

7/31/14

9/24/18

03/11/2019

**NORTH OTTAWA COMMUNITY HOSPITAL
BYLAWS
OF THE
MEDICAL STAFF**

TABLE OF CONTENTS

	<u>Page</u>
ARTICLE 1	DEFINITIONS1
ARTICLE 2	NAME4
ARTICLE 3	PURPOSE/INTERPRETATION OF THE BYLAWS4
Section 3.1	PURPOSE OF THE BYLAWS4
Section 3.2	PURPOSES OF THE MEDICAL STAFF4
ARTICLE 4	MEDICAL STAFF MEMBERSHIP5
Section 4.1	NATURE OF MEDICAL STAFF MEMBERSHIP5
Section 4.2	BASIC QUALIFICATIONS, REQUIREMENTS, AND RESPONSIBILITIES FOR THOSE SEEKING OR HOLDING MEDICAL STAFF MEMBERSHIP5
Section 4.3	HISTORY AND PHYSICAL8
Section 4.4	HOSPITAL-FOCUSED CONSIDERATIONS FOR INITIAL APPOINTMENTS9
Section 4.5	PROCESS FOR PRIVILEGING, CREDENTIALING, AND APPOINTMENT10
Section 4.6	SPECIAL RESPONSIBILITY REGARDING THE APPLICATION AND REAPPOINTMENT PROCESS – MATERIAL INACCURACIES OR OMISSIONS11
Section 4.7	NON-DISCRIMINATION11
Section 4.8	CONDITIONS AND DURATION OF APPOINTMENT11
Section 4.9	STAFF DUES12
Section 4.10	PROFESSIONAL CONDUCT12
Section 4.11	ACTIONS FOR UNAVAILABLE OR UNRESPONSIVE PHYSICIANS13
ARTICLE 5	STRUCTURE AND CATEGORIES OF THE MEDICAL STAFF13
Section 5.1	DIVISIONS OF THE MEDICAL STAFF13
Section 5.2	ACTIVE STAFF13
Section 5.3	ASSOCIATE STAFF14
Section 5.4	REFER AND FOLLOW STAFF15
Section 5.5	EMERGENCY AND TEMPORARY PRIVILEGES16
ARTICLE 6	ALLIED HEALTH PROFESSIONALS (AHP)18
ARTICLE 7	OFFICERS18
Section 7.1	OFFICERS OF THE MEDICAL STAFF18
Section 7.2	QUALIFICATIONS OF OFFICERS18
Section 7.3	ELECTION OF OFFICERS18
Section 7.4	NOMINATION PROCESS18
Section 7.5	TERM OF OFFICE19
Section 7.6	VACANCIES OF OFFICERS19

Section 7.7	DUTIES OF OFFICERS	19
Section 7.8	REMOVAL FROM OFFICE.....	20
ARTICLE 8	MEDICAL DIRECTORS	21
ARTICLE 9	MEDICAL STAFF ORGANIZATION	22
Section 9.1	DEPARTMENTS	22
Section 9.2	SURGERY DEPARTMENT	22
Section 9.3	MEDICINE DEPARTMENT	22
Section 9.4	EMERGENCY DEPARTMENT	22
Section 9.5	FAMILY PRACTICE DEPARTMENT	22
Section 9.6	OBSTETRICS AND GYNECOLOGY DEPARTMENT	22
Section 9.7	PEDIATRICS DEPARTMENT.....	23
Section 9.8	OPTIONAL SECTIONS	23
Section 9.9	QUALIFICATIONS, SELECTION, TENURE, AND REMOVAL OF DEPARTMENT CHIEF AND VICE CHIEF	23
Section 9.10	QUALIFICATIONS, ROLES AND RESPONSIBILITIES OF DEPARTMENT CHIEFS.....	24
Section 9.11	FUNCTIONS OF DEPARTMENTS	25
Section 9.12	ASSIGNMENT TO DEPARTMENT.....	25
ARTICLE 10	COMMITTEES.....	25
Section 10.1	DESIGNATION AND AUTHORITY OF COMMITTEES AND MEMBERS	25
Section 10.2	MEDICAL EXECUTIVE COMMITTEE (MEC).....	27
Section 10.3	MEDICAL PRACTICES COMMITTEE	28
Section 10.4	BYLAWS COMMITTEE	29
Section 10.5	ETHICS COMMITTEE.....	30
Section 10.6	PHYSICIAN WELLNESS COMMITTEE.....	30
Section 10.7	SURGICAL SERVICES COMMITTEE	31
Section 10.8	EMERGENCY DEPARTMENT COMMITTEE	31
Section 10.9	PEDIATRIC DEPARTMENT COMMITTEE	31
Section 10.10	OB/GYN DEPARTMENT COMMITTEE.....	31
Section 10.11	ICU COMMITTEE.....	32
Section 10.12	MEDICINE DEPARTMENT COMMITTEE	32
Section 10.13	OTHER COMMITTEES	32
Section 10.14	STAFF FUNCTIONS	32
ARTICLE 11	MEDICAL STAFF MEETINGS.....	33
Section 11.1	ANNUAL MEDICAL STAFF MEETINGS	33
Section 11.2	SPECIAL MEETINGS	33
Section 11.3	ATTENDANCE REQUIREMENTS	33
Section 11.4	PARTICIPATION BY CEO OF THE HOSPITAL.....	34
Section 11.5	ROBERT’S RULES OF ORDER.....	34
Section 11.6	NOTICE OF MEETINGS	34

Section 11.7	ACTION OF COMMITTEE/DEPARTMENT.....	34
Section 11.8	RIGHTS OF EX-OFFICIO STAFF MEMBERS	35
Section 11.9	MINUTES.....	35
ARTICLE 12	PRACTITIONER RIGHTS.....	35
ARTICLE 13	SUSPENSION AND CORRECTIVE ACTION.....	35
Section 13.1	CORRECTIVE ACTION	35
Section 13.2	SUMMARY SUSPENSION.....	37
Section 13.3	AUTOMATIC SUSPENSION	38
ARTICLE 14	HEARING AND APPELLATE REVIEW PROCEDURE FOR ALL MEMBERS OF THE MEDICAL STAFF INCLUDING ACTIVE, ASSOCIATE, AND REFER AND FOLLOW	39
Section 14.1	RIGHT TO HEARING AND TO APPELLATE REVIEW	39
Section 14.2	NOTICE OF PROPOSED ACTION	40
Section 14.3	REQUEST FOR HEARING.....	40
Section 14.4	NOTICE OF HEARING.....	41
Section 14.5	COMPOSITION OF HEARING COMMITTEE	41
Section 14.6	CONDUCT OF HEARING	41
Section 14.7	MEDICAL EXECUTIVE COMMITTEE ACTION	44
Section 14.8	FINAL DECISION BY THE GOVERNING BODY.....	44
ARTICLE 15	AUTHORIZATIONS AND IMMUNITY FROM LIABILITY	44
Section 15.1	REQUIRED CONDITIONS.....	44
ARTICLE 16	REVIEW, REVISION, ADOPTION, AMENDMENT, AND ADMINISTRATION OF MEDICAL STAFF BYLAWS, RULES, AND REGULATIONS.....	46
Section 16.1	GENERAL PROVISIONS OF BYLAWS AND RULES AND REGULATIONS.....	46
Section 16.2	MEDICAL STAFF RESPONSIBILITY FOR BYLAWS.....	47
Section 16.3	METHODS OF ADOPTION AND AMENDMENT OF BYLAWS.....	47
Section 16.4	METHODS OF ADOPTION OF RULES AND REGULATIONS	48
Section 16.5	RELATED POLICIES.....	49
Section 16.6	JOINT CONFERENCE	49
	ADOPTION AND APPROVAL OF THE MEDICAL STAFF	50
	ADOPTION AND APPROVAL OF THE BOARD OF DIRECTORS	51

ARTICLE 1 DEFINITIONS

“Administration” means the executive and administrative organization of the Hospital.

“Allied Health Professional” or “AHP” means a health care professional who is duly licensed (e.g., a certified registered nurse anesthetist, physician assistant or nurses affiliate) or, in the case of a profession not subject to licensure, duly trained in accordance with policies and rules approved by the Governing Body. It does not include nurses, physical therapists, social workers and professionals who are Hospital employees in fields traditionally credentialed through Hospital employment mechanisms.

“Board” means the Board of Trustees of the Hospital.

“Board Certified” means that a Practitioner, if a physician, is certified as a specialist by a specialty board organization recognized as such by the American Medical Association's Council for Graduate Medical Education or the American Osteopathic Association; if an Oral Surgeon, is specialty certified as such by the Michigan Board of Dentistry and American Board of Maxillo-Facial Surgery; and if a Podiatrist, is certified by the American Board of Podiatric Surgery.

“Board Eligible” or “Board Qualified” means that a Practitioner has met the educational, post-graduate training and skill qualifications to be qualified, admissible or eligible to sit for the board certification examination of a specialty board recognized by the Council for Graduate Medical Education, the American Osteopathic Association or the American Podiatric Medical Association, but:

- (a) Has not yet had the opportunity to meet minimum experience following post-graduate training required by a certifying specialty board before taking its board certification examination; or
- (b) Has not had at least two (2) opportunities to sit for board certification examination (based on board examination requirements) and remains eligible to take further examinations.

Whether a Practitioner is or is not Board Eligible is a matter within the sole discretion of the Medical Executive Committee.

“Bylaws” means North Ottawa Community Hospital Medical Staff Bylaws.

“CEO” means the executive appointed by the Board to act on its behalf in the overall management of the Hospital. Any duty of the CEO may be performed by a person or persons designated by the CEO, directly or by means of an organizational chart which the CEO or Governing Body approves.

“Clinical Privileges” means the permission granted to medical staff members and others to provide patient care and includes access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.

“COS” means the Chief of Staff who is chief officer of the Medical Staff and functionally its president.

“Data Bank” means the National Practitioner Data Bank operated under the auspices of the federal government.

“Dentist” refers to an individual with either a D.M.D. or D.D.S. degree licensed to practice in Michigan applying for or exercising clinical privileges at North Ottawa Community Hospital.

“Department” (without further modification) means a clinical administrative subdivision of the Medical Staff as described in SECTION 9.1 of these Bylaws.

“Ex-officio” refers to a member of committee or board by virtue of holding some particular office.

“Governing Body” refers to the Board of Directors of North Ottawa Community Hospital.

“He”, “His” or “Himself” refers to both he and she, his and her or himself and herself throughout the Medical Staff Bylaws and Rules and Regulations.

“Hospital” refers to North Ottawa Community Hospital which provides inpatient care (for more than twenty-four (24) consecutive hours), and may provide emergency care and outpatient procedures.

“Joint Conference” means a meeting between representatives of the Governing Body and the Practitioners on the Medical Executive Committee.

“MEC” means the Medical Executive Committee of the Medical Staff.

“Medical Practice Committee” refers to Credentialing and Peer Review activities at North Ottawa Community Hospital.

“Medical Staff” or “Staff” refers to the formal organization of all licensed physicians, dentists and podiatrists who are privileged to attend to patients in the North Ottawa Community Hospital.

“Medical Staff Member” or “Staff Members” refer to graduates of the professional schools granting M.D., D.O., D.D.S. and D.P.M. degrees who have met the requirements for Medical Staff membership and have been granted such membership and clinical privileges by the Governing Body.

“Medical Staff Leadership” refers to the Medical Staff Officers, Department Chairmen and Department Vice Chairmen

“Medical Staff Year” refers to the period from January 1 to December 31.

“Member” (capitalized and without modification) means a member of the Medical Staff.

“Officer” means the COS, Vice COS, Past COS, and Treasurer.

“Oral Surgeon” means a dentist, practicing as an oral and maxillofacial surgeon, who has been issued health profession specialty certification in that field by the Michigan Board of Dentistry.

“Physician” refers to an individual with an M.D., D.O. or equivalent degree licensed to practice in Michigan applying for or exercising clinical privileges at North Ottawa Community Hospital facilities.

“Podiatrist” refers to an individual with a D.P.M. degree licensed to practice in Michigan applying for or exercising clinical privileges at North Ottawa Community Hospital facilities.

“Policy Manual” means compiled medical policies of the Staff containing the specifics governing the activities of Staff Members and Allied Health Professionals.

“Practice” (of medicine) means the diagnosis, treatment, prevention, cure or relieving of human disease, ailment, defect, complaint or other physical or mental condition by attendance, advice, device, diagnostic test or other means, or offering, undertaking, attempting to do or holding oneself out as able to do any of these acts.

“Practitioner” refers to, unless otherwise expressly limited, any appropriately licensed physician, dentist or podiatrist applying for or exercising clinical privileges at North Ottawa Community Hospital’s facilities.

“Privileges” means the permission granted to Staff Members to provide patient care and includes unrestricted access to those Hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.

