Appellate Review and the adverse recommendation or decision shall remain in effect.
- c. Within fifteen (15) days after receipt of a complete written request for an Appellate Review, the Board shall schedule a date, time and place for the Appellant Review and notify the Appellant of same via Special Notice. The Appellate Review shall be held within sixty (60) days after the date the Appellant's request for Appellate Review is received. The Appellant shall have the burden of proving there was no reasonable basis for the adverse recommendation/action that is the subject of the Appellate Review.
- d. The Board will determine whether the Appellate Review is conducted by the full Board or by an ad hoc committee of the Board composed of not fewer than three (3) of its members.
- e. Prior to the Appellate Review, the Medical Executive Committee or Board, as applicable, may submit a written response to the Appellant's written statement. Such a written response shall be submitted to the President, with a copy to the Appellant by Special Notice.
- f. The Appellate Review body, in its discretion, will determine whether oral statements will be allowed and, if so, the maximum duration of statements. If the Appellant requested an opportunity to make an oral statement and the Appellate Review body elects to permit oral statements, the Appellant or the Appellant's attorney shall be permitted to speak against the adverse decision and the Appellant and the Appellant's attorney shall answer questions from members of the Appellate Review body. The Board may also be represented by one of its members and/or an attorney to present its position and answer questions from any member of the Appellate Review body.
- g. New or additional matters not raised during the original hearing or in the Hearing Committee report may be introduced at the Appellate Review only if the evidence is relevant and could not have been presented at the hearing. The Appellate Review body shall, in its sole discretion, determine whether such new matters will be accepted.
- h. Within thirty (30) days after the conclusion of the Appellate Review, the Appellate Review Committee, if a Committee was appointed, shall make a written recommendation to the Board.

18.6.2 Final Decision by the Board.

- a. After the Appellate Review, the Board shall make its final decision in the matter. If the Board's decision is in accordance with the Medical Executive Committee's last recommendation, this decision will be final.
- b. If the Board's decision is not in accordance with the Medical Executive Committee's last recommendation, the Board shall refer the matter, within ten (10) days of its decision to a Joint Conference, as outlined in Section 17.1. After receipt of the recommendation of the Joint Conference, the Board shall take final action.
- c. The President shall send notice of the Board's final action to the Appellant by Special Notice and to the Medical Executive Committee of each Hospital, the Chair of the Credentials Committee, and the Chief Operating Officer or designated administrator of each Hospital. The final action by the Board shall be binding on both Hospitals and shall be effective at the Hospital(s) where the applicant or member holds or has applied for Delineated Clinical Privileges.

18.7 DUE PROCESS COORDINATION

18.7.1 Right to One Hearing and Appeal Only.

Notwithstanding any other provision of these Bylaws or the Medical Staff Bylaws of another Trinity Health-Michigan hospital, no applicant or Medical Staff member shall be entitled to more than one hearing and one Appellate Review at the Hospitals collectively on any matter that has been the subject of a recommendation or an action of the Medical Executive Committee and/or the Board.

18.7.2 Effect of Final Decision.

The final action of the Board shall be binding on the Hospital(s) where the applicant or member holds or has applied for Delineated Clinical Privileges.

Approved by: Board
Last Revision Date: 3/22/2022