

**Bylaws**

**of the**

**St. Mary Mercy Hospital  
Medical Staff**

**Updated: June 2015**

**Bylaws**  
**Rules and Regulations**  
**of the**  
**St. Mary Mercy Hospital Medical Staff**

I acknowledge receipt of a copy of the Bylaws, Rules and Regulations of the Medical Staff of St. Mary Mercy Hospital which outline my privileges and obligations as a member of the Medical Staff, Allied Health Professional or House Physician.

I have studied the contents carefully and agree to abide by them.

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Signature

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Type or Print Name

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Date

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**St. Mary Mercy Hospital**

**Livonia, Michigan**

**BYLAWS OF THE MEDICAL STAFF**

**MISSION**

We serve together in Trinity Health,  
In the spirit of the Gospel,  
To heal body, mind and spirit,  
To improve the health of our communities  
And to steward the resources entrusted to us.

**VISION**

To be a truly great community hospital, providing comprehensive,  
coordinated and compassionate care, every time to everyone.

**PREAMBLE**

WHEREAS, St. Mary Mercy Hospital, a Member Organization of Trinity Health, a nonprofit corporation, is organized under the laws of the State of Michigan; and

WHEREAS, its purpose is to serve as a community hospital, providing comprehensive patient care; and

WHEREAS, it is recognized that under the ultimate authority of the Board of Trustees, the Medical Staff is granted responsibility for the quality and appropriateness of care furnished in the Hospital; and

WHEREAS, the Medical Staff has the duty to recommend to the Board of Trustees those practitioners who should be appointed or reappointed to the Medical Staff, as well as those who should be granted initial or renewed clinical privileges.

THEREFORE, in order to discharge these duties and responsibilities, the physicians, dentists and podiatrists practicing in this Hospital, are hereby organized into a Medical Staff in conformity with the following Bylaws, and the Bylaws of St. Mary Mercy Hospital.



## DEFINITIONS

1.           ACTIVITY UNIT                           An inpatient admission, consultation or outpatient procedure performed by a practitioner at the Hospital.
  
2.           ADMINISTRATION                        Chief Executive Officer and Hospital Executive Management Team.
  
3.           ALLIED HEALTH PROFESSIONAL or AHP           A licensed practitioner (other than a physician, dentist or podiatrist) who has been granted clinical privileges at the Hospital. The Board of Trustees, after soliciting the recommendation of the Medical Executive Committee, shall determine from time to time which licensed professions are eligible for AHP status. AHPs are not members of the Medical Staff.
  
4.           APPELLANT                                    A Medical Staff member, a practitioner who has been granted clinical privileges at the Hospital, or a practitioner who is applying for Medical Staff membership and/or clinical privileges, who has requested a hearing and/or appellate review pursuant to Article VIII.
  
5.           BOARD CERTIFIED or BOARD CERTIFICATION           Certification as a specialist or subspecialist by a certifying board that is recognized as such by the American Board of Medical Specialties, the American Osteopathic Association, or the American Dental Association, or certification by the American Board of Podiatric Surgery.
  
6.           BOARD ELIGIBLE or BOARD ELIGIBILITY           A physician or dentist who possesses the qualifications that make him eligible to sit for the certification examination of a specialty or subspecialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Dental Association, or a podiatrist who possesses the qualifications that make him eligible to sit for the certification examination of the American Board of Podiatric Surgery.
  
7.           BOARD OF TRUSTEES or BOARD                The governing body of the Hospital.

8.	BOARD CREDENTIALS COMMITTEE	The committee of the Board of Trustees charged with oversight of quality and credentialing of the Medical Staff.
9.	BYLAWS	The Bylaws of the Medical Staff.
10.	CHIEF EXECUTIVE OFFICER or CEO	Most senior executive position of the Hospital.
11.	CLINICAL PRIVILEGES or PRIVILEGES	Authorization granted by the Board of Trustees to a practitioner to provide specific care, treatment and services to patients in the Hospital.
12.	CONTRACTUAL PRACTITIONERS	Practitioners who provide services at the Hospital pursuant to a contract between the practitioner and the Hospital or on behalf of an entity that contracts with the Hospital.
13.	CREDENTIALING POLICY	A policy, adopted by the Medical Executive Committee and approved by the Board of Trustees, which describes the procedures for credentialing applicants for Medical Staff appointment and reappointment and for clinical privileges.
14.	HOSPITAL	St. Mary Mercy Hospital.
15.	HOSPITAL-BASED	A department, division or section whose members are Contractual Practitioners.
16.	HOUSE PHYSICIAN	A licensed physician who provides emergency and other care in the Hospital during the absence of the attending physician. House physicians are not members of the Medical Staff.
17.	MEDICAL EXECUTIVE COMMITTEE	Medical Executive Committee of the Medical Staff.
18.	MEDICAL STAFF or STAFF	Allopathic and osteopathic physicians, dentists and podiatrists holding licenses from the State of Michigan, who have been granted membership on the Medical Staff of the Hospital by the Board of Trustees.
19.	MEDICAL STAFF YEAR	The Medical Staff year shall commence on Jan. 1.

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|-----|---------------------------------|---|
| 20. | ORAL SURGEON                    | An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the American Dental Association, and who holds both a dental license and a specialty certification in oral and maxillofacial surgery issued by the State of Michigan. |
| 21. | PHYSICIAN                       | An individual who is licensed to practice allopathic or osteopathic medicine.   |
| 22. | PRACTITIONER                    | Any individual who is licensed as a physician, dentist, podiatrist, or licensed in a profession that is eligible for Allied Health Professional status.   |
| 23. | RULES                           | The Rules and Regulations of the Medical Staff.   |
| 24. | SPECIAL NOTICE                  | Written notice (a) delivered personally, (b) sent by registered or certified mail, return receipt requested, or (c) sent by overnight delivery service, to the person to whom the notice is directed.   |
| 25. | VICE PRESIDENT, MEDICAL AFFAIRS | The physician who occupies the position of Vice President of Medical Affairs of the Hospital.   |

In these Bylaws, the word "he" shall be used as synonymous with the word "she," "it" and "they," and the word "his" synonymous with the word "her," "its" and "their."

**ARTICLE I  
NAME AND ORGANIZATION**

- 1.1 The name of this organization shall be the Medical Staff of St. Mary Mercy Hospital.

**ARTICLE II  
PURPOSES**

The purpose of this organization shall be:

- 2.1 To provide patients treated in any of the facilities of the Hospital with quality care;
- 2.2 To make recommendations to the Board of Trustees regarding all requests for Medical Staff appointment and reappointment and initial and renewed clinical privileges;
- 2.3 To conduct and support appropriate continuing medical educational programs designed to advance professional competence, knowledge, and skills;
- 2.4 To initiate and enforce rules of self-governance of the Medical Staff in accordance with the Bylaws of the Hospital;
- 2.5 To provide a mechanism whereby issues of common interest may be discussed among the Medical Staff, the Administration and the Board of Trustees;
- 2.6 To evaluate the appropriateness of care, cost effectiveness, and the changing health care needs of the community, based on new or changing medical technology, and to devise and recommend to the Administration and the Board of Trustees strategies to fill these needs.

**ARTICLE III  
ETHICS AND ETHICAL RELATIONSHIPS**

Acceptance of membership on the Medical Staff or clinical privileges constitutes the practitioner's commitment to abide by:

- 3.1 The Ethical and Religious Directives for Catholic Health Care Services, promulgated by the National Conference of Catholic Bishops.
- 3.2 The Code of Ethics of the American Medical Association, the American Osteopathic Association, the American Dental Association, or the American Podiatric Medical Association, as applicable.
- 3.3 Trinity Health's Corporate Compliance Plan, and applicable federal and state statutes, including those relating to fraud and abuse.

**ARTICLE IV  
MEDICAL STAFF MEMBERSHIP**

**4.1 GENERAL**

Membership on the Medical Staff of St. Mary Mercy Hospital is a privilege which shall be granted only to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. No practitioner shall be entitled to membership on the Medical Staff or to the exercise of clinical privileges in the Hospital merely by virtue of the fact that he/she is duly licensed to practice a health profession in this or any other State, or that he/she is a member of any professional organization, or that he/she had in the past, or presently has, such privileges at another hospital. A practitioner may exercise only those clinical privileges which are conferred by the Board of Trustees. Sex, race, creed and/or national origin shall not be considered when making decisions regarding Staff membership or privileges.

**4.2 QUALIFICATIONS FOR MEDICAL STAFF MEMBERSHIP**

4.2.1 Membership on the Medical Staff shall be limited to physicians, dentists and podiatrists who hold an unrestricted license to practice their respective profession in the State of Michigan, who document their background, experience, training and current competence, their health status, their adherence to the ethics of their profession, their good reputation, and their ability to work harmoniously with others, such that the Medical Staff and the Board are assured that they will furnish quality care in a manner that does not disrupt Hospital operations. Decisions regarding Medical Staff membership shall also take into account patient need, available Hospital facilities and resources, and utilization standards in effect at the Hospital.

4.2.2 Board Certification

4.2.2.1 Except as otherwise provided in Section 4.2.2.3, prior to application to the Medical Staff, each physician, podiatrist and oral surgeon must be Board Certified in his/her specialty. This requirement applies to all specialties recognized by the American Board of Medical Specialties, the American Osteopathic Association, the American Dental Association, or the American Board of Podiatric Surgery. Practitioners achieving Board Certification in a foreign country may be considered as an exception to the above, based upon individual merit and on the clinical, educational, and research needs of the Hospital and the specific department. The requirement for Board Certification or re-certification shall not apply to those practitioners who were members of the Medical Staff prior to April 6, 1993.

- 4.2.2.2 All applicants who seek subspecialty privileges, as defined by the Department or Section Chair, must be Board Certified in their respective subspecialty.
- 4.2.2.3 Medical Staff members who allow their board certification to expire in their practicing specialty must achieve board recertification within 3 consecutive examination opportunities for certification from the earliest date of eligibility post-expiration. Failure to achieve board recertification within the prescribed period will result in automatic termination of medical staff membership as described in Article VII, 7.3.7. Failure to achieve subspecialty recertification within the prescribed period will result in automatic loss of subspecialty privileges only; if primary specialty board certification is still valid, primary specialty privileges will be maintained. Physicians who were members of the medical staff prior to April 6, 1993, who obtained board certification in their respective specialty, will be considered grandfathered and will not be required to recertify to maintain their medical staff membership and privileges.
- 4.2.2.4 Recent graduates from an approved training program who are Board Eligible may be admitted to the Medical Staff, but must achieve Board Certification within three (3) consecutive examination opportunities for certification from the earliest date of eligibility. Failure to obtain Board Certification within the prescribed period will result in automatic termination of Medical Staff membership, as described in Section 7.3. Failure to achieve subspecialty certification within the prescribed period will result in automatic loss of subspecialty privileges only, if primary specialty Board Certification is still valid, primary specialty privileges are maintained.
- 4.2.2.5 Board Certification requirement will not apply to Community Affiliate status.

### 4.3 **APPLICATION FOR MEDICAL STAFF MEMBERSHIP**

- 4.3.1 A request for an application for Medical Staff membership shall be made to the Medical Staff Office or the Central Credentialing Department. If the prospective applicant satisfies the minimum qualifications for membership as described in Article 4.2, an application packet shall be sent to the applicant based on
  - 4.3.1.1 The ability of the Hospital to provide adequate facilities and supportive services for the prospective applicant and his patients;

- 4.3.1.2 Patient care needs for additional Medical Staff members with the prospective applicant's skill and training;
- 4.3.1.3 The geographic location of the prospective applicant's practice;
- 4.3.1.4 The prospective applicant's apparent compliance with the provisions of Section 4.2.

If an application will not be sent, the reason(s) for not doing so must be presented by the Chair of the department to the Medical Executive Committee. Following review by the Medical Executive Committee, the Chief of Staff and Vice President, Medical Affairs will jointly present this information to the Board Credentials Committee.

- 4.3.2 The application for Medical Staff membership shall be typewritten or printed on the prescribed form. The contents of the application form and the documentation necessary to complete an application shall be set forth in the Credentialing Policy.
- 4.3.3 By applying for appointment to the Medical Staff, each applicant:
  - 4.3.3.1 Signifies his willingness to appear for interview(s) in connection with his application for appointment and any reappointment application.
  - 4.3.3.2 Agrees to read the Bylaws and Rules and to be bound by the terms thereof and by the Hospital's Bylaws in connection with the disposition of this application, and thereafter if he is granted Medical Staff membership.
  - 4.3.3.3 Agrees to provide the Medical Executive Committee or Board of Trustees, at any time upon request, with written evidence that the practitioner's current physical and mental health does not threaten or interfere with his ability to practice safely.
- 4.3.4 The applicant must submit a complete application form with all required documentation to the Medical Staff Office within ninety (90) days of issuance of the application. An application form which is incomplete ninety (90) days after its issuance shall be considered null and void and voluntarily withdrawn by the applicant.
- 4.3.5 Inaccuracies in an application for appointment or reappointment or supporting documents, including misleading or incomplete statements, which are attributable to the applicant and are deemed material by the Medical Executive Committee or Board may be grounds for rejection of the application or for corrective action.

#### 4.4 PROCESSING APPLICATION FOR APPOINTMENT

4.4.1 The privileging and credentialing process endeavors to improve the depth, breadth, and quality of services provided to the community at the Hospital, while serving the Mission and Vision of Trinity Health. Each individual and committee that is responsible for making a recommendation regarding an application shall recommend acceptance or rejection of the application and, if acceptance is recommended, recommend which clinical privileges should be granted. The reason(s) for any adverse recommendation will be stated in the report.

#### 4.4.2 Medical Staff Office Review

The Medical Staff Office reviews each application to determine completeness of the application, and verifies the credentials of the applicant in accordance with the Credentialing Policy, before forwarding the application to the Department Chair.

#### 4.4.3 Department Chair Review and Recommendation

Within forty-five (45) days after receipt, the Chair of the department shall review the application and conduct an interview with the applicant. Following the interview, the Chair shall recommend to the Credentials Committee that the application be rejected or accepted.

#### 4.4.4 Credentials Committee Review and Recommendation

The Credentials Committee shall review the application form and supporting documentation and the Chair's recommendation. Within one hundred twenty (120) days after receipt of the completed application, the Credentials Committee shall submit its recommendation to the Medical Executive Committee.

#### 4.4.5 Medical Executive Committee Review and Recommendation

The Medical Executive Committee shall consider the recommendation of the Credentials Committee. Within forty-five (45) days after receipt of the Credentials Committee's recommendation, the Medical Executive Committee shall submit its recommendation to the Board Credentials Committee.

#### 4.4.6 Board Credentials Committee Review

The Board Credentials Committee shall consider the recommendation of the Medical Executive Committee. Within forty-five (45) days after receipt of the recommendation of the Medical Executive Committee, the Board



Credentials Committee shall submit its recommendation to the Board of Trustees.

4.4.7 Board of Trustees Review

The Board of Trustees shall consider the report of the Board Credentials Committee and shall attempt in good faith to make a preliminary decision on the application at its next regularly scheduled meeting following receipt of the recommendation. In all cases, the CEO shall notify the Chair of the appropriate department of the action taken by the Board of Trustees. The Board may decide that the application either be:

4.4.7.1 Accepted, with All Requested Privileges:

A decision by the Board to accept an application and grant all privileges requested by the applicant is final. The CEO shall send the applicant written notice of the Board's decision.