“Rules” (capitalized and without further modification) means the rules of the Medical Staff.

“Service” refers to those representatives participating in a multi-disciplinary approach to promote complementary programs.

“Surgery” means all procedures done in the Operating Room, with or without anesthesia services.

“Vice COS” means the Vice Chief of Staff of the Medical Staff who is functionally its vice president.

ARTICLE 2 NAME

The name of this organization shall be the Medical Staff of North Ottawa Community Hospital.

ARTICLE 3 PURPOSE/INTERPRETATION OF BYLAWS

SECTION 3.1 PURPOSE OF BYLAWS

These Bylaws are adopted in order to provide for the organization of the Medical Staff and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care and to govern the orderly resolution of these purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body and relations with applicants to and Members of the Medical Staff.

All captions and titles used in these Bylaws and Rules and Regulations are for convenience only and shall not limit or otherwise affect in any way the scope or manner of interpretation of any provision.

SECTION 3.2 PURPOSES OF THE MEDICAL STAFF

The purposes of this organization are:

To provide quality and continuous care to all patients treated in any of the facilities of North Ottawa Community Hospital and to assist the Hospital in meeting the goals described in its mission statement.

To provide a forum in which issues of concern to the Medical Staff may be discussed with the CEO of the Hospital and Governing Body.

To initiate and maintain Bylaws and Rules and Regulations for self-governance of the Medical Staff.

To promote a high level of professional performance by all Medical Staff members through appropriate delineation of privileges for each. Ongoing review and evaluation of each Medical Staff member's performance will be utilized to maintain a high standard of care.

To ensure that all members of the Medical and Allied Health Staff have appropriate education, training and experience and are credentialed, and to ensure that health care is provided only by appropriately credentialed staff.

To screen applicants for Membership, review Privilege requests from all Practitioners and AHPs permitted to practice in the Hospital.

ARTICLE 4 MEDICAL STAFF MEMBERSHIP

4.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of the Hospital is a privilege which shall be extended only to professionally competent Practitioners who continuously meet the qualifications; standards and requirements set forth in these Bylaws and associated policies of the Medical Staff and the Hospital.

Membership on the Medical Staff is not required for practitioners who refer patients to members of the Medical Staff.

4.2 BASIC QUALIFICATIONS, REQUIREMENTS, AND RESPONSIBILITIES FOR THOSE SEEKING OR HOLDING MEDICAL STAFF MEMBERSHIP

To be a Staff Member and hold Privileges, a Practitioner must personally establish and thereafter, if appointed, must continuously fulfill the following basic requirements and responsibilities:

- 4.2.1 **Education and Licensure.** Graduation from a professional school or program generally recognized for its quality of education and licensure in good standing to practice his profession by the State of Michigan.
- 4.2.2 **Board Certified or Board Qualified.** All Medical Staff members initially credentialed after the effective date of these Bylaws shall have or obtain initial Board Certification during their initial appointment period.
- 4.2.3 **Background, Experience and Competency.** Background, experience, training and competency which are sufficient to demonstrate to the satisfaction of the Governing Body that He can capably and safely exercise Privileges within the Hospital. An Oral Surgeon must be specialty licensed as such. However, no Practitioner shall be entitled to become a Staff Member or to exercise any particular Privileges in the Hospital merely by virtue of the fact that He is licensed to practice his profession in this or any other state, or because He is a member of any professional organization or practice, or because he is certified by any specialty board or because he had, or presently has, membership or clinical privileges at another health care facility or in another practice setting.
- 4.2.4 **Ethics and Reputation.** Adherence to the ethics of his profession, consistent with the Hospital mission and philosophy, and maintaining a good personal and professional reputation regardless of profession.
- 4.2.5 **Work Cooperatively With Others.** Demonstrated interest and ability to work cooperatively with other Practitioners, support staff, Administration and the Governing Body, consistent with the Policy Manual and Governing Body policies regarding communications among persons working in the Hospital.
- 4.2.6 **Physical and Mental Capacity to Practice.** Freedom from physical or mental illness or chemical dependencies which would interfere with his ability to safely exercise Privileges whether with or without reasonable accommodation. In this respect, the Governing Body

or MEC may pre-condition the exercise of Privileges upon the Practitioner undergoing a physical and/or mental health examination conducted by one or more health care professionals selected in accordance with these Bylaws and established Hospital policies. Further, each Practitioner who is an applicant or Staff Member shall immediately report his condition to the CEO if He contracts a contagious disease which is reportable to public health authorities under law and which could endanger the health of the patients, the Practitioner or others working with the Practitioner if the Practitioner practices in the Hospital.

- 4.2.7 **Recognized Quality of Care.** Provision of professional care at the recognized professional level of quality and efficiency and within the scope of his Privileges. This includes appropriate and continuous care of patients and he shall be responsible for those AHPs and others acting under his supervision (but not other providers).
- 4.2.8 **Compliance With Bylaws, Rules and Regulations, and Policies.** Compliance with the Bylaws, Rules and Regulations, and Medical Staff policies, as well as all rules and policies of the Hospital as applicable to Practitioners.
- 4.2.9 **Discharge of Medical Staff Responsibilities.** Discharge of such Medical Staff and Hospital functions for which He is responsible by appointment, election or otherwise, including meaningful service upon Medical Staff, Hospital and interdisciplinary committees when so appointed to serve.
- 4.2.10 **Timely and Accurate Completion of Records.** Preparation and completion in a timely and accurate manner of the medical and other required records for all patients for whom he provides care, consistent with these Bylaws, Rules and Regulations, and Hospital policy.
- 4.2.11 **Compliance With Law.** Demonstrated compliance at all times with applicable local, Michigan and Federal law.
- 4.2.12 **Risk Management.** Meaningful participation in Hospital's programs for risk management and promotion of patient and staff safety and support activities designed to address issues identified by these programs.
- 4.2.13 **Use of Hospital Name.** Shall not use the Hospital's name or other service marks of the Hospital or Medical Staff in any commercial message, advertisement or other writing for the purpose of promoting the services of the Practitioner or any entities of which He is owner, partner, shareholder or employee without the advance written authorization of the CEO.
- 4.2.14 **Evidence of Financial Responsibility.** Shall provide evidence of professional liability insurance of a kind, type and limits prescribed by the Governing Body.
- 4.2.15 **Preservation of Confidentiality.** Preserve and affirmatively protect the confidential patient, Hospital and Medical Staff information except as otherwise requested by law or as defined in the hospital policy.
- 4.2.16 **Reporting of Resignations and Adverse Action Procedures.** Report to the CEO relevant

facts and documents: the institution of disciplinary proceedings by any health facility (including HMOs), professional society or licensing authority; limitations, suspension, revocation or resignation of clinical privileges at any health facility; suspension, restriction, probation or limitation of professional licensure by any licensing authority; previously successful or currently pending challenges or voluntary relinquishments of medical licensure or censure of any kind by any professional organization.

4.2.17 Reporting Legal Matters. Report to CEO the facts and circumstances of: any judgment or settlement arising from professional practice in civil cases; any current formal criminal charges (e.g., indictment) and any conviction of any crime growing out of professional practice.

4.2.18 Continuing Education. Participate in continuing education programs and activities which relate, in part, to his core Privileges pursuant to appointment/reappointment and other applicable policies.

4.2.19 Continuity of Care Responsibilities. Meet proximity of practice and/or residency requirements established pursuant to these Bylaws by the MEC and Governing Body for continuity of care purposes. Each practitioner must assure timely, accurate, professional care for his patients in the hospital by being available or having available through his office an eligible alternate practitioner with whom prior arrangements have been made and who has appropriate clinical privileges to render care at all times. Alternate coverage schedules must be submitted to the Medical Staff Office. Patients admitted with critical care problems shall be seen by their physician or his designee in an appropriate timeframe. Any failure to do so will be reported to the appropriate Department Chief.

4.2.20 Consultation Requirements. Consultation is mandatory whenever a medical issue is not included in the admitting practitioner's scope of practice as determined by their Professional College or Academy.

4.2.21 On-Call Requirements. Participate in providing inpatient consultations, emergency department consultations for those patients potentially requiring admission, and inpatient attending coverage for those patients who are not under the ongoing care of a Staff Member in accordance with policies passed by the MEC and the hospital. When on-call, the Staff Member must be available in a geographic location and circumstances enabling Him to physically respond in a timely fashion.

4.2.21.1 Active and Associate staff agree to provide on-call coverage in the Emergency Room as a condition of appointment to the medical staff. Each department of the medical staff will arrange for a call schedule for its specialties and the Chief of each department shall provide a list of such assigned on-call physicians to the Medical Staff Office at least two (2) weeks prior to the applicable month. The decision to excuse from, remove from, or not grant Emergency Department coverage responsibility rests with the Department Chief and will be subject to the approval of the MEC. The physician may appeal the Chief's decision to the MEC.

- i. Each schedule will be distributed by the Medical Staff Office to the appropriate departments of the hospital.

- ii. The physician assigned each day is responsible for coverage from 7:00 a.m. of that day until 7:00 a.m. the next day.

4.2.21.2 It is the responsibility of the-on-call physician to notify the Medical Staff Office of changes in schedule or prolonged unavailability as well as to find an appropriate substitute for coverage and to notify the Medical Staff Office of the name of the substitute.

4.2.22 Communication Skills. Effectively understand and communicate in the English language sufficient for patients, colleagues and Hospital staff to understand his spoken words (or equivalent if medically speech impaired) and for his medical records to be reasonably understood by others.

4.2.23 Submission of Documentation. Submit documentation as required by policies with regard to staff dues, professional liability insurance, TB and other immunization verification, and licensure. Failure to submit documentation as required will be considered a voluntary resignation of medical staff membership and associated privileges.

4.3 HISTORY AND PHYSICAL

4.3.1 A medical history and physical examination (H & P) for each patient shall be completed and documented in the medical record no more than thirty (30) days before or twenty-four (24) hours after an admission or registration, and prior to any high risk procedure, surgery, procedures requiring anesthesia services, or other procedures requiring an H & P, and placed in the patient's medical record with twenty-four (24) hours after admission. The H & P must be in the medical record prior to any high-risk procedure, surgery or other procedure requiring anesthesia services.

4.3.2 An H & P completed within thirty (30) days prior to admission or registration shall include an entry in the medical record documenting an H & P update examination for any change in the patient's current medical condition completed by a doctor of medicine or osteopathy, oromaxillofacial surgeon or other qualified individual who has been granted these privileges by the Medical Staff in accordance with State law. This update shall be documented and placed in the medical record within 24 hours after admission or registration of the patient but prior to surgery or other procedure requiring anesthesia services.

4.4 HOSPITAL-FOCUSED CONSIDERATIONS FOR INITIAL APPOINTMENTS

In addition to the professional qualifications and competence of a Practitioner (or any other health professional), initial appointments and grants of Privileges shall take into account the present and future needs of the Hospital and the community it serves, including but not limited to:

- i. Maintaining a continuity of service by the Medical Staff;
- ii. Supplying the medical skills and experience necessary for the continued ability of the Hospital or Medical Staff to carry out the programs and projects of the Hospital;

- iii. Delivering quality of care in a cost-effective manner, taking into account the limited resources of the Hospital; however, a Practitioner's qualifications for Medical Staff membership or Clinical Privileges shall not be based solely on economic criteria unrelated to quality of care or professional competency.
- iv. Having adequate facilities and supportive services in the Hospital for the Practitioner and his patients;
- v. Needing the professional skills of the Practitioner in the Hospital's delivery of care to its patients;
- vi. Having pre-existing, available and sufficient services in the Hospital which are redundant to the services offered by the Practitioner; and,
- vii. Meeting Hospital contractual obligations and organizational plans.

4.4.1 In clinical services in which the Hospital contracts for the provision of Hospital-based professional services including anesthesiology, diagnostic radiology, emergency medicine, laboratory medicine, pathology, and other contracted professional services, appointment to the Medical Staff and access to Hospital resources is restricted to physicians who are members of the group under contract or who are designated by that group's Chief as adjunct members of the group pursuant to the applicable contract so as to enable the service to fulfill its obligations for patient care and education.

4.4.2 An Intended Practice Plan on a form designated by the Medical Practices Committee and approved by the Governing Body is required prior to completion of an Application for Medical Staff Appointment for all prospective applicants except AHPs and those who are covered by a contract pursuant to Section 4.4.1 of these Bylaws. Neither the Intended Practice Plan nor any discussions regarding the Plan shall give the prospective applicant any right to a hearing or appellate review as set forth in these Bylaws.

4.4.3 The Board of Trustees and the Medical Staff, in order to fulfill their commitment to assure balanced use of Hospital resources, may impose restrictions upon or designate special circumstances for Staff selection. Denial solely for these reasons is not and will not be considered an expression as to the competence or professional conduct of the applicant.

