



**Trinity Health-Michigan  
St. Joseph Mercy Oakland**

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**MEDICAL STAFF BYLAWS**

**Part I: Governance**

Board Approval: March 22, 2022

## Table of Contents

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Section 1.	Medical Staff Purpose and Authority	i-1
Section 2.	Medical Staff Membership	i-5
Section 3.	Categories of the Medical Staff	i-11
Section 4.	Officers of the Medical Staff	i-14
Section 5.	Medical Staff Organization	i-21
Section 6.	Committees	i-29
Section 7.	Medical Staff Meetings	i-31
Section 8.	Conflict Resolution	i-34
Section 9.	Professional Practice Review Functions	i-34
Section 10.	Review, Revision, Adoption, and Amendment	i-35

## **Section 1. Medical Staff Purpose and Authority**

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### **1.1 Purpose**

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at St. Joseph Mercy Oakland, an operating division of Trinity Health-Michigan in order to carry out, in conformity with these bylaws, the functions delegated to the Medical Staff by the Hospital Board of Directors. The purposes of this organization shall include:

- 1.1.1 Rendering care to patients at a level of professional quality and efficiency reasonably obtainable by the healing arts and the resources and facilities available at Hospital.
- 1.1.2 Advancing scientific medical education, improving methods in the delivery of medical care, and maintaining educational standards designed to accomplish higher levels of excellence in patient care.
- 1.1.3 Espousing and advancing the cause of total community health care service by the Hospital in a manner consistent with the mission and philosophy of Trinity Health.
- 1.1.4 Providing effective input into the process of analyzing and improving patient care, safety and satisfaction.
- 1.1.5 Providing for effective self-governance of the organized Medical Staff.
- 1.1.6 As authorized by the Board, providing oversight to the process of analyzing and improving patient care, safety and satisfaction.

### **1.2 Authority**

Subject to the authority and approval of the Board of Directors, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and associated rules, regulations, and policies and under the corporate bylaws of Trinity Health-Michigan and the local Board charter of St. Joseph Mercy Oakland.

### **1.3 Definitions**

“Advanced Practice Professional” or “APP” means those individuals eligible for Privileges but not Medical Staff Membership who provide a level of service including the evaluation and treatment of patients, documentation in the medical record and the prescribing of medications, as applicable in accordance with their scope of practice. The Board, after soliciting the recommendation of the Medical Executive Committee, shall determine from time to time which licensed professions are eligible for APP status.

“Adverse Recommendation” means a recommendation to limit, restrict, or terminate Membership or Privileges for reasons related to professional competence or conduct that adversely affect or could adversely affect the health or welfare of a patient.

“Affected Individual” means a physician, dentist or podiatrist who holds or is an applicant for Membership or Privileges against whom an Adverse Recommendation has been made that may entitle such individual to the fair hearing rights described in Part II.

“Hospital President” or “President” is the individual appointed by the Board of Directors to serve as the Board’s representative in the overall administration of the Hospital. The term Hospital President includes a representative appointed by the President who may, consistent with his or her authority granted by the Hospital Bylaws, perform certain administrative duties identified in these Bylaws, as well as a duly appointed acting administrator serving when the Hospital President is away from the Hospital.

“Chief Medical Officer” or “CMO” is the individual appointed by the Hospital President to serve as a liaison between administration and the Medical Staff. This term is meant to include Chief Clinical Officers and, unless otherwise specified, is inclusive for the purposes of this document of both Hospital level and regional positions. If there is no CMO, the Hospital President shall serve in their stead.

“Clinical Assistant” means those individuals eligible for Privileges but not Medical Staff Membership or APP status who provide a limited scope of activity that requires them to be privileged. The Board, after soliciting the recommendation of the Medical Executive Committee, shall determine from time to time which professions are eligible for Clinical Assistant status.

“Clinical Privileges” or “Privileges” mean the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental surgical or other professional health services with the Hospital.

“Days” shall mean calendar days unless otherwise stipulated in the Medical Staff Bylaws.

“Dentist” means an individual who has received a Doctor of Dental Medicine or Doctor of Dental Surgery degree and is currently licensed to practice dentistry in Michigan.

“Department” means a grouping of like Practitioners as note in Part I, Section 5 of the Medical Staff Bylaws and further defined in the Organization and Functions Manual.

“Department Chair” means an Active Medical Staff Member who has been selected in accordance with and has the qualifications and responsibilities for Department Chair as outlined in Part I, Section 5 of these Bylaws.

“Division” means a grouping of like Practitioners within a Department as note in Part I, Section 5 of the Medical Staff Bylaws and further defined in the Organization and Functions Manual.

“Good Standing” means having no adverse actions, limitations, or restriction on Privileges or Medical Staff Membership at the time of inquiry based on professional competence or conduct.

“Governing Body”, “Board of Directors” or “Board” means the Trinity Health-Michigan Board and its committees, including the local Board of Directors of St. Joseph Mercy Oakland acting under the authority delegated to it by the Trinity Health-Michigan Board.

“Hearing Committee” means the committee appointed to conduct an evidentiary hearing pursuant to a properly filed request and pursued by a Practitioner in accordance with Part II, Section 5 of these Medical Staff Bylaws.

“THM Hospital” means any Trinity Health-Michigan Hospital.

“Hospital” means St. Joseph Mercy Oakland and includes any associated ambulatory facility under the Hospital’s license.

“Hospital Bylaws” mean those corporate bylaws established by the Board of Directors and the local Board charter of Hospital.

"House Physicians" means a physician in good standing in a residency training or in a fellowship, who is under direct or indirect contract with the Hospital to provide specified limited services outside the scope of their residency or training program at the Hospital (e.g., moonlighters). House Physicians may provide services only within the scope of their clinical Privileges, and are not Members of the Medical Staff.

“Medical Executive Committee”, “MEC” and “Executive Committee” and shall mean the Executive Committee of the Medical Staff provided for in Part I, Section 6 of the Medical Staff Bylaws.

“Medical Staff or “Staff” means the physicians, dentists and podiatrists who are granted Privileges and admitted to the Medical Staff of Hospital in accordance with these Bylaws.

“Medical Staff Bylaws” or “Bylaws” means these Bylaws covering the operations of the Medical Staff of Hospital.

“Medical Staff Rules and Regulations” means the rules and regulations adopted by the Medical Executive Committee and approved by the Board.

“Medical Staff Year” is defined as the 12-month time period beginning on January 1 of each year and ending December 31.

“Meeting attendance” or “presence” at a meeting or “present” at a meeting is defined to include in person attendance or participation by electronic means is permissible if approved by the meeting chair after giving due consideration to confidentiality and security issues. However, no Medical Staff, Department, Section, Division, or committee meetings will be concurrently electronically recorded or the electronic media stored without the written consent of the chair of the meeting after due consideration and discussion of confidentiality issues with the CMO.

“Member” is a physician, dentist, oral and maxillofacial surgeon, or podiatrist who has been granted this status by the Board of Directors of Hospital.

“Oral and Maxillofacial Surgeon” means a licensed dentist with advanced training qualifying him for board certification by the American Board of Oral and Maxillofacial Surgery. The term “dentist” as used in these Bylaws includes oral surgeons.

“Physician” means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in Michigan.

“Podiatrist” means an individual who has received a Doctor of Podiatric Medicine degree and is currently licensed to practice podiatry in Michigan.

“Practitioner” means an appropriately licensed medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, podiatrist, Advanced Practice Professional, or Clinical Assistant who has been granted Membership and/or Clinical Privileges.

“Prerogative” means the rights, by virtue of Staff category or otherwise, granted to a Practitioner, and subject to the ultimate authority of the Board and the conditions and limitations imposed in these Bylaws and Medical Staff or Hospital policies.

“Section” means a grouping of like Practitioners within a Division as note in Part I, Section 5 of the Medical Staff Bylaws and further defined in the Organization and Functions Manual.

“Special Notice” means written notice sent via certified mail, return receipt requested, by overnight delivery with confirmation of delivery, or by in person delivery.

## **Section 2. Medical Staff Membership**

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### **2.1 Nature of Medical Staff Membership**

Membership on the Medical Staff of the Hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated rules, regulations, policies, and procedures of the Medical Staff and the Hospital.

### **2.2 Qualifications for Membership**

The qualifications for Medical Staff Membership are delineated in Part III of these Bylaws (Credentials Procedures).

### **2.3 Nondiscrimination**

The Hospital shall not discriminate in granting Membership and/or Clinical Privileges on the basis of national origin, race, gender, gender identification, sexual orientation, religion, color, age, veteran status, marital status, disability unrelated to the provision of patient care or required Medical Staff responsibilities, or any other basis prohibited by applicable law.

### **2.4 Conditions and Duration of Appointment**

The Board shall make initial appointment and reappointment to the Medical Staff. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC), except for temporary, emergency and disaster Privileges in accordance with these Bylaws and Medical Staff policies and procedures. Appointment and reappointment to the Medical Staff shall be for no more than twenty-four (24) calendar months.

### **2.5 Medical Staff Membership and Clinical Privileges**

Requests for Medical Staff Membership and/or Clinical Privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board. Membership and/or Privileges will be granted and administered as delineated in Part III (Credentials Procedures) of these Bylaws and applicable Medical Staff and Hospital policies and procedures.

### **2.6 Medical Staff Members Responsibilities**

2.6.1 Each staff Member and Practitioner must provide for appropriate, timely, and continuous care of their patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances. This includes alternate coverage by a Member with similar Privileges at this Hospital that can care for the Member's patients when the Member is absent, and meeting proximity of practice requirements that may be established to allow prompt and responsive care for patients in the Hospital and in the community served by the Hospital, or obtaining an exemption to such proximity requirement in accordance with Hospital and Medical Staff policies and procedures.

2.6.2 Each staff Member and Practitioner must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other Medical Staff functions (including service on appropriate Medical Staff committees) as may be required.

- 2.6.3 Each staff Member, consistent with their granted Clinical Privileges, must participate in the on-call coverage of the emergency department or in other Hospital coverage programs as determined by the MEC and the Board and documented in the rules and regulations and applicable Department rules, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.
- 2.6.4 Each staff Member and Practitioner must submit to any pertinent and appropriate type of health evaluation as requested by any the COS, local Hospital CMO, or Hospital President, and/or their Department Chair when it appears necessary to protect the well-being of the Member or Practitioner, patients and/or staff, or when requested by the MEC or Credentials Committee as part of an evaluation of the Member's or Practitioner's ability to exercise Privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital policies addressing physician/Practitioner health or impairment.
- 2.6.5 Each staff Member and Practitioner must abide by the Medical Staff Bylaws and any other rules, regulations, policies, procedures, and standards of the Medical Staff and Hospital, including the Ethical and Religious Directives for Catholic Health Care Services.
- 2.6.6 Each staff Member and Practitioner must provide evidence of professional liability coverage of a type and in an amount established by the Board. In addition, staff Members and Practitioners shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff Member and Practitioner, upon receipt or other knowledge of any and all malpractice settlements or judgments against the Member or Practitioner, shall notify the CMO, or Hospital President if no CMO, or designee as soon as possible but no later than fifteen (15) days.
- 2.6.7 Each applicant for Privileges, staff Member and Practitioner agrees to release from any liability, to the fullest extent permitted by law, all persons acting in good faith and without malice for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Member or Practitioner and his/her credentials.
- 2.6.8 Each staff Member and Practitioner shall prepare and complete in timely fashion, according to Medical Staff and Hospital policies, the medical and other required records for all patients to whom the Member or Practitioner provides care in the Hospital, or within its facilities, Sections, or Departments.
  - a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon or other qualified licensed individual in accordance with State law and Hospital and Medical Staff policy and Privilege criteria.