4.4.7.2 Accepted, with Less Than All Requested Privileges:

A preliminary decision by the Board to accept an applicant, but grant less than all privileges requested, is subject to hearing and appeal pursuant to Article VIII of these Bylaws. The CEO shall send the applicant written notice of the Board's preliminary decision and his right to a hearing. The Board shall issue a final decision after the applicant waives or exhausts his hearing and appeal rights.

4.4.7.3 Rejected:

A preliminary decision by the Board to reject an applicant triggers the same procedures as described in Section 4.4.7.2.

4.4.8 Applications for Medical Staff membership shall be considered in a timely manner and, except for good cause (such as the need to table an application in order to secure additional information), shall be processed within the time periods stated in Section 4.4 of these Bylaws.

4.5 **CONDITIONS AND DURATION OF APPOINTMENT**

4.5.1 All initial appointments to the Medical staff shall be for a period of six (6) months and shall be Provisional. Provisional membership may be extended for a total period not to exceed 18 months, as described in Section 6.1.

4.5.2 Non-provisional reappointments shall be for a period of up to two (2) years.

#### 4.6 **REAPPOINTMENT PROCESS**

4.6.1 At least 5 months before a practitioner's Medical Staff membership expires, the Medical Staff Office will send the practitioner a reappointment application form. At least 90 days before a practitioner's Medical Staff membership expires, he shall complete and submit to the Medical Staff Office the prescribed reappointment application form. A practitioner who does not submit a complete reapplication form to the Medical staff Office at least 90 days before his Medical Staff membership expires, shall be deemed to have voluntarily resigned from the Medical Staff as of the date his membership expires. The contents of the application form and the documentation necessary to complete an application shall be set forth in the Credentialing Policy. The reappointment review normally shall be complete within 90 days of receipt of a complete application.

4.6.2 The reappointment review will include evaluation of:

4.6.2.1 At reappointment, the results of Ongoing Professional Practice Evaluations will be utilized to review, but not be limited to, the following:

1. Professional performance and judgment.
2. Current clinical and technical skills and ability to perform requested privileges.
3. Quality and utilization indicators.
4. Professional ethics and conduct.
5. Compliance with Bylaws and Rules.
6. Appropriate use of Hospital facilities.
7. Relationships with other practitioners, hospital employees and patients including any conduct which is disruptive of the activities of other practitioners, Hospital employees, patients or Hospital operations.
8. Practitioner's current physical and mental health.

4.6.2.2 Activity Units performed. A practitioner must perform at least six Activity Units per year to retain Active membership; a practitioner who does not meet this standard will be transferred to another appropriate Medical Staff category, if eligible, and this change in category will not be subject to hearing or appeal. If a member of the Courtesy Staff admits more than six (6) patients per year or performs more than twenty-four (24) outpatient procedures per year, he must apply for Active membership. If a member of the Active or Courtesy category performs no Activity Units in two consecutive years, his Medical Staff membership will terminate automatically, without a right to hearing or appeal, unless the Medical Executive Committee and Board of Trustees determine there is good cause for an exception. Members of the Consulting and Affiliate categories and Contractual Practitioners are not required to perform a minimum number of Activity Units.

#### 4.6.3 Review Process

4.6.3.1 Each individual and committee that is responsible for making a recommendation regarding a reappointment application shall recommend acceptance or rejection of the application and, if acceptance is recommended, recommend which clinical privileges should be granted. The reason(s) for any adverse recommendation will be stated in the report.

#### 4.6.3.2 Medical Staff Office Review

The Medical Staff Office reviews each reappointment application to determine completeness of the application, and verifies the credentials of the applicant in accordance with the Credentialing Policy, before forwarding the application to the Department Chair.

#### 4.6.3.3 Department Chair Review and Recommendation

The reappointment application will be reviewed by the Department Chair. The Department Chair's recommendation will be delivered to the Credentials Committee.

#### 4.6.3.4 Credentials Committee Review and Recommendation

The Credentials Committee shall review the application and the Chair's recommendation. The Credential Committee's recommendation will be delivered to the Medical Executive Committee.

4.6.3.5 Medical Executive Committee Review and Recommendation

The Medical Executive Committee shall review the recommendation of the Credentials Committee. The Medical Executive Committee's recommendation will be delivered to the Board Credentials Committee.

4.6.3.6 Board Credentials Committee Review and Recommendation

The Board Credentials Committee shall review the recommendation of the Medical Executive Committee. The Committee's recommendation will be delivered to the Board of Trustees.

4.6.3.7 Board of Trustees Review

The Board of Trustees shall consider the report of the Board Credentials Committee and shall attempt in good faith to make a preliminary decision on the application at its next regularly scheduled meeting following receipt of the recommendation. In all cases, the CEO shall notify the Chair of the appropriate department of the action taken by the Board of Trustees. The Board may decide that the application either be:

a. Accepted, with All Requested Privileges:

A decision by the Board to accept an application for reappointment and grant all privileges requested by the Medical Staff member is final. The CEO shall send the Medical Staff member written notice of the Board's decision.

b. Accepted, with Less Than All Requested Privileges:

A preliminary decision by the Board to accept an application for reappointment, but grant less than all privileges requested, is subject to hearing and appeal pursuant to Article VIII of these Bylaws. The CEO shall send the Medical Staff member written notice of the Board's preliminary decision and his right to a hearing. The Board shall issue a final decision after the practitioner waives or exhausts his hearing and appeal rights.

c. Rejected:

A preliminary decision by the Board to reject an application for reappointment triggers the same procedures as described in Subsection (b).

**4.7 ANNUAL DUES**

- 4.7.1 Annual dues shall be levied upon all Active, Provisional, Courtesy, Consultant and Affiliate members of the Medical Staff. The amount of the dues shall be established by the Medical Staff.
- 4.7.2 New Medical Staff members shall pay their dues within thirty (30) days of their appointment to the Medical Staff. If a new Medical Staff appointment begins on a date other than January 1, the practitioner's first year dues will be prorated over the number of months remaining in the Medical Staff year.
- 4.7.3 If a Medical Staff member does not pay dues within ninety (90) days after the date they are due, the member's clinical privileges will be suspended until dues are paid in full. The Medical Staff Office will notify the member of his suspension by Special Notice.

**ARTICLE V  
CLINICAL PRIVILEGES**

**5.1 REQUIRED CHARACTERISTICS**

- 5.1.1 All individuals who are credentialed through the Medical Staff (including Allied Health Professionals and House Physicians), whether or not they are members of the Medical Staff, may furnish in the Hospital only those services for which they have been granted clinical privileges. The delineated clinical privileges granted to each such practitioner are hospital-specific and are granted by the Board of Trustees in accordance with the Bylaws and Rules.
- 5.1.2 Every application for Medical Staff appointment and reappointment (as well as each request for clinical privileges by an Allied Health Professional or House Physician) shall contain a request for the specific scope and extent of privileges desired by the practitioner. The practitioner shall have the responsibility of establishing his qualifications and current competency for the clinical privileges requested. Privilege delineation is based on the criteria stated in Sections 4.2 and 4.6.2.

- 5.1.3 Privileges to admit patients to the Hospital's inpatient, outpatient, and observation facilities may be granted to qualified physicians, oral surgeons, and podiatrists who are members of the Medical Staff.
- 5.1.4 The scope and extent of surgical procedures each dentist or podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the supervision of the Chair of the Department of Surgery. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff, selected by the dentist or podiatrist, shall be responsible for the medical evaluation and care of the patient.
- 5.1.5 Privileges granted to Allied Health Professionals shall be based on the practitioner's education, training, experience, licensure or certification, current competence and judgment. The scope and extent of privileges to be granted to each Allied Health Professional shall be specifically delineated. No patient shall be admitted to the Hospital solely under the care of an Allied Health Professional. When inpatient admission is necessary, a physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.
- 5.1.6 Practitioners in administrative positions at the Hospital who have clinical privileges shall maintain their clinical privileges through the same procedures as all other practitioners with delineated clinical privileges.
- 5.1.7 Each clinical department shall establish its criteria for recommending clinical privileges. The scope of each level of privileges is defined in the Department Policies.
- 5.1.8 Application for additional clinical privileges must be in writing, designating the scope and extent of clinical privileges desired, supported by documentation of and competence to perform the privileges requested. Such an application shall be processed in the same manner as an application for initial appointment.
- 5.1.9 The duration of clinical privileges granted shall be for a period of up to two (2) years.
- 5.1.10 All practitioners with delineated clinical privileges shall be assigned to an appropriate department. A practitioner with the requisite qualifications (as determined by the Medical Executive Committee and Board of Trustees) may be granted clinical privileges in departments, divisions or sections other than that to which he is principally assigned.

- 5.1.11 Modifications in clinical privileges or other appropriate actions may be recommended to or by the appropriate Department Chair when a practitioner has performance problems.
- 5.1.12 The medical history and physical examination shall be completed and documented by a physician, maxillofacial surgeon, podiatrist, nurse practitioner, or physician assistant with privileges to do so. The history and physical must be completed in accordance with the St. Mary Mercy Medical Staff Rules and Regulations and shall include, at a minimum, the following:
  - a. For inpatient admissions: completion of the H&P no more than 30 days before or within 24 hours after admission but prior to any procedure. If the H&P is within 30 days prior to admission, an update is required. The elements to be contained in the H&P are defined in the Rules and Regulations, section 17.5.2.
  - b. For ambulatory patients: an H&P is required for all outpatients that includes the elements defined in the Rules and Regulations, section 17.5.2.2 B.

## 5.2 **TEMPORARY, EMERGENCY AND DISASTER PRIVILEGES**

### 5.2.1 Temporary Clinical Privileges

- 5.2.1.1 A qualified practitioner may be granted temporary clinical privileges (a) to fulfill an important patient care or service need or (b) while an initial applicant for Medical Staff membership or clinical privileges, who has submitted a complete application that raises no concerns, is awaiting review and approval of his application. It must be verified that there is or has been no current or previously successful challenge to licensure or registration, no objection to involuntary termination of medical staff membership at another organization, and applicant has never been subjected to involuntary limitation, reduction, denial, or loss of clinical privileges. All persons requesting and/or receiving temporary privileges shall be bound by the Bylaws and Rules.
- 5.2.1.2 If temporary privileges are to be granted to fulfill an important patient need, the Vice President of Medical Affairs must first verify the practitioner's current licensure and competence. In all other cases, temporary privileges may be granted only if the practitioner has submitted a complete application which satisfies the requirements for temporary privileges stated in the Credentialing Policy.
- 5.2.1.3 Temporary privileges may be granted in appropriate cases by the Chief Executive Officer, on the recommendation of the

Chair of the applicable clinical department, the Vice President of Medical Affairs, or the Chief of Staff, for a maximum period of one hundred twenty (120) days. A designated representative has authority to grant or recommend such privileges when any of these individuals is not available.

5.2.1.4 A practitioner who is granted temporary privileges shall act under the supervision of the Chair of the department to which the practitioner is assigned, and shall inform the Chair, or the Chair's designee, as to his or her activities within the Hospital.

5.2.1.5 At any time, temporary privileges may be terminated by the Chief Executive Officer, with the concurrence of the Chair of the department, Vice President of Medical Affairs or the Chief of Staff, or by their designee(s), subject to review by the Medical Executive Committee at its next meeting. In such cases, the appropriate department Chair or his designee shall assign a member of the Medical Staff to assume responsibility for the care of the individual's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member or Allied Health Professional.

5.2.1.6 A person is not entitled to the procedural rights afforded by Article VIII because a request for temporary privileges is refused, or because the granting of temporary privileges is made subject to conditions (such as proctoring), or because all or any portion of temporary privileges are terminated or suspended.

## 5.2.2 Emergency Privileges (e.g. Code Calls)

In case of an emergency, each member of the Medical Staff and practitioner who holds clinical privileges is permitted to do everything possible within the scope of the practitioner's license to save a patient's life or to save a patient from serious harm, regardless of the practitioner's Medical Staff status or clinical privileges.

## 5.2.3 Disaster Privileges

5.2.3.1 Disaster privileges may be granted to volunteer practitioners only when the emergency management plan has been activated in response to an internal or external disaster, and the hospital is unable to meet immediate patient needs. Privileges will end at the end of the disaster.

5.2.3.2 Disaster privileges may be granted by the Chief Executive Officer, Chief of Staff (or his/her Designee) upon presentation of a valid government-issued photo identification issued by a



state or federal agency (e.g., driver's license or passport) and at least one of the following:

- Current picture hospital ID card with professional designation.
  - Current license to practice.
  - Disaster Medical Assistance Team identification.
  - Identification that individual has been granted authority to render patient care in emergency circumstances, granted by federal, state or municipal entity.
  - Identification by current hospital/medical staff member(s) with personal knowledge regarding practitioner identity and ability to act as a licensed independent practitioner during disaster.
1. All licensed volunteers will be directed to a specified volunteer registration center.
  2. The Chief of Staff (or his/her designee) will verify required identification as noted above.
  3. The Chief of Staff (or designee) will assign volunteer to area consistent with volunteer's expertise.
  4. Volunteer will be given ID badge stating his/her name, credentials (i.e., MD, DO, CRNA, etc.) and area of expertise (i.e., Obstetrics, Orthopedic Surgery, etc.).

The verification process for the volunteers shall begin as soon as the immediate situation is under control and will be completed within 72 hours from the time the volunteer presents to the hospital. If primary source verification cannot be completed due to no means of communication, lack of resources, etc., verification will be completed as soon as possible with documentation of events causing delay and resolution steps taken.

Verification process will include completion of Disaster Credentialing Form and Disaster Privilege Form. Each volunteer will be monitored via direct observation and periodic chart review to determine ability to provide adequate care, treatment and services. Findings will be recorded and any adverse findings will be immediately reported to the Chief of

Staff (or designee) who will take action as he/she deems appropriate.

The Chief of Staff (or designee) will make a decision (based on review information) within 72 hours related to continuation of the disaster privileges initially granted.

All disaster privileges granted in a disaster event shall immediately terminate at the time the emergency is declared over.

### **5.3 HOUSE PHYSICIANS**

5.3.1 A House Physician is a licensed physician who provides emergency care or other services in the Hospital, as specified by contract, during the absence of the attending physician. House Physicians provide patient care in the Hospital in accordance with delineated clinical privileges, but are not members of the Medical Staff. The granting, exercise and termination of House Physician clinical privileges are governed by the Bylaws and Rules.

5.3.2 Prospective House Physicians shall complete the same application form, and are subject to the same credentialing and privileging process, as applicants for Medical Staff membership. House Physicians must possess the same qualifications as members of the Medical Staff who are granted comparable privileges, except those House Physicians who are participating in an approved residency program are exempt from the Board Eligibility and Board Certification requirements while they are residents.

5.3.3 A House Physician may be granted clinical privileges for up to two years. Privileges are subject to review and renewal using the same procedures as those used for reappointment of Medical Staff members. House Physicians' clinical privileges are subject to disciplinary procedures in accordance with Articles VII and VIII.

5.3.4 Each House Physician is assigned to an appropriate department and is subject to the authority of the Chair of that department.

### **5.4 ALLIED HEALTH PROFESSIONALS**

5.4.1 Allied Health Professionals provide patient care in the Hospital in accordance with delineated clinical privileges, but are not members of the Medical Staff. The granting, exercise and termination of AHP clinical privileges are governed by the Bylaws and Rules.