4.5 PROCESS FOR PRIVILEGING, CREDENTIALING, AND APPOINTMENT

4.5.1 An interested practitioner who meets all the requirements of Section 4.2 and has completed an Intended Practice Plan pursuant to Section 4.4.2 may request an Application for Medical Staff Appointment. An applicant for initial appointment to the medical staff must meet qualifications including, but not limited to:

- i. Primary source verification of licensure, education, specific training, experience, and current competence;
- ii. Current Federal Narcotics Registration Certificate (DEA) number;

- iii. Two peer recommendations;
- iv. Review of involvement in any professional liability action including receipt of a Notice Of Intent; and,
- v. If available, review of individual performance data for variation from benchmark. Variation shall go to peer review for determination of validity, written explanation of findings and, if appropriate, an action plan to include improvement strategies.
- vi. Provide evidence of their background, experience and training, current competence, knowledge, judgment, ability to perform, and technique in their specialty for all privileges requested.

The completed application and privilege delineation form shall be submitted to the Medical Staff Office by the practitioner. The Medical Staff Office shall review the application pursuant to Medical Staff Office policy and categorize the application. The appropriate Department Chief shall review the application and supporting documentation pursuant to Medical Staff Office policy and make a recommendation on the application to the Medical Practices Committee. The Medical Practices Committee shall review the application and recommendation pursuant to Medical Staff Office policy and make a recommendation to the Governing Body within a reasonable period of time.

The Board of Trustees and the MEC may implement policies and practices in accordance with applicable State or Federal laws, regulations, or regulatory agencies that provide for different privileging, credentialing, and appointment processes for telemedicine providers under contract with the Hospital.

4.5.2 All members of the Medical Staff interested in pursuing re-privileging, re-credentialing, and re-appointment shall complete and submit a reapplication form at least ninety (90) days prior to the expiration of their current membership pursuant to Medical Staff Office policy. An applicant for reappointment to the medical staff must meet qualifications including, but not limited to:

- i. Primary source verification of licensure and current competence;
- ii. Current DEA number;
- iii. Review of involvement in any professional liability action; and,
- iv. Review of individual performance data for variation from benchmark. Variation shall go to peer review for determination of validity, written explanation of findings and, if appropriate, an action plan to include improvement strategies.

The Medical Practices Committee shall review the reapplication and make a recommendation to the Governing Body within a reasonable period of time.

The Board of Trustees and the MEC may implement policies and practices in accordance

with applicable State or Federal laws, regulations, or regulatory agencies that provide for different privileging, credentialing, and appointment processes for telemedicine providers under contract with the Hospital.

4.6 SPECIAL RESPONSIBILITY REGARDING THE APPLICATION AND REAPPOINTMENT PROCESS - MATERIAL INACCURACIES OR OMISSIONS

Each Practitioner seeking to be or who is a Staff Member shall be required to produce adequate information in the application and reappointment processes for proper evaluation of his experience, background, training, demonstrated ability and physical and mental health status as well as resolve any doubts about these or any other qualifications. This responsibility includes obtaining meaningful and timely responses to Hospital reference requests from persons the Hospital deems appropriate. The Practitioner shall further have the responsibility of completing any application or reappointment form in a full, complete and intellectually honest manner and to update any information which changes while the application is pending. In this respect and with regard to the reporting requirements of Section 4.2.16 and Section 4.2.17, if the Practitioner has any doubt as to whether disclosure of any information is required during the application or reappointment process, He shall disclose the information with an explanation of his uncertainty as to whether the information is required or not.

4.7 NON-DISCRIMINATION

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

4.8 CONDITIONS AND DURATION OF APPOINTMENT

- 4.8.1 Governing Body Action.** Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments and reappointments only after there has been a formal assessment and recommendation by the Medical Practice Committee and the MEC in accordance with the provisions of these Bylaws and related manuals approved by the Medical Staff and Governing Body in accordance with these Bylaws. Provided, however, in the event that either or both of these committees should fail to act within the time limits set forth in these Bylaws the Governing Body may (but is not required to) act on its own motion, but then only in consultation with these committees.
- 4.8.2 Duration.** Appointments to the Medical Staff will normally be for no more than twenty-four (24) calendar months. Shorter appointment periods may be used at the discretion of the MEC and/or Governing Body.
- 4.8.3 Privileges.** Appointment to the Medical Staff shall confer on the Staff member only such Privileges as have been granted by the Governing Body upon recommendation from the MEC. Each Hospital department shall maintain a record of physicians with privileges pertaining to that department. The nursing staff, via the Hospital's chain of command, shall ensure that each physician practices within the scope of his privileges.

4.9 STAFF DUES

- 4.9.1 Setting Dues.** Annual Medical Staff dues shall be governed by the most recent dues action which has been adopted at a regular or special Medical Staff meeting and paid to the Medical Staff Office annually.
- 4.9.2 Exceptions.** Refer and Follow Staff Members will not be required to pay dues.
- 4.9.3 Payment Date.** Dues shall be due and payable upon request. Failure to pay dues within one hundred twenty (120) days of written request shall be regarded as a voluntary resignation from the Staff.

4.10 PROFESSIONAL CONDUCT

- 4.10.1 Objective.** A good working relationship among all members of the health care team is necessary in order to provide and maintain quality patient care and a professional health care environment. The relationship among members of the Medical Staff and with professional and non-professional personnel must reflect mutual respect in order to avoid threats to patient care and disruption of Hospital operations.
- 4.10.2 Policy.** Members of the Medical Staff shall strive to achieve a professional environment in which all Staff members and Hospital employees are treated with respect. Professional Conduct Policy(ies) governing the conduct of all of the North Ottawa Community Hospital Medical Staff Members shall be adopted by the Governing Body with the approval of the MEC which shall not be withheld without good cause. (In the event of a disagreement between the MEC and the Governing Body over the adoption of any such policies, the matter will be resolved pursuant to the Joint Conference provisions of these Bylaws.)

Disruptive or inappropriate behavior by a Staff member that impedes the harmonious interaction of health care personnel at North Ottawa Community Hospital is unacceptable. Any Staff member or Hospital employee who observes inappropriate behavior by a Staff member may report the incident to his immediate supervisor or Medical Staff administration. Inappropriate behavior by a Staff member may result in corrective action.

4.11 ACTIONS FOR UNAVAILABLE OR UNRESPONSIVE PHYSICIANS

- 4.11.1** Each North Ottawa Community Hospital Medical Staff member pledges to provide for continuous medical care of his patients. The attending physician is responsible for all care of his patients. If the attending physician is going to be unavailable for his patients he shall make coverage arrangements and notify the hospital Medical Staff Office in advance of the coverage arrangements for his patients. If the attending physician or his designee is not available or does not respond to a request for assistance, the following measures should be taken:

- i. The appropriate Department Chief will be contacted.
- ii. If the appropriate Department Chief cannot be reached, the Chief of Staff and then, if needed, the Vice Chief of Staff will be contacted.

- iii. If the situation is life threatening or emergent in nature, the Emergency Physician will be called to assist until the attending or other appropriate physician is contacted or has arrived.

4.11.2 It is understood that the responding physician has Privileges for and is expected to take appropriate action in emergency situations. Attempts will continue to be made to contact and inform the attending physician of the situation. Responsibility for the patient will revert to the primary or attending physician when the physician is available, unless other consultative arrangements are made between involved physicians.

4.11.3 Situations as described above will be monitored through the Medical Practices Committee.

ARTICLE 5 STRUCTURE AND CATEGORIES OF THE MEDICAL STAFF

SECTION 5.1 DIVISIONS OF THE MEDICAL STAFF

The Medical Staff is divided into three regular categories: “Active”, “Associate” and “Refer and Follow”.

SECTION 5.2 ACTIVE STAFF

5.2.1 Qualifications. A member assigned to the active category must be appointed to the medical staff and have served on the medical staff for the two (2) most recent consecutive years, be involved in twelve (12) patient contacts per year (a patient contact is defined as an inpatient admission, consultation, or an inpatient or outpatient surgical procedure) at the hospital.

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 all bylaws, rules, regulations, and policies of the staff, the member may be appointed to the associate category.

5.2.2 Responsibilities. Members of the active category shall:

- i. Continuously meet the requirements for Membership set forth in Article Four (4);
- ii. Contribute to the organizational and administrative affairs of the Medical Staff;
- iii. Take call in the emergency room in accordance with policies passed by the MEC and Board.
- iv. Provide appropriate coverage to meet the needs of his patients at all times when he is unavailable, out of town or at distance from the hospital. This coverage must be arranged in advance and all covering practitioner(s) must have clinical privileges at the hospital.
- v. 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, monitoring activities, and the discharge of other staff functions as may be required.

5.2.3 Prerogatives. Members of the active category may:

- i. Exercise such clinical privileges as are granted by the Board
- ii. Vote on all matters presented by the medical staff and by appropriate department and committee(s) to which the appointee is assigned.
- iii. Hold office and sit on or be the chairperson of any committee in accordance with any qualifying criteria set forth elsewhere in the Medical Staff Bylaws, Rules and Regulations, and Medical Staff policies.

SECTION 5.3 ASSOCIATE STAFF

5.3.1 Qualifications. The associate category is reserved for Medical Staff members who do not meet the eligibility requirements for the active category or who choose not to pursue active category status.

5.3.2 Responsibilities. Appointees to the associate category shall:

- i. Continuously meet the requirements for Membership set forth in Article Four (4);
- ii. Contribute to the organizational and administrative affairs of the Medical Staff;
- iii. Take call in the emergency room in accordance with policies passed by the MEC and Board.
- iv. Provide appropriate coverage to meet the needs of his patients at all times when he is unavailable, out of town or at distance from the hospital. This coverage must be arranged in advance and all covering Practitioner(s) must have clinical Privileges at the hospital.
- v. 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, monitoring activities, and the discharge of other Staff functions as may be required.

5.3.3 Prerogatives. Appointees to the associate category may:

- i. Exercise such clinical Privileges as are granted by the Board;

- ii. Vote on all matters presented by the Medical Staff and by appropriate department and committee(s) to which the appointee is assigned. Members of the associate category may not hold office.

SECTION 5.4 REFER AND FOLLOW STAFF

5.4.1 Qualifications. The Refer and Follow category shall consist of Medical Staff members who will not admit or treat patients at the hospital but wish to monitor their patients while they are in the hospital and access the patient's medical record. There is no limitation to the number of patient contacts allowed. Members of this category may subsequently apply for membership and clinical Privileges in another Medical Staff category at any time.

5.4.2 Responsibilities. Appointees to the Refer and Follow category shall:

- i. Continuously meet the requirements for membership set forth in Article Four (4), except completion of medical records and on-call/consultation requirements.

5.4.3 Prerogatives. Appointees to the Refer and Follow category:

- i. Shall not hold clinical Privileges to admit, consult or treat patients at the hospital;
- ii. May not enter or give verbal orders or otherwise document in the medical record;
- iii. May not perform any procedures or provide any treatment;
- iv. May attend Medical Staff meetings and department meetings to which they are appointed, as well as attend any Staff or hospital education program.
- v. May not vote, hold office, or serve on Medical Staff committees;
- vi. May visit and follow his referred hospitalized patients;
- vii. May access his referred patient's medical record;
- viii. Shall not be required to pay dues.

SECTION 5.5 EMERGENCY AND TEMPORARY PRIVILEGES

5.5.1 Emergency Privileges. Emergency Privileges may be granted when there is a disaster and the emergency management plan has been activated; the number and needs of the patients exceed the organization's ability to provide emergent care with the existing Medical Staff alone.

- i. Emergency Privileges may be granted providing:

- a) The emergency management plan has been activated;
 - b) There is not adequate Staff to provide emergent care to all the patients presenting at the hospital; and
 - c) Physicians and other professionals volunteer to provide care.
- ii. The CEO of the Hospital, or the COS or his designee(s) have the authority to approve emergency privileges.
- a) The authorized individual is not required to approve Emergency Privilege and will make privileging decisions on a case-by-case basis at his discretion.
 - b) The authorized individual may grant Emergency Privileges upon review, evaluation, and upon obtaining the Practitioner's valid government issued photo identification (for example, a driver's license or passport) and at least one of:
 - i. A current picture hospital ID that clearly defines professional designation;
 - ii. A current license to practice;
 - iii. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.
 - iv. Primary source verification of licensure
 - v. Confirmation by a Licensed Independent Practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer Practitioner's ability to act as a Licensed Independent Practitioner during a disaster.
 - c) The approved volunteer providers will wear a "Volunteer Provider" name tag and will be paired with Medical Staff members, preferably members of the same specialty. The Medical Staff members will manage the activities of the volunteers.
 - d) The Medical Staff Coordinator will begin the credentials verification process as soon as the immediate situation is under control following the bylaw/policy directives for granting Temporary Privileges to fulfill an important patient care need.