- b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, shall be completed when the medical history and physical examination was completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with State law, Hospital and Medical Staff policy and Privilege criteria.
  - c. The content of complete and focused history and physical examinations may be delineated in the rules and regulations or other Medical Staff or Hospital policy.
- 2.6.9 Each staff Member and Practitioner will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform Medical Staff responsibilities. For purposes of these Bylaws, confidential information means patient information, peer review information, and the Hospital's business information designated as confidential by the Hospital or its representatives prior to disclosure.
- 2.6.10 Each staff Member and Practitioner must participate in any type of clinical competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that Member's or Practitioner's Clinical Privileges.
- 2.6.11 Each Medical Staff Officer, MEC At-Large Member, Department Chair, Division Chief, Section Chief and other Medical Staff leader designated by the MEC shall disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Hospital. Medical Staff leadership will deal with conflict of interest issues per the Trinity Health System and Hospital Conflict of Interest policies.
- 2.6.12 Each Member and Practitioner must report, in writing, to the Hospital Medical Staff Office any of the following circumstances as soon as possible after imposition but no later than 5 days after imposition:
- a. Loss, limitation, reduction, suspension or termination of medical staff membership or clinical privileges at any health care organization or termination of employment for cause.
  - b. Voluntary relinquishment of any medical staff membership or clinical privileges at any health care organization while under investigation or to avoid investigation or disciplinary action.
  - c. Loss, limitation, reduction, suspension, probation, termination, lapse or relinquishment of medical licensure in any state.
  - d. Any loss or cancellation of, or material change in, professional liability insurance under any circumstance.
  - e. Any felony charge or other charge relating to or arising out of the practice of health care.
  - f. Any misdemeanor or felony conviction, guilty plea, or no contest plea.
  - g. Any imposition of sanctions by any health care insurer or the federal government.

- 2.6.13 Each Member and Practitioner must work cooperatively and harmoniously with the Board, administration, staff, patients and other Members and Practitioners so that the Hospital and Medical Staff can operate in an orderly, productive manner that promotes efficient, high quality patient care, supports patient safety and patient rights, rules and policies and promotes the community's confidence in the Hospital and Medical Staff.
- 2.6.14 Acceptance of a unified medical staff. If the Board of Directors elects to have a unified medical staff, then the medical staff of each affected separately certified THM Hospital must vote, by majority, in accordance with their respective medical staff bylaws, whether to accept unification or remain a separate medical staff. Each Active Member of the Hospital's Medical Staff will be eligible to vote on the proposed unification via printed or secure electronic ballot in a manner determined by the MEC. All Active Members of the Hospital's Medical Staff shall receive at least thirty (30) days advance notice of the proposed unification. The proposed unification shall be considered approved by Hospital's Medical Staff if the vote is taken at a meeting, when the proposed unification amendment receives a simple majority (fifty percent plus one) of those present and eligible to vote.
- 2.6.15 Opting out of a unified medical staff. If there is a unified medical staff, the Active category Members at each affected THM Hospital in which the Members have clinical privileges, has the ability to vote to "opt out" of the unified medical staff. This would require a petition signed by ten percent (10%), but not less than two (2), of the Members who would qualify for voting Privileges at that hospital. Upon presentation of such a petition, a medical staff meeting will be scheduled. Each Active category member who would qualify for voting privileges at that hospital will be eligible to vote on the proposed "opt out" proposal. Each Active category Member of the Medical Staff at each affected THM Hospital will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active category Members of each affected THM Hospital's Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by each affected THM Hospital's Medical Staff if the vote is taken at a meeting, when the proposed unification amendment receives a simple majority (fifty percent plus one) of those present and eligible to vote.

## **2.7 Medical Staff Member Rights**

- 2.7.1 Each staff Member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such Member is unable to resolve a matter of concern after working with their Department Chair or other appropriate Medical Staff leader(s), that Member may, upon written notice, which may be mailed or delivered electronically, to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.
- 2.7.2 Each staff Member in the Active category has the right to initiate a recall election of a Medical Staff Officer by following the procedure outlined in Part I Section 4.7 of these Bylaws, regarding removal and resignation from office.

- 2.7.3 Each staff Member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by twenty percent (20%) of the Members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.
- 2.7.4 Each staff Member in the Active category may challenge any rule, regulation, or policy established by the MEC exempting those policies mandated by Trinity Health System, law, or regulatory standard. In the event that a rule, regulation, or policy is thought to be inappropriate, any Active Medical Staff Member may submit a petition signed by twenty percent (20%) of the Members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Part I Section 10.3 will be followed.
- 2.7.5 Each staff Member in the Active category may call for a Department meeting by presenting a petition signed by twenty percent (20%) of the Members of the Department. Upon presentation of such a petition the Department Chair will schedule a Department meeting.
- 2.7.6 The above sections 2.7.1 to 2.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or Clinical Privileges, or any other matter relating to individual Membership or Privileges. Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.
- 2.7.7 Any individual eligible for Medical Staff appointment may have a right to a hearing/appeal pursuant to the conditions and procedures described in the Medical Staff's hearing and appeal plan (Part II of these Bylaws).

## **2.8 Staff Dues**

Annual Medical Staff dues, if any, shall be determined by the MEC. Failure of a Medical Staff Member to pay dues shall be considered a voluntary resignation from the Medical Staff in accordance Part II, Section 3.1.6.

## **2.9 Indemnification**

- 2.9.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the Hospital and Medical Staff.
- 2.9.2 Subject to applicable law and policy, the Hospital shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a Medical Staff Member in connection with the defense of any pending or threatened action, suit, or proceeding to which he or she is made a party by reason of his or her having acted in an official capacity in good faith on behalf of the Hospital or Medical Staff. Official capacity for purposes of this provision means any instance wherein the Member is
- a. acting in their official capacity as an Officer of the Medical Staff; or
  - b. a duly appointed member of a Medical Staff committee; or
  - c. a member of a peer review investigatory process; or
  - d. requested by an Officer/Chair or duly charged member to:
    - i. participate in a peer review investigation;

- ii. consult on a credentialing matter; or
  - iii. participate on an ad hoc or support basis to a Medical Staff committee.
- 2.9.3 However, no Member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

## Section 3. Categories of the Medical Staff

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### 3.1 The Active Category

#### 3.1.1 Qualifications

Members of this category must satisfy one of the following (a or b):

- a. Has served on the Medical Staff for one (1) year and has either:
  - i. At least twenty-four (24) patient contacts per two (2) years (a patient contact is defined as an inpatient admission, consultation, an inpatient or outpatient surgical procedure, shifts performed by an emergency department practitioner, hospitalist, pathologist, radiologist, anesthesiologist, or practitioner in a provider-based clinic) and attend at least four (4) general Medical Staff, Departmental or Division meetings per two (2) years, at least one of which must be a general Medical Staff meeting and at least one of which must be a Departmental or Division meeting, **OR**
  - ii. Attended at least ten (10) general Medical Staff, Departmental or Division meetings per two (2) years.
- b. Is appointed to a medical leadership role (i.e., Department Chair and Division Chief) or another key role identified and approved by the MEC at Hospital.

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

#### 3.1.2 Prerogatives

Members of this category may:

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

#### 3.1.3 Responsibilities

Members of this category shall:

- a. Contribute to the organizational and administrative affairs of the Medical Staff;
- b. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion and in the discharge of other staff functions as may be required; and

- c. Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

### **3.2 The Associate Category**

#### **3.2.1 Qualifications**

The Associate category is reserved for Medical Staff Members with Privileges who do not meet the eligibility requirements for the Active category.

#### **3.2.2 Prerogatives**

Members of this category may:

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

#### **3.2.3 Responsibilities**

Members of this category shall have the same responsibilities as Active Category Members.

### **3.3 Affiliate Category**

#### **3.3.1 Qualifications**

The Affiliate category is reserved for Medical Staff Members who do not have Privileges and who do not meet the requirements for eligibility for the Active category.

#### **3.3.2 Prerogatives**

Members of this category may:

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

#### **3.3.3 Responsibilities**

Members of this category shall have the same responsibilities as Active Category Members, with the exception of those responsibilities related to the possession of Clinical Privileges.

### **3.4 Honorary and Honorary Emeritus Recognition**

Honorary and Honorary Emeritus Recognition is restricted to those individuals recommended by the MEC and approved by the Board. This recognition is entirely discretionary and may be rescinded at any time. The rescission of Honorary or Honorary Emeritus Recognition or failure by the MEC to recommend such recognition for an individual is not an Adverse Recommendation and shall not entitle the individual to a hearing or appeal as set forth in these Medical Staff bylaws. Practitioners granted Honorary Recognition shall be those Members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the Hospital. Practitioners granted Honorary Emeritus Recognition shall be those Members who have retired from active hospital practice, who are of outstanding reputation, who held Active Membership on the Medical Staff for at least 25 years, and who served in one or more of the following leadership positions on the Medical Staff: COS, Chair of a Department, Chief of a Division, Chair of the Credentials Committee or Chair of the Constitution and Bylaws Committee. Individuals with Honorary or Honorary Emeritus Recognition may attend Medical Staff and Department meetings, continuing medical education activities, and may be appointed to committees. They shall not hold Clinical Privileges, pay dues, hold office or be eligible to vote on Medical Staff or Department matters although they may vote on matters in committees to which they are assigned. Honorary and Honorary Emeritus Recognition does not require recredentialing.

## **Section 4. Officers and At-Large Members of the Medical Staff**

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### **4.1 Officers and MEC At-Large Members**

#### 4.1.1 Officers of the Medical Staff.

- a. Chief of Staff (COS)
- b. Chief of Staff Elect
- c. Secretary-Treasurer
- d. Immediate Past COS

#### 4.1.2 At-Large Members. There shall be two (2) MEC At-Large Members.

### **4.2 Qualifications of Officers and MEC At-Large Members**

#### 4.2.1 Officers must meet the following qualifications:

- a. COS and Chief of Staff Elect must be members in Good Standing of the Active category for at least five (5) years total, including the three (3) years immediately preceding the start of the term; at the time of the election and continuously during the term, hold such Active category Membership pursuant to Part I, Sections 3.1.1.a.i or 3.1.1.b; indicate a willingness and ability to serve; have no pending Adverse Recommendations concerning Medical Staff appointment or Clinical Privileges; shall not be subject to any corrective action plan at the time election, shall not have been removed from any position as an elected Officer by recall or MEC action within the past three (3) years; have previous leadership experience either as a Department Chair, Division Chief, Section Chief, Medical Director, or membership on a committee and commit to attend continuing education relating to medical staff leadership and/or credentialing prior to or during the first year of office as Chief of Staff Elect; have demonstrated an ability to work well with others, have excellent administrative and communication skills; disclose in advance of nomination any conflicts of interest consistent with the Medical Staff and Hospital Conflict of Interest policies; be in compliance with the professional conduct policies of the Hospital. The Medical Staff Nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.