5.4.2 Each AHP, other than clinical psychologists, must practice under the supervision of a designated member of the Medical Staff. If an AHP's affiliation with the designated supervising Medical Staff member ends, or if

the supervising practitioner ceases to be a member of the Medical Staff, the AHP's clinical privileges terminate automatically, without hearing or appeal.

5.4.3 Prospective AHPs shall complete an application form comparable to that required of applicants to the Medical Staff, and are subject to the same credentialing and privileging process as applicants for Medical Staff membership. Clinical privileges shall be granted or denied to AHPs based on an evaluation of the same criteria considered with respect to other practitioners, such as education, experience, current competence and health status.

5.4.4 An AHP may be granted clinical privileges for up to two years. Privileges are subject to review and renewal using the same procedures as those used for reappointment of Medical Staff members. AHPs' clinical privileges are subject to disciplinary procedures in accordance with Articles VII and VIII.

5.4.5 Clinical Psychologists seeking clinical privileges at the Hospital must hold a Ph.D. Degree in Clinical Psychology from an accredited university in the United States or Canada and must be fully licensed in Michigan to practice clinical psychology. The only privileges which may be granted to Clinical Psychologists are:

5.4.5.1 Psychological Evaluation

5.4.5.2 Psychological Testing (administration and interpretation of standard psychological tests)

5.4.5.3 Individual Psychotherapy

5.4.5.4 Group Therapy

Clinical Psychologists shall not have admitting privileges nor privileges to prescribe any medication, or perform any invasive procedure. Clinical Psychologists render services at the Hospital only at the request of the attending physician or as required by Hospital, state or federal rules and regulation.

5.4.6 Each AHP is assigned to an appropriate department and is subject to the authority of the Chair of that department. Clinical Psychologists are assigned to the Department of Behavioral Medicine.

## 5.5 RESIDENTS

Physicians or practitioners in approved training programs, possessing a Michigan medical educational limited license, shall at all times be under the direction of appropriately credentialed members of the Medical Staff provided such practice is in accordance with these Bylaws and the policies established by St. Mary Mercy Hospital.

**5.5.1 Medical Students**

All medical students will be under the direct supervision of appropriately credentialed members of the Medical Staff. Medical students may not write orders. All documentation must be commented upon and signed by the supervising physician.

**ARTICLE VI  
CATEGORIES OF THE MEDICAL STAFF**

**6.1 PROVISIONAL MEMBERSHIP**

6.1.1 Criteria for Membership: Newly appointed members of the Medical Staff or Allied Health Professional service shall be placed in the Provisional category for a period of at least six (6) months. Each practitioner shall be monitored by the Focused Professional Practice Evaluation process as described in Credentialing Policy 015. If, at the conclusion of such a review, the practitioner's Provisional membership is not extended, the Medical Executive Committee shall recommend to the Board Credentials Committee that the Provisional member be:

- a. Advanced to Active, Courtesy, Consulting or Affiliate membership; or
- b. Terminated from the Medical Staff, following the procedures stated in Article VIII.

Provisional status may be extended by the Medical Executive Committee for up to two additional six (6) month periods (i.e. a total of up to 18 months) if there is an inadequate basis for evaluating the practitioner's clinical performance or if there are deficiencies in the practitioner's clinical performance or fulfillment of Medical Staff responsibilities. If a Provisional member is not advanced to another Medical Staff category within 18 months after joining the Medical Staff, such practitioner's Medical Staff membership shall not be renewed and the practitioner shall have the same hearing and appeal rights as a Medical Staff member who is not reappointed.

6.1.2 Responsibilities:

- 6.1.2.1 Fulfill those responsibilities imposed on all Medical Staff members.
- 6.1.2.2 Perform a sufficient number of Activity Units to qualify for Active or Courtesy membership. A practitioner who performs

no Activity Units while a Provisional member will be terminated from Medical Staff membership automatically, without hearing or appeal, unless the practitioner qualifies for Affiliate status.

6.1.2.3 Serve on committees to which appointed.

6.1.2.4 Pay dues.

6.1.3 Prerogatives:

6.1.3.1 May attend Medical Staff and departmental meetings without voting privileges.

6.1.3.2 Serve as a voting member of Medical Staff and/or Hospital committee(s) to which appointed.

## 6.2 **ACTIVE MEMBERSHIP**

6.2.1 **Criteria for Membership:** Active membership shall consist of those Medical Staff members who have completed at least six months of Provisional membership and who otherwise satisfy the requirements for Active membership. Members who were Active Junior as of April 6, 1993, shall be designated as Active members, but they shall not be eligible to hold an office for which Board Certification is required.

6.2.2 **Responsibilities:**

6.2.2.1 Fulfill those responsibilities imposed on all Medical Staff members.

6.2.2.2 Perform a sufficient number of Activity Units to qualify for Active membership (see Section 4.6.2.5).

6.2.2.3 Participate in on-call coverage for the Hospital's emergency department, in accordance with policies adopted by the department and approved by the Medical Executive Committee or adopted by the Medical Executive Committee.

6.2.2.4 Serve on committees to which appointed.

6.2.2.5 Pay dues.

6.2.3 **Prerogatives:**

6.2.3.1 May attend and vote at Medical Staff and department meetings.

6.2.3.2 Serve as a voting member of Medical Staff or Hospital committee(s) to which appointed.

6.2.3.3 Hold a Medical Staff office for which otherwise qualified.

### 6.3 **COURTESY MEMBERSHIP**

6.3.1 Criteria for Membership: Courtesy membership shall consist of those Medical Staff members who only occasionally admit patients to the Hospital and who are members of the active staff at another hospital or were previously Active members of the Medical Staff.

If a member of the Courtesy staff admits more than six (6) patients per year or performs more than twenty-four (24) outpatient procedures per year, he must apply for Active membership.

6.3.2 Responsibilities:

6.3.2.1 Fulfill those responsibilities imposed on all Medical Staff members.

6.3.2.2 Perform a sufficient number of Activity Units to qualify for Courtesy membership (see Section 4.6.2.5).

6.3.2.3 Pay dues.

6.3.3 Prerogatives:

6.3.3.1 May attend Medical Staff and department meetings without voting privileges.

### 6.4 **CONSULTING MEMBERSHIP**

6.4.1 Criteria for Membership: Consulting membership shall consist of those Medical Staff members whose knowledge and experience are of value to the Medical Staff and the Hospital, but whose primary practice is not at the Hospital. Consulting members may not admit patients. They provide a ready resource for medical consultation to members of the Medical Staff.

6.4.2 Responsibilities:

6.4.2.1 Fulfill those responsibilities imposed on all Medical Staff members.

6.4.2.2 Pay dues.

- 6.4.3 Prerogatives:
  - 6.4.3.1 May attend Medical Staff and department meetings without voting privileges.

## 6.5 **AFFILIATE MEMBERSHIP**

- 6.5.1 Criteria for Membership: There are two categories of Affiliate membership – Community Affiliate and Coverage Affiliate.
  - 6.5.1.1 Community Affiliate membership consists of physician members of the Medical Staff who practice primarily in an office setting and who arrange with another member of the Medical Staff to admit and attend their patients in the Hospital. Community Affiliate members do not have admitting or other clinical privileges.
  - 6.5.1.2 Coverage Affiliate membership consists of members of the Medical Staff whose use of the Hospital’s facilities is limited to providing coverage for another member of the Medical Staff when the latter is unavailable and who are members of the active staff of at least one other hospital that is accredited by the Joint Commission on the Accreditation of Healthcare Organizations or the American Osteopathic Association.
- 6.5.2 Responsibilities:
  - 6.5.2.1 Fulfill those responsibilities imposed on all Medical Staff members (except Community Affiliate members are not required to fulfill any responsibility that requires clinical privileges).
  - 6.5.2.2 Pay dues.
- 6.5.3 Prerogatives:
  - 6.5.3.1 May attend Medical Staff and department meetings without voting privileges.

## 6.6 **EMERITUS MEMBERSHIP**

- 6.6.1 Criteria for Membership: Physicians, dentists and podiatrists who were formerly Active members of the Medical Staff and who have retired from

active practice may be appointed to this category upon application to and approval of the Medical Executive Committee.

6.6.2 Responsibilities and Prerogatives: Emeritus members hold no clinical privileges, and have no prerogatives or responsibilities.

## 6.7 CONTRACTUAL PRACTITIONERS

6.7.1 Contractual Practitioners shall obtain and maintain clinical privileges and, if applicable, Medical Staff membership, in the same manner as non-contractual practitioners. Contractual Practitioners who work up to 500 hours per year at the Hospital will be included in Contractual Courtesy membership. Contractual Practitioners who work 500 hours or more per year at the Hospital will be included in Contractual Active membership.

6.7.2 Continuation of a Contractual Practitioner's clinical privileges and, if applicable, his Medical Staff membership, is dependent on continuation of the contract with the Hospital or the Practitioner's association with the entity that contracts with the Hospital, unless otherwise stated in the contract. A Contractual Practitioner is entitled to hearing and appeal rights pursuant to Article VIII only with respect to adverse actions that are based on the Practitioner's professional or clinical performance relating directly to patient care, and then only if the Practitioner has not waived such rights by contract.

6.7.3 Contractual Active Responsibilities:

6.7.3.1 Fulfill those responsibilities imposed on all Medical Staff Members.

6.7.3.2 Pay dues.

6.7.4 Contractual Active Prerogatives:

6.7.4.1 May attend and vote at Medical Staff and department meetings.

6.7.5 Contractual Courtesy Responsibilities:

6.7.5.1 Fulfill those responsibilities imposed on all Medical Staff members.

6.7.5.2 Pay dues.

6.7.6 Contractual Courtesy Prerogatives:

6.7.6.1 May attend Medical Staff and department meetings without voting privileges.



## **6.8 LEAVE OF ABSENCE**

- 6.8.1 Any member in good standing may request a leave of absence from the Medical Staff for a period not to exceed 2 years, by written request to the Chief of Staff, stating the reason(s) for the leave. The Medical Executive Committee will recommend to the Board of Trustees that the request be granted or denied, and the Board will take final action on the request. All records for which the member is responsible must be timely completed. Members on leave of absence will not be eligible to vote, hold office, or serve on committees, and will not be assessed dues or required to attend meetings.
- 6.8.2 For leaves of absence three months or less, as in the instance of maternity or short term medical leave, request for leave and reinstatement will be handled at the department level in lieu of utilizing the formal leave of absence process. However, the physician and/or department must assure that there is appropriate patient care coverage during such absence. Further, reinstatement is contingent upon health status and clinical ability pursuant to specified clinical privileges. At the discretion of the Chair, Focused Professional Practice Evaluation (FPPE) may be instituted upon return.
- 6.8.3 For leaves of absence greater than three months, at least 45 days prior to expiration of the leave of absence, or at any earlier time, the member may request reinstatement of his privileges by submitting a written notice to that effect to the Chief of Staff. In addition, the member shall submit a written summary of his relevant activities during the leave. The practitioner will also be monitored via Focused Professional Practice Evaluation (FPPE) by the department chair upon returning from any type of leave. In the event of a leave of absence due to illness, the member shall additionally submit a letter from his attending physician stating that the member is able safely to resume his professional practice. A request for reinstatement shall be submitted and processed in the manner specified for reappointment to the Medical Staff. Failure, without good cause, to request reinstatement at least 45 days prior to the expiration date of the leave of absence or to provide a requested summary of activities or other relevant information, shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership. A member whose request for reinstatement from a leave of absence is denied by the Board shall be entitled to the procedural rights provided in Article VIII.

## **ARTICLE VII CORRECTIVE ACTION**

### **7.1 CORRECTIVE ACTION PROCEDURE**

- 7.1.1 Whenever the activities or professional conduct of any practitioner with clinical privileges:
- 7.1.1.1 Are lower than the standards or aims of the Medical Staff, or
  - 7.1.1.2 Are disruptive to the operations of the Hospital or the Medical Staff, or
  - 7.1.1.3 Create a hostile work environment relative to any Medical Staff member or Hospital employee, or
  - 7.1.1.4 Constitute sexual harassment or are morally offensive conduct toward any Medical Staff member, Hospital employee/representative, or patient, or
  - 7.1.1.5 Violate the Bylaws, Rules and Regulations, or
  - 7.1.1.6 Are reflective of unwillingness or incapability to work with and relate to Staff members, members of other health disciplines, Hospital management or employees, or patients, or
  - 7.1.1.7 Indicate that the practitioner is impaired or dysfunctional due to mental or physical deterioration including excessive use or abuse of alcohol and/or illicit drugs, corrective action against such practitioner may be requested by any Officer of the Medical Staff, the Chair of any Department, the Chair of any Standing Committee of the Medical Staff, the Vice President of Medical Affairs, the Chief Executive Officer or designee, or the Board of Trustees. (Complaints regarding a practitioner that are lodged by anyone other than the individuals listed in the preceding sentence shall be directed to the Chair of the department to which the practitioner is assigned.) All requests for corrective action shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct which constitute the grounds for the request.
- 7.1.2 The Medical Executive Committee shall consider a request for corrective action at its first meeting following receipt of the request.
- 7.1.2.1 If the Medical Executive Committee determines the request contains information sufficient to warrant an immediate recommendation of some form of corrective action, the Medical Executive Committee may make a recommendation immediately.
  - 7.1.2.2 If the Medical Executive Committee determines the request does not contain information sufficient to warrant an immediate

recommendation of some form of corrective action or if it otherwise wishes to do so, the Medical Executive Committee shall arrange for an investigation of the matter. The Medical Executive Committee may:

1. investigate the matter itself as a whole or through an ad hoc subcommittee of one or more Medical Executive Committee members; or
2. direct the chairperson(s) of the appropriate Medical Staff department(s) or another appropriate Medical Staff member(s) to investigate the matter, or direct the chairperson(s) to appoint an ad hoc investigating committee to investigate the matter; or
3. appoint an ad hoc investigating committee consisting of practitioners who may or may not be Medical Staff members.

7.1.2.3 The investigating party shall investigate and determine the facts and circumstances surrounding each activity of the practitioner that is the basis for the request for corrective action. The investigating party shall make a written report of its findings to the Medical Executive Committee within thirty (30) days after the Medical Executive Committee appoints the investigating party. The practitioner against whom corrective action has been requested shall be given an opportunity for an interview with the investigating party before the investigating party submits its written report to the Medical Executive Committee. At such interview, the practitioner shall be informed of the charges against him, and shall be invited to respond to the charges. This interview shall not be deemed a hearing as that term is used in Article VIII, and none of the procedural rules provided in Article VIII with respect to hearings shall apply. The practitioner shall not be entitled to legal counsel at such interview. A record of such interview shall be made by the investigating party and included with its written report to the Medical Executive Committee.

7.1.2.4 As soon as practical after receiving the investigating party's report or after completing its own investigation, as applicable, the Medical Executive Committee shall take action upon the request. The affected practitioner shall be permitted to make an appearance and a presentation before the Medical Executive Committee prior to the Committee taking action. The appearance shall not be deemed a hearing as that term is used in Article VIII in these Bylaws, and none of the procedural rules

provided in Article VIII with respect to hearings shall apply hereto. The affected practitioner shall not be entitled to legal counsel at such appearance. A record of such appearance shall be made by the Medical Executive Committee. The Medical Executive Committee's action may include, without limitation:

1. Reject the request for corrective action;
2. Impose appropriate corrective action as follows:
  - a. Issue a warning letter, a letter of admonition, or a letter of reprimand;
  - b. Impose requirements of proctoring or consultation (with consent of the consultant or proctor not being required before patient care may be provided), additional training, retraining or continuing education;
  - c. Require medical examination, report and appropriate treatment.
3. Recommend to the Board of Trustees:
  - a. Reduction, limitation, suspension, or revocation of clinical privileges;
  - b. That the practitioner's Staff appointment be suspended or revoked;
  - c. Any other form of discipline that materially limits the practitioner's right to provide direct patient care as previously authorized (such as requiring proctoring or consultation, with consent of the proctor or consultant being required before patient care may be provided).