5.5.2 Temporary Privileges. Temporary Privileges may be issued for important patient care needs for a limited time. Temporary Privileges may be granted on a case-by-case basis

when an important patient care need mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. An example would be that a specific Physician has the necessary skills to provide care to a patient that a current member of the Medical Staff does not possess. In these circumstances, the CEO of the Hospital, upon the recommendation of the COS or the Department Chief, as a representative of MEC, may grant Temporary Privileges for a designated period of time not to exceed sixty (60) days, if current licensure and competence are verified. The Medical Staff Coordinator would need to verify the following information:

- i. Current state health professional licensure;
- ii. Current malpractice insurance;
- iii. Relevant training or experience;
- iv. Current competency;
- v. Ability to perform the privileges requested.

National Practitioner Data Bank (NPDB) must be queried and evaluated. If the temporary privileges warrant being extended, the Governing Body may grant up to one (1) additional sixty (60) day extensions.

Also, in the case of organ procurement, the same rules shall apply (with the exception of State Licensure) in regard to Temporary Privileges. The organ transplant coordinator will be responsible for overseeing this process.

5.5.3 Emergency Temporary Privileges. In an emergency, any Medical Staff member with Clinical Privileges is "Temporarily Privileged" to provide any type of patient care necessary as a life saving measure or to prevent serious harm, regardless of his current Clinical Privileges, if the care provided is within the scope of the Physician's license.

ARTICLE 6 ALLIED HEALTH PROFESSIONALS (AHP)

Allied Health Professionals are health care providers who are not Practitioners, but by virtue of their special training, are able to provide services which are not already available to the Hospital or its Medical Staff. AHPs may include, but are not necessarily limited to, nurse anesthetists, nurse practitioners, physician assistants, surgical technicians, registered nurses, social workers and clinical psychologists. AHPs are not eligible to be members of the Medical Staff. AHPs, and members who supervise AHPs, shall be subject to and governed by the provisions set forth in AHP policies which are part of the Medical Staff policies.

ARTICLE 7 OFFICERS

SECTION 7.1 OFFICERS OF THE MEDICAL STAFF

The Officers of the Medical Staff shall be the COS, Vice COS, Past COS and Treasurer.

SECTION 7.2 QUALIFICATIONS OF OFFICERS

Officers must be Staff Members of the Active Staff in good standing. No officer, except the Past COS, may simultaneously hold similar leadership positions at other institutions. No officer may simultaneously serve as a Department Chief.

SECTION 7.3 ELECTION OF OFFICERS

Officers, other than the Past COS, shall be elected with voting procedures by the majority vote of the Active and Associate Staff members present and voting at a meeting of the Medical Staff. Only members of the Active and Associate Staff shall be eligible to vote. The MEC shall have the authority to adopt reasonable voting procedures. The Past COS shall normally attain that office by successful completion, without removal or resignation, of a term as COS immediately before the current COS was elected. All officers are subject to being confirmed by the Governing Body. In the event of a disagreement between the Medical Staff and the Governing Body over the confirmation of any such officer, the matter will be resolved pursuant to the Joint Conference provisions of these Bylaws.

SECTION 7.4 NOMINATION PROCESS

7.4.1 Nominating Committee. There shall be a Nominating Committee composed of the members of the MEC.

7.4.2 Responsibilities. The Nominating Committee shall be responsible to:

- i.** Present nominations for election to the office of COS, Vice COS, Secretary/Treasurer and any elected at-large members of the MEC at the Medical Staff meeting immediately prior to the annual meeting of the Medical Staff in which the election is to be held.
- ii.** Accept additional nominations from the Staff Members when and if supported by a petition signed by at least fifteen percent (15%) of all voting Staff members received at least fifteen (15) days before the election of the officers.
- iii.** Prepare a written ballot containing the names of nominees for election of officers.

SECTION 7.5 TERM OF OFFICE

Standard terms of the offices shall be for two (2) years. Officers shall take office on the first day of January following their election or when they are elected or succeed to an office, if filling a vacancy.

SECTION 7.6 VACANCIES OF OFFICERS

If there is a vacancy in the office of the COS, the Vice COS shall serve the unexpired portion of the term. All other vacancies in office during the term shall be filled by the MEC. However, if there is a simultaneous vacancy in both the office of COS and Vice COS, a special election shall be called by the MEC for both positions. In the event that the Past COS resigns or is

removed, or the prior COS is not qualified to serve as Past COS, the MEC shall select another former chief of staff to serve as Past COS.

SECTION 7.7 DUTIES OF OFFICERS

7.7.1 COS. The COS shall serve as the senior officer of the Medical Staff and will fulfill the following duties in addition to duties stated elsewhere in these Bylaws and the Medical Staff Rules and Regulations:

- i.** To serve as an ex-officio member of the Hospital Board of Trustees and a voting member of the MEC.
- ii.** To serve as Chair of the MEC.
- iii.** To preside at general staff meetings of the Medical Staff.
- iv.** To present the views, policies, needs, and grievances of the Medical Staff to the Board and the CEO of the Hospital working together with the Vice-Chief of Staff.
- v.** To be the spokesman for the Medical Staff in its external professional and public relations.
- vi.** To be responsible for the preparation of the agenda for meetings of the MEC.
- vii.** To serve as an ex-officio member of all Medical Staff committees.
- viii.** Subject to the terms of the Hospital Bylaws, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, and policies adopted pursuant to the foregoing, the Chief of Staff shall be responsible to oversee the quality of medical care of patients of North Ottawa Community Hospital.
- ix.** To appoint the members and chairpersons of all standing and special committees of the Medical Staff as provided by these Bylaws except the MEC. He shall appoint members of the Medical Staff to such other special committees as may be created by the MEC.
- x.** To perform such other duties as may be assigned to him/her by the MEC and to act with the authority of this committee.
- xi.** To be responsible for the implementation of these Bylaws as written and as hereinafter amended.

7.7.2 Vice COS. In the absence of the COS, the Vice COS shall assume all the duties and have the authority of the COS. He shall perform such further duties to assist the COS as the COS may from time to time request, shall be a member of the MEC, and shall serve as Chair of the Medical Practices Committee, or appoint a designee.

7.7.3 Past COS. The Past COS will be a member of the MEC, may be a member of the Medical

Practices Committee, and will serve as consultant to all other Medical Staff officers.

7.7.4 Treasurer. The Treasurer will be a member of the MEC and shall maintain responsibility for overseeing the finances of the MEC and Medical Staff.

SECTION 7.8 REMOVAL FROM OFFICE

Officers of the Medical Staff may be removed from office:

- i.** For failure to perform the duties of the office in a timely or appropriate manner;
- ii.** For physical or mental infirmity that renders the Officer incapable of fulfilling the duties of the office;
- iii.** For failure to be re-appointed as a Staff member of the Active Medical Staff;
- iv.** If the Officer's clinical Privileges are revoked, limited or suspended (except suspension or relinquishment of Privileges due to incomplete medical records); or
- v.** For any other conduct, statement or action tending to injure the reputation of the Medical Staff or Hospital, as determined by the Medical Staff and the Governing Body. In the event of a disagreement between the Medical Staff and the Governing Body over the removal of any such Officer, the matter will be resolved pursuant to the Joint Conference provisions of these Bylaws.

If the removal is to be initiated by Medical Staff action rather than Governing Body action, a petition to remove an Officer must be signed by four (4) members of the MEC or fifteen percent (15%) of the Staff Members of the Active Medical Staff. Removal of an Officer by the Medical Staff shall be upon an affirmative vote of sixty-seven percent (67%) of the Staff members of the Active Medical Staff who are present at a duly convened meeting. Any Officer subject to a petition to remove shall have the right at the time prior to any such meeting, to submit a written statement to those entitled to attend such meeting setting forth the reason or reasons why such Officer should not be removed.

ARTICLE 8 MEDICAL DIRECTORS

The Hospital may appoint Medical Directors to achieve its purpose. The Medical Director will be the medical officer in charge of an identified area or program, reporting to the CEO or his designee. The following information summarizes the typical responsibilities.

- i.** In a collaborative relationship with Administration, assumes accountability for the delivery of quality services through consistent development, revision, implementation, and interpretation of procedures, protocols, and standards of care affecting patients.
- ii.** Develops yearly quality improvement goals in collaboration with the Chief Nursing Officer (CNO).

- iii. Working in collaboration with administrative and physician colleagues, accepts lead accountability to develop and lead initiatives to improve clinical care, lead the implementation of outcome reporting systems and physician-level clinical reports, participate in patient safety initiatives, provide an active leadership role in the design and implementation of process improvements specific to his areas of responsibility, and serve as spokesperson for Hospital in his area of clinical expertise as appropriate.
- iv. Participates on Health System, Hospital, Medical Staff, and community committees.
- v. Maintains frequent communication with executives and medical leaders.
- vi. In a collaborative relationship with Administration, maintains accountability for the development of capital and operational budgets for the service. Monitors, evaluates, and advocates for appropriate utilization of resources within the service.
- vii. Enforces approved Privileges for Medical Staff, interpreting boundaries and limits, as indicated, for quality patient care.
- viii. Participates in short- and long-range planning within the Hospital in order to provide effective and efficient delivery of care and improved continuity and coordination of services and, with the Administration, develops and monitors the strategic plan for the service.
- ix. Takes a leadership role in the planning, implementation, and evaluation of quality improvement activities.
- x. Acts as an advocate and provides ongoing communication with patients/families, staff, and the multidisciplinary team regarding patient, staff, management, quality care issues, and divisional/hospital goals.
- xi. Medical Directors document related activities on a monthly basis and submit to Medical Staff office monthly.
- xii. Performs other duties as assigned and/or as set forth in appropriate job descriptions.

ARTICLE 9 MEDICAL STAFF ORGANIZATION

SECTION 9.1 DEPARTMENTS

The Medical Staff shall be organized into six (6) Departments: Surgery, Medicine, Emergency, Family Practice, Obstetrics and Gynecology, and Pediatrics. Each Department shall have a Chief with overall responsibility for the supervision and satisfactory discharge of assigned functions of the Department. The Departments shall be responsible to the MEC for the promotion of quality of care, reviewing the professional performance of members rendering care in the Hospital and making recommendations on appointment and reappointment.

SECTION 9.2 SURGERY DEPARTMENT

The Medical Staff shall organize and establish a Department of Surgery which shall include: Anesthesiology, General Surgery, Neurosurgery, Ophthalmology, Oral & Maxillofacial Surgery, Orthopedics, Otorhinolaryngology, Pain Management, Pathology, Plastic Surgery, Podiatry, Proctology, Thoracic, Urology and Vascular.

SECTION 9.3 MEDICINE DEPARTMENT

The Medical Staff shall organize and establish a Department of Medicine which shall include Allergy & Immunology, Cardiology, Dermatology, Gastroenterology, Infectious Diseases, Internal Medicine, Medical Oncology/Hematology, Nephrology, Neurology, Physiatry & Rehabilitation, Psychiatry, Pulmonary Medicine, Radiology and Rheumatology.

SECTION 9.4 EMERGENCY DEPARTMENT

The Medical Staff shall organize and establish a Department of Emergency Medicine.

SECTION 9.5 FAMILY PRACTICE DEPARTMENT

The Medical Staff shall organize and establish a Department of Family Practice.

SECTION 9.6 OBSTETRICS AND GYNECOLOGY DEPARTMENT

The Medical Staff shall organize and establish a Department of Obstetrics and Gynecology.

SECTION 9.7 PEDIATRICS DEPARTMENT

The Medical Staff shall organize and establish a Department of Pediatrics.

SECTION 9.8 OPTIONAL SECTIONS

9.8.1 Section Formation. The MEC may recognize any group of Practitioners who have organized themselves into Sections of a Department.

9.8.2 Role. Sections are completely optional and may exist to perform any of the following activities:

- i.** Continuing education;
- ii.** Discussion of policies;
- iii.** Discussion of equipment needs;
- iv.** Development of recommendations for Department Chiefs or the MEC;
- v.** Participation in the Department criteria for Section Privileges (when requested by a Department Chief or Medical Practice Committee or MEC); and

vi. Discuss a specific issue at the request of a Department Chief or the MEC.

9.8.3 Section Operation. A Section, if organized, will not be required to hold regularly scheduled meetings. Except in extraordinary circumstances, no minutes or reports will be required reflecting the activities of the Section. Only when Sections are making formal recommendations to a Department will a report be required to be sent to the Department Chief documenting the Section's specific position. Sections may have a Section Chief elected by a simple majority vote of the Active and Associate Staff Members of the Section present and voting at the last meeting of the Section in each odd-numbered year, subject to MEC and Governing Body ratification. Section meetings will ordinarily not be staffed by representatives of the Medical Staff Office. Attendance will not be taken, nor will any rigid agenda be followed. Sections that are organized by the Medical Staff and formally recognized by the MEC will be listed in the Policy Manual, and may have requirements as determined by the MEC.