- b. The Secretary-Treasurer must be a member in Good Standing of the Active category, preferably for at least five (5) years total, including the three (3) years immediately preceding the start of the term; at the time of the election and continuously during the term, hold such Active category Membership pursuant to Part I, Sections 3.1.1.a.i or 3.1.1.b; indicate a willingness and ability to serve; have no pending Adverse Recommendations concerning Medical Staff appointment or Clinical Privileges; shall not be subject to any corrective action plan at the time election, shall not have been removed from any position as an elected Officer by recall or MEC action within the past three (3) years; have previous leadership experience either as a Department Chair, Division Chief, Section Chief, Medical Director, or membership on a committee and/or commit to attend continuing education relating to medical staff leadership and/or credentialing prior to or during the term of office; have demonstrated an ability to work well with others, have excellent administrative and communication skills; disclose in advance of nomination any conflicts of interest consistent with the medical staff and Hospital Conflict of Interest policies; and be in compliance with the professional conduct policies of the Hospital. The Medical Staff Nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.
  - c. Immediate Past COS shall be the individual who served as COS during the term immediately preceding the current term. The Immediate Past COS must be a Member in Good Standing; indicate a willingness and ability to serve; have no pending Adverse Recommendations concerning Medical Staff appointment or Clinical Privileges; and be in compliance with the professional conduct policies of the Hospital. The Medical Staff Nominating Committee will have discretion to determine if the individual who served as COS during the preceding term meets the qualifying criteria.
- 4.2.2 MEC At-Large members must be members in Good Standing of the Active Category for at least three (3) years, at the time of the election and continuously during the term, hold such Active category Membership pursuant to Part I, Sections 3.1.1.a.i or 3.1.1.b, indicate a willingness and ability to serve, have no pending Adverse Recommendations concerning Medical Staff appointment or Clinical Privileges, and be in compliance with the professional conduct policies of the Hospital. Previous leadership experience either as a Department Chair, Division Chief, Section Chief, Medical Director, or membership on a committee is preferred, but not mandatory.
- 4.2.3 Officers and MEC At-Large members may not simultaneously hold a leadership position (i.e., position on the MEC, administration or Board) on another unaffiliated hospital's medical staff or in a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in the Officer or MEC At-Large member being automatically removed from office.

#### **4.3 Nominating Committee and Election of Officers and MEC At-Large Members**

- 4.3.1 The Nominating Committee shall consist of at least five (5) Active Members. The Chief of Staff Elect shall participate as an ex-officio member of the committee and function as the chair of the nominating committee without a vote. The members of the Nominating Committee shall be recommended by the Chief of Staff and appointed by the MEC. The committee shall provide an annual slate of nominees for the open elected Medical Staff positions. The Nominating Committee shall be an ad hoc committee.

- 4.3.2 The Nominating Committee shall nominate at least one (1) candidate for each of the positions of Chief of Staff Elect, Secretary-Treasurer and any MEC At-Large members. Nominations must be announced, and the names of the nominees announced thirty (30) days prior to the election.
- 4.3.3 A petition signed by at least twenty-five (25) Members of the Active staff may add nominations to the ballot, with written consent of the individuals being nominated. The Medical Staff must submit such a petition to the Medical Staff Office at least fifteen (15) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating Committee must determine if the candidate meets the qualifications in section 4.2 above before they can be placed on the ballot.
- 4.3.4 The MEC shall review and approve all nominees that meet the eligibility rules.
- 4.3.5 Candidates will be announced to the Active Voting Medical Staff via regular communication channels at least two weeks prior to dissemination of ballots.
- 4.3.6 Ballots will be delivered to all Active Members at least 14 days prior to the election. Elections shall take place by ballots cast by Active Medical Staff Members returned to the Medical Staff Office on or before the election date. Ballots shall be in a form approved by the MEC.
- 4.3.7 At-Large Member(s) Election. The MEC At-Large member nominee(s) who receives a plurality of votes cast will be elected.
- 4.3.8 Chief of Staff Elect and Secretary-Treasurer Elections.
  - a. The nominee who receives a majority of votes cast will be elected to that office.
  - b. If a simple majority is not obtained for those officers, a run-off election will take place between the candidates who had the two (2) highest vote totals, according to the process below. The Chief of Staff shall be authorized to hold the run-off vote, without waiting until the MEC has met.
  - c. The process of the run-off election shall be conducted in the same manner as listed above. Ballots, in a form approved by the MEC, shall be due in the Medical Staff Office no later than ten (10) days after the delivery of the ballots.
  - d. Results of the run-off election will be reviewed and ratified by the MEC at its next meeting and the MEC shall forward the results to the Board for ratification.
- 4.3.9 In the event that a Member is elected to two positions, the elected Member shall choose one position and a second election shall be held to fill the vacated position. No Member of the Medical Staff may hold a Department Chair position and a Medical Staff elected position concurrently.
- 4.3.10 **Board Ratification of the Election:**
  - a. Following validation of the election by the MEC, the slate of Officers and MEC At-Large Members must be reviewed and ratified by the Board.
  - b. If the Board does not ratify the election of a Member for office or MEC At-Large position following validation of the election by the MEC, the Board shall identify the specific concerns or reasons for the Board's decision not to approve the Member and shall communicate these to the MEC.

- c. In the event one or more Officers or MEC At-Large members is not ratified, a meeting of a special joint conference committee for the specific purpose of discussing the recommendation shall be called including:
  - i. The current sitting Officers and At-large Members of the Medical Staff;
  - ii. The Chair of the Board;
  - iii. The chair of the Quality and Safety Committee of the Board;
  - iv. Two (2) additional members of the Board appointed by the Board Chair;
  - v. The Hospital President;
  - vi. The CMO;
- d. An arbitrator for the meeting may be used upon the mutual agreement of the COS and the Chair of the Board.
- e. Following the meeting of the special conference committee, the Board shall review the issue and may:
  - i. Approve the appointment of the Member to the office.
  - ii. Set specific requirements or conditions as a condition of approval of the appointment of the Member to office.
  - iii. Uphold its previous decision and require a new election for the office.

#### **4.4 Term of Office**

All Officers and MEC At-Large members serve a term of two (2) years except as provided in Section 4.5. They shall take office on January 1st following their election. The COS shall assume the office of Immediate Past COS upon expiration of the COS' term of office. The Chief of Staff Elect shall assume the office of COS upon expiration of the COS' term of office. The Secretary-Treasurer, and MEC At-Large members may be elected to two (2) successive terms, for a total of six years. An Officer or MEC At-Large member may run again for the same position after having not been an Officer for one two-year cycle. Each Officer and/or MEC At-Large member shall serve in office until the end of their term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office. Filling a vacancy shall not be counted as a term for term limit purposes.

#### **4.5 Vacancies of Office**

4.5.1 Chief of Staff: In the event of a vacancy in this office, the Chief of Staff Elect shall serve the remainder of the term. Where the Chief of Staff Elect fills a vacancy, such individual will serve the remainder of the vacant COS term, and the following two (2) year COS term that individual was elected to serve. In the event of a vacancy in both the Chief of Staff and Chief of Staff Elect offices, the Secretary-Treasurer shall serve as the interim Chief of Staff until such time as a new election can be held. In the event of a vacancy in the Chief of Staff, Chief of Staff Elect, and the Secretary-Treasurer offices, the MEC shall select an interim Chief of Staff until such time as a new election can be held.

4.5.2 Chief of Staff Elect: In the event of a vacancy in this office, an election will be held according to the procedure used for election of officers to fill the vacancy. The individual elected to fill the vacancy may be elected to serve the remainder of the vacant term, and the following two (2) year term as Chief of Staff Elect.

- 4.5.3 Immediate Past Chief of Staff: In the event of a vacancy in this office, the position will remain vacant for the remainder of the term.
- 4.5.4 Secretary–Treasurer: In the event of a vacancy in this office:
  - a. If there is a vacancy of less than six (6) months, the MEC will select an Active Medical Staff member on an interim basis to fill the position for the remainder of the term; a member of the MEC may be appointed to fill such a vacancy.
  - b. If there is a vacancy of more than six (6) months, an election will be held according to the procedure used for the election of Officers to fill the vacancy.
- 4.5.5 At Large Representatives: In the event of a vacancy in this office of greater than three (3) months, an election will be held according to the procedure used for election of officers to fill the vacancy. Vacancies of three (3) months or less will not be filled.

#### **4.6 Duties of Officers**

- 4.6.1 **Chief of Staff (COS):** The COS must represent the interests of the Medical Staff to the MEC and the Board. The COS is the primary elected officer of the Medical Staff and is the Medical Staff’s advocate and representative in its relationships to the Board and the administration of the Hospital. The COS, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff bylaws, rules, regulations, and policies. Specific responsibilities and authority of the COS, or designee, are to:
  - a. Call and preside at all general and special meetings of the Medical Staff;
  - b. Serve as chair of the MEC and as ex officio member of all other Medical Staff standing committees without vote, and to participate as invited by the CMO, or Hospital President if no CMO, or the Board on Hospital or Board committees;
  - c. Serve as the individual assigned responsibility for the organization and conduct of the Hospital’s medical staff;
  - d. Enforce Medical Staff bylaws, rules, regulations, and Medical Staff/Hospital policies;
  - e. Except as stated otherwise, appoint committee chairs and all members of Medical Staff standing and ad hoc committees; in consultation with Hospital administration, appoint Medical Staff Members to appropriate Hospital committees or to serve as Medical Staff advisors or liaisons to carry out specific functions; advise the chair of the Board regarding the appointment of Medical Staff Members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;
  - f. Support and encourage Medical Staff leadership and participation on interdisciplinary clinical performance improvement activities;
  - g. Report to the Board the MEC’s recommendations concerning appointment, reappointment, delineation of Clinical Privileges, and corrective action with respect to Practitioners who are applying for appointment or Privileges, or who are granted Privileges or providing services in the Hospital;

- h. Continuously evaluate and periodically report to the Hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;
  - i. Review and enforce compliance with standards of ethical conduct and professional demeanor among the Member on the Medical Staff in their relations with each other, the Board, Hospital management, other professional and support staff, and the community the Hospital serves;
  - j. Communicate and represent the opinions and concerns of the Medical Staff and its individual Members on organizational and individual matters affecting Hospital operations to Hospital administration, the MEC, and the Board;
  - k. Attend Board meetings and Board committee meetings as invited by the Board;
  - l. Ensure that the decisions of the Board are communicated and carried out within the Medical Staff; and
  - m. Perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.
- 4.6.2 **Chief of Staff Elect:** The Chief of Staff Elect shall chair the Medical Staff Quality Improvement Committee and the Nominating Committee. S/he shall perform such further duties to assist the COS as the COS may request from time to time. In the absence of the COS, the Chief of Staff Elect shall assume all the duties and have the authority of the COS.
- 4.6.3 **Secretary-Treasurer:** This Officer will collaborate with the Hospital's Medical Staff Office, assure maintenance of minutes, attendance and other records, attend to correspondence, and coordinate communication within the Medical Staff, act as custodian of the funds of the medical staff in accordance with the direction of the MEC or Medical Staff, as applicable, prepare a proposed budget for approval at the annual meeting including the threshold amount of unbudgeted expenditures requiring approval by the Medical Staff, and prepare financial reports for presentation at medical staff and MEC meetings. S/he shall perform such further duties to assist the COS as the COS may request from time to time.
- 4.6.4 **Immediate Past Chief of Staff/COS:** This Officer will serve as a consultant to the COS and Chief of Staff Elect. The Immediate Past Chief of Staff shall serve on the MEC for the first year that they are Immediate Past Chief of Staff.
- 4.6.5 **MEC At-Large Members:** These members will advise and support the Medical Staff Officers and are responsible for representing the needs/interests of the entire Medical Staff, not simply representing the preferences of their own clinical specialty. They shall perform such further duties to assist the COS as the COS may request from time to time.

#### 4.7 **Removal and Resignation from Office**

- 4.7.1 **Removal by Vote of the Medical Staff:** Criteria for removal are failure to meet the responsibilities assigned within these Bylaws, failure to comply with rules and regulations, policies and procedures of the Medical Staff or Hospital, or for conduct or statements that damage the Hospital, its goals, or programs. The Medical Staff may initiate the removal of any Officer or MEC At-Large member if at least twenty percent (20%) of the Active members sign a petition advocating for such action. Removal shall become effective upon an affirmative vote by two-thirds (2/3rds) supermajority of those Active staff Members casting ballot/electronic votes.