7.1.3 Any recommendation by the Medical Executive Committee listed in Section 7.1.2.4.3 shall entitle the practitioner to the procedural rights provided in Article VIII and the matter shall proceed in accordance with the provisions of Article VIII.

7.1.4 The Chair of the Medical Executive Committee shall promptly notify the Chief Executive Officer and the Vice President of Medical Affairs, in writing, of all requests for corrective action received by the Medical Executive Committee and shall continue to keep the Chief Executive Officer and the Vice President of Medical Affairs fully informed of all action taken in connection therewith.

## **7.2 SUMMARY SUSPENSION OF CLINICAL PRIVILEGES**

- 7.2.1 The Chief of Staff, the Chair of the department in which the practitioner holds privileges, the Chief Executive Officer, the Vice President of Medical Affairs, or the Executive Committee of either the Medical Staff or the Board of Trustees shall have the authority to suspend summarily all or any portion of the clinical privileges of a practitioner whenever immediate action must be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the mental or physical health or safety of any patient, employee, or other person present in the Hospital. Such summary suspension shall become effective immediately upon imposition. The Chief Executive Officer shall promptly notify the practitioner of the suspension by Special Notice.
- 7.2.2 Such summary suspension shall be deemed an interim precautionary step in the professional review activity unless and until it is reviewed and continued by the Medical Executive Committee or Board.
- 7.2.3 Within five (5) business days after the affected practitioner receives notice of the summary suspension, he may make a written request to the Chief of Staff that the Medical Executive Committee review the suspension at a special meeting. If the suspended practitioner makes a timely request, the Medical Executive Committee will hold a special meeting to review the suspension within five (5) business days from receipt of the practitioner's request. If an affected practitioner does not make a timely request, the Medical Executive Committee shall review the suspension at its next regular meeting. The Medical Executive Committee's review of the suspension shall be an informal proceeding and shall not be deemed a hearing. The suspended practitioner will be invited to present his or her point of view to the Medical Executive Committee at the meeting provided for in this Section. The Medical Executive Committee may recommend modification, continuation or termination of the terms of the summary suspension and shall recommend the future status of the practitioner's Medical Staff membership/privileges (e.g. reinstate after suspension of a specified duration, or terminate Medical Staff membership/privileges).
- 7.2.4 If the Medical Executive Committee, acting pursuant to Section 7.2.3, recommends termination of the suspension and a disposition of the matter which does not trigger hearing/appeal rights, such recommendation shall be transmitted immediately, together with all supporting documentation, to the Board. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision of the Board, provided, however, that unless the Board makes a final decision to the contrary within fifteen (15) days after the Medical Executive Committee's recommendation is transmitted to it, the action of the Medical Executive Committee to terminate the suspension shall become effective.

- 7.2.5 If the Medical Executive Committee, acting pursuant to Section 7.2.3, recommends a continuation of the suspension and/or a disposition of the matter that triggers hearing/appeal rights, the practitioner shall be entitled to the procedural rights provided in Article VIII. The terms of the suspension shall remain in effect pending a final decision by the Board.
- 7.2.6 Immediately upon the imposition of a summary suspension, the Chief of Staff, Department Chair, Chief Executive Officer, and Vice President of Medical Affairs shall have authority to provide for alternative medical coverage for patients of the suspended practitioner still in the Hospital. The wishes of the patients shall be considered in the selection of an alternative practitioner.

### **7.3 AUTOMATIC SUSPENSION/TERMINATION OF CLINICAL PRIVILEGES/MEMBERSHIP**

The events listed below shall result in automatic suspension or termination of a practitioner's Medical Staff membership or privileges, as specified, without right of hearing or appeal. Upon notification by the practitioner, Medical Staff Office or Medical Records Department of one of the listed events, the Chief of Staff, Vice President of Medical Affairs, Chief Executive Officer or their designee shall immediately notify the practitioner, in writing, of the suspension or termination.

- 7.3.1 Professional License. A practitioner whose license to practice a health profession in the State of Michigan is suspended shall automatically be suspended from practicing in the Hospital. If a practitioner's health profession license in the State of Michigan is revoked or otherwise terminated, or is suspended for more than thirty (30) consecutive days, the practitioner's Medical Staff membership and clinical privileges shall terminate automatically.
- 7.3.2 Drug Enforcement Administration (DEA) Registration or Michigan Controlled Substances License. A practitioner whose DEA registration or Michigan controlled substances license is revoked or suspended shall automatically be divested of the right to prescribe medications covered by such registration/license. As soon as practical after such automatic suspension, the Medical Executive Committee shall convene to review and consider the facts under which the DEA registration or Michigan controlled substances license was revoked or suspended. The Medical Executive Committee shall then take such further corrective action, if any, pursuant to Section 7.1 or 7.2, as the Medical Executive Committee determines appropriate.
- 7.3.3 Medical Records. In accordance with the Rules, an automatic suspension of a practitioner's clinical privileges shall be imposed for failure to complete medical records within the periods prescribed in the Rules.

- 7.3.4 Malpractice Insurance. A practitioner who fails to maintain professional liability insurance as required by the Board of Trustees shall be automatically suspended from practicing in the Hospital. If the practitioner fails to provide the Hospital with adequate evidence of the required insurance within ninety (90) days after being suspended, the practitioner's Medical Staff membership and clinical privileges shall terminate automatically. However, if the practitioner submits a request for a leave of absence pursuant to Section 6.9 during the first 90 days of suspension, the suspension shall continue while the request is being processed. Lack of insurance will not cause an automatic termination of Medical Staff membership during a leave of absence.
- 7.3.4.1 Malpractice Insurance requirement will not apply to Community Affiliate status.
- 7.3.5 Federal Program Exclusion. A practitioner who is excluded from a federal health care program shall automatically have his Medical Staff membership and clinical privileges terminated. (The terms of this Section 7.3.5 do not apply to a voluntary decision by a practitioner not to participate in federal health care program(s).)
- 7.3.6 Dues. If a Medical Staff member fails to pay Medical Staff dues within ninety (90) days after the due date, his clinical privileges shall be suspended automatically until dues are paid in full.
- 7.3.7 Board Certification. A practitioner's Medical Staff membership and clinical privileges shall terminate automatically upon failure to obtain Board Certification or Recertification by the end of the grace period as provided in Article IV, Section 4.2.2.3 and Section 4.2.2.4.
- 7.3.8 Documentation. A practitioner who fails to provide the Medical Staff Office with written evidence of current and continuous professional license and professional liability insurance shall automatically be suspended from practicing at the Hospital until such documentation is furnished. If a practitioner fails to provide the Medical Staff Office with written evidence of current and continuous DEA registration and Michigan controlled substances license (if applicable), the practitioner's right to prescribe medications covered by such registration/license shall automatically be suspended until such documentation is furnished.
- 7.3.8.1 Teleradiologists and Pathologists, by nature of their practice, shall be exempt from the requirements for Michigan controlled substances license and DEA registration.

## **7.4 EFFECT ON STATUS**

In the event that the practitioner's clinical privileges or Medical Staff membership is suspended, terminated or not renewed, the practitioner shall not enter upon the Hospital's premises at any time to conduct any activity directly or indirectly related to the practice of medicine (other than to complete medical records).

## 7.5 REPORTING REQUIREMENTS

Reporting requirements shall follow Federal and State regulations.

### ARTICLE VIII THE HEARING AND APPELLATE REVIEW PROCESS

#### 8.1 RIGHT TO A HEARING

- 8.1.1 Appealable Recommendations. Any of the following recommendations by the Medical Executive Committee shall entitle the affected practitioner to a hearing:
- 8.1.1.1 denial of requested increased clinical privileges;
  - 8.1.1.2 suspension or revocation of Medical Staff membership;
  - 8.1.1.3 reduction, suspension or revocation of clinical privileges; or
  - 8.1.1.4 other material limitation of the right to provide direct patient care as previously authorized (such as requiring proctoring or consultation, with consent of the proctor or consultant being required before patient care may be provided).
- 8.1.2 Appealable Board Actions. Any of the following actions by the Board of Trustees shall entitle the affected practitioner to a hearing, unless the Board's action was preceded by an adverse recommendation listed in Section 8.1.1:
- 8.1.2.1 denial of Medical Staff membership;
  - 8.1.2.2 denial of Medical Staff reappointment;
  - 8.1.2.3 denial of requested initial clinical privileges;
  - 8.1.2.4 denial of requested increased clinical privileges;
  - 8.1.2.5 suspension or revocation of Medical Staff membership;
  - 8.1.2.6 reduction, suspension or revocation of clinical privileges; or



- 8.1.2.7 other material limitation of the right to provide direct patient care as previously authorized (such as requiring proctoring or consultation, with consent of the proctor or consultant being required before patient care may be provided)
- 8.1.3 Non-Appealable Matters. A recommendation or action involving the following matters does not entitle a practitioner to a hearing:
  - 8.1.3.1 voluntary resignation of clinical privilege(s) or Medical Staff membership;
  - 8.1.3.2 issuance of a warning, a letter of admonition or a letter of reprimand;
  - 8.1.3.3 imposition of a consultation or proctoring requirement, if the consent of the consultant/proctor is not required before patient care may be provided;
  - 8.1.3.4 imposition of automatic suspension or termination pursuant to Section 7.3 of these Bylaws;
  - 8.1.3.5 denial of a request for, or termination of, temporary privileges;
  - 8.1.3.6 denial of a request for a leave of absence; or
  - 8.1.3.7 imposition of a requirement for retraining, additional training or continuing education;

## **8.2 THE HEARING PROCESS**

- 8.2.1 Preliminary Phase – Notice:
  - 8.2.1.1 The Chief Executive Officer shall notify the practitioner (including Allied Health Professionals and House Physicians), by Special Notice of a recommendation by the Medical Executive Committee or decision of the Board of Trustees which entitles the practitioner to a hearing under this Article. The notice shall be directed to the practitioner's professional office address.
  - 8.2.1.2 The notice referred to in Section 8.2.1.1 shall state the following:
    - The acts or omissions with which the practitioner is charged;
    - 2. A list of specific or representative charts being questioned, if any;

3. Such other reasons and subject matter, if any, that were considered in making the adverse recommendation or decision;
4. The practitioner's right to request a hearing;
5. A time limit of thirty (30) days from the date of receipt of the notice within which the practitioner may submit a written request for a hearing to the Chief Executive Officer; and
6. A summary of the practitioner's hearing rights.

8.2.1.3 Failure by the practitioner to request a hearing within the specified time period shall constitute a waiver of the practitioner's right to such a hearing and appellate review.

8.2.1.4 Within thirty (30) days after receipt of a timely request for a hearing, the Chief Executive Officer shall notify the Appellant by Special Notice of the date, time and place for the hearing.

8.2.1.5 The notice of the hearing shall be given at least thirty (30) days in advance of the scheduled hearing date and shall include a list of the witnesses, if any, expected to testify at the hearing on behalf of the Hospital; the Hospital shall supplement the list with a written list of the names of additional witnesses as they are determined.

8.2.1.6 Not less than 14 days before the hearing, the Appellant shall furnish to the Vice President of Medical Affairs a written list of the names of the individuals expected to testify at the hearing on behalf of the Appellant; the Appellant shall supplement the list with a written list of the names of additional witnesses as they are determined.

## 8.2.2 Composition and Appointment of Hearing Committee

8.2.2.1 When a hearing is triggered by an adverse recommendation of the Medical Executive Committee, such hearing shall be conducted by a Hearing Committee of not less than five (5) members of the Medical Staff appointed jointly by the Chief of Staff and Chief Executive Officer, in consultation with the Medical Executive Committee. One of the members shall be designated as Chairperson.

8.2.2.2 When a hearing is triggered by an adverse decision of the Board of Trustees, such hearing shall be conducted by the Board of Trustees who shall appoint a Hearing Committee of not less

than five (5) members of the Board of Trustees, at least one of whom shall be a member of the Medical Staff, appointed jointly by the Chairperson of the Board of Trustees and the Chief of Staff. One of the members shall be designated as Chairperson.

8.2.2.3 No member of a Hearing Committee shall be in direct economic competition with the Appellant or be a professional or business associate of the Appellant.

### **8.3 HEARING PHASE**

#### **8.3.1 Preliminary Rules**

8.3.1.1 At least a majority of the members of the Hearing Committee shall be present when the hearing takes place.

8.3.1.2 An accurate record of the hearing shall be kept. The mechanism for record taking shall be established by the Hearing Committee and may be accomplished by use of a court reporter or an electronic recording unit. Upon request, the Appellant shall be entitled to a copy of the hearing record.

8.3.1.3 Postponement of a hearing beyond the time set forth in these Bylaws shall be made only with approval of the Hearing Committee. Such postponements shall be granted for a good reason only, and in the sole discretion of the Hearing Committee.

#### **8.3.2 Presence of Appellant**

8.3.2.1 The personal presence of the Appellant shall be required.

8.3.2.2 An Appellant who fails, without good cause, to appear at a hearing shall waive his rights to a hearing and to appellate review.

#### **8.3.3 Hearing Officer**

The individuals who appoint the Hearing Committee may appoint a hearing officer, who may not be legal counsel to the Hospital, to preside at the hearing. The Hearing Officer must not act as a prosecuting officer, or as an advocate for the Board of Trustees, the Medical Executive Committee or the Appellant. The hearing officer will, at the request of the Hearing Committee, participate in the deliberations of the Hearing Committee and serve as a legal advisor to it, but shall not be entitled to vote. If a Hearing Officer is not appointed, the Chairperson of the Hearing Committee shall preside.

#### 8.3.4 Representation

8.3.4.1 If the hearing is triggered by an adverse recommendation of the Medical Executive Committee, the Chief of Staff shall appoint a Medical Staff member or an attorney to represent the Medical Executive Committee at the hearing to present evidence in support of the adverse recommendation and to examine witnesses.

8.3.4.2 If the hearing is triggered by an adverse decision of the Board of Trustees, the Chair of the Board of Trustees shall appoint one of its members or an attorney to represent the Board of Trustees at the hearing to present evidence in support of the adverse decision and to examine witnesses.

8.3.4.3 The Appellant shall be entitled to be represented by a member of the Medical Staff or an attorney to present evidence in response to the adverse recommendation or decision and to examine witnesses.

#### 8.3.5 Pre-Hearing Conference.

Prior to or at the beginning of any hearing the presiding officer may, in his discretion, require the representatives of the parties to attend a conference to consider:

8.3.5.1 The framing and simplification of issues to be presented at the hearing;

8.3.5.2 Admission of facts or documents which will avoid unnecessary hearing testimony and proof;

8.3.5.3 Limitation of the number of witnesses to be called by the Parties in order to reduce cumulative and repetitive testimony;

8.3.5.4 Such other matters as may aid in the expeditious disposition of the matters before the Hearing Committee.

The presiding officer may submit a summary of the decisions reached at the conference to the Hearing Committee and such summary may be used to control the subsequent course of the hearing.