SECTION 9.9 QUALIFICATIONS, SELECTION, TENURE, AND REMOVAL OF DEPARTMENT CHIEF AND VICE CHIEF

9.9.1 Each clinical department shall have an elected Department Chief.

9.9.2 Term. The term of service for Chiefs shall be two (2) years commencing on January 1 of each even-numbered year. All Chiefs must be Staff Members in the Active Staff with relevant Privileges and Board Certified or Board Eligible. Each Department Chief shall also meet the qualifications specified in the Policy Manual.

9.9.3 Election. Department Chiefs will be elected by simple majority vote of the Active and Associate Staff Members of the Department present and voting at the last meeting of the Department, in each odd-numbered year, subject to ratification by the MEC and Governing Body.

9.9.4 Removal. A Department Chief may be removed by the Governing Body and MEC for good cause, including those grounds for which an officer may be removed. In the event of a disagreement between the MEC and the Governing Body over the removal of a Department Chief, the matter will be resolved pursuant to the Joint Conference provisions of these Bylaws.

If removal of a Chief occurs, the COS shall appoint a replacement until the Department elects a replacement.

SECTION 9.10 QUALIFICATIONS, ROLES AND RESPONSIBILITIES OF DEPARTMENT CHIEFS

The qualifications, roles, and responsibilities of the Department Chiefs shall include those described below. In the absence or unavailability of a Department Chief, the Section Chief most relevant to the subject matter shall act in the Department Chief's stead. However, if that Section Chief is unavailable or otherwise inappropriate as determined by the COS, any other Section Chief or Staff Officer designated by the COS may act on behalf of the Department Chief.

9.10.1 Qualifications. Active Staff member assigned to the Department who has certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

9.10.2 Roles and Responsibilities.

- i. To act, in general, as the highest elected Officer of the department;
- ii. To serve as a member of the MEC of the Medical Staff;
- iii. To serve on or appoint an appropriate alternate to the Medical Practice Committee;
- iv. To present the views, policies, needs (including, without limitation, recommendations for space and resources), and the grievances of the members of his/her department to the MEC;
- v. To be responsible for maintaining a continuing review and improvement of professional performances of all Practitioners with clinical Privileges in his/her department, maintenance of quality control programs as appropriate, and report regularly thereon to the MEC;
- vi. To assemble recommendations concerning Medical Staff classification, initial appointment, reappointment, and delineation of clinical Privileges for all Practitioners or prospective Practitioners in the department, assemble recommendations for a sufficient number of qualified and competent persons to provide care in the department; and assemble recommendations regarding outside sources for needed services; and to transmit the same to the MEC of the Medical Staff;
- vii. In the event that there is no part-time or full-time Medical Director for his/her Department, the Department Chief shall carry out all duties of such part-time or full-time Director as hereinafter described;
- viii. To call and preside at regular department meetings;
- ix. To integrate the department into the primary functions of the organization and coordinate interdepartment and intradepartment services;
- x. To develop and implement policies and procedures that guide and support the provision of services; and
- xi. To monitor the orientation and continuing education of all persons in the department;

SECTION 9.11 FUNCTIONS OF DEPARTMENTS

Each Department shall systematically evaluate the effectiveness and efficiency of the care of selected patients by its Staff Members as provided in the Policy Manual, based on national

quality standards and criteria. This may be performed in whole or part through a Department Management Committee if one is established in the Rules and Regulations.

SECTION 9.12 ASSIGNMENT TO DEPARTMENT

The MEC will, after consideration of the recommendations of the Chief of the appropriate Department as transmitted through the Medical Practices Committee, recommend Department assignments for all Staff Members in accordance with their qualifications. Each Staff Member will be assigned to one primary Department. Privileges are independent of Department assignment.

ARTICLE 10 COMMITTEES

SECTION 10.1 DESIGNATION AND AUTHORITY OF COMMITTEES AND MEMBERS

10.1.1 All Medical Staff committees are under the authority of the MEC through its Chief of Staff. Unless otherwise specified in these Bylaws, Medical Staff members are appointed to and/or removed from Medical Staff Committees by the Chief of Staff. There shall be a MEC and Medical Practices Committee which shall perform, among their activities, professional review functions and such other standing and special committees of the Medical Staff responsible to the MEC as may from time to time be necessary and desirable to fulfill the meaning and intent of these Bylaws. Those functions requiring participation of, rather than direct oversight by, the Medical Staff may be discharged by the Medical Staff representation on such Hospital committees as are established to perform such functions.

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

- i.** Review of professional practices of the Hospital in an effort to reduce morbidity and mortality;
- ii.** Review of professional practices in an effort to improve the care and treatment provided patients in the Hospital, which shall include monitoring Hospital and Medical Staff policies and procedures, requirements for alternate coverage and consultations, and recommending methods of enforcement and changes when appropriate;
- iii.** Review and analyze medical records for adequacy, quality, and necessity;
- iv.** Review of preventability of complications and deaths occurring in the Hospital;
- v.** Directing, ordering and requiring the collection of records, data and knowledge in furtherance of its duties; and
- vi.** Submittal of reports to the MEC concerning:

- a) Findings of the committee's review and evaluation activities, actions taken thereon and the results of such actions;
- b) Recommendations for maintaining and improving the quality of care provided in the Hospital; and
- c) Such other matters as may be requested from time to time by the MEC.

All data, knowledge and records of these committees shall and must be kept in a confidential manner and shall not be subject to being subpoenaed or produced in legal proceedings consistent with the provisions of Michigan and federal statutes (including, but not limited to, the Michigan Public Health Code, MCL §§ 333.20175; 333.21513; 333.21515; and 331.531-533).

10.1.3 Scope of Authority. Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to, the MEC or a Department, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

10.1.4 Voting. Regardless of the number of voting capacities any one person may hold on a committee (e.g., Department Chief and Section Chief on the MEC), each voting member of a committee shall have only one vote.

10.1.5 Committee Meetings. Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. A special meeting may be called by or at the request of the COS.

SECTION 10.2 MEDICAL EXECUTIVE COMMITTEE (MEC)

10.2.1 Composition. The MEC shall consist of the COS, Vice COS, Past COS and Treasurer as well as the Department Chiefs and designated Section Chiefs. The Chair of the Governing Body, the CEO (or designee) and Administrative staff shall be ex-officio members without vote. The chairperson will be the COS. In the event a MEC member is removed, pursuant to Section 7.8 of these Bylaws, from the role of Officer or Chief that led to their membership on the MEC as defined in this section, such person shall also be removed from the MEC.

10.2.2 Authority and Function. The Medical Staff delegates authority to the MEC via these Bylaws to carry out the following duties. The Medical Staff may delegate or remove duties of the MEC by amending these Bylaws.

- i. Receive or act upon reports and recommendations concerning patient care quality, service quality and appropriateness reviews; evaluate monitoring functions and the discharge of their delegated administrative responsibilities; and recommend to the Governing Body specific programs and systems to implement these functions;
- ii. Coordinate the activities required by and policies adopted by the Governing Body;

- iii. Submit recommendations or evaluations or qualifications to the Governing Body concerning all matters relating to appointments, reappointment, Medical Staff category, Department assignments, Privileges and corrective action;
- iv. Account to the Governing Body and to the Medical Staff for the overall quality and efficiency of patient care in the Hospital and the participation of the Medical Staff in organization performance improvement activities;
- v. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Staff Members including initiating investigations and initiating and pursuing corrective action, when warranted;
- vi. Make recommendations on medical administrative and Hospital operational matters affecting the Medical Staff;
- vii. Periodically advise the Medical Staff concerning the current licensure and accreditation status of the Hospital;
- viii. Consistent with the mission and philosophy, participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;
- ix. Represent and act on behalf of the Staff between meetings of the organized Medical Staff, subject to such limitations as may be imposed by these Bylaws;
- x. Formulate Medical Staff Rules and Regulations for review and vote by the Active Medical Staff;
- xi. Formulate Medical Staff policies and communicate such policies to the Medical Staff;
- xii. Oversee the Medical Staff aspect of compliance with accreditation and regulatory requirements.
- xiii. The MEC, in conjunction with the Governing Body, shall establish standing committees, arrange Staff Member participation in Hospital-Wide committees, and establish committee protocols which address clinical and professional review functions.
- xiv. Have authority and responsibility over daily medical education activities at the Hospital and shall schedule educational programs at the regular Medical Staff meetings.

10.2.3 Meetings. The MEC shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

10.2.4 Exclusive Service Areas. The Governing Body shall consult with and seek MEC approval relative to the quality, clinical and related issues and consequences of any proposal by the Hospital to make a non-exclusive area of clinical practice exclusive or to grant an exclusive contract within an exclusive Department or other area of clinical practice.

SECTION 10.3 MEDICAL PRACTICES COMMITTEE

10.3.1 Composition. The Medical Practices Committee shall consist of at least five (5) Staff Members. The committee will include the Department Chief or an appointee from each Department appointed by his Department Chief. The Vice COS shall serve as Medical Practices Committee Chair or appoint a designee from the Medical Practices Committee. The COS may appoint other Staff Members for two-year terms. The Committee Members shall have been in the Medical Staff of the Hospital for at least two (2) years.

10.3.2 Duties. The duties of the Medical Practices Committee shall be to investigate the character and qualifications of all initial applicants for Membership or appointment as an AHP; to review the current competence and qualifications of Staff members who are subject to reappointment, and in conjunction with the Department Chief, to make recommendations to the MEC regarding the initial appointments and reappointment. The committee shall also be responsible for clinical and professional review functions and overseeing the operation of any AHP credentialing committee. Other duties will include to review and make recommendations to the MEC relating to ethical concerns as they relate to patient care and/or Medical Staff concerns. Other duties or modification of the foregoing duties may be prescribed in the Medical Staff Policies.

10.3.3 Meetings. The Medical Practices Committee shall meet at least ten (10) times per year, and maintain a permanent record of its proceedings.

10.3.4 Special Professional Review

10.3.4.1 Purpose of Special Professional Review. A confidential, professional Medical Practices Committee review, study or investigation of the practice of one or more Staff Members or affiliated AHPs may be initiated on a Department (or Section) basis for the purpose of formulating policy or resolving concerns regarding patient care.

10.3.4.2 Special Professional Review Limitation. A professional review study or investigation at the Department (or Section) level may be initiated by: joint request of the COS and CEO; request of the MEC; request of the Governing Body; or a request of a Department Chief or the Departmental Committee with the concurrence of the CEO and notice to the COS.

10.3.4.3 Professional Review Scope and Protocol. The scope of the professional review shall be specified in writing agreed upon by those initiating the review, or if those individuals do not agree, by the COS with input from the Department Chief and/or Section Chief. The protocol may direct that Staff Members, Hospital Staff, and others be interviewed in the process if so specified. All those from whom an interview is requested

shall comply.

10.3.4.4 Reporting. Upon completion of its study or investigation, the Medical Practices Committee shall report its findings to the Department Chief, MEC (through the COS) and the CEO of the Hospital. Confidentiality shall be maintained consistent with the Bylaws.

SECTION 10.4 BYLAWS COMMITTEE

The Bylaws Committee is considered a sub-committee under Medical Practices Committee.

10.4.1 Composition. This committee shall consist of six (6) members of the Active Medical Staff, including the Chief of Staff and the Vice-Chief of Staff.

10.4.2 Duties. This Committee shall be concerned with the revision of the Bylaws and Rules and Regulations of the Medical Staff so they are kept up-to-date and consistent with the needs of the Hospital.

10.4.3 Meetings. As needed.

SECTION 10.5 ETHICS COMMITTEE

The Ethics Committee is a multidisciplinary group which acts as a facilitative, educational and consultative resource for the Hospital, affiliates, care providers, patients and families.

10.5.1 Composition. Membership will include, but not necessarily be limited to, representation from Medical Staff, nursing, administration, pastoral care, Board of Trustees, medical social work, risk management, patient relations, the community, and others with experience and a perspective that may improve the functions of the committee.

10.5.2 Duties.

- i.** Education - To promote educational programs on biomedical ethical issues designed to increase the sensitivity and knowledge among committee members, Medical Staff, System staff, patients/families, and the community.
- ii.** Policy Consultation - To review and give advice on proposed institution or system policies and/or procedures that have ethical implications.
- iii.** Case Consultation - To provide advisory consultation for individual patient situations at the request of any involved individual. The Chairperson(s) may delegate consultative groups composed of committee members for the purpose of responding to such requests.

Note: In each of these functions, the Committee acts as a consultative resource and will not make medical treatment decisions or hospital policy.