- 4.7.2 **Automatic Removal:** An Officer or MEC At-Large member shall be automatically removed in the event an Officer or MEC At-Large member fails to maintain Active category Membership in Good Standing for any reason or fails to comply with Section 4.2.3. This removal is not discretionary and is effectuated by the COS, or if it pertains to the COS, by the Chief of Staff Elect.
- 4.7.3 **Resignation:** Any elected Officer or MEC At-Large member may resign at any time by giving thirty (30) days' written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.

## **Section 5. Medical Staff Organization**

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### **5.1 Organization of the Medical Staff**

- 5.1.1 The Medical Staff shall be organized into Departments. The Departments organized by the Medical Staff and formally recognized by the MEC are:
- a. Anesthesiology
  - b. Behavioral Medicine
  - c. Emergency Medicine
  - d. Family Medicine
  - e. Medicine
  - f. Obstetrics and Gynecology
  - g. Pathology
  - h. Pediatrics
  - i. Radiology
  - j. Surgery
- 5.1.2 The Medical Staff may create Divisions and Sections within a Department in order to facilitate Medical Staff activities. A list of Divisions and Sections organized by the Medical Staff and formally recognized by the MEC is listed in medical staff policy.

### **5.2 Departments**

- 5.2.1 The Departments of the Medical Staff will be organized according to these Bylaws, the Rules and Regulations and Departmental rules and regulations.
- 5.2.2 The MEC, with approval of the Board, may designate new Medical Staff Departments or dissolve current Departments as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging. A group of at least five (5) Active Members in a specialty not currently organized as a Department may submit a written petition to the MEC requesting that such specialty be recognized as a new department, provided however, that the MEC, with approval of the Board, shall decide whether a new department is organized. Such petition shall include a description of the need for the specialty to be organized as a separate department.
- 5.2.3 No Department shall have fewer than five (5) Members, provided however, that in the event an established Department's number of Members falls below five (5), the MEC may waive the minimum number for good cause.
- 5.2.4 Each Department will formulate and be governed by rules and regulations pertaining to the respective Department. These rules and regulations must be reviewed every three years and any changes submitted through the Constitution and Bylaws Committee to the Medical Executive Committee and St. Joseph Mercy Oakland Board for approval.
- 5.2.5 Each Department will meet on a regular basis, but not less frequently than four times per year, for the purpose of the transaction of business pertaining to the Department. At these meetings, a record of attendance and minutes shall be kept.



- a. At these meetings, reports will be made to the Department from the Department leadership and/or the management team to keep the Department informed of activities within the Department, including, if applicable, the activities of the Divisions and Sections within the Department. Department leadership and/or the management team shall keep the Department informed of the following on a timely basis by any appropriate method of communication:
  - i. Relevant clinical work of the Department.
  - ii. Relevant clinical indicators of quality of care and performance improvement.
  - iii. Relevant patient safety or quality issues pending before the Department.
  - iv. Reports from Department committees and appropriate Medical Staff committees.
  - v. Reports from Divisions or Sections within the Department.
  - vi. Relevant reports related to graduate and/or continuing medical education.
  - vii. Aggregate issues related to Ongoing and Focused Professional Practice Evaluations (not specific peer review issues).
  - viii. Aggregate issues related to credentialing and privileging within the Department (not specific peer review issues).
  - ix. Issues related to the management and coordination of patient care.
  - x. Updates on policy changes or practice changes within the organization.
- b. At these meetings, there should be an opportunity for dialogue and communication among the members of the Department, Department leadership and management team on issues related to the care of patients within the organization.

#### 5.2.6 Officers and Advisory Committee.

- a. Except as otherwise approved by the MEC for good reason, (e.g., small Departments that can operate effectively without a separate advisory committee), each Department shall:
  - i. Have an advisory committee, and
  - ii. Select the following officers: Chair, vice-chair, secretary, and two at-large members of the Department advisory committee.
- b. The advisory committee shall include at least the Chair, vice-chair, secretary, two at-large members and, if the Hospital sponsors a residency program in the Department's specialty, the Program Director of that residency. Additional details



regarding the advisory committee's composition and selection may be described in the Department Rules and Regulations.

- c. The function of the Advisory Committee will include:
- i. Review Departmental/Divisional quality data and make recommendations for areas of improvement and/or continuing medical education.
  - ii. Review and address issues of ongoing professional practice performance.
  - iii. Review performance of Practitioners with newly approved clinical Privileges.
  - iv. Review Departmental Rules and Regulations, and delineation of Privileges.
  - v. Participate in review of Departmental-sponsored graduate medical education programs.
  - vi. Initiate/implement identified opportunities for improvement, new policies and/or procedures applicable to the Department/Division.
  - vii. Appoint members of the Departmental nominating committee for Departmental positions/officers as provided in Section 5.3.1.b.
  - viii. Participate in appointment/reappointment and credentialing/privileging processes for Departmental applicants/members/APPs/Clinical Assistants.
  - ix. Advise the Department Chair as needed.
  - x. Assist in communication with Department membership.

### **5.3 Qualifications, Selection, Term, and Removal of Department Officers**

#### **5.3.1 Appointment or Election of Department Officers**

- a. **Qualifications for Department Officers:** All Officers must be Members of the Active Medical Staff, have relevant Clinical Privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. In addition, Department Officers shall indicate a willingness and ability to serve, have no pending Adverse Recommendations, and be in compliance with the professional conduct policies of the Hospital. It is preferential that Department Chairs and Vice Chairs have previous leadership experience, or be willing to participate in leadership training. Department Chairs must have (at the time of the election and continuously during the term) Active category Membership pursuant to Part I, Sections 3.1.1.a.i or 3.1.1.b. Department Chairs may not simultaneously hold a leadership position (any position in which the individual serves on the MEC or the board) on another unaffiliated hospital's medical staff or in a facility that is directly competing with the Hospital. Noncompliance with this requirement will result in the Department Chair being automatically removed from office.
- b. **Selection of Department Officers:** Nominees for Department Officers shall be nominated by the Departmental nominating committee each term. The Departmental nominating committee shall offer one (1) or more candidates for each available position. Except as otherwise provided by contract or policy for a closed Department made up of an exclusively contracted group, each Departmental nominating committee shall consist of: (1) the CMO or designee; and (2) at least two (2) Members from the Department appointed by the advisory committee of the Department. Department Officers will be elected by plurality vote of the Active Members of the Department, subject to ratification by the MEC and Board. Ballots will be mailed or delivered electronically to all Active Members of the Department at least 14 days prior to the election. Elections shall take place by ballots cast by Active Members of the Department returned to the Medical Staff Office on or before the date specified. The nominee(s) who receives a plurality of votes cast will be elected, as long as they receive at least one-third (1/3) of the votes cast. If no one receives at least one-third (1/3) of the votes cast, a run-off election will occur with the top three (3) vote receivers. The election of Department Officers is subject to ratification by the MEC and the Board. If the Board disagrees with the decision of the MEC, the matter will be taken to the Joint Conference Committee for resolution.
- c. **Term and Term Limits:** Each Department Chair shall be elected to serve a term of three (3) years commencing on January 1<sup>st</sup>. After the initial term, a Department Chair may be elected by the majority vote of the Department to serve up to one (1) additional successive term of three years. Each Department Chair may serve for a total of six (6) years, unless there are no other qualified Active Members willing to serve and the Chair is approved by a two-thirds (2/3rds) supermajority of the Active Department Members voting. All Active category Members of the Department must have the opportunity to vote. Unless additional terms are approved by supermajority vote, a Department Chair may serve additional terms as Chair after having not been Chair for one three (3) year cycle. Each Department Chair shall serve until the end of their term or until a successor is appointed or unless s/he resigns sooner or is removed from the position. Filling a vacancy shall not be counted as a term for term limit purposes. For Department officers other than the Department Chair, there shall be no limit to the number of successive terms to which they may be elected.

### 5.3.2 Removal of Department Officers

- a. Removal of Elected Department Officers by Vote: Criteria for removal are failure to meet the responsibilities assigned within these Bylaws, failure to comply with policies and procedures of the Medical Staff and Hospital, or for conduct or statements that damage the Hospital, its goals, or programs. A request for removal by a petition signed by twenty percent (20%) of the Active Members of the Department shall initiate the removal of any Department Officer. Removal shall become effective upon an affirmative vote by two-thirds (2/3) supermajority of those Active Department Members casting ballot/electronic votes. Removal of a Department Officer is subject to ratification by the MEC and Board.
- b. Automatic Removal of elected Department Officers: The Department Officer may be automatically removed from their position if they no longer meet the qualifications of the position as defined in these Bylaws.
- c. If a Department Chair is removed through these processes, or a vacancy occurs for any other reason, the Vice Chair shall serve as interim Chair until the permanent replacement Chair is identified. If there is no Vice Chair, the Chief of Staff and CMO will jointly identify an interim Chair until a permanent replacement Chair is identified.

#### **5.4 Responsibilities of Department Chair**

- 5.4.1 To oversee all clinically-related activities of the Department;
- 5.4.2 To oversee all administratively-related activities of the Department, unless otherwise provided by the Hospital;
- 5.4.3 To provide ongoing surveillance of the performance of all individuals in the Medical Staff Department who have been granted Clinical Privileges;
- 5.4.4 To recommend to the Credentials Committee the criteria for requesting Clinical Privileges that are relevant to the care provided in the Medical Staff Department;
- 5.4.5 To recommend Clinical Privileges for each member of the Department and other Practitioners within the scope of the Department;
- 5.4.6 To assess and recommend to the MEC and Hospital administration off-site sources for needed patient care services not provided by the Medical Staff Department or the Hospital;
- 5.4.7 To integrate the Department into the primary functions of the Hospital;
- 5.4.8 To coordinate and integrate interdepartmental and intradepartmental services and communication;
- 5.4.9 To develop and implement Medical Staff and Hospital policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;
- 5.4.10 To recommend to the CMO, or Hospital President if no CMO, sufficient numbers of qualified and competent persons to provide patient care and service;
- 5.4.11 To provide input to the CMO, or Hospital President if no CMO, regarding the qualifications and competence of Department or service personnel who are not licensed independent practitioners (LIPs) but provide patient care, treatment, and services;

- 5.4.12 To continually assess and improve of the quality of care, treatment, and services;
- 5.4.13 To maintain quality control programs as appropriate;
- 5.4.14 To orient and continuously educate all persons in the Department; and
- 5.4.15 To make recommendations to the MEC and the Hospital administration for space and other resources needed by the Medical Staff Department to provide patient care services.

## **5.5 Department Vice Chairs**

Department Vice Chairs shall act in the temporary absence of the Department Chair shall perform such other duties as assigned by the Department Chair. In the event the Department Chair position becomes vacant, the Vice Chair shall assume the Department Chair position and shall serve out the remainder of that term. If the position of Department Vice Chair becomes vacant, a new election will be held as soon as possible using the process noted in Part I Section 5.2.1.b.ii.

## **5.6 Assignment to Department**

The MEC will, after consideration of the recommendations of the Chair of the appropriate Department, recommend Department assignments for all Members in accordance with their qualifications. Each Member and APP will be assigned to one primary Department. Clinical Privileges are independent of Department assignment.