#### 8.3.6 Conduct of Hearing

8.3.6.1 The presiding officer shall preside over the hearing, determine the order of procedures during the hearing, ensure that all

participants in the hearing have a reasonable opportunity to present oral and documentary evidence, rule on any issues that arise, set deadlines for the submission of briefs or other documentation, maintain decorum, and ensure that all parties present their positions without delay and that no party abuses its privileges under this Article.

8.3.6.2 The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule that might make the evidence inadmissible over objection in a civil or criminal action. It is the intent of this Section that evidentiary disputes be resolved in favor of admissibility, with the Hearing Committee deciding the appropriate weight to be accorded all evidence. Each party shall, prior to, during and at the close of the hearing, be entitled to submit memoranda concerning any issues of procedure or of fact, and such memoranda shall become part of the hearing record. Upon the request of either of the parties, the presiding officer shall order that oral evidence be taken only on oath or affirmation administered by any person designated by the presiding officer and entitled to notarize documents in the State of Michigan. Members of the Hearing Committee may question witnesses.

8.3.6.3 The parties to the hearing shall have the following rights:

1. To call and examine witnesses;

To introduce written evidence;

1. To cross-examine any witness on any relevant matter;

4. To challenge any witness and to rebut any evidence.

8.3.6.4 The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its action. The Appellant shall have the burden of proving that the adverse recommendation/action lacks any substantial factual basis or that the conclusions drawn therefrom were arbitrary or capricious.

8.3.7 Recess of Hearing

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

## **8.4 POST HEARING PHASE**

### **8.4.1 Decision of Hearing Committee**

8.4.1.1 Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereafter, at a time convenient to itself, conduct its deliberation outside the presence of the parties to the hearing. No member may vote by proxy. Within fourteen (14) days after the closing of the hearing or the deadline for filing post-hearing statements, if applicable, the Hearing Committee shall make a written report and recommendations, and shall forward the same, together with the complete hearing record and all written evidence and exhibits, to the body whose action triggered the hearing (either the Medical Executive Committee or the Board of Trustees).

8.4.1.2 The Hearing Committee's report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Medical Executive Committee or adverse decision of the Board of Trustees.

8.4.1.3 At its next regularly scheduled meeting, but not more than thirty (30) days after receiving the Hearing Committee's written report, the Medical Executive Committee or the Board of Trustees, whichever initiated the hearing, shall affirm, modify or reverse its original recommendation/action.

### **8.4.2 Notice of Post-Hearing Recommendation**

#### **8.4.2.1 Medical Executive Committee-Initiated Hearing**

Within seven (7) days after the Medical Executive Committee makes its post-hearing recommendation, the Chief Executive Officer shall forward the recommendation, together with all supporting documentation, to the Board of Trustees for its decision.

1. At its next regularly scheduled meeting, but not later than thirty (30) days after receipt of the Medical Executive Committee's recommendation, the Board of Trustees shall elect one of the following options:

Concur with favorable Medical Executive Committee recommendation; case is closed.

Overrule unfavorable Medical Executive Committee recommendation; the Board of Trustees' decision is final and case is closed.

Overrule favorable Medical Executive Committee recommendation; Appellant has the right to request an Appellate Review.

Concur with unfavorable Medical Executive Committee recommendation, affected practitioner has the right to request an Appellate Review.

2. Within seven (7) days after the Board of Trustees acts, the Chief Executive Officer shall notify the Appellant of the Board of Trustees' decision by Special Notice.

#### 8.4.2.2 Board of Trustees-Initiated Hearing

1. When the Board of Trustees' post-hearing decision is favorable to the Appellant, the Board of Trustees' decision is final and the case is closed. The Chief Executive Officer shall notify the Appellant of the favorable decision by Special Notice.
2. When the Board of Trustees' post-hearing decision is unfavorable to the Appellant, the Chief Executive Officer shall, within seven (7) days after the Board of Trustees acts, notify the Appellant by Special Notice of the adverse decision and his right to request an Appellate Review.

## **8.5 APPELLATE REVIEW**

### 8.5.1 Appeal to the Board of Trustees

8.5.1.1 An Appellant who has received a Special Notice of an action by the Board of Trustees after a hearing, which is adverse to the Appellant in any of the respects listed in Section 8.1.2, shall have fifteen (15) days following receipt of the Special Notice in which to file a written request for Appellate Review with the Chief Executive Officer by means of Special Notice.

8.5.1.2 If Appellate Review is not requested within the fifteen (15) day deadline, the Appellant shall waive his right of appeal and the adverse recommendation or decision shall remain in effect.

- 8.5.1.3 Within fifteen (15) days of receipt of a written request for an Appellate Review, the Board of Trustees shall schedule a date, time and place for the Review and notify the Appellant of same via Special Notice. The date of the Appellate Review shall not be more than sixty (60) days after the date of receipt of the Appellant's request for Appellate Review.
- 8.5.1.4 The Appellate Review shall be conducted by an ad hoc committee of the Board of Trustees, composed of not less than three (3) of its members.
- 8.5.1.5 Upon request, the Chief Executive Officer shall make available to the Appellant the complete hearing record and all other evidence that was considered in making the adverse decision.
- 8.5.1.6 The Appellant may, at least fifteen (15) days prior to the scheduled date for the Appellate Review, submit a written statement, regarding those factual and procedural matters with which he disagrees, and the reasons for such disagreement. Such written statement shall be submitted to the Chief Executive Officer by Special Notice and shall state whether the Appellant requests the opportunity to make an oral statement to the Appellate Review Committee.
- 8.5.1.7 The Appellate Review Committee, in its discretion, will determine whether oral statements will be allowed. If oral statements are requested and permitted, the Appellant or his attorney shall be permitted to speak against the adverse decision and shall answer questions by members of the Appellate Review Committee. The Board of Trustees shall also be represented by one of its members, or an attorney if so desired, to present its position and answer questions by any member of the Appellate Review Committee.
- 8.5.1.8 New or additional matters not raised during the original hearing or in the Hearing Committee report, may be introduced at the Appellate Review only due to unusual circumstances, and the Appellate Review Committee shall, in its sole discretion, determine whether such new matters shall be accepted.
- 8.5.1.9 Within twenty (20) days after the conclusion of the Appellate Review, the Appellate Review Committee shall make a written recommendation to the Board of Trustees.

8.5.2 Final Decision by the Board of Trustees

At its next regularly scheduled meeting, but not more than thirty (30) days after receipt of the Appellate Review Committee's recommendation, the



Board of Trustees shall consider the Committee's recommendation and make its final decision in the matter and shall send notice of its final decision to the Appellant by Special Notice and to the Medical Executive Committee.

8.5.3 Right to One Hearing and Appeal Only

No practitioner shall be entitled to more than one hearing and Appellate Review on any matter which may be the subject of a hearing/appeal, without regard to whether such matter is the subject of a recommendation or an action of the Medical Executive Committee or the Board of Trustees, or a combination of recommendations or actions of such bodies.

**ARTICLE IX  
ORGANIZATION OF DEPARTMENTS, DIVISIONS AND SECTIONS  
AND CLINICAL LEADERSHIP**

**9.1 ORGANIZATION**

The Medical Staff shall be divided into clinical departments. A department may be further divided, as appropriate, into divisions, which shall be directly responsible to the department within which they function. Each division shall have a Division Chief, selected and entrusted with the authority and responsibilities specified in Article X. Each division may be further divided, as appropriate, into sections, which shall be directly responsible to the division within which they function. Each section shall have a Section Head, selected and entrusted with the authority and responsibilities as specified in Article X.

**9.2 DEPARTMENTS, DIVISIONS, AND SECTIONS**

The Medical Staff is organized into the following units:

- 9.2.1 Department of Anesthesiology
- 9.2.2 Department of Behavioral Medicine
  - 9.2.2.1 Division of General Psychiatry
  - 9.2.2.2 Division of Chemical Dependency
- 9.2.3 Department of Emergency Medicine
- 9.2.4 Department of Family Medicine
- 9.2.5 Department of Maternal and Child Services
  - 9.2.5.1 Division of Obstetrics and Gynecology
  - 9.2.5.2 Division of Pediatrics and Neonatology

- 9.2.6 Department of Medicine
  - 9.2.6.1 Division of Internal Medicine
    - 1. Section of Cardiology
    - 2. Section of Critical Care and Pulmonary Medicine
    - 3. Section of Gastroenterology
  - 9.2.6.2 Division of Dermatology
  - 9.2.6.3 Division of Neurology
  - 9.2.6.4 Division of Physical Medicine and Rehabilitation
- 9.2.7 Department of Pathology and Laboratory Medicine
  - 9.2.7.1 Division of Anatomic Pathology
  - 9.2.7.2 Division of Clinical Pathology
- 9.2.8 Department of Diagnostic, Interventional and Therapeutic Radiology
  - 9.2.8.1 Division of Diagnostic Radiology
  - 9.2.8.2 Division of Nuclear Medicine
  - 9.2.8.3 Division of Therapeutic Radiology
- 9.2.9 Department of Surgery
  - 9.2.9.1 Division of General Surgery
  - 9.2.9.2 Division of Ophthalmology
  - 9.2.9.3 Division of Orthopedics
  - 9.2.9.4 Division of Urology
  - 9.2.9.5 Division of Vascular Surgery

### **9.3 FUNCTIONS OF DEPARTMENTS/DIVISIONS/SECTIONS**

- 9.3.1 Each clinical department/division/section shall recommend to the Medical Executive Committee criteria for delineating and granting clinical privileges within the department/division/section.

- 9.3.2 Each clinical department shall hold regular meetings to review care, draw conclusions, formulate recommendations, initiate actions and communicate to members the findings and opportunities to improve care.
- 9.3.3 Each department/division/section shall enforce compliance with the Bylaws and Rules.
- 9.3.4 Each department/division/section shall be fully accountable for all professional and administrative activities within its jurisdiction.
- 9.3.5 When appropriate, the Medical Executive Committee may recommend to the Medical Staff an amendment to the Bylaws which creates, eliminates, modifies or combines department(s), division(s) or section(s).
- 9.3.6 The specific policies for each department, division, and section shall be delineated in the Department Policies, which are effective when approved by the Medical Executive Committee and Board of Trustees.

#### **9.4 ASSIGNMENT TO DEPARTMENTS AND SECTIONS**

Each member of the Medical Staff shall be assigned membership in one department, and to a division and section, if applicable. Assignment to more than one department/division/section may be granted to Medical Staff members upon approval of the Chairs/Chiefs/Heads of the applicable departments/divisions/sections/ if the member possesses appropriate qualifications. If a Medical Staff member is assigned to multiple departments/divisions/sections, a single department/division/section must be identified as principal.

### **ARTICLE X DEPARTMENT, SECTION AND DIVISION LEADERSHIP**

#### **10.1 DEPARTMENTS AND DEPARTMENT CHAIRS**

- 10.1.1 **Chair:** Each department of the Medical Staff shall have a Chair who shall be responsible for supervising the work of its members and shall be responsible for the programs and activities conducted by the department. The department Chair shall be responsible for maintaining standards of care within the department, consistent with the standards of the Hospital. The department Chair shall be responsible to the Medical Executive Committee for the performance of duties within the Department. Periodically, the department Chair shall confer with the Vice President of Medical Affairs regarding the functioning of the department.
- 10.1.2 **Qualifications:** To be eligible for the position of Department Chair, the candidate must meet credentialing criteria for Medical Staff membership, be qualified to provide high quality patient care consistent with recognized standards of care, document administrative experience in relevant areas and

demonstrate a willingness and ability to work with others (e.g. Hospital employees, other departments, Administration), as well as demonstrate the capacity to devote sufficient effort and presence to accomplish the clinical and administrative work required by the chair role. The candidate must be Board Certified in his specialty or subspecialty at the time he assumes office.

10.1.3. Selection:

10.1.3.1 Department Chair Candidates shall be nominated by an Ad Hoc Search Committee appointed by the Chief of Staff and Vice President of Medical Affairs of the Hospital. Candidates must be acceptable to the Medical Executive Committee and the Board of Trustees. In addition to the Chief of Staff and Vice President of Medical Affairs, the search committee shall, at a minimum, have 3 representatives from the involved department, and at least one representative from another department.

10.1.3.2 The Department Chair Candidate must be approved by a simple majority of Department members who are eligible to vote (by virtue of belonging to the “active” staff category). Eligible members of the Department shall approve the Department Chair by confidential ballot at an announced departmental meeting. If the Department fails to approve the Department Chair Candidate, the Ad Hoc Search Committee shall be reconvened and a new search activated.

10.1.3.3 The Department Chair must be approved by the Medical Executive Committee and by the Board of Trustees.

10.1.4 Terms and Vacancies

10.1.4.1 Department Chairs shall be approved for an initial five (5) year term. At the end of this five-year term, Chairs may be reaffirmed by a simple majority vote of department members eligible to vote. After the second term, the Chair may again be considered for candidacy by the Ad Hoc Search Committee.

10.1.4.2 A Department Chair shall be automatically removed if he/she ceases to be a member in good standing of the Active Staff. In addition, a Department Chair may be removed by action of the relevant Department or by the Board of Trustees as described below.

- a. The members of the Department may request removal for breach of responsibilities as outlined in Section 10.5.1 or by vote of no confidence, utilizing the following process.

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

10.1.4.3 In the event of a vacancy in the office of an elected Chair, the Medical Executive Committee shall meet promptly and appoint a temporary Chair who shall serve until a successor is established. Within sixty (60) days the Chief of Staff and Vice President of Medical Affairs shall convene an Ad Hoc Search Committee.

10.1.5 Responsibilities:

10.1.5.1 Administrative

1. Responsible for all professional and administrative activities within the department including compliance with the Bylaws and Rules and Regulations, and pertinent actions of the Medical Executive Committee, and submission of timely reports;
2. Develop criteria for membership and clinical privileges in the department;
3. Recommend initial membership and/or clinical privileges and reappointments for each practitioner in the department;

4. Serve as a member of the Medical Executive Committee; give guidance on the overall medical policies of the Medical Staff; and make specific recommendations regarding his department to maintain quality patient care;
5. Design departmental structure, including recommendations to the Medical Executive Committee regarding designation of Divisions and Sections; participate in the appointment of Division Chiefs and Section Heads, in accordance with Sections 10.2.3 and 10.3.3;
6. Integrate the department into the primary functions of the Medical Staff and Hospital;
7. Coordinate and integrate interdepartmental and intradepartmental services;
8. Develop and implement policies and procedures that guide and support the provision of services in the department;
9. Orient new members and develop continuing education programs in the department;
10. Make recommendations for space, resources and other needs of the department, and for sufficient and qualified personnel;
11. Cooperate with nursing and other departments/services to establish and monitor policies and procedures for patient care;
12. Determine the qualifications and competence of department service personnel who are not licensed independent practitioners and who provide patient care services.

#### 10.1.5.2 Performance

1. Continuously monitor, via the Ongoing Professional Practice Evaluation process as described in Credentialing Policy 014, the professional performance of all individuals who have delineated clinical privileges in the department;

2. Review cases and reports referred by various committees of the Medical Staff and Hospital-wide committees, with the purpose of taking measures to continually assess and improve the quality and appropriateness of patient care within the department;
3. Assure that medical records accurately document important aspects of patient care provided in the department;
4. Conduct regularly scheduled department meetings in order to present committee reports for action and follow-up, inform the membership of Hospital administrative decisions, and discuss other items of business;
5. Serve as an ex-officio member on department committees;
6. Self-assess and improve, including continuing professional and administrative education;
7. Assess and recommend any off-site sources of patient care.