10.5.3 Meetings. The committee shall meet as needed.

SECTION 10.6 PHYSICIAN WELLNESS COMMITTEE

10.6.1 Composition. Physician Wellness Committee members are appointed by the Chief of Staff and shall consist of six (6) members from various specialties.

10.6.2 Duties. The primary purpose of the committee is to implement the Medical Staff policy regarding Physician Health. The focus of the committee is to be corrective, not punitive, in helping the Medical Staff member rectify an impairment. Equally important, the committee must strive to protect the patients, the hospital, and the colleagues of the impaired physician. The committee shall investigate allegations of physician impairment as requested by the Chief of Staff and in accordance with the Medical Staff Policy regarding Physician Health.

10.6.3 Meetings. The committee shall meet as needed.

SECTION 10.7 SURGICAL SERVICES COMMITTEE

10.7.1 Composition. The Co-Chairs of the committee are the Chief of Surgery and Director of Surgical Services. The committee members may include other department and surgical medical staff. Hospital Administration and Nursing Administration will also have representatives on the committee.

10.7.2 Duties. The committee shall:

- i. Govern the performance, quality, and access of the Surgical Services and Recovery Room.
- ii. Make recommendations to the MEC for action needed to maintain or improve the proper functioning and efficiency of the Operating Room and Recovery Room.

10.7.3 Meetings. The committee shall meet at least four (4) times per year.

SECTION 10.8 EMERGENCY DEPARTMENT COMMITTEE

10.8.1 Composition. Membership will include, but not necessarily be limited to, representation from the Emergency Department Medical Staff, Nursing Administration, nursing, and others with experience and a perspective which may improve the functions of the committee.

10.8.2 Duties. Govern the performance improvement, quality, and access of the Emergency Department. Make recommendations for actions needed to maintain or improve proper function and efficiency of the Emergency Department.

10.8.3 Meetings. The committee shall meet at least four (4) times per year.

SECTION 10.9 PEDIATRIC DEPARTMENT COMMITTEE

10.9.1 **Composition.** Membership will include, but not necessarily be limited to, Chief of Pediatrics, Pediatric Department Medical Staff, Nursing Administration, nursing, and others with experience and a perspective which may improve the functions of the committee.

10.9.2 **Duties.** Govern the performance improvement, quality, and access of the Pediatric Department. Make recommendations for actions needed to maintain or improve proper function and efficiency of the Pediatric Department.

10.9.3 **Meetings.** The committee shall meet at least four (4) times per year.

SECTION 10.10 OB/GYN DEPARTMENT COMMITTEE

10.10.1 **Composition.** Membership will include, but not necessarily be limited to, Chief of OB/GYN, OB/GYN Department Medical Staff, Nursing Administration, nursing, and others with experience and a perspective which may improve the functions of the committee.

10.10.2 **Duties.** Govern the performance improvement, quality, and access of the OB/GYN Department. Make recommendations for actions needed to maintain or improve proper function and efficiency of the OB/GYN Department.

10.10.3 **Meetings.** The committee shall meet at least four (4) times per year.

SECTION 10.11 ICU COMMITTEE

10.11.1 **Composition.** Membership will include, but not necessarily be limited to, the Medical Director of ICU, Medical Staff, Nursing Administration, nursing, and others with experience and a perspective which may improve the functions of the committee.

10.11.2 **Duties.** Govern the performance improvement, quality, and access of the ICU Department. Make recommendations for actions needed to maintain or improve proper function and efficiency of the ICU Department.

10.11.3 **Meetings.** The committee shall meet at least four (4) times per year.

SECTION 10.12 MEDICINE DEPARTMENT COMMITTEE

10.12.1 **Composition.** Membership will include, but not necessarily be limited to, representation from the Medicine Department, Medical Staff, Nursing Administration, nursing, and others with experience and a perspective which may improve the functions of the committee.

10.12.2 Duties. Govern the performance improvement, quality, and access of the Medicine Department. Make recommendations for actions needed to maintain or improve proper function and efficiency of the Medical Department.

10.12.3 Meetings. The committee shall meet at least four (4) times per year.

SECTION 10.13 OTHER COMMITTEES

Other committees may be appointed from time to time by the Chief of Staff or MEC.

SECTION 10.14 STAFF FUNCTIONS

Provisions shall be made in these Bylaws or by resolution of the MEC approved by the Governing Body, either through assignment to the Departments and Department Chiefs, to staff committees, to Staff officers or officials, or to interdisciplinary Hospital committees, for the effective performance of the Staff functions specified in the Medical Staff Policies and other Staff functions as the MEC or the Governing Body shall reasonably require. The Medical Staff shall participate in at least the following organization activities: medical management oversight, infection control oversight, tissue review, utilization review, medical record review, and the quality management system.

ARTICLE 11 MEDICAL STAFF MEETINGS

SECTION 11.1 ANNUAL MEDICAL STAFF MEETINGS

- i.** The Medical Staff year shall follow and comprise a calendar year. An annual meeting of the Medical Staff shall be held during the last quarter of each year. Written notice of the meeting shall be sent to all Medical Staff members and conspicuously posted.
- ii.** The primary objective of the meetings shall be to report on the activities of the Medical Staff and conduct such other business as may properly come before the meeting. Written minutes of all meetings shall be prepared and recorded.

SECTION 11.2 SPECIAL MEETINGS

- i.** The COS may call a special meeting of the Medical Staff at any time. The COS shall call a special meeting within twenty (20) calendar days after receipt of a written request for such a meeting signed by not less than fifteen percent (15%) of the Active Medical Staff, or upon a resolution by the MEC. Such request or resolution shall state the purpose of the meeting. The COS shall designate the time and place of any special meeting.
- ii.** Written or printed notice stating the time, place and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least seven (7) days before the date of such meeting. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be

transacted at any special meeting except that stated in the notice of such meeting.

SECTION 11.3 ATTENDANCE REQUIREMENTS

Members of the Active Medical Staff are expected to attend meetings of the Medical Staff. Other members of the Medical Staff may attend Medical Staff meetings and shall have only such voting rights as otherwise delineated in these Bylaws.

11.3.1 Medical Executive and Medical Practices Committee Meetings. Staff Members of the MEC and Medical Practices Committee are expected to attend at least fifty percent (50%) of the meetings held.

11.3.2 Special Attendance Requirements.

- i. A practitioner whose patient's clinical course is scheduled for discussion at a regular Department meeting or Medical Practice Committee shall be so notified and expected to attend the regular Department meeting or Medical Practice Committee meeting.
- ii. Failure by a Practitioner to attend any meeting to which he was given notice that attendance was mandatory, unless excused by the MEC upon a showing of good cause, may result in a request for corrective action. In all other cases, if the Practitioner shall make a timely request for postponement supported by an adequate showing that his absence will be unavoidable, such presentation may be postponed by the Chief of the Department (or by the MEC if the Chair or Chief is the Practitioner involved), until not later than the next regular meeting of the required Department or Committee meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.
- iii. Whenever a pattern of suspected deviation from standard clinical or professional practice is identified, the COS or the applicable Department Chief may require the Practitioner to confer with him or with a standing or ad hoc committee considering the matter. The Practitioner will be given special notice of the conference at least seven (7) days prior to the conference, including the date, time, and place, a statement of the issue involved and a statement that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such conference, unless excused by the MEC upon showing good cause, will result in an automatic suspension in accordance with the provisions of these bylaws.

SECTION 11.4 PARTICIPATION BY CEO OF THE HOSPITAL

The CEO of the Hospital and any representative assigned by the CEO may attend any committee or department meetings of the Medical Staff in a non-voting capacity.

SECTION 11.5 ROBERT'S RULES OF ORDER

The latest edition of ROBERT'S RULES OF ORDER shall prevail at all meetings of the Medical Staff, MEC and departmental meetings unless waived, except that the Chair of any meeting may vote.

SECTION 11.6 NOTICE OF MEETINGS

Written notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee or department not less than seven (7) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting unless, at the beginning of the meeting the member objects to the meeting or the transacting of business at the meeting and does not thereafter vote upon or assent to any action taken at the meeting.

SECTION 11.7 ACTION OF COMMITTEE/DEPARTMENT

The action of a majority of its members present at a meeting shall become the action of a committee or department.

SECTION 11.8 RIGHTS OF EX-OFFICIO STAFF MEMBERS

Except as otherwise provided in these Bylaws, persons serving as ex-officio members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote.

SECTION 11.9 MINUTES

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. After committee review, copies thereof shall be submitted to the MEC. Minutes of each committee and department meeting shall be maintained in a permanent file.

ARTICLE 12 PRACTITIONER RIGHTS

In the event a Practitioner is unable to resolve a difficult issue through his respective Chief, he may, upon written notice, request to meet with the MEC. Each member of the Medical Staff may request discussion of a documented and unresolved concern by the MEC. This concern may be related to, but not limited to, Hospital administrative and/or nursing issues. This request should be in writing to the COS with documentation of all steps taken to resolve his issue to date.

Any Practitioner may raise a challenge to any rule, regulation, or policy established by the MEC. In the event that a rule, regulation or policy is felt to be inappropriate, any Physician may submit a petition signed by fifteen percent (15%) of the members of the Active Staff. When such petition has been received by the MEC, it will either:

- i. Provide the petitioners with information clarifying the intent of such rule, regulation or policy; and/or
- ii. Schedule a meeting with the petitioners to discuss the issue.

Any subspecialty group may request a department meeting when a majority of the members/sub specialists believe that the department has not acted appropriately.

A Medical Staff member may, upon reasonable request and within policies and procedures as approved by the MEC, review his own credentialing files and Medical Staff files other than those materials which the Hospital and/or Medical Staff has designated as confidential peer or professional review materials, as per policy.

ARTICLE 13 SUSPENSION AND CORRECTIVE ACTION

SECTION 13.1 CORRECTIVE ACTION

Whenever the activities or professional conduct of any Practitioner with clinical privileges at North Ottawa Community Hospital are considered below applicable standards of the Medical Staff, contrary to the Medical Staff Bylaws or Rules and Regulations, or disruptive to the operations of the Hospital, corrective action toward such Practitioner may be requested.

13.1.1 Request. Request for corrective action toward a Medical Staff member may be initiated by any of the following:

- i. An officer of the Medical Staff;
- ii. A Chief of a Clinical Department;
- iii. A Vice COS;
- iv. the COS;
- v. the CEO of the Hospital;
- vi. The Governing Body, or
- vii. Any officer of the Governing Body.

Requests for corrective action must be submitted in writing to the MEC along with supporting documentation of the specific activity or conduct by the Practitioner which constitutes the grounds for the request. Documentation of the rationale for a request is required of any of the above who initiates the request.

13.1.2 Investigation. The MEC, after receiving the documentation, may conclude that an investigation is warranted. The MEC will assign this investigation to the Medical Practice Committee unless a Department has already conducted an investigation. The Practitioner who is the subject of the request for corrective action shall be promptly notified that an investigation is being conducted. He shall be given an opportunity to provide information

on terms the Medical Practice Committee deems appropriate. The Medical Practice Committee may conduct interviews with persons involved; however, such investigation shall not constitute a hearing as the term is used in Hearing and Appellate Review Procedures provisions of the bylaws, nor shall the procedural rules with respect to hearings apply. The Medical Practice Committee shall investigate the allegations, promptly conclude, and forward a written report to the MEC. This report may include recommendations for corrective action. Despite the status of any investigation, the MEC and the Governing Body shall at all times retain authority and discretion to take whatever action may be warranted by the circumstances. Options for this action may include: summary suspension, termination of the investigation process, or other action.

13.1.3 Medical Executive Committee Responsibilities. As soon as practical after the conclusion of the investigation, the MEC shall take action which may include, but is not limited to:

- i. Determining no corrective action is required.
- ii. Deferring action for a reasonable time when circumstances warrant additional time.
- iii. Issuing letters of warning or reprimand. In the event such letters are issued, the Practitioner may make a written response to be placed in his Medical Staff file. This action shall not preclude a Department Chief from issuing informal written or oral warning to the Practitioner outside of the mechanism for corrective action in this Article.
- iv. Recommending limitation of Medical Staff membership which may include suspension, change of category, probation, or revocation.
- v. Recommending limitations of clinical privileges that may include requirements for co-admission, mandatory consultation or proctoring of patient care, reduction, modification, suspension or revocation.

If corrective action is recommended by the MEC, the recommendation shall be transmitted to the Practitioner in writing. The Practitioner shall be entitled to rights set forth under Practitioner Rights or Hearing and Appellate Review Procedures provisions of the bylaws if applicable. If the Practitioner does not exercise his rights under Practitioner Rights or Hearing and Appellate Review Procedures provisions of the bylaws if applicable, the MEC shall forward its recommendations to the Governing Body. The decision of the Governing Body shall be final, and there shall be no further right of appeal.