## **5.7 Divisions**

Within a Department, a Division may be organized and continue to operate, if it adheres to the following rules:

- 5.7.1 The MEC, with approval may designate new Medical Staff Divisions or dissolve current Divisions as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging. In addition, if at least five (5) members of the Medical Staff in a specific specialty request of the MEC the establishment of a specialty Division with its own officers and meetings, MEC shall approve or disapprove of such a Division within 90 days of the request.
- 5.7.2 There must be a minimum of five (5) Active Members with special interests in the subspecialty area.
- 5.7.3 The Division shall elect Divisional officers and an advisory committee. The Division Chiefs shall report to Department Chair. The Department Chair will decide matters of disagreement. A Division Chief is subject to removal in the same manner as is a Department Chair.
- 5.7.4 The Division within the Department shall meet at regular intervals, no less than twice a year.
  - a. At the Divisional meetings, a critical review of Division functions shall be undertaken.
  - b. Minutes and a record of attendance shall be kept.

- c. Subject to the authority of the rules and regulations of the sponsoring Department, the Division shall formulate and keep current Divisional rules and regulations pertinent to the affected function of the Division. They shall be presented to the Department Advisory Committee and the MEC and the Board for approval.
- d. Each Division will have an Advisory Committee.
  - i. The advisory committee composition and selection will be as described in the Division Rules and Regulations.
  - ii. The Advisory Committee's function with respect to a Division will be comparable to that of the Department Advisory Committee with respect to the Department, as outlined in Section 5.2.6. The Division shall make credentialing/privileging recommendations to the Department.

## 5.8 Sections

- 5.8.1 A Section may be formed for the purpose of providing input into issues of safety, quality, credentialing efficiency or satisfaction in the focused area of care, including, but not limited to, continuing education, grand rounds, discussion of policies, and discussion of equipment needs, participation in peer review, FPPE, OPPE, and the development of criteria for Clinical Privileges when requested by a Department Chair, CMO or MEC.
- 5.8.2 Members of the Medical Staff in a specific specialty, or across specialties with a common clinical area of focus, may request that the MEC approve the establishment of a specialty Section with its own Chief and meetings. The MEC shall approve or disapprove of such a Section request within 90 days.
- 5.8.3 A Section Chief will be appointed in accordance with the following:
  - a. If the Section is comprised solely of members within a single Department or Division, then the Chair of the Department will appoint a member to function as the Section Chief.
  - b. If the Section is comprised of members from 2 or more Departments, then the Chief of Staff will recommend to MEC that leadership be appointed by one of the following options, as approved by MEC:
    - i. The appointment by the MEC of a member from within the Section to function as the Section Chief.
    - ii. Rotating the Section Chief position between/among the Departments represented.
    - iii. The appointment of an independent Member of the Medical Staff to provide interim leadership.
    - iv. The election of a Section Chief by the Section.

- c. The Medical Executive Committee will assign the length of the term(s) of the Section Chief. Section Chiefs serve at the pleasure of the Department Chair or MEC, as applicable, who appointed them.
- 5.8.4 Sections of the Medical Staff and the Section Chief will report to the Department Chair if the Section is comprised solely of members within a single Department, and to the Chief of Staff if the Section is comprised of members from 2 or more Departments.
- 5.8.5 The Section shall be responsible for keeping minutes and attendance records and reporting these to the appropriate Department(s) and Division(s) reflecting the Section membership.
- 5.8.6 Sections are not required to promulgate their own rules and regulations, have a minimum number of participants holding voting privileges, or meet with defined regularity.

## **Section 6. Committees**

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### **6.1 Designation and Substitution**

There shall be a Medical Executive Committee (MEC) and such other standing and ad hoc committees as established by the MEC and enumerated in the Organization and Functions Manual. Meetings of these committees will be either regular or special. Those functions requiring participation of, rather than direct oversight by the Medical Staff may be discharged by Medical Staff representation on such Hospital committees as are established to perform such functions. The COS may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

### **6.2 Medical Executive Committee (MEC)**

#### **6.2.1 Committee Membership:**

- a. **Composition - voting:** The MEC shall be a standing committee consisting of the following voting members: the Officers of the Medical Staff (provided that the Immediate Past COS shall only serve on the MEC for the first year after serving as COS), each Department Chair, and the elected At-Large Members. The chair will be the COS.
- b. **Composition – nonvoting:** The non-voting attendees to the MEC shall consist of the Hospital President, Chief Medical Officer (CMO), the Chief Quality Officer (CQO), if any, the Chief Nursing Officer (CNO), the Chair of the Credentials Committee, and the Chair of the Constitution and Bylaws Committee. The chair of the Professional Practice Evaluation Committee shall serve as a non-voting guest, as invited by the COS. If a Department Vice Chair is attending the MEC in the absence of the Chair, they will attend as a non-voting member of the MEC.
- c. **Removal from MEC:** Any individual serving on the MEC ex officio who is removed from that position (e.g., a Medical Staff Officer, MEC At-Large Member or Department Chair removed from such position in accordance with Section 4.7 and/or Section 5.2 above) will automatically lose their membership on the MEC.

#### **6.2.2 Duties:** The duties of the MEC, as delegated by the Medical Staff, shall be to:

- a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws and provide oversight for all Medical Staff functions;
- b. Coordinate the implementation of policies adopted by the Board;
- c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, Medical Staff category, Department assignments, Clinical Privileges, and corrective action;
- d. Report to the Board and to the Medical Staff for the overall quality and efficiency of professional patient care services provided by individuals with Clinical Privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;
- e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of Practitioners including educational efforts and investigations, when warranted;

- f. Make recommendations to the Board on medical administrative and, as requested, provide recommendations on Hospital management matters;
  - g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital;
  - h. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;
  - i. Review and act on reports from Medical Staff committees, Departments, and other assigned activity groups;
  - j. Formulate and recommend to the Board Medical Staff rules, policies, and procedures, including but not limited to rules, policies and procedures containing details associated with requirements outlined in these Bylaws;
  - k. Request evaluations of Practitioners privileged through the Medical Staff process when there are questions about an applicant or Practitioner's ability to perform Privileges requested or currently granted;
  - l. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff Membership or Privileges may be terminated, and the mechanisms for fair hearing procedures for physician, dentists and podiatrists, and other procedures for APPs, and Clinical Assistants;
  - m. Consult with administration on the quality, timeliness, and quality metrics of contracts for patient care services provided to the Hospital by entities outside the Hospital;
  - n. Assist with that portion of the corporate compliance plan that pertains to the Medical Staff;
  - o. Hold Medical Staff leaders, committees, and Departments accountable for fulfilling their duties and responsibilities;
  - p. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws;
  - q. Approve expenditures below the amount determined at the annual meeting of the Medical Staff. Expenditures in excess of that amount shall be expended only upon vote of a majority of the Active Staff members present at a meeting; and
  - r. The MEC is empowered to act for the organized Medical Staff between meetings of the organized Medical Staff.
- 6.2.3 Meetings: The MEC shall meet at least ten (10) times per year and more often as needed to perform its assigned functions. Records of its proceedings and actions shall be maintained in accordance with Hospital's record retention policies.



## **Section 7. Medical Staff Meetings**

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### **7.1 Medical Staff Meetings**

- 7.1.1 There shall be at least four (4) meetings of the Medical Staff per year, which shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff Members.
- 7.1.2 Special Meetings of the Medical Staff
  - a. The COS may call a special meeting of the Medical Staff at any time. Additionally, the COS must call a special meeting if so directed by resolution of the MEC, the Board, or by a petition signed by twenty percent (20%) of the Active Medical Staff. Such request or resolution shall state the purpose of the meeting. The COS shall designate the time and place of any special meeting.
  - b. Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each Member of the Medical Staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.
- 7.1.3 If action is taken at a meeting, the action of a majority of the Active Members present and voting at a meeting of the Medical Staff is the action of the group, except as otherwise specified in these Bylaws. Action may be taken without a meeting of the Medical Staff by presentation of the question to each Member eligible to vote, in person, via telephone, secure video conferencing or other remote means approved by the MEC, and/or by mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the Active Member votes cast.

### **7.2 Regular Meetings of Medical Staff Committees and Departments**

Committees, Departments, Divisions, and Sections may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments, Divisions, Sections, and committees shall meet at least annually, unless otherwise stipulated in these Bylaws or Department Rules and Regulations. Meeting attendance shall be as defined in Section 1.3.

### **7.3 Special Meetings of Committees and Departments**

A special meeting of any committee, Department, Divisions, or Sections may be called by the committee chair or Chair or of the Department, Division, or Section, as applicable, or by the COS.

### **7.4 Quorum**

- 7.4.1 Medical Staff Meetings: Those present (as defined in Section 1.3) and eligible Active Medical Staff Members voting on an issue.

- 7.4.2 MEC, Credentials Committee, and Professional Practice Evaluation Committee: When dealing with expedited Category 1 requests for routine appointment, reappointment, and Clinical Privileges the MEC quorum will consist of at least two (2) voting members. When dealing with expedited Category 1 requests for routine appointment, reappointment, and Clinical Privileges the Credentials Committee quorum will consist of the committee chair or designee. For all other matters, a quorum will exist when fifty percent (50%) of the voting members are present.
- 7.4.3 Medical Staff committees other than those listed in 7.4.2 above: Those present (as in accordance with Section 1.3) and eligible members voting on an issue.
- 7.4.4 Department, Division, or Section meetings: Those present (as defined in Section 1.3) and eligible Active Medical Staff Members voting on an issue.

## **7.5 Attendance Requirements**

- 7.5.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff and of the Departments.
- a. MEC, Credentials Committee, Professional Practice Evaluation Committee and Department Advisory Committee meetings: Members of these committees are expected to attend at least two-thirds (2/3rds) of the meetings held. Failure to meet the attendance requirement will result in replacement on the committee.
  - b. Special meeting attendance requirements: Whenever there is a reason to believe that a Practitioner is not complying with Medical Staff or Hospital policies or has deviated from standard clinical or professional practice or there are other circumstance meriting review, the COS or the applicable Department Chair or Medical Staff committee chair may require the Practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The Practitioner will be given special notice of the meeting at least seven (7) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the Practitioner's appearance is mandatory. Failure of the Practitioner to appear at any such meeting may result in automatic suspension as provided in Part II, Section 3.1.8.
  - c. Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of Clinical Privileges as outlined in Part II of these bylaws (Corrective Action, Hearing and Appeal Plan).

## **7.6 Participation by the Hospital President and the CMO**

The Hospital President and the CMO, or their designees, may attend any general, committee, Department, Section, or Division meetings of the Medical Staff as an ex-officio member without vote.

## **7.7 Robert's Rules of Order**

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest abridged edition of Robert's Rules of Order shall determine procedure.

## **7.8 Notice of Meetings**

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Department, Division, Section or committee not less than three (3) days before the time of such meeting, unless otherwise deemed necessary, by the person or persons calling the meeting. The attendance of a member at a meeting (as defined in Section 1.3) shall constitute a waiver of notice of such meeting.

## **7.9 Action of Committee, Department, Division and Section**

If action is taken at a meeting, the recommendation of a majority of its members who are eligible to vote and present (as defined in Section 1.3) at a meeting at which a quorum is present shall be the action of a committee, Department, Divisions or Sections . Action may be taken without a meeting with the consent of the committee chair and presentation of the question to each member eligible to vote, in person, via telephone, video conference or other remote means, and/or by mail or internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the Active Member votes cast. Such recommendation will then be forwarded to the MEC for action. The chair of a committee or meeting shall vote only in order to break a tie.

## **7.10 Minutes**

Minutes of each regular and special meeting of a committee, Department, Division, or Section shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair or Department/Section/Division Chair shall authenticate the minutes and copies thereof shall be submitted to the MEC or another designated committee. A file of the minutes of each meeting shall be maintained in accordance with document retention procedures.