10.1.6 Reports to:

10.1.6.1 Vice President of Medical Affairs

10.1.6.2 Medical Executive Committee

## **10.2 DIVISIONS AND DIVISION CHIEFS**

10.2.1 Each division of the Medical Staff shall have a Chief who shall be responsible for supervising the work of its members and shall be responsible for the programs and activities conducted by the division. The Division Chief shall be responsible for maintaining standards of care within the Division, consistent with the standards of the Hospital. The Division Chief shall be responsible to the Department Chair for the performance of duties within the Division. Periodically, the Division Chief shall confer with the Vice President of Medical Affairs regarding the functioning of the division.

10.2.2 **Qualifications:** Only an Active member of the Medical Staff who is Board Certified in his specialty or subspecialty at the time he assumes office may serve as Chief of a Division.

10.2.3 **Selection:**

- 10.2.3.1 The chiefs of non-Hospital-Based divisions are recommended by the Department Chair, in consultation with the Chief of Staff and Vice President of Medical Affairs, to the Medical Executive Committee.
  - 10.2.3.2 The Medical Executive Committee is responsible for approving the appointment.
  - 10.2.3.3 The chiefs of Hospital-Based divisions are selected, and may be removed, as specified in the applicable contract.
- 10.2.4 Terms and Vacancies
- 10.2.4.1 The chief of a non-Hospital-Based division shall hold office for a term of two (2) years after which he/she is eligible for reappointment.
  - 10.2.4.2 The chief of a Hospital-Based division shall hold office for a term specified in the contract.
  - 10.2.4.3 The chief of a non-Hospital-Based division may be removed by (a) recommendation of the Department Chair, following consultation with the Chief of Staff and Vice President of Medical Affairs, and (b) approval by the Medical Executive Committee.
  - 10.2.4.4 In the event of vacancy in the office of a non-Hospital-Based Chief, the vacancy will be filled in accordance with Sections 10.2.3.1 and 10.2.3.2.
- 10.2.5 Responsibilities:
- 10.2.5.1 Administrative
    1. Responsible for all professional and administrative activities within the division including compliance with the Bylaws and Rules and Department Policies, and pertinent actions of the Medical Executive Committee, and submission of timely reports;
    2. Develop criteria for membership and clinical privileges in the division;
    3. Make specific recommendations to sustain and improve quality of care within the division;
    4. Make recommendations to the Department Chair regarding design of division structure, including



organization of sections; participate in the appointment of the Section Heads in accordance with Section 10.3.3;

5. Integrate the division into the primary functions of the Medical Staff and Hospital;
6. Coordinate and integrate interdivisional and intradivisional services;
7. Develop and implement policies and procedures that guide and support the provision of services in the division;
8. Orient new members and develop continuing education programs in the division;
9. Make recommendations for space, resources and other needs of the division, and for sufficient and qualified personnel;
10. Cooperate with nursing and other departments/services to establish and monitor policies and procedures for patient care;
11. Determine the qualifications and competence of division service personnel who are not licensed independent practitioners and who provide patient care services.

#### 10.2.5.2 Performance

1. Monitor the professional performance of all individuals who have delineated clinical privileges in the division;
2. Review cases and reports referred by various committees of the Medical Staff and Hospital-wide committees, with the purpose of taking measures to continually assess and improve the quality and appropriateness of patient care within the division;
3. Assure that medical records accurately document important aspects of patient care provided in the division;
4. May conduct division meetings;
5. Serve as an ex-officio member on division committees;

6. Self-assess and improve, including continuing professional and administrative education;
7. Assess and recommend to the Department Chiefs any off-site sources of patient care.

10.2.6 Reports to:

- 10.2.6.1 Department Chair
- 10.2.6.2 Vice President of Medical Affairs
- 10.2.6.3 Medical Executive Committee

### **10.3 SECTIONS AND SECTION HEADS**

10.3.1 Each section of the Medical Staff shall have a Head who shall be responsible for supervising the work of its members and shall be responsible for the programs and activities conducted by the section. The Section Head shall be responsible for maintaining standards of care within the Section, consistent with the standards of the Hospital. The Section Head shall be responsible to the Division Chief and Department Chair for the performance of duties within the Section. Periodically, the Section Head shall confer with the Vice President of Medical Affairs regarding the functioning of the Section.

10.3.2 Qualifications: Only an Active member of the Medical Staff who is Board Certified in his subspecialty at the time he assumes office may serve as Head of a Section.

10.3.3 Selection:

10.3.3.1 The heads of non-Hospital-Based sections are recommended by the Division Chief to the Department Chair. The Department Chair, in consultation with the Chief of Staff and Vice President of Medical Affairs, recommends the Heads of Sections to the Medical Executive Committee.

10.3.3.2 The Medical Executive Committee is responsible for approving the appointment.

10.3.3.3 The heads of Hospital-Based sections will be selected, and may be removed, as specified in the applicable contract.

10.3.4 Terms and Vacancies

- 10.3.4.1 The head of a non-Hospital-Based section shall hold office for a term of two (2) years, after which he/she is eligible for reappointment.
- 10.3.4.2 Each head of a Hospital-Based section shall hold office for a term specified in the contract.
- 10.3.4.3 The head of a non-Hospital-Based Section may be removed by (a) recommendation of the Department Chair, following consultation with the Division Chief, Chief of Staff and Vice President of Medical Affairs and (b) approval by the Medical Executive Committee.
- 10.3.4.4 In the event of a vacancy in the office of a non-Hospital-Based head, the vacancy will be filled in accordance with Sections 10.3.3.1 and 10.3.3.2.
- 10.3.5 Responsibilities:
- 10.3.5.1 Administrative
1. Responsible for all professional and administrative activities within the section including compliance with the Bylaws and Rules and Department Policies, and pertinent actions of the Medical Executive Committee, and submission of timely reports;
  2. Develop criteria for membership and clinical privileges in the Section;
  3. Make specific recommendations to sustain and improve quality of care within the section;
  4. Make recommendations to the Department Chair and Division Chief regarding design of section structure;
  5. Integrate the section into the primary functions of the Medical Staff and Hospital;
  6. Coordinate and integrate intersectional and intrasectional services;
  7. Develop and implement policies and procedures that guide and support the provision of services in the section;
  8. Orient new members and develop continuing education programs in the section;

9. Make recommendations for space, resources and other needs of the section, and for sufficient and qualified personnel;
10. Cooperate with nursing and other departments/services to establish and monitor policies and procedures for patient care;
11. Determine the qualifications and competence of section service personnel who are not licensed independent practitioners and who provide patient care services.

10.3.5.2 Performance

1. Monitor the professional performance of all individuals who have delineated clinical privileges in the section;
2. Review cases and reports referred by various committees of the Medical Staff and Hospital-wide committees with the purpose of taking measures to continually assess and improve the quality and appropriateness of patient care within the section;
3. Assure that medical records accurately document important aspects of patient care provided in this section;
4. May conduct section meetings;
5. Serve as an ex-officio member on section committees;
6. Self assess and improve, including continuing professional and administrative education;
7. Assess and recommend to the Department Chair and Division Chief any off-site sources of patient care.

10.3.6 Reports to:

- 10.3.6.1 Division Chief
- 10.3.6.2 Department Chair
- 10.3.6.3 Vice President of Medical Affairs
- 10.3.6.4 Medical Executive Committee

**ARTICLE XI**  
**OFFICERS/MEMBERS-AT-LARGE**

**11.1 OFFICERS**

The Medical Staff shall have the following officers:

- 11.1.1 Chief of Staff
- 11.1.2 Chief of Staff-Elect
- 11.1.3 Secretary/Treasurer

**11.2 MEMBERS-AT-LARGE**

The Members-at-Large serve on the Medical Executive Committee. They are not officers of the Medical Staff.

**11.3 QUALIFICATIONS**

- 11.3.1 Chief of Staff and Chief of Staff-Elect: To be eligible for the office of Chief of Staff or Chief of Staff-Elect the candidate must have been an Active member of the Medical Staff for a minimum of five (5) years and shall have served for at least one (1) year as a member of a standing committee or as Chair of a department at the Hospital. The candidate must be Board Certified at the time of assumption of the office.
- 11.3.2 Secretary/Treasurer: To be eligible for the office of Secretary/ Treasurer the candidate must have been an Active member of the Medical Staff for a minimum of five (5) years and shall have served for at least one (1) year as a member of a standing committee at the Hospital. The candidate must have the ability to record accurate minutes of the meetings of the Medical Executive Committee and the Medical Staff. The candidate must have the ability to keep an exact accounting of all Medical Staff funds. The candidate must be Board Certified at the time of assumption of the office.
- 11.3.3 Member-at-Large: To be eligible to serve as a Member-at-Large, the candidate must have been an Active member of the Medical Staff for a minimum of three (3) years and shall have served for at least one (1) year as a member of a standing committee at the Hospital. The candidate must be Board Certified at the time of assumption of the office.

**11.4 ELECTION**

- 11.4.1 The Nominating Committee will solicit from all Active members of the Medical Staff candidates for the offices of Chief of Staff-Elect and Secretary/Treasurer. The Nominating Committee shall submit the names of those eligible practitioners who wish to stand for election to those offices to

the Medical Executive Committee for approval before its October meeting. Within three (3) days after the Medical Executive Committee's October meeting, the Medical Executive Committee shall submit the names of approved candidates to the Board of Trustees. The Board of Trustees can accept the candidates for the offices of Chief of Staff-Elect and Secretary/Treasurer or return the list of candidates to the Medical Executive Committee for modification.

- 11.4.2 The Chief of Staff shall publish a roster of approved candidates for the positions of Chief of Staff-Elect and Secretary/Treasurer.
- 11.4.3 Active members of the Medical Staff shall elect officers by secret ballot by the 15<sup>th</sup> of December. A plurality of votes shall determine each winner. In case of a tie vote, a run-off election between the tying candidates will be held one week after the original election, under the same rules and conditions as the original election.
- 11.4.4 The Department of Medicine shall elect three (3) Members-at-Large and the Department of Surgery shall elect one (1) Member-at-Large. The Members-at-Large shall be nominated and elected. If a candidate runs unopposed then there will still be an election and the candidate must be approved by a majority vote of those present.

## **11.5 TERM OF OFFICE**

- 11.5.1 The term of office for Chief of Staff and Chief of Staff-Elect shall each be two (2) years. The Chief of Staff-Elect shall succeed to the office of Chief of Staff upon expiration of his term as Chief of Staff-Elect.
- 11.5.2 The term of office for Secretary/Treasurer shall be two (2) years.
- 11.5.3 The term of office for Members-at-Large shall be two (2) years.

## **11.6 DUTIES**

- 11.6.1 Chief of Staff
  - 11.6.1.1 Calls, presides at, and is responsible for the agenda of all meetings of the Medical Staff and the Medical Executive Committee;
  - 11.6.1.2 Serves with vote as Chair of the Medical Executive Committee and a member of the Board Credentials Committee;
  - 11.6.1.3 Serves as ex-officio member of all other Medical Staff committees; the Chief of Staff shall have no vote unless his membership on a particular committee is required by these Bylaws;

- 11.6.1.4 Unless otherwise stated, appoints all committee members, in consultation with the Vice President of Medical Affairs;
  - 11.6.1.5 Enforces the Bylaws and Rules, implementing sanctions where indicated and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
  - 11.6.1.6 Interacts with the CEO and Vice President of Medical Affairs and reports on the actions of the Medical Executive Committee to the Board of Trustees;
  - 11.6.1.7 Serves as a spokesperson for the Medical Staff in external professional and public relations;
  - 11.6.1.8 Appoints special committees as needed;
  - 11.6.1.9 Serves as a member of the Board Quality and Credentialing Committee;
  - 11.6.1.10 Attends meetings of the Board of Trustees, without vote;
  - 11.6.1.11 Performs other such functions as may be assigned to him by these Bylaws, the Medical Staff, or the Medical Executive Committee.
- 11.6.2 Chief of Staff-Elect
- 11.6.2.1 Assumes all duties and authority of the Chief of Staff in the absence of the Chief of Staff;
  - 11.6.2.2 Serves with vote as a member of the Medical Executive Committee and the Board Credentials Committee;
  - 11.6.2.3 Serves as Chair of the Credentials Committee;
  - 11.6.2.4 Performs such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or by the Medical Executive Committee.
- 11.6.3 Secretary/Treasurer
- 11.6.3.1 Maintains a roster of members of the Medical Staff;
  - 11.6.3.2 Serves with vote as a member of the Medical Executive Committee;

- 11.6.3.3 Calls meetings on the order of the Chief of Staff or the Medical Executive Committee;
- 11.6.3.4 Responsible for accurate and complete minutes of all meetings of the Medical Executive Committee and the Medical Staff;
- 11.6.3.5 Attends to all correspondence and notices;
- 11.6.3.6 Responsible for the collection of annual dues, an accurate account of all funds entrusted to his care, and an annual financial report to the Medical Executive Committee;
- 11.6.3.7 Responsible for payment of all financial obligations of the Medical Staff upon approval by the Medical Executive Committee;
- 11.6.3.8 Excuses absences from meetings of the Medical Executive Committee;
- 11.6.3.9 In the absence of the Chief of Staff and the Chief of Staff-Elect, assumes all of their duties and has all of their authority;
- 11.6.3.10 Performs such other duties that ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or the Medical Executive Committee.

11.6.4 Members-at-Large serve on the Medical Executive Committee with vote.

## **11.7REMOVAL OF OFFICERS**

Officers are subject to removal in the following manner:

- 11.7.1 A petition for the recall of any Officer bearing signatures of not less than twenty-five percent (25%) of the Active staff, may be submitted to the Chief of Staff with a copy to the Chief Executive Officer listing the cause(s) for removal from the following:
  - 11.7.1.1 Failure to conduct those responsibilities assigned by the Bylaws, Rules or other applicable policies;
  - 11.7.1.2 Failure to satisfy continuously the qualifications for the position;
  - 11.7.1.3 Conduct or statements damaging to the best interests of the Medical Staff or the Hospital or to their goals, programs or public image;



- 11.7.1.4 Physical or mental infirmity that renders the Officer incapable of fulfilling the duties of his or her position.
- 11.7.2 The petition shall be presented at the next regular meeting of the Medical Executive Committee following receipt. The Medical Executive Committee shall verify the signatures, determine that each signer is eligible to vote, and determine that the number of signatures is equal to at least twenty-five percent (25%) of the Active staff.
- 11.7.3 If the petition complies with all requirements of Section 11.7.2, the Medical Executive Committee shall instruct the Secretary to deliver a recall ballot to each Active member. The ballot shall be returned to the Chief Executive Officer within ten (10) days in order to be counted.
- 11.7.4 The ballot shall be in the following form:
- Shall \_\_\_\_\_ be recalled as \_\_\_\_\_ of the Medical Staff?
- YES: \_\_\_\_\_ NO: \_\_\_\_\_
- Vote and return this ballot to the Chief Executive Officer on or before \_\_\_\_\_.
- 11.7.5 The Chief Executive Officer shall present the ballots to the Medical Executive Committee at its next regular meeting following the date of the recall election. They shall be counted by a teller appointed by the Medical Executive Committee.
- 11.7.6 If two-thirds (2/3) of the Active Staff vote in favor of the recall, such Officer shall be recalled and shall be relieved of his duties immediately. A successor shall be selected as provided in Section 11.8.
- 11.7.7 An Officer may also be removed by two-thirds (2/3) vote of the Medical Executive Committee (by confidential ballot) for any of the grounds stated in Section 11.7.1.