If a request for corrective action originated with the Governing Body and the MEC decides that no action is warranted, the Governing Body has the authority to take action after the matter is reviewed by a Joint Conference Committee as described in Section 16.6 of these Bylaws.

SECTION 13.2 SUMMARY SUSPENSION

13.2.1 Initiation. If a Practitioner's conduct is inappropriate toward other persons as described in the Medical Staff Professional Conduct Policy or appears to present a

danger of immediate and serious harm to the life, health or safety of any patient, immediate action may be required. Any two (2) individuals, one of whom must be a physician and one administration representative, from the following: the COS, Vice COS, the Immediate Past COS, the CEO, any Vice President of the Hospital or the Chief of the Department in which the Practitioner holds Privilege, may summarily suspend the clinical Privileges of the involved Practitioner. Unless otherwise stated, such summary suspension shall become effective immediately and written notice shall be promptly given to the Practitioner, COS and CEO. Within forty-eight (48) hours of such suspension, the action must be confirmed or rescinded by the COS and/or the CEO. The summary suspension shall remain in effect for the period stated or, if none, until resolved as set forth within these Articles. Unless otherwise indicated by the terms of the summary suspension, the Practitioner's patients shall be promptly assigned to another Practitioner by the Department Chief or by the COS considering, where feasible, the wishes of the patient for his choice of a substitute Practitioner.

- 13.2.2 Medical Executive Committee Action.** As soon as practical after such summary suspension has been imposed, the MEC shall meet to review the matter. The involved Practitioner shall be given notice of this meeting and shall have an opportunity to appear. He shall be informed of the allegations and shall be invited to discuss, explain or refute the charges. A meeting of the MEC, with or without the Practitioner, does not constitute a "hearing" within the meaning of Hearing and Appellate Review Procedures provisions of these bylaws. The MEC has the option to modify, continue, or terminate the summary suspension. If the MEC does not terminate the summary suspension within fourteen (14) days of its effective date, the Practitioner shall be entitled to his rights as set forth in Practitioner Rights or Hearing and Appellate Review Procedures provisions of the bylaws if applicable. In any event, it shall promptly furnish the Practitioner, CEO and the Governing Body with notice of its decision. All MEC decisions shall be transmitted to the Governing Body for final action.

SECTION 13.3 AUTOMATIC SUSPENSION

In certain circumstances, practice Privileges or Medical Staff membership may be automatically suspended, revoked or limited. This action will be final and automatic without a right to hearing as described under SECTION 14.1.

13.3.1 Licensure.

- i. Revocation and Suspension.** Whenever a Practitioner's license to practice in the state of Michigan is revoked or suspended, the Practitioner shall notify the CEO and the MEC. His Medical Staff membership and clinical Privileges shall automatically be suspended or revoked as of the date the licensing action becomes effective.
- ii. Restriction.** Whenever a Practitioner's license to practice in this state is limited or restricted by the licensing authority, the Practitioner shall notify the CEO and the MEC. Any Medical Staff membership or clinical Privileges

which the Practitioner has been granted which are within the scope of that limitation or restriction shall be automatically limited or restricted to the same extent and duration as of the date the licensing authority action becomes effective.

- iii. **Probation.** Whenever a Practitioner is placed on probation by the licensing authority, the Practitioner shall notify the CEO and the MEC. His membership and clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date the licensing authority action becomes effective.

13.3.2 **Controlled Substance.**

- i. **Restriction.** Whenever a Practitioner's Drug Enforcement Administration (DEA) certificate or a prescribing authority is revoked, limited or suspended, the Practitioner shall notify the CEO and MEC. The Practitioner shall automatically be prohibited from prescribing medications covered by the certificate to the same extent and for the same duration.
- ii. **Probation.** Whenever a Practitioner's DEA certificate or prescribing authority is subject to probation, the Practitioner shall notify the CEO and the MEC. Practitioner's right to prescribe such medications shall automatically become subject to the same terms of probation and for the same duration as of the dates such probation becomes effective.

13.3.3 **Insurance.** Whenever a Practitioner has less than the professional liability insurance coverage required by the Governing Body, the Practitioner shall notify the CEO and the MEC. His medical staff membership and clinical Privileges shall automatically be suspended as of the date the coverage fell below the required level.

13.3.4 **Medical Records.** The rules for completion of medical records are outlined in the Rules and Regulations section of these Bylaws.

13.3.5 **Federal Program Exclusion.** Whenever a Practitioner is placed on a federal or state program excluded provider list, such as the Office of Inspector General (OIG) or General Service Administration (GSA), or is otherwise prohibited from providing services under a government payment program such as Medicare or Medicaid, the Practitioner shall notify the CEO of the Hospital or the Chief Nursing Officer. Any Medical Staff membership or clinical Privileges which the Practitioner has been granted which are within the scope of that limitation or restriction shall be automatically limited or restricted to the same extent and duration as of the date the governmental action becomes effective.

13.3.6 **Failure to Satisfy Special Appearance Requirements.** A Practitioner who fails to appear, after proper notification, at any meeting for which attendance was mandatory, shall automatically have his Privileges suspended unless he has requested postponement documenting that absence at that meeting would be unavoidable. As soon as practical, the MEC shall convene to review the facts, and may recommend further corrective action as it determines following the procedure generally set forth in Section 13.1.

13.3.7 Corrective Action. If a recommendation for corrective action should originate with the Governing Body, the hearing will be conducted as if the Medical Staff originated, according to the same procedures utilized when a recommendation originates with the Staff. This is consistent with the self-governing nature of the Staff.

ARTICLE 14 HEARING AND APPELLATE REVIEW PROCEDURE FOR ALL MEMBERS OF THE MEDICAL STAFF INCLUDING ACTIVE, ASSOCIATE, AND REFER AND FOLLOW

SECTION 14.1 RIGHT TO HEARING AND TO APPELLATE REVIEW

If an adverse action described in this section is proposed to be taken, the applicant or Medical Staff member must exhaust the remedies afforded by these Bylaws or waive them before resorting to legal action. Except as otherwise specified in these Bylaws, any one or more of the following actions shall be deemed adverse action and constitute grounds for a hearing:

- i.** Denial of initial staff appointment;
- ii.** Denial of reappointment;
- iii.** Suspension of staff membership;
- iv.** Revocation of staff membership;
- v.** Denial of requested modification in staff category;
- vi.** Reduction in staff category;
- vii.** Limitation of admitting prerogatives;
- viii.** Denial of requested department assignment;
- ix.** Denial of requested clinical Privileges;
- x.** Limitation of clinical Privileges;
- xi.** Suspension of clinical Privileges;
- xii.** Revocation of clinical Privileges.

An applicant or Medical Staff member against whom an adverse action has been taken shall be entitled to a hearing before an Ad Hoc Hearing Committee of the MEC of the Medical Staff. If the recommendation of the Ad Hoc Hearing Committee following such hearing is adverse to the affected Practitioner, He shall then be entitled to an appellate review by the Governing Body before the Governing Body makes a final decision on the matter.

SECTION 14.2 NOTICE OF PROPOSED ACTION

All notices of proposed action shall:

- i. Inform the Practitioner that an adverse action or recommendation has been proposed to be taken against the Practitioner and identify the reasons for such action.
- ii. Advise the Practitioner of his right to request a hearing pursuant to this procedure.
- iii. Specify a thirty (30) day time period in which he must request, in writing, a hearing review as provided in these Bylaws.
- iv. State that failure to request a hearing or appellate review within the specified time period shall constitute a waiver of his right to same.

SECTION 14.3 REQUEST FOR HEARING

- i. The CEO shall be responsible for giving prompt written notice of an adverse action to the affected Practitioner. Such notice shall be given by certified mail, return receipt requested, addressed to the Practitioner at his address as it appears on the records of the Hospital.
- ii. The affected Practitioner shall have thirty (30) days following the receipt of such notice to request a hearing. Such request shall be in writing, addressed and delivered to the CEO, by certified mail, return receipt requested or hand delivered in person.
- iii. The failure of a Practitioner to request a hearing to which he is entitled by the Medical Staff Bylaws within the time and in the manner herein provided shall be deemed a waiver of his right to such hearing and to appellate review to which He might otherwise have been entitled on the matter.
- iv. In the request for hearing, the affected Practitioner must set forth the basis of the appeal, including the facts upon which he relies, the identity of any persons who may be called as witnesses in support of the appeal, the substance of their proposed testimony, any documents that may be offered in support of the appeal and the substance thereof. Failure to include within the request for a hearing the above information constitutes a waiver of the right to present such witnesses or documents at the hearing.

SECTION 14.4 NOTICE OF HEARING

- i. As soon as practical after receipt of a request for hearing from a Practitioner entitled to the same, the MEC shall schedule and arrange for such a hearing and shall, through the CEO, notify the Practitioner of the time, place and date so scheduled by certified mail, return receipt requested. The hearing date shall be not less than thirty (30) days from the date of the notice of hearing.
- ii. The notice will include a list of witnesses, if any, expected to testify at the hearing on behalf of the Medical Staff.

SECTION 14.5 COMPOSITION OF HEARING COMMITTEE

A hearing shall be conducted by three (3) or more members of the Active Medical Staff appointed by the MEC, and one (1) of the members so appointed shall be designated as Chief. The MEC shall choose members of the Hearing Committee in a manner that minimizes potential conflicts.

SECTION 14.6 CONDUCT OF HEARING

- i.** All members of the Hearing Committee must be present when the hearing takes place and no member may vote by proxy. The decision of the majority of the members of the Hearing Committee shall be the decision of the committee.
- ii.** An accurate record of the hearing shall be made by such means as are established by the Hearing Committee, including, without limitation, use of a court reporter, electronic recording unit, detailed transcription or by the taking of adequate minutes. The Practitioner may obtain copies of the record upon payment of a reasonable preparation fee.
- iii.** The Practitioner requesting the hearing must be present in person and his absence is equivalent to a waiver of his procedural rights under the Article and renders the prior proposed adverse recommendation or action final.
- iv.** Postponement of hearings beyond the time set forth in the Medical Staff Bylaws shall be made only with the approval of the Hearing Committee. Granting of such postponements shall be only for good cause shown and at the sole discretion of the hearing committee.
- v.** The affected Practitioner shall be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing, or by a member of his local professional society, or by legal counsel, or another person of the physician's choice.
- vi.** A hearing officer, if one is appointed, or the Chief of the Hearing Committee or his designee, shall preside over the hearing to determine the order of procedure during the hearing and allow all participants reasonable opportunity to present relevant oral and documentary evidence and to maintain decorum.
- vii.** Rules of courtroom procedure shall not apply. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered irrespective of any statute or rule of law to the contrary. The Practitioner for whom the hearing is being held shall be, prior to or during the hearing, entitled to submit memoranda concerning any issue of procedure or of fact, and such memoranda shall become a part of the hearing record.

- viii.** The MEC shall send a representative or representatives to the hearing to present the facts in support of its adverse recommendation and to examine witnesses.
- ix.** The affected Practitioner shall have the following rights: to call and examine witnesses, to cross-examine any witnesses, rebut any evidence, and to introduce written evidence on any matter relevant to the issue of the hearing, regardless of its admissibility in a court of law. If the Practitioner does not testify on his own behalf, He may be called and examined as if under cross-examination. The Practitioner may submit a written statement at the close of the hearing.
- x.** Legal counsel shall be allowed for the Practitioner, the MEC, the Governing Body and/or the Hospital at the hearing, provided that all parties are notified five (5) days prior to the hearing. If any party gives notice that legal counsel shall appear for it, legal counsel may appear for all other parties without further notice. If a hearing officer is utilized, He may be an attorney at law.
- xi.** The Hearing Committee, without special notice, may recess the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall conduct its deliberations outside the presence of the Practitioner for whom the hearing was convened. It shall consider only evidence which was introduced at the hearing.
- xii.** Burden of presenting evidence and proof: At the hearing, unless otherwise determined for good cause, the MEC or the Hospital shall have the initial duty to present evidence for each case or issue in support of its proposed action or recommendation. The Practitioner shall be obligated to present evidence in response and throughout the hearing shall bear the burden of demonstrating by a preponderance of the evidence that the adverse action or recommendation was unreasonable or unwarranted.
- xiii.** Within fourteen (14) days after final adjournment of the hearing, the Hearing Committee shall deliberate in closed session on the evidence introduced at the hearing, including all logical reasonable inferences from the evidence and testimony. To preserve the integrity of the hearing and appeals procedure, no member of the Hearing Committee who has not been present during the entire hearing may be present in the deliberations or vote in the hearing committee's decision. The Hearing Committee shall, within three (3) days after the deliberation session, make a written report and recommendation regarding affirmation, modification or reversal of the original proposed adverse action. Their recommendation shall include a statement of the basis for the recommendation and shall be forwarded, together with the hearing record and all other documentation, to the MEC.