## **Section 8. Conflict Resolution**

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### **8.1 Conflict Resolution**

- 8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the Officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.
- 8.1.2 To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff, the chair of the Board, Hospital President, or the COS may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.
- 8.1.3 Any conflict between the Medical Staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.5 of Part I of these Bylaws.

## **Section 9. Professional Practice Review Functions**

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### **9.1 Review Functions of Medical Staff and Administration**

- 9.1.1 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 Part II and the following committees, which are further described in these Bylaws or other policies and procedures: MEC, Credentials, Professional Practice Evaluation, Medical Records, Utilization and Review and Department, Division and Section advisory committees.
- 9.1.2 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 Hospital administration, by the participants in the proceedings that are described in Part II, and by Joint Conference Committees, all of whom are assigned professional practice review functions.
- 9.1.3 Employees and other staff of the Hospital are assigned and perform professional practice review functions by providing information, records, data and knowledge to, gathering information for, and otherwise assisting, individuals and committees in the performance of their professional practice review functions.

### **9.2 Board's Authority and Functions**

All professional practice review functions are carried out under the direction and authority of the Board, 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.

### **9.3 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 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, Act 270 of the Public Acts of 1967, and Section 1143(a) of the Michigan Mental Health Code, as amended.

## **Section 10. Review, Revision, Adoption, and Amendment**

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### **10.1 Medical Staff Responsibility**

- 10.1.1 The Medical Staff shall have the responsibility to formulate, review at least every three years, and recommend to the Board any Medical Staff Bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the Bylaws, rules & regulations and policies shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its Membership.
- 10.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these Bylaws.

### **10.2 Methods of Adoption and Amendment to these Bylaws**

- 10.2.1 Proposed amendments to these Bylaws may originate from the MEC or by a petition signed by twenty percent (20%) of the Active Members.
- 10.2.2 Each Active Member of the Medical Staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active Members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed changes.
- 10.2.3 Except as otherwise provided in Section 10.3.6, the amendment shall be considered approved by the Medical Staff when at least two-thirds of the ballots cast by Active Members vote to approve the amendment.
- 10.2.4 Amendments so adopted shall be effective when approved by the Board.

### **10.3 Methods of Adoption and Amendment to any Medical Staff Rules, Regulations, and Policies**

- 10.3.1 The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.
- 10.3.2 When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to voting.
- 10.3.3 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations and policies may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board.
- 10.3.4 In addition to the process described in 10.3.3 above, the organized Medical Staff itself may recommend to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by twenty percent (20%) of the members of the Active category using the Conflict Resolution Mechanism noted in Part I Section 8.1.3. Upon presentation of such petition, the adoption process outlined in Part I Section 10.2.1 above will be followed.

- 10.3.5 In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with federal, state or local law or regulation, the MEC may provisionally adopt and the Board may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the MEC shall immediately inform the Medical Staff after provisional adoption. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the MEC, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the MEC is implemented. If necessary, a revised amendment is then submitted to the Board for action. During the pendency of the conflict resolution process, the provisional amendment shall continue to be effective.
- 10.3.6 The MEC may adopt such amendments to these Bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or nonsubstantive legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws, rules and regulations or policies. The procedures specified in the Bylaws are the only procedures by which the Bylaws may be amended, superseded or repealed.



**Trinity Health-Michigan**

**MEDICAL STAFF BYLAWS**

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**Part II: Corrective Actions, Hearing and Appeal  
Plan**

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## Table of Contents

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Section 1.	Educational and/or Informal Proceedings	ii-1
Section 2.	Investigations	ii-2
Section 3.	Corrective Action	ii-5
Section 4.	Initiation and Notice of Hearing	ii-10
Section 5.	Hearing Committee and Presiding Officer	ii-13
Section 6.	Pre-Hearing and Hearing Procedure	ii-15
Section 7.	Appeal to the Hospital Board	ii-18

## **Section 1. Educational and/or Informal Proceedings**

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### **1.1 Criteria for Initiation**

These Bylaws encourage Medical Staff leaders and Hospital management to use progressive steps, where appropriate, beginning with education efforts and other remedial monitoring, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to and resolve questions that have been raised. All educational intervention efforts by Medical Staff leaders and Hospital management shall be considered confidential and part of the Hospital's performance improvement and professional and peer review activities. Educational intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management. Educational intervention efforts may include but are not limited to the following:

- a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- b. Following up on any questions or concerns raised about the clinical practice and/or conduct of Practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and
- c. Sharing summaries of comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

Following educational intervention efforts, the applicable Medical Staff leaders and/or Hospital management representative shall evaluate the appropriate next steps, if any, for the Practitioner. Educational intervention is a discretionary process and is not intended to prohibit or restrict other options, including peer review and/or disciplinary action or intervention. When any observations arise before, during or after educational intervention suggesting opportunities for a Practitioner to improve their clinical skills or professional behavior, the matter should be referred for peer review in accordance with the peer review and performance improvement policies adopted by the Medical Staff and Hospital. If at any point before, during or after educational intervention efforts, it appears that corrective action is merited, or that other intervention described in these Bylaws or in Medical Staff or Hospital policies is more appropriate, such action may be implemented in accordance with Section 2 and other applicable policies and procedures.

## **Section 2. Corrective Action and Investigations**

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### **2.1 Initiation of Corrective Action**

Any of the Medical Staff Officers, Professional Practice Evaluation Committee Chair, Department Chairs, Hospital President, CMO, or the Board may initiate a request for corrective action with respect to a Practitioner based on reasonable grounds including, but not limited to, any of the following:

- 2.1.1 It appears the Practitioner no longer possesses the qualifications for Medical Staff Membership or for the Clinical Privileges held.
- 2.1.2 Personal activity, professional conduct, or clinical practice that is, or is likely to be, detrimental to patient safety or to delivery of patient care, or disruptive to Hospital operations.
- 2.1.3 Unethical professional practice in or outside of the Hospital or other Hospital and Medical Staff policies and procedures.
- 2.1.4 Conduct that constitutes sexual harassment or morally offensive conduct toward any Medical Staff Member, APP, Clinical Assistant, Hospital personnel, patient, or Hospital visitor.
- 2.1.5 Violation of these Bylaws or the rules and regulations.
- 2.1.6 Conduct that indicates unwillingness or inability to work harmoniously with Medical Staff Members, APPs, Clinical Assistants, Hospital personnel, or patients.

The request must be in writing and supported by references to the specific activities or conduct that are of concern. Upon receipt of a request for corrective action, the MEC may, in its discretion, elect to conduct an investigation, in accordance with Section 2.2. below, or may determine that an investigation is unnecessary and take action on the request. If the MEC itself initiates corrective action, it shall appropriately document its reasons.

### **2.2 Investigation**

- 2.2.1 If, after a request for corrective action, the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution. The MEC shall assign the task to an appropriate standing or ad hoc committee of the Medical Staff.

- 2.2.2 The committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant, consistent with Section 2.2.4 below, if it deems a consultant is necessary and such action is approved by the MEC and the CMO. The investigating committee may also require the Practitioner under investigation to undergo a physical and/or mental examination and may access the results of such exams. The investigating committee may, in its discretion, provide to the Practitioner an opportunity to provide information in a manner and upon such terms as the investigating committee deems appropriate. Any such meeting between the Practitioner in question and the investigating committee (and meetings with any other individuals the investigating committee chooses to interview) shall not constitute a “hearing” as that term is used in the hearing and appeals sections of these Bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to such a meeting, nor to be represented by legal counsel before the investigating body nor to compel the Medical Staff to engage external consultation.
- 2.2.3 Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, taking action on the corrective action request as provided in Section 2.3, or other action. The MEC may also direct the investigating committee to interview individuals, compile reports or other documents, investigate other issues, or provide additional information. The MEC will evaluate the report generated by the investigating committee and take prompt action after the conclusion of the investigation.
- 2.2.4 An external peer review consultant may be considered when:
- a. The Hospital is faced with ambiguous or conflicting recommendations from Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances, consideration may be given by the MEC or the Board to retain an objective external reviewer;
  - b. There is no one on the Medical Staff with expertise in the subject under review, or when the only Members on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the Practitioner under review.

### **2.3 MEC Action**

As soon as practical but no later than 90 days after receiving the corrective action request or, if an investigation was performed, after receipt of the investigating committee’s report, the MEC shall act on the request. The MEC’s response to a corrective action request may include, without limitation:

- a. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the investigation in the first instance, removing any adverse information from the Practitioner’s file;

- b. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate committee chairs or Department Chairs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected Practitioner may make a written response, which shall be placed in the Practitioner's file;
- c. Recommending completion of one or more training or other educational courses;
- d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff Membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring with or without limiting privileges;
- e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of Clinical Privileges;
- f. Recommending reductions of Membership status or limitation of any prerogatives directly related to the Practitioner's delivery of patient care;
- g. Recommending suspension, revocation, or probation of Medical Staff Membership;
- h. Requiring the Practitioner to undergo a physical and/or mental examination and provide access to the results of such exams; or
- i. Taking other actions deemed appropriate under the circumstances.

In addition to considering and acting upon recommendations of the MEC regarding corrective action, the Board may, at any time, respond to a corrective action request by imposing corrective action against the Practitioner, subject to the Practitioner's right, if applicable, to hearing or review.

#### **2.4 Subsequent Action**

All MEC actions relating to a corrective action request shall be reported promptly to the Board. If the MEC recommends any of the actions triggering a fair hearing and appeal right for a physician, dentist or podiatrist under Section 4.1, or other due process procedures for other Practitioners under Section 7.7, the Board will not act on the recommendation until the affected Practitioner has either waived or completed a hearing. The Board may then adopt, modify, or reject the MEC's recommendation.

## Section 3. Automatic Action

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### 3.1 Automatic Suspension and/or Relinquishment

In the following triggering circumstances, which are not based on professional competence or conduct, the Practitioner's Privileges and/or Membership (if applicable) will be considered suspended or relinquished, or limited as described, and the action shall be final without a right to a hearing and generally do not constitute a reportable event. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand unless the MEC determines it is not applicable. The MEC will evaluate the circumstances, and make such a determination as soon as feasible. The COS, with the approval of the CMO, may reinstate the Practitioner's Privileges or Membership (as applicable) after determining that the triggering circumstances have been rectified or are no longer present. Except as otherwise provided in this Section, if the triggering circumstances have not been resolved within **sixty (60) days** of such circumstance, the Practitioner will have to reapply for Membership (if applicable) and/or Privileges as a new applicant. In addition to triggering automatic suspension and/or relinquishment/voluntary resignation, further corrective action may be recommended in accordance with these Bylaws whenever any of the following circumstances occur:

#### 3.1.1 Licensure

- a. **Revocation and suspension:** Whenever a Practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, Medical Staff Membership and Clinical Privileges shall be automatically relinquished by the Practitioner as of the date such action becomes effective.
- b. **Restriction:** Whenever a Practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any Clinical Privileges that the Practitioner has been granted at this Hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- c. **Probation:** Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her Membership status and/or Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

- 3.1.2 **Medicare, Medicaid, Tricare or other federal programs:** Whenever a Practitioner is excluded, precluded, or barred from participation in Medicare, Medicaid, Tricare, or other federal programs, Medical Staff Membership and Clinical Privileges shall be considered automatically relinquished as of the date such action becomes effective. Any Practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities will be considered to have automatically relinquished his or her Membership and/or Privileges.

### 3.1.3 **Controlled Substances**

- a. **DEA Certificate or Michigan CSR:** Whenever a Practitioner's United States Drug Enforcement Agency (DEA) certificate or Michigan Controlled Substance Registration (CSR) is revoked, limited, or suspended, the Practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- b. **Probation:** Whenever a Practitioner's DEA certificate or Michigan Controlled Substance Registration (CSR) is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.4 **Medical Record Completion Requirements:** A Practitioner will be considered to have their Privileges suspended whenever s/he fails to timely complete medical records as provided by Medical Staff policy on medical records completion. The suspended Privileges will be automatically restored upon completion of the medical records and compliance with medical records policies, in accordance with Medical Staff policy on medical records completion.