## **11.8REMOVAL OF A MEMBER-AT-LARGE**

- 11.8.1 A Member-at-Large may be removed by action of the Active members of the department which elected that Member-at-Large, using the same procedure as those specified in Sections 11.7.1 – 11.7.6, except that action is taken by the Active members of the department, rather than by all Active staff members.
- 11.8.2 A Member-at-Large may also be removed in accordance with Section 11.7.7.

## **11.9VACANCIES**

- 11.9.1 In the event of a vacancy in the office of Chief of Staff, the current Chief of Staff-Elect shall serve out that remaining term, in addition to the term as Chief of Staff for which he was elected.
- 11.9.2 In the event of a vacancy in the office of Chief of Staff-Elect, the vacancy shall be filled by a special election which shall be conducted as soon as practicable in accordance with Section 11.4.1.
- 11.9.3 In the event of a vacancy in the office of Secretary/Treasurer, the Medical Executive Committee shall appoint one of its members to fill the vacancy until the next regular election.
- 11.9.4 In the event of a vacancy in a Member-at-Large position, the Medical Executive Committee shall meet promptly and appoint a temporary Member-at-Large who shall serve until a successor is elected. Within sixty (60) days of his appointment, the applicable Department Chair shall conduct an election, in accordance with Section 11.4.4, to fill the unexpired term of the departed Member-at-Large.

**ARTICLE XII  
COMMITTEES**

**12.1 GENERAL PROVISIONS**

- 12.1.1 OUTLINE OF COMMITTEES
  - 12.1.1.1 Bylaws Committee
  - 12.1.1.2 Cancer Committee
  - 12.1.1.3 Pharmacy, Therapeutics and Transfusion Committee
  - 12.1.1.4 Credentials Committee
  - 12.1.1.5 Medical Executive Committee
  - 12.1.1.6 Medical Records Committee
  - 12.1.1.7 Nominating Committee
  - 12.1.1.8 Clinical Performance Improvement Committees
  - 12.1.1.9 Surveillance, Prevention, Control of Infection Committee
  - 12.1.1.10 Institutional Review Board
  - 12.1.1.11 Education Committee

12.1.2 COMMITTEE MEMBERS AND CHAIRS

Unless otherwise stated in these Bylaws, the Chief of Staff, in consultation with the Vice President of Medical Affairs, shall appoint the chairs and members of all Medical Staff committees and, upon request, shall recommend Medical Staff members to serve on Hospital committees. The Vice President of Medical Affairs shall be an ex-officio non-voting member of all Medical Staff committees of whom he is not otherwise a member.

12.1.3 QUORUM

Decisions will be made by a majority of those present.

12.1.4 REPORTS

Each Committee shall maintain a written record of its conclusions, recommendations, and actions taken and shall report same to the Medical Executive Committee.

12.1.5 ADDITIONAL COMMITTEE FUNCTIONS

In addition to the functions described in these Bylaws, each committee shall perform such additional duties as may be assigned to it by the Medical Executive Committee.

**12.2 BYLAWS COMMITTEE**

12.2.1 PURPOSE

The purpose of the Bylaws Committee is to review, and revise when necessary, the Bylaws and Rules.

12.2.2 COMPOSITION

Active Medical Staff, and non-voting advisory members as necessary.

12.2.3 FUNCTIONS

Review Bylaws and Rules regularly and make recommendations for revisions to reflect the Hospital's current practices and compliance with Hospital policy and legal requirements. The Bylaws Committee may make grammatical corrections (e.g. grammar, spelling, punctuation, where the meaning of the language is not altered) without approval by the Medical Executive Committee or Medical Staff.

12.2.4 MEETINGS

As needed.

## 12.3CANCER COMMITTEE

### 12.3.1 PURPOSE

The purpose of the Cancer Committee is to plan, initiate, stimulate and assess all cancer-related activities in the Hospital to improve the quality and appropriateness of care rendered to patients with cancer, as referenced in *Standards of the Commission on Cancer of the American College of Surgeons*.

### 12.3.2 COMPOSITION

#### 12.3.2.1 Physician representative from:

- a. Diagnostic Radiology
- b. Medical Oncology
- c. Pathology
- d. Radiation Oncology
- e. Surgery
- f. The physician designated as Cancer Liaison for the Hospital's Cancer Program
- g. Other related disciplines as needed

#### 12.3.2.2 Non-physician representative from:

- a. Administration
- b. Nursing
- c. Social work
- d. Quality improvement
- e. Nutrition services
- f. Pharmacy services
- g. Rehabilitation services
- h. Certified tumor registrar

### 12.3.3 FUNCTIONS

- 12.3.3.1 Designate coordinator for each of the following four areas of Cancer Committee activity: cancer conference, quality control of cancer registry data, quality improvement, and community outreach.
- 12.3.3.2 Develop and evaluate the annual goals and objectives for the clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.
- 12.3.3.3 Establish the cancer conference frequency and format and multidisciplinary attendance requirements, on an annual basis.
- 12.3.3.4 Ensure that the required number of cases are discussed at the cancer conference on an annual basis and that at least 75 percent of the cases discussed are presented prospectively.
- 12.3.3.5 Monitor and evaluate the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis.
- 12.3.3.6 Establish and implement a plan to evaluate the quality of cancer registry data and activity. The plan includes procedures to monitor casefinding, accuracy of data collection, abstracting timeliness, follow-up, and data reporting on an annual basis.
- 12.3.3.7 Each year, analyze patient outcomes and disseminate the results of the analysis.
- 12.3.3.8 Ascertain that educational programs, cancer conferences and other clinical activities include all major sites of cancer seen at the Hospital.
- 12.3.3.9 Evaluate the quality of care of patients with cancer, either directly or by interaction with, and review of, audit data from other committees.
- 12.3.3.10 Serve as registry physician-advisor(s) to the individual responsible for maintaining the Hospital's cancer registry.

12.3.4 MEETINGS

Bimonthly (every two months) or as needed.

**12.4PHARMACY, THERAPEUTICS AND TRANSFUSION COMMITTEE**

#### 12.4.1 PURPOSE

The purpose of the Pharmacy, Therapeutics and Transfusion Committee is to develop policies and procedures governing safe administration of drugs, biologicals, blood, blood products, and diagnostic testing materials. The Committee reviews all blood reactions and adverse drug reactions.

#### 12.4.2 COMPOSITION

##### 12.4.2.1 Physician representative from:

- a. Medicine
- b. Surgery
- c. Maternal and Child Services
- d. Behavioral Medicine
- e. Pathology
- f. Emergency Medicine
- g. Anesthesiology

##### 12.3.2.1 Non-physician representatives:

- a. Hospital Epidemiologist
- b. Director and Assistant Director of the Pharmacy and a Clinical Pharmacist
- c. Administration
- d. Nursing Service
- e. Blood Bank
- f. Other departments as appropriate

#### 12.4.3 FUNCTIONS

12.4.3.1 Drug Usage Evaluation: Conduct a criterion-based, on-going, planned and systematic evaluation of drug use, to continuously assess and improve the appropriate and effective use of drugs including:

- a. Develop and/or approve policies and procedures relating to the selection, distribution, use and administration of drugs and diagnostic testing materials;
- b. Collect and assess information to identify opportunities to improve the use of drugs and resolve problems in their use, such as drugs that are (a) frequently prescribed, (b) known or suspected to present significant risk or problem to patients, or (c) are a critical components for a specific diagnosis, condition or procedure;
- c. Evaluate and approve protocols for the use of investigational or experimental drugs in studies that have been approved by the Institutional Review Board;
- d. Monitor and evaluate the appropriateness of the use of drugs based on objective criteria that reflect current knowledge, clinical experience, and relevant literature; and include the use of screening mechanisms to identify, for more intensive evaluation, problems in or opportunities to improve the use of a specific drug or category of drugs; analyze significant untoward drug reactions;
- e. Provide feedback, as necessary, to Medical Staff members regarding their ordering practices, and advise Department Chair regarding information if necessary.
- f. Blood Utilization Review: The Committee performs blood usage review on an ongoing basis to continuously improve the appropriateness and effectiveness with which blood and blood components are used through:
  - g. Use screening criteria to identify single cases or patterns of cases that require more intensive evaluation;
  - h. Intensively evaluate all confirmed transfusion reactions;
  - i. Develop or approve policies and procedures relating to the distribution, handling, and use of blood and blood components;
  - j. Review the adequacy of transfusion services to meet the needs of the Hospital's patients; and
  - k. Review ordering practices for blood and blood components.

#### 12.4.4 MEETINGS

Monthly.

### **12.5 CREDENTIALS COMMITTEE**

#### 12.5.1 PURPOSE

The purpose of the Credentials Committee is to review, evaluate and make recommendations on applicants for appointment and reappointment to the Medical Staff, and for initial and renewed clinical privileges.

#### 12.5.2 COMPOSITION

The Credentials Committee shall consist of (a) the Chief of Staff-Elect, who shall chair the Committee, (b) the Chairs of the Departments of Maternal and Child Services, Medicine and Surgery, and (c) three or more additional Active Staff members as appointed by the Chief of Staff in consultation with the Vice President of Medical Affairs. If the Chief of Staff-Elect also serves as Chair of one of the departments specified above, the Chief of Staff shall appoint a fourth Active Staff member to the Committee.

#### 12.5.3 FUNCTIONS

12.5.3.1 Review and evaluate the qualifications and credentials of all applicants and make recommendations for Medical Staff membership.

12.5.3.2 Recommend all delineated clinical privileges (including for House Physicians and Allied Health Professionals) based on verified information regarding the practitioner's licensure, specific training, experience, and current competence.

12.5.3.3 Review all provisional appointments at the end of the Provisional period as specified in Section 6.1.

12.5.3.4 Review and evaluate information regarding the clinical performance and competence of Staff members and Allied Health Professionals, and as a result of the review, in conjunction with the department Chairs, make recommendations for the granting, renewal and changing of privileges, reappointments, and the assignments of practitioners to the various departments and Medical Staff categories.

12.5.3.5 Review requests for reinstatement of members of the Medical Staff returning from a Leave of Absence.



12.5.4 MEETING

Monthly.

**12.6 MEDICAL EXECUTIVE COMMITTEE**

12.6.1 PURPOSE

The purpose of the Medical Executive Committee is to oversee the responsibilities of the Medical Staff, and to act on its behalf in the intervals between Medical Staff meetings. Authority to act on behalf of the Medical Staff is granted by approval of these Bylaws. Should authority need to be changed or revoked, a proposal shall be presented by any voting Medical Staff member at the next General Staff meeting for vote by the Medical Staff, followed by review for approval by the Board of Trustees.

In the event of conflict between the Medical Executive Committee and the Medical Staff, the concerned party/parties shall submit their concern to the Chief of Staff for presentation to the Medical Executive Committee. The concerned party may be invited to the Medical Executive Committee meeting to present his/her concern. If the Medical Executive Committee and the concerned party are unable to reach resolution, the issue will be referred to the Board of Trustees. The Medical Staff Office will assist the concerned parties in having their issue added to the Board agenda. Nothing in the above process is intended to prevent medical staff members from communicating directly with the Board of Trustees.

12.6.2 COMPOSITION

12.6.2.1 Chief of Staff (chairs the Committee)

12.6.2.2 Chief of Staff-Elect

12.6.2.3 Secretary/Treasurer

12.6.2.4 Three (3) Members-at-Large elected by the Department of Medicine and one (1) Member-at-Large elected by the Department of Surgery

12.6.2.5 Chair of Department of Anesthesiology

12.6.2.6 Chair of Department of Behavioral Medicine

12.6.2.7 Chair of Department of Emergency Medicine

12.6.2.8 Chair of Department of Family Medicine

12.6.2.9 Chair of Department of Maternal and Child Services

- 12.6.2.10 Chair of Department of Medicine
- 12.6.2.11 Chair of Department of Pathology and Laboratory Medicine
- 12.6.2.12 Chair of Department of Diagnostic, Interventional and Therapeutic Radiology
- 12.6.2.13 Chair of Department of Surgery
- 12.6.2.14 Vice President Medical Affairs, ex-officio without vote
- 12.6.2.15 Chief Executive Officer, ex-officio without vote
- 12.6.2.16 Vice President of Patient Care Services, ex-officio without vote
- 12.6.2.17 May include other licensed independent practitioners.
- 12.6.2.18 Designated Institutional Official, ex-officio without vote.

### 12.6.3 FUNCTIONS

The Medical Executive Committee recommends to the Board of Trustees matters pertaining, but not necessarily limited, to:

- 12.6.3.1 The organization of the Medical Staff;
- 12.6.3.2 The mechanism used to review and to delineate clinical privileges;
- 12.6.3.3 Medical Staff appointments, reappointments, clinical privileges and corrective action;
- 12.6.3.4 The organization of the performance improvement activities of the Medical Staff, as well as the mechanism used to conduct, evaluate, and revise such activities;
- 12.6.3.5 Conclusions, recommendations, and actions taken by the Medical Executive Committee.

In addition, the Medical Executive Committee:

- 12.6.3.6 Receives and acts on reports and recommendations from Medical Staff committees, clinical departments, and special assigned groups;
- 12.6.3.7 Coordinates the activities and general policies of the various departments;

- 12.6.3.8 Considers and recommends action to Administration on all matters of a medical-administrative nature;
- 12.6.3.9 Informs the Medical Staff of the accreditation program and accreditation status of the Hospital;
- 12.6.3.10 Appoints special or ad hoc committees as may seem necessary;
- 12.6.3.11 Reviews and approves relevant patient care policies;
- 12.6.3.12 Provides leadership in activities related to patient safety.
- 12.6.3.13 Provides oversight in the process of analyzing and improving patient satisfaction.
- 12.6.3.14 Interprets the Bylaws and Rules;
- 12.6.3.15 Advises Administration and the Board of Trustees regarding the clinical aspects of all clinical contracts.

12.6.4 MEETINGS

Monthly.

(Additional meetings may be called by the Chief of Staff, or designee.)

12.6.5 REPORTS TO

The Medical Staff  
The Board of Trustees

**12.7 MEDICAL RECORDS COMMITTEE**

12.7.1 PURPOSE

The purpose of the Medical Records Committee is to assure appropriate documentation of the medical care of each Hospital patient.

12.7.2 COMPOSITION

- 12.7.2.1 Appropriate Medical Staff representation
- 12.7.2.2 Manager of Medical Records
- 12.7.2.3 Representative from Administration
- 12.7.2.4 Representative from Nursing Services
- 12.7.2.5 Representatives of other departments as necessary

12.7.3 FUNCTIONS

- 12.7.3.1 Review and evaluate a representative sample of medical records, to determine whether they:
- a. properly describe the condition, diagnosis, and progress of the patient during hospitalization and at the time of discharge; the treatment and tests provided and the results thereof; and identify the individuals responsible for orders given and treatment rendered; and
  - b. are sufficiently complete to facilitate continuity of care and communication among individuals providing patient care services in the Hospital.
- 12.7.3.2 Review and make recommendations for Medical Staff and Hospital policies, rules and regulations relating to medical records, including content, completion, forms and formats, permitted abbreviations, storage, destruction, availability and use of electronic records.
- 12.7.3.3 Enforce Medical Staff requirements regarding timely completion of medical records.
- 12.7.3.4 Provide reports to the Department Chairs on the compliance of Medical Staff and practitioners with medical records standards.