- xiv. The affected Practitioner shall be notified promptly by the CEO of any recommendation of the Hearing Committee.
- xv. The Practitioner, upon completion of the hearing, has the right to receive the written recommendation of the committee, including a statement of the basis for the recommendation.
- xvi. The hearing committee's functions constitute peer or professional review. All participants in the hearing process, including without limitation, the applicant or Medical Staff member, witnesses, members of the hearing committee and all records, data and knowledge collected for or by the committee are required to keep such information and material confidential under law, regulation and the provisions of these Bylaws.

SECTION 14.7 MEDICAL EXECUTIVE COMMITTEE ACTION

The MEC shall consider the recommendation of the hearing committee at its next regular meeting and shall affirm, modify or reverse any MEC previous recommendation. In the event that prior to reaching its decision, the MEC desires to receive from either the appellant or the representatives of the Hospital new matters not contained in the records, the MEC upon majority vote shall arrange a mutually convenient time for presentation and rebuttal limited solely to such issues. In the interests of time and the desirability of promoting a final judgment, such procedure shall be employed as required for unusual circumstances. The decision of the MEC, including a statement of the basis for the decision, shall then be transmitted to the Joint Conference Committee as described in Section 16.6 of these Bylaws, and then to the Governing Body for final consideration.

SECTION 14.8 FINAL DECISION BY THE GOVERNING BODY

The Governing Body may affirm, modify or reverse the recommendation or decision of the MEC and/or Joint Conference Committee, or it may refer the matter back to either entity for further review and recommendation. Upon decision by the Governing Body regarding the recommendation or actual adverse action, that action shall be final. The decision of the Governing Body, including a statement of the basis for the decision, will be delivered to the appellant by registered mail within thirty (30) days.

- i. Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.
- ii. NOTE: Days referred to in this Article are "calendar days".

ARTICLE 15 AUTHORIZATIONS AND IMMUNITY FROM LIABILITY

SECTION 15.1 REQUIRED CONDITIONS

The following shall be required conditions to any applicant or Medical Staff Member's application for and exercise of Staff membership and clinical Privileges at North Ottawa Community Hospital.

15.1.1 Good Faith Disclosure Privileged. Any act, communication, report, recommendation, or disclosure with respect to the professional ability and qualifications of any such individual made in good faith and without malice at the request of an authorized representative of the Hospital, the Medical Staff, or any other health facility or review entity for the purpose of achieving and maintaining the quality of appropriate patient care in this or any other health facility shall be privileged to the fullest extent permitted by law.

15.1.2 Extension of Privilege. Such Privileges shall extend to members of the Governing Body, the Medical Staff and its officers and committee members, and to third parties who supply information to any of the foregoing authorized to receive, release or act on the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Medical Staff or the Hospital.

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

15.1.4 Scope of Immunity. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosure performed or made in connection with this or any other health care institution's activities related but not limited to:

- i. Application for appointment or clinical Privileges;
- ii. Periodic reappraisals for reappointment or clinical Privileges;
- iii. Corrective action, including immediate action;
- iv. Hearings and appellate review;
- v. Medical care evaluations;
- vi. Utilization review;
- vii. Peer or professional review organizations, activities, or procedures, and other Hospital Services, Department, program, or committee activities related to quality patient care and inter-professional conduct.

15.1.5 Indemnity. Staff Members who serve in good faith as officers of the Hospital or Medical Staff, or upon committees of the Hospital or Medical Staff, to the fullest extent permitted by law, shall have and be entitled to the same level of corporate indemnity protection that a Hospital officer or employee would have under the Articles and Bylaws of the Hospital in similar circumstances.

- 15.1.6 Time Limits.** The time limits for Committee or Administration action in all parts of these Bylaws, including time limits for actions required for reappointment, may be altered by the MEC (for processes for which the Medical Staff has authority) or the Governing Body (for all processes) for what, in their discretion, is good cause.
- 15.1.7 Internal Reporting.** Any action taken concerning a Staff member's membership or Privileges, including at time of appointment, reappointment, or corrective or other action, shall be reported, if not already known, to the COS, CEO, Governing Body Chief and, on a need-to-know basis consistent with applicable law, to Staff Members and Hospital Staff (e.g., reduction in surgical Privileges would have to be reported to the operating room supervisor).
- 15.1.8 Nature of Information.** The acts, communications, reports, recommendations, and disclosure referred to in this Article may relate to an applicant or Staff Member's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics or any other matter that might directly or indirectly have an effect on maintaining the quality of appropriate patient care.
- 15.1.9 Execution of Releases.** Each applicant or Staff Member shall, upon the request of the Hospital or the Medical Staff of North Ottawa Community Hospital, execute releases as required by the individuals and organizations described above.
- 15.1.10 Authorization for Consultation and Review.** The applicant or Medical Staff member authorizes North Ottawa Community Hospital, the Governing Body, the Medical Staff and its officers and committee members to consult with members of the medical staffs of other hospitals with which the applicant or Staff Member is or has been associated and with others who may have information bearing on his competence, character and ethical qualifications. Furthermore, the applicant or Staff Member consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications for Staff membership. The applicant or Staff Member also releases from any liability all representatives of the Hospital and its Staff for their acts performed in good faith and without malice concerning the applicant's or Staff Member's competence, ethics, character or other qualifications for Staff appointment and clinical Privileges, including otherwise privileged or confidential information.
- 15.1.11 Confidentiality of Information.** The applicant or Staff Member recognizes and agrees that all records (including without limitation, medical records), information, data and knowledge respecting professional practice review functions of the Hospital are required to be kept confidential pursuant to federal and state law, including without limitation, proceedings for appointment, reappointment, advancement, denial or termination of appointment, reduction, suspension or termination of Privileges, and transfer to any other department of the Staff, and that dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Staff, or with the express approval of the MEC or its designee. The applicant or Staff Member specifically agrees to keep all such information confidential, recognizing that any breach of such confidentiality may result in the MEC undertaking such action as it deems appropriate.

ARTICLE 16 REVIEW, REVISION, ADOPTION, AMENDMENT, AND
ADMINISTRATION OF MEDICAL STAFF BYLAWS, RULES, AND
REGULATIONS

**SECTION 16.1 GENERAL PROVISIONS OF BYLAWS AND RULES AND
REGULATIONS**

The Medical Staff and the Governing Body agree to be bound by the Medical Staff Bylaws and the Rules and Regulations and abide by Hospital policies. Neither the Medical Staff nor the Hospital's Governing Body shall unilaterally adopt, alter, amend, modify or repeal the Medical Staff Bylaws or the Rules and Regulations except as provided in this Article. The Medical Staff Bylaws, and the Rules and Regulations, as they exist now or hereafter, shall apply to the Hospital's successors or assigns upon any merger or sale of North Ottawa Community Hospital or the sale of substantially all of the assets of North Ottawa Community Hospital for a transition period not to exceed eighteen (18) months. During the transition period, the Medical Staff and the Governing Body of the successors or assigns shall adopt Medical Staff Bylaws or agree to amend existing Bylaws.

SECTION 16.2 MEDICAL STAFF RESPONSIBILITY FOR BYLAWS

The Medical Staff shall have the responsibility to develop, adopt, review periodically, and recommend directly to the Governing Body Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Governing Body. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner.

SECTION 16.3 METHODS OF ADOPTION AND AMENDMENT OF BYLAWS

All proposed amendments, whether originated by the MEC, another standing committee, or by a member of the Active Staff of the Medical Staff, must be reviewed and discussed by the Medical Staff Bylaws Committee and MEC prior to a MEC vote. Such amendments must also be approved by the Active and Associate Staff prior to recommendation to the Governing Body.

16.3.1 General Amendments. Proposed amendment(s) will be distributed to MEC members, after review by the Medical Staff Bylaws Committee, at least twenty-one (21) days prior to a MEC vote. If the amendment is approved by the MEC, the amendment will be distributed to the Active Medical Staff for review and will be discussed at the next Medical Staff meeting. The amendment will be voted upon by the Active Medical Staff through secret ballot. A majority of those voting must approve the amendment.

16.3.2 Technical/Legal Amendments. The MEC shall have the power to adopt such amendments to the Bylaws as are, in the committee's judgment, technical or minor legal modifications or clarifications, reorganization or renumbering, or amendments needed because of punctuation, spelling or other errors of grammar or expression without prior distribution to or vote by the Active Medical Staff. Such amendments shall be effective when approved by the Governing Body.

16.3.3 Effective Date. Amendments proposed by the Governing Body and subsequently adopted by the Medical Staff shall become effective following approval by the Medical Staff. Amendments proposed and adopted by the Medical Staff shall become effective following approval by the Governing Body.

16.3.4 Special Procedure for Legally Required Amendments. Notwithstanding the provisions set forth above, the MEC and the Governing Body shall have the authority to provisionally adopt an urgent amendment necessary to comply with law or regulation without prior notification to the Medical Staff. In such cases, the MEC shall immediately notify the Medical Staff.

- i. An urgent legal amendment shall be reported at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. Voting on an urgent legal amendment shall be completed by the Medical Staff within sixty (60) days after the amendment has been provisionally adopted by the Governing Body.
- ii. An urgent legal amendment may be formally adopted by the affirmative vote of one-half of the Medical Staff who have the right to vote and are present at the meeting.
- iii. If the Medical Staff fails to formally adopt an urgent legal amendment within sixty (60) days after the amendment is provisionally adopted by the Governing Body, the issue of formally adopting the amendment shall be referred to a Special Joint Conference Committee. This Special Joint Conference Committee will be composed of four (4) members of the Governing Body appointed by the Chief of the Governing Body or designee, and four (4) members of the Medical Staff appointed by the COS or designee. Within a reasonable time (but no later than 120 days after the amendment was initially proposed by the Governing Body), the Special Joint Conference Committee shall meet and shall issue a recommendation to the Governing Body as to whether the Governing Body should formally adopt the provisionally adopted amendment. After receiving a report from the Special Joint Conference Committee or after the time such a recommendation is due, the Governing Body shall determine whether or not to formally adopt the provisionally adopted amendment, and shall issue a written decision explaining its rationale for formally adopting or rescinding the provisionally adopted amendment. The Medical Staff has the right to retain its own legal counsel to advise on the legal necessity for such an amendment.
- iv. If the Hospital and Medical Staff legal counsels disagree over the legal necessity for such an amendment, another legal opinion from neutral counsel will be obtained.

SECTION 16.4 METHODS OF ADOPTION OF RULES AND REGULATIONS

The MEC will formulate a set of Medical Staff Rules and Regulations in regard to Admission and Discharge of Patients, General Conduct of Care, General Rules Regarding Surgical

Care and Medical Records that further define the general principles contained in these Bylaws, as well as amendments, modifications and/or repeal provisions for the same. The MEC will distribute the proposed Rules and Regulations to the Active Medical Staff for review and discussion at the next Medical Staff meeting. The proposed Rules and Regulations will be voted upon by the Active Medical Staff through secret ballot. A majority of those voting must approve the amendment. The results of such vote shall be forwarded by the MEC to the Governing Body.

In addition, the Medical Staff may petition the MEC for a Medical Staff vote to recommend the amendment, modification or repeal of provisions of the Rules and Regulations. Such proposed recommendation for amendment, modification or repeal will be discussed at the next regularly scheduled Medical Staff meeting. Voting on such recommendation for proposed amendment, modification or repeal shall be conducted by secret ballot of the Active Medical Staff in attendance at the meeting, requiring that for recommendation to the Governing Body of such measure at least one-third of the ballots are returned and two-thirds of the returned ballots are in favor of the recommendation for amendment, modification or repeal. The results of such vote shall be forwarded by the MEC to the Governing Body

Upon approval by the Governing Body, any proposed formulation, amendment, modification or repeal shall become effective.

SECTION 16.5 RELATED POLICIES

The MEC has the authority to create and approve Medical Staff policies. All policies shall be distributed to Medical Staff members after approval.

SECTION 16.6 JOINT CONFERENCE

If the Governing Body has determined not to accept a recommendation submitted to it by the MEC within ninety (90) days, or if there is a disagreement between the MEC and Governing Body over an action to be taken, the MEC is entitled to a Joint Conference between the Officers of the Governing Body and the Officers of the Medical Staff. Such Joint Conference shall be for purposes of further communicating to the Governing Body rationale for its contemplated action, and to permit the officers of the Medical Staff to fully articulate the rationale for the MEC's recommendation. Such a Joint Conference will be scheduled by the CEO within two (2) weeks after receipt of a request of same submitted by the COS.

ADOPTION AND APPROVAL OF THE MEDICAL STAFF

Adopted by the Medical Staff:

Date: _____

ADOPTION AND APPROVAL OF THE BOARD OF DIRECTORS

Adopted by the Board of Directors:

Date: _____

_____ **of the Board of Directors**