3.1.5 **Professional Liability Insurance:** Failure of a Practitioner to maintain professional liability insurance in the amount required by state regulations and Medical Staff and Hospital policies and sufficient to cover the Clinical Privileges granted shall result in immediate automatic suspension of a Practitioner's Clinical Privileges. If within sixty (60) calendar days of the suspension the Practitioner does not provide evidence of required professional liability insurance (including prior acts or "nose" coverage for any period during which insurance was not maintained), the Practitioner shall be considered to have voluntarily resigned the Practitioner's Privileges and Membership on the Medical Staff. As provided in Part I, Section 2.6.12, the Practitioner must notify the Medical Staff office of any change in professional liability insurance carrier or coverage.

3.1.6 **Medical Staff Dues/Special Assessments:** Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic suspension of a Practitioner's appointment and Privileges. If the Practitioner does not remit such payments within the time period set by the MEC in Medical Staff policy after written warning of the delinquency, the Practitioner shall be considered to have voluntarily resigned Membership and Privileges on the Medical Staff.

### 3.1.7 **Felony Convictions:**

- a. A Practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to any of the following: death or injury of another person, insurance or healthcare fraud or abuse, violence, abuse (physical, sexual, child, or elder) in any jurisdiction shall automatically relinquish Medical Staff Membership and Privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed.
- b. Except as provided in 3.1.7.a, a Practitioner who has been convicted of or entered a plea of "guilty" or "no contest" or its equivalent to a felony relating to alcohol, controlled substances or illegal drugs, in any jurisdiction shall automatically relinquish Medical Staff Membership and Privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved

by subsequent action of the Board or through corrective action, if necessary. This does not preclude the MEC from taking action on charges or indictments of the above offenses.

- 3.1.8 **Failure to Satisfy the Special Appearance Requirement:** A Practitioner who fails without good cause to appear at a meeting where their special appearance is required in accordance with these Bylaws shall be considered to have all Clinical Privileges automatically suspended with the exception of emergencies and imminent deliveries. These Privileges will be restored when the Practitioner complies with the special appearance requirement, subject to the reapplication requirements in Section 3.1. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation of the Practitioner's Privileges and Membership on the Medical Staff.
- 3.1.9 **Failure to Participate in an Evaluation:** A Practitioner who fails to participate in an evaluation of their qualifications for Medical Staff Membership or Privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills) and fails to authorize the release of this information to the MEC, shall be considered to have all Privileges automatically suspended. These Privileges will be restored when the Practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation of the Practitioner's Privileges and Membership on the Medical Staff.
- 3.1.10 **Failure to Fulfill Mandatory Health Requirements:** A Practitioner who fails to be compliant with Hospital or Medical Staff policy on required testing (i.e., Tb testing) or required vaccinations/immunizations shall be automatically suspended until policy compliance is noted. Failure to comply within sixty (60) calendar days will be considered a voluntary resignation of the Practitioner's Privileges and Membership on the Medical Staff, unless a longer time period is provided by policy.
- 3.1.11 **Failure to Become Board Certified:** A Practitioner who fails to become board certified in compliance with these Bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and Clinical Privileges.
- 3.1.12 **Failure to Maintain Board Certification:** A Practitioner who fails to maintain their board certification in compliance with these Bylaws or Medical Staff credentialing policies will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and Clinical Privileges unless an exception is granted in accordance with Medical Staff policy.
- 3.1.13 **Failure to Execute Release and/or Provide Documents:** A Practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the COS or designee to evaluate the competency and credentialing/privileging qualifications of the Practitioner shall be considered to have all Privileges automatically suspended. If the release is executed and/or documents provided within thirty (30) calendar days of notice of the automatic suspension, the Practitioner may be reinstated. After sixty (60) calendar days, the Practitioner will be deemed to have resigned voluntarily their Privileges and Membership on the Medical Staff.



- 3.1.14 **Summary Suspension at a THM Hospital:** If a Medical Staff Member's delineated clinical privileges are summarily suspended or summarily restricted at a THM Hospital, the Member's delineated Clinical Privileges at this Hospital shall automatically be subject to the same restriction or suspension, at such time as the summary suspension or restriction is affirmed by the MEC at the THM Hospital. If the summary suspension or restriction is lifted at the THM Hospital, the summary suspension restriction is automatically lifted at this Hospital as well, subject to the Medical Staff's/Hospital's right to take any appropriate action provided for in these Bylaws.
- 3.1.15 **Other Adverse Action at a THM Hospital:** If a Medical Staff Member's medical staff membership or delineated clinical privileges at another THM Hospital is/are involuntarily terminated, restricted, or subject to conditions, the Medical Staff member's status at this Hospital shall automatically be subject to the same action or restrictions at such time as the final adverse decision of the Board at the other THM Hospital is made. This Section shall not be triggered by automatic or administrative action at another THM Hospital.
- 3.1.16 **Loss of supervising/collaborating Member for Advanced Practice Professionals or Clinical Assistants:** If an APP or Clinical Assistant loses their relationship with a supervising/collaborating Member on Staff at this Hospital for any reason or the supervising/collaborating Member will no longer supervise the full scope of the APPs, or Clinical Assistant's Privileges for any reason, then the APP or Clinical Assistant is automatically suspended until the APP or Clinical Assistant develops a new supervision/collaboration relationship with another Member of the Medical Staff. If another supervising/collaborating relationship is not developed within thirty (30) days, then the APP or Clinical Assistant shall be deemed to have automatically relinquished their Privileges.
- 3.1.17 **Leave of Absence:** Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation of Membership and Privileges. A request for Medical Staff Membership or Privileges subsequently received from a Member or Practitioner whose Membership and Privileges were terminated under this Section shall be submitted and processed in the manner specified for applications for initial applicants.
- 3.1.18 **MEC Deliberation:** As soon as feasible after action is taken or warranted as described above, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in these Bylaws.

## 3.2 Summary Restriction or Suspension

3.2.1 **Criteria for Initiation:** A summary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when Medical Staff leaders and/or the CMO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to adversely affect patient, employee or staff safety or the effective operation of the Hospital. Under such circumstances, any two of the following individuals, COS, Chief of Staff Elect, Hospital President, or CMO, may restrict or suspend the Medical Staff Membership or Clinical Privileges of such Practitioner. If there is a dispute over whether the Practitioner should be summarily suspended, a third individual from the above-named group shall make the decision. A suspension of all or any portion of a Practitioner's clinical privileges at another hospital may be grounds for a summary suspension of all or any of the Practitioner's Clinical Privileges at this Hospital.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the Practitioner, the MEC, the CMO, the Hospital President, and the Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The summary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.

Unless otherwise indicated by the terms of the summary restriction or suspension, the Practitioner's patients shall be promptly assigned to another Medical Staff Member by the COS or designee, considering, where feasible, the wishes of the affected Practitioner and the patient in the choice of a substitute Practitioner.

3.2.2 **MEC Action:** As soon as feasible and within fourteen (14) calendar days after such summary restriction or suspension has been imposed, the MEC shall meet to review and consider the action and, if necessary, begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the Practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the Practitioner, constitute a "hearing" as defined in this hearing and appeal plan, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the Practitioner with notice of its decision.

3.2.3 **Procedural Rights:** Unless the MEC promptly terminates the summary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the physician, dentist or podiatrist with Membership or Privileges (or applicant for the above) may be entitled to the procedural rights afforded by this hearing and appeal plan once the restrictions or suspension last more than 14 calendar days. All summary actions shall be reported promptly to the Board. If the summary action entitles the physician, dentist or podiatrist to a fair hearing or entitles an APP or Clinical Assistant to the procedural rights afforded by the Part II, Section 7.7, the Board will not act on the action until such procedural right has been waived or completed. The Board may then adopt, modify, or reject the MEC's action.

## **Section 4. Initiation and Notice of Hearing**

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### **4.1 Initiation of Hearing**

Any Affected Individual shall be entitled to request a hearing whenever an Adverse Recommendation has been made by the MEC or the Board. Hearings will be triggered only by the following “Adverse Recommendations” when the basis for such action is related to clinical competence or professional conduct that adversely affect or could adversely affect the health or welfare of a patient:

- 4.1.1 Denial of Medical Staff appointment or reappointment;
- 4.1.2 Revocation of Medical Staff appointment;
- 4.1.3 Denial or restriction of requested Clinical Privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by an Automatic Action or any other reason unrelated to clinical competence or professional conduct;
- 4.1.4 Involuntary reduction, limitation, or revocation of Clinical Privileges;
- 4.1.5 Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an Affected Individual and is imposed for more than fourteen (14) calendar days; or
- 4.1.6 Suspension of Medical Staff appointment or Clinical Privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by an Automatic Action or any other reason unrelated to clinical competence or professional conduct.

### **4.2 Hearings Will Not Be Triggered by the Following Actions**

- 4.2.1 Issuance of a letter of guidance, warning, or reprimand;
- 4.2.2 Imposition of a requirement for proctoring (i.e., observation of the physician, dentist, or podiatrist’s performance by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on Privileges;
- 4.2.3 Failure to process a request for a Privilege when the physician, dentist, or podiatrist does not meet the eligibility criteria to hold that Privilege;
- 4.2.4 Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
- 4.2.5 Requirement to appear for a special meeting under the provisions of these Bylaws;
- 4.2.6 Automatic Action, relinquishment or voluntary resignation of appointment or Privileges;
- 4.2.7 Imposition of a suspension related to competence or conduct that does not exceed fourteen (14) calendar days;
- 4.2.8 Denial of a request for leave of absence, or for an extension of a leave;
- 4.2.9 Determination that an application is incomplete or untimely;
- 4.2.10 Determination that an application will not be processed due to misstatement or omission;
- 4.2.11 Decision not to expedite an application;

- 4.2.12 Denial, termination, or limitation of temporary Privileges unless for demonstrated incompetence or unprofessional conduct;
- 4.2.13 Determination that an applicant for Membership does not meet the requisite qualifications/criteria for Membership;
- 4.2.14 Ineligibility to request Membership or Privileges or continue Privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement;
- 4.2.15 Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;
- 4.2.16 Termination of Privileges as a result of the termination of any contract with or employment by Hospital, or termination of a contract with the entity that employed or contracted with the physician, dentist or podiatrist to provide services for or at Hospital;
- 4.2.17 Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any accreditation standards on focused professional practice evaluation;
- 4.2.18 Any recommendation voluntarily accepted by the Affected Individual waiving their right to a hearing;
- 4.2.19 Expiration of Membership and Privileges as a result of failure to submit an application for reappointment within the allowable time period;
- 4.2.20 Change in assigned Medical Staff category that is not related to professional competence or conduct;
- 4.2.21 Refusal of the Credentials Committee or MEC to consider a request for appointment, reappointment, or Privileges after a final adverse decision at any THM Hospital regarding such request;
- 4.2.22 Removal or limitations of emergency department call obligations;
- 4.2.23 Any requirement to complete an educational assessment that does not limit Privileges for more than fourteen (14) days or is not based on professional competence or conduct;
- 4.2.24 Retrospective chart review;
- 4.2.25 Any requirement to complete a health and/or psychiatric/psychological assessment required under these Bylaws;
- 4.2.26 Grant of conditional appointment or appointment for a limited duration; or
- 4.2.27 Appointment or reappointment for duration of less than 24 months.