12.7.4 MEETINGS

At least quarterly.

12.7.5 REPORTS TO

Medical Executive Committee  
Clinical Performance Improvement Committees

**12.8NOMINATING COMMITTEE**

12.8.1 PURPOSE

The purpose of the Nominating Committee is to solicit nominees for the offices of Chief of Staff-Elect and Secretary/Treasurer and submit the names of eligible nominees to the Medical Executive Committee for approval.

12.8.2 COMPOSITION

The Nominating Committee shall consist of seven (7) members of the Active Medical Staff, one of whom shall be designated as Chair by the Chief of

Staff. Three (3) members shall be appointed by the Chief of Staff and four (4) shall be appointed annually by the applicable Department Chair, two (2) by the Department of Medicine, and one (1) each by the Departments of Maternal and Child Services and Surgery. Members of the nominating committee are not eligible for office.

#### 12.8.3 FUNCTIONS

12.8.3.1 Nominate and vet qualified candidates for the Offices of Chief of Staff-Elect and Secretary/Treasurer and present a list of at least two and not more than three candidates to the medical staff for vote.

12.8.3.2 Count the ballots in Medical Staff Officer elections.

#### 12.8.4 MEETINGS

As necessary.

### **12.9 CLINICAL PERFORMANCE IMPROVEMENT COMMITTEES**

#### 12.9.1 PURPOSE

The purpose of these committees is to monitor, evaluate and improve the quality and appropriateness of patient care and the clinical performance of all practitioners with delineated clinical privileges. Opportunities to improve care shall be addressed and important problems in patient care shall be identified and resolved.

#### 12.9.2 COMPOSITION

The Departments of Behavioral Medicine, Maternal and Child Health, Medicine and Surgery shall each have a Clinical Performance Improvement Committee. The Chief of Staff shall, in consultation with the department Chair and the Vice President of Medical Affairs, appoint a sufficient number of Medical Staff members to these committees. Each committee will have appropriate department representation to evaluate care across the continuum. The Surgery Clinical Performance Improvement Committee shall include at least one endoscopist. An emergency medicine physician will be assigned to each committee. The applicable Department Chair will be an ex-officio non-voting member of the committee. A Clinical Improvement Committee may, in its discretion, arrange for a practitioner who is not a member of the Committee to participate in a review when additional expertise is needed.

#### 12.9.3 FUNCTIONS

- 12.9.3.1 Identify the indicators used to monitor the quality and appropriateness of the important aspects of patient care.
  - 12.9.3.2 Monitor and evaluate the quality and appropriateness of patient care provided by all practitioners.
  - 12.9.3.3 Measure, assess and take necessary steps to improve quality of care at the Hospital.
  - 12.9.3.4 Notify Department Chair of results of committee's activities and of any cases when intervention with respect to a particular practitioner appears warranted and coordinate with Department Chair plans to improve care.
  - 12.9.3.5 Work with Administration to select and achieve the Hospital's annual performance improvement goals and communicate with the Medical Staff regarding the goals.
- 12.9.4 MEETINGS
- At least quarterly.
- 12.9.5 REPORTS TO
- Applicable Department Chair  
Medical Executive Committee

## **12.10 INFECTION PREVENTION COMMITTEE**

### 12.10.1 PURPOSE

The purpose of the Surveillance, Prevention, Control of Infection Committee is to monitor Hospital infections, promote an educational program designed to minimize the incidence of Hospital infections, and identify and implement changes to prevent infections.

### 12.10.2 COMPOSITION

- 12.10.2.1 Epidemiologist
- 12.10.2.2 Infection Control Analyst
- 12.10.2.3 Appropriate Medical Staff representation

### 12.10.3 FUNCTIONS

- 12.10.3.1 Monitor infection control in all phases of the Hospital's activities, including operating rooms, delivery rooms, and special care units.
- 12.10.3.2 Monitor nosocomial infections.
- 12.10.3.3 Review infection hazards.
- 12.10.3.4 Monitor sterilization procedures, isolation procedures and techniques, testing of Hospital personnel for carrier status in selected infectious diseases, and disposal of infectious materials.
- 12.10.3.5 Develop policies for infection control, assist in the implementation of these policies, and undertake on-going education on the use and observance of these policies.
- 12.10.3.6 Evaluate annually adherence to the standards of Joint Commission on Accreditation of Healthcare Organizations for the Infection Control Program.
- 12.10.3.7 Make recommendations to Administration and the Medical Staff regarding infection control issues.

### 12.10.4 CHAIR

Hospital Epidemiologist.

### 12.10.5 MEETINGS

Monthly.

### 12.10.6 REPORTS TO

Medical Executive Committee  
Hospital Operations Committee

## **12.11 INSTITUTIONAL REVIEW BOARD**

### 12.11.1 PURPOSE

The purpose of the Institutional Review Board (IRB) is review, approve and oversee all human subject research conducted at the Hospital.

## 12.11.2 COMPOSITION

- 12.11.2.1 The IRB shall have at least five (5) members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the Hospital.
- 12.11.2.2 The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members, including consideration of race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects.
- 12.11.2.3 IRB members shall have the professional capacity to evaluate the proposals before them and shall be qualified to assess the acceptability and appropriateness of these proposals in light of Hospital commitments and policies, standards of professional conduct and practice, applicable law, local community standards and attitudes, and ethical standards.
- 12.11.2.4 If the IRB regularly reviews research that involves a vulnerable category of subjects, such as children, prisoners, pregnant women, or handicapped or mentally disabled persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these subjects.
- 12.11.2.5 The IRB may not consist entirely of members of one profession.
- 12.11.2.6 The IRB shall include at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.
- 12.11.2.7 The IRB shall include at least one member who is not otherwise affiliated with the Hospital and who is not part of the immediate family of a person who is affiliated with the Hospital.
- 12.11.2.8 No member of the IRB may participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. The IRB determines whether a member has a conflicting interest.
- 12.11.2.9 The IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.



12.11.3 FUNCTIONS

12.11.3.1 Review and have authority to approve, require modifications in, disapprove and/or terminate all clinical human research activities at the Hospital.

12.11.3.2 Oversee content, procedures and documentation of informed consent by research subjects.

12.11.3.3 Conduct continuing review of approved research activities at intervals appropriate to the degree of risk, but not less than once per year, and have authority to observe or have a third party observe the consent process and the research.

12.11.4 MEETINGS

Ad hoc

12.11.5 QUORUM

Except as otherwise provided in the IRB's policies, the IRB shall review proposed research at convened meetings at which a majority of the IRB members are present, including one member whose primary concerns are in non-scientific areas. In order for research to be approved, it shall receive the approval of a majority of those members present at the meeting.

12.11.6 REPORTS TO

Medical Executive Committee  
Board of Trustees

**12.12 EDUCATION COMMITTEE**

12.12.1 PURPOSE

The purpose of the Education Committee is to develop, support and improve educational services and resources for the Medical Staff. Included in this obligation is responsibility for continuing medical education, library services, and development and supervision of education programs with undergraduate medical and allied health professional schools. The Committee plans continuing medical education programs for the Medical Staff regarding relevant scientific and medical topics and in areas where the Hospital's performance improvement activities have identified a need for additional education.

12.12.2 COMPOSITION

12.12.2.1 Appropriate Medical Staff representation

12.12.2.2 Medical Librarian

12.12.2.3 Coordinator of Continuing Medical Education

12.12.3 FUNCTIONS

12.12.3.1 Adopt and implement a vision of library services.

12.12.3.2 Organize and conduct Continuing Medical Education programs.

12.12.3.3 Organize and maintain undergraduate medical and allied health professional education programs conducted at the Hospital.

12.12.4 MEETINGS

Ad hoc

**ARTICLE XIII  
GENERAL STAFF MEETINGS**

**13.1 GENERAL STAFF MEETINGS**

The Medical Staff shall conduct General Staff meetings at least three (3) times per year. The day, hour and location of the meetings shall be posted in advance.

**13.2 SPECIAL MEETINGS**

The Chief of Staff may call a Special Meeting of the Medical Staff at any time. The place, day and hour of any Special Meeting shall be posted or mailed to Staff members in advance.

**13.3 QUORUM**

The presence (in person or by mail ballot) of one hundred (100) voting members of the Medical Staff at any General Staff Meeting or Special Meeting shall constitute a quorum for the purpose of amending these Bylaws, and the presence (in person or by mail ballot) of fifty (50) of such members shall constitute a quorum for all other actions.

**13.4 NOTICES**

The Bulletin Board in the Medical Staff Lounge is the official place for posting of Medical Staff and department notices.

**ARTICLE XIV  
DEPARTMENT, DIVISION, SECTION MEETINGS**

**14.1 REGULAR MEETINGS**

The primary purpose of department meetings is to monitor and evaluate the quality and appropriateness of patient care. Any other issue may be presented and discussed. Regular meetings shall be held by each department. Divisions and sections may hold their own meetings with approval of their department Chair.

**14.2 SPECIAL MEETINGS**

The Chair or Chief of Staff may call a Special Meeting of the department. The place, day and hour shall be posted or mailed to respective department members in advance.

**14.3 QUORUM**

A quorum consists of the number of voting members present. Decisions will be made by a majority of those present, except as otherwise provided in Section 10.1.4.3.

**14.4 MINUTES**

Minutes shall include a record of the attendance of members and the vote taken on each matter. They shall be signed by the presiding officer. Each department shall maintain a permanent file of the minutes of each meeting. If a division or section holds meetings, a permanent file of the minutes of the meetings shall be kept by the division, with a copy sent to the Department Chair.

**ARTICLE XV  
WAIVER OF CLAIMS/GRANTING OF AUTHORITY  
TO PROCESS CONFIDENTIAL INFORMATION**

Each applicant to and member of the Medical Staff and each applicant for and holder of clinical privileges (including Allied Health Professionals and House Physicians):

- 15.1 Waives any claim, present or future, against the Hospital, the Medical Staff, and/or any of their representatives, relative to any good faith act, communication or recommendation made or requested, concerning such practitioner's qualifications and conduct and evaluation thereof. This waiver shall also apply to third parties that furnish information described in this section, including otherwise privileged or confidential information, to the Medical Staff, the Hospital and their representatives.
- 15.2 Authorizes the representatives of the Medical Staff and Hospital to consult with other hospitals and medical associations, licensing boards and other organizations and individuals who may have information bearing on his character, conduct, ethics, physical and mental health, competence and other qualifications;

- 15.3 Consents to representatives of the Medical Staff and Hospital inspecting all records and documents that may be material to an evaluation of his qualifications and competence to carry out the clinical privileges requested and to his ethical qualifications;
- 15.4 Authorizes representatives of the Hospital and the Medical Staff to provide other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality of patient care with any relevant information regarding the practitioner.

**ARTICLE XVI  
PROFESSIONAL PRACTICE REVIEW FUNCTIONS**

**16.1 REVIEW FUNCTIONS OF MEDICAL STAFF AND ADMINISTRATION**

- 16.1.1 The Medical Staff is organized in a manner to provide ongoing review of the professional practices of the Hospital, for the purposes of striving to reduce morbidity and mortality and to improve the care of patients. Such review includes the quality and necessity of care provided and the preventability of complications and deaths. To the extent any committee of the Medical Staff performs such functions, that committee is hereby designated as a committee assigned professional practice review functions. The committees so designated include, but are not limited to, the investigative, hearing and appeal bodies described in Articles VII and VIII and the following committees, which are further described in these Bylaws: Medical Executive, Credentials, Cancer, Clinical Performance Improvement, Medical Records, Pharmacy, Therapeutics and Transfusion, Institutional Review Board, and Infection Prevention.
- 16.1.2 Professional practice review functions are also performed in the various clinical departments, divisions and sections of the Medical Staff, the clinical programs of the Hospital, by the Medical Staff Officers, by Administration, and by the participants in the proceedings that are described in Article VIII, all of whom are assigned professional practice review functions.
- 16.1.3 Employees of the Hospital are assigned and perform professional practice review functions by providing information, records, data and knowledge to, and otherwise assisting, individuals and committees in the performance of their professional practice review functions.

**16.2 BOARD'S AUTHORITY AND FUNCTIONS**

All professional practice review functions are carried out under the direction and authority of the Board of Trustees, which itself carries out professional practice review functions, such as receiving and acting on the reports and recommendations of committees and individuals assigned such functions.

### **16.3 CONFIDENTIALITY OF INFORMATION**

All records, data, and knowledge collected by or for individuals and committees assigned professional practice review functions shall be confidential, shall be used only for carrying out of such functions, and shall be made available only to other persons and entities that have been assigned such functions for the Hospital. Such records, data and knowledge shall be entitled to the protection of Sections 20175 and 21515 of the Michigan Public Health Code and Act 270 of the Public Acts of 1967, as amended.

## **ARTICLE XVII AMENDMENTS**

### **17.1 PROPOSAL OF BYLAW AMENDMENTS**

All proposed amendments to these Bylaws shall be presented to the Bylaws Committee. The Bylaws Committee shall promptly report on the proposed amendment to the Medical Executive Committee. If the Medical Executive Committee approves the proposed amendment, notice of the proposed amendment shall be included in the notice of the General Staff meeting at which it shall be voted on. In the event of a conflict between the Medical Executive Committee and the Medical Staff, resolution will be sought as described in Article 12.6.1. If no resolution can be reached, the Medical Staff has the ability to propose the amendment directly to the Board of Trustees.

### **17.2 ADOPTION OF AMENDMENTS**

- 17.2.1** The presence of 100 voting members of the Medical Staff constitutes a quorum for purpose of amending the Bylaws and Rules. Voting members may be present in person or by mail ballot.
- 17.2.2** To be adopted, an amendment shall require the affirmative vote of two-thirds of the total number of voting members present (in person or by mail ballot) at a General Staff Meeting.
- 17.2.3** Bylaw amendments must be adopted by the Medical Staff and approved by the Board of Trustees before becoming effective. Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Bylaws.
- 17.2.4** The Medical Staff has the ability to adopt Medical Staff Bylaws, Rules and Regulations, and policies, and amendments thereto following majority vote as described in 17.2.1 and 17.2.2 and propose them directly to the Board of Trustees.

### **17.3 NOTICE OF ADOPTED AMENDMENTS**

Members of the Medical Staff and practitioners with clinical privileges shall be notified of adopted amendments to the Bylaws by posting.

## **17.4RULES**

The Medical Staff may adopt or amend Rules, subject to approval by the Board of Trustees.

The Medical Executive Committee, with provisional approval by the Board of Trustees, may provisionally adopt or amend Rules if necessary to comply with applicable law, regulation, or to maintain the Hospital's accreditation or Medicare certification. The Medical Staff will immediately be notified by the Medical Executive Committee and be provided an opportunity for retrospective review and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendment shall stand. If there is conflict over the provisional amendment, the conflict resolution process described in Article 12.6.1 shall be initiated. If necessary, a revised amendment shall then be submitted to the Board of Trustees for action. Departmental policies are effective if adopted by the voting members of the Department and approved by the Medical Executive Committee.

### **ARTICLE XVIII ADOPTION OF BYLAWS**

These Bylaws were adopted at a meeting of the Medical Staff on July 29, 2015, and approved by the St. Joseph Mercy Health System Board of Trustees and shall supersede any previous Bylaws.