### **4.3 Notice of Adverse Recommendation**

When a summary suspension lasts more than fourteen (14) calendar days or when an Adverse Recommendation is made which entitles an individual to request a hearing prior to a final decision of the Board, the Affected Individual shall promptly be given written notice by the CMO/Medical Staff Office delivered by Special Notice. This notice shall contain:

- 4.3.1 A statement of the recommendation made and the general reasons for it (Statement of Reasons);
- 4.3.2 Notice that the individual shall have thirty (30) calendar days following the date of such Special Notice within which to request a hearing on the recommendation.

#### **4.4 Request for Hearing**

An Affected Individual shall have thirty (30) calendar days following the date of the Special Notice within which to request the hearing. The request shall be made in writing to the CMO/Medical Staff Office, or designee. In the event the Affected Individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final Board action. The Affected Individual shall provide the name of the Affected Individual's counsel, if known, in the request for hearing.

#### **4.5 Notice of Hearing and Statement of Reasons**

Upon receipt of the Affected Individual's timely request for a hearing, the CMO, in conjunction with the COS, shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

- a. The time, place, and date of the hearing;
- b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC (or the Board if the Board made the Adverse Recommendation) at the hearing;
- c. The names of the Hearing Committee members and Presiding Officer, if known; and
- d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or Clinical Privileges of the Affected Individual requesting the hearing, and that the Affected Individual and the Affected Individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties.

#### **4.6 Witness List**

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Committee and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the Presiding Officer (or Hearing Committee chair), be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The Presiding Officer (or Hearing Committee chair) shall have the authority to limit the number of witnesses.

## **Section 5. Hearing Committee and Presiding Officer (or Hearing Committee Chair)**

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### **5.1 Hearing Committee**

- 5.1.1 When a hearing is requested, a Hearing Committee of not fewer than three (3) individuals will be appointed. This panel will be appointed by the Chief of Staff, in conjunction with the CMO and Hospital President. No individual appointed to the Hearing Committee shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Committee. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Committee. Hearing Committee members need not be Members of the Hospital Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical providers. Panel members need not be clinicians in the same specialty as the member requesting the hearing.
- 5.1.2 The Hearing Committee shall not include any individual who is in direct economic competition with the Affected Individual or any such individual who is in professional practice with or related to the Affected Individual. This restriction on appointment shall include any individual designated as the chair or the Presiding Officer (or Hearing Committee chair).
- 5.1.3 The CMO/Medical Staff Office, or designee shall notify the Affected Individual requesting the hearing of the names of the panel members and the date by which the Affected Individual must object, if at all, to appointment of any member(s). Any objection to any member of the Hearing Committee or Presiding Officer (or Hearing Committee chair) shall be made in writing to the CMO/Medical Staff Office. The President/Chief of Staff, in conjunction with the CMO, shall determine whether a replacement panel member should be identified. Although the Affected Individual who is the subject of the hearing may object to a panel member, s/he is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the CMO.

### **5.2 Hearing Committee Chairperson or Presiding Officer**

- 5.2.1 The CMO, acting for the MEC (or Board, if the hearing is occasioned by a Board determination), and after considering the recommendations of the COS (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as Presiding Officer. The Presiding Officer should have no previous relationship with either the Hospital (other than in the capacity of a Presiding Officer), organized Medical Staff, or the Affected Individual. Such Presiding Officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Committee and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.
- 5.2.2 If no Presiding Officer has been appointed, a chair of the Hearing Committee shall be appointed by the CMO to preside over the hearing and shall be entitled to one vote.
- 5.2.3 The Presiding Officer (or Hearing Committee chair) shall do the following:

- a. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
- b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay;
- c. Maintain decorum throughout the hearing;
- d. Determine the order of procedure throughout the hearing;
- e. Have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;
- f. Act in such a way that all information reasonably relevant to the continued appointment or Clinical Privileges of the Affected Individual requesting the hearing is considered by the Hearing Committee in formulating its recommendations;
- g. Conduct arguments by counsel on procedural points, which may be done outside the presence of the Hearing Committee; and
- h. Seek legal counsel when s/he feels it is appropriate. Legal counsel to the Hospital may advise the Presiding Officer or Hearing Committee chair.



## **Section 6. Pre-Hearing and Hearing Procedure**

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### **6.1 Provision of Relevant Information**

- 6.1.1 The Hearing is not a court of law and Affected Individuals are not afforded the same rights as defendants in a civil or criminal matter. There is no right to formal “discovery” in connection with the hearing. The Presiding Officer or Hearing Committee chair shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the Affected Individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the Affected Individual’s counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:
- a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at his or her expense;
  - b. Reports of experts relied upon by the MEC or Board;
  - c. Copies of any other documents relied upon by the MEC or the Board;
  - d. No information regarding other Affected Individuals shall be requested, provided, or considered; and
  - e. Evidence unrelated to the reasons for the recommendation or to the Affected Individual’s qualifications for appointment or the relevant Clinical Privileges shall be excluded.
- 6.1.2 Prior to the hearing, on dates set by the Presiding Officer (or Hearing Committee chair) or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The Presiding Officer (or Hearing Committee chair) shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

### **6.2 Pre-Hearing Conference**

The Presiding Officer (or Hearing Committee chair) may require a representative for the Affected Individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer (or Hearing Committee chair) shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness’s testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

### **6.3 Failure to Appear**

Failure, without good cause, of the Affected Individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the Presiding Officer or chair of the Hearing Committee.



#### **6.4 Record of Hearing**

The Hearing Committee shall maintain a record of the hearing by a court reporter present to make a record of the hearing or a recording of the proceedings. The cost of such court reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the Affected Individual requesting the hearing at the Affected Individual's expense. The Hearing Committee may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Michigan.

#### **6.5 Rights of the Affected Individual and the Hospital**

6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer (or Hearing Committee chair):

- a. To call and examine witnesses to the extent available;
- b. To introduce exhibits;
- c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
- d. To have representation by counsel who may be present at the hearing, advise his or her client, and participate in resolving procedural matters. Attorneys may not argue the case for their client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing;
- e. To submit a written statement at the close of the hearing.

6.5.2 Any Affected Individuals requesting a hearing who do not testify on their own behalf may be called and examined as if under cross-examination.

6.5.3 The Hearing Committee may question the witnesses, call additional witnesses or request additional documentary evidence.

#### **6.6 Admissibility of Evidence**

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

#### **6.7 Burden of Proof**

It is the initial obligation of the MEC (or Board of Directors) to present evidence in support of its action. It is the burden of the Affected Individual under review to demonstrate by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

#### **6.8 Official Notice**

The Presiding Officer (or Hearing Committee chair) shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

## **6.9 Postponements and Extensions**

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the Presiding Officer (or Hearing Committee chair) or the Hospital President on a showing of good cause. The hearing shall not proceed unless all hearing panel members are present.

## **6.10 Persons to be Present**

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the COS or CMO. All members of the Hearing Committee shall be present, absent good cause, for all stages of the hearing and deliberations.

## **6.11 Order of Presentation**

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the Affected Individual who requested the hearing to present evidence.

## **6.12 Adjournment and Conclusion**

The Presiding Officer (or Hearing Committee chair) may recess the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the Hearing Committee, the hearing shall be closed.

## **6.13 Deliberations and Recommendation of the Hearing Committee**

Within thirty (30) calendar days after final adjournment of the hearing, the Hearing Committee shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

## **6.14 Basis of Recommendation**

The Hearing Committee shall recommend in favor of the MEC (or the Board) if it finds that the Affected Individual who requested the hearing has failed to prove, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence. The Hearing Committee shall recommend in favor of the Affected Individual if it finds that the Affected Individual has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence. The Hearing Committee's recommendation shall include the basis for its recommendation.

## **6.15 Disposition of Hearing Committee Report**

The Hearing Committee shall deliver its report and recommendation to the CMO who shall forward it, along with all supporting documentation, to the MEC or, if the Board made the original recommendation, to the Board, for further action. The CMO shall also send a copy of the report and recommendation, by Special Notice, to the individual who requested the hearing. The MEC or Board, as applicable, may uphold its original recommendation or modify or adjust its recommendation and submit its new recommendation in writing to the Affected Individual, including a statement of the basis for its recommendation. If the final recommendation is an Adverse Recommendation, the Affected Individual shall have the right to appellate review as outlined in Section 7 below.

## **Section 7. Appeal to the Hospital Board**

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### **7.1 Time for Appeal**

Within ten (10) calendar days after the final Adverse Recommendation, the Affected Individual subject to the hearing may appeal. The request for appellate review shall be in writing, and shall be delivered to the CMO/Medical Staff Office either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the Hearing Committee's report and recommendation shall be forwarded to the Board.

### **7.2 Grounds for Appeal**

The grounds for appeal shall be limited to the following:

- a. There was substantial failure to comply with the Medical Staff Bylaws prior to or during the hearing so as to deny a fair hearing; or
- b. The recommendation of the Hearing Committee was made arbitrarily, capriciously, or with prejudice; or
- c. The recommendation of the Hearing Committee was not supported by substantial evidence based upon the hearing record.

### **7.3 Time, Place, and Notice**

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The Affected Individual shall be given notice of the time, place, and date of the appellate review. The chair of the Board may extend the time for appellate review for good cause.

### **7.4 Nature of Appellate Review**

- a. The Chair of the Board shall appoint a review panel composed of at least one (1) member of the Board to consider the information upon which the recommendation before the Board was made. Member(s) of this review panel may not be direct competitors of the Affected Individual under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
- b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the Hearing Committee. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the individual requesting the review at that individual's expense. The review panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Michigan.

- c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty (30) minute oral argument. The review panel shall recommend final action to the Board.
- d. The Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and Clinical Privileges.

## **7.5 Final Decision of the Hospital Board**

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the Affected Individual by Special Notice and notify the chairs of the Credentials Committee and MEC.

## **7.6 Right to One Appeal Only**

No applicant or Medical Staff Member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or Clinical Privileges or deny the application of an Affected Individual, that Affected Individual may not apply for Medical Staff appointment or for those Clinical Privileges at this or another THM Hospital unless the Board advises otherwise.

## **7.7 Meeting and appeal for APPs and Clinical Assistants**

APPs and Clinical Assistants are not entitled to the hearing and appeals procedures set forth in the Medical Staff Bylaws. In the event one of these APPs/Clinical Assistants is notified by Special Notice of a recommendation by the Medical Executive Committee described in Section 4.1 and based on professional competence or conduct that adversely affect or could adversely affect the health or welfare of a patient, the APP/Clinical Assistant and their supervising Member, if applicable, shall have the right to meet personally with two Members and a peer jointly assigned by the COS and CMO to discuss the recommendation. The APP/Clinical Assistant and the supervising Member, if applicable, must request such a meeting in writing to the Hospital President within ten (10) business days from the date of the Special Notice. At the meeting, the APP/Clinical Assistant and the supervising Member, if applicable, must be present to discuss, explain, or refute the recommendation, but such meeting shall not constitute a hearing and none of the procedural rules set forth in the Medical Staff Bylaws with respect to hearings shall apply. Findings from this review body will be forwarded to the affected APP/Clinical Assistant and the MEC. The MEC shall make its recommendation, including any modifications to the review body's recommendations, to the Board.

The APP/Clinical Assistant and the supervising Member, if applicable, may request an appeal in writing to the Hospital President within ten (10) days of receipt of the findings of the MEC, if such findings continue to be adverse to the APP/Clinical Assistant. At least one (1) member of the Board assigned by the chair of the Board shall hear the appeal from the APP/Clinical Assistant and the supervising Member. A representative from the Medical Staff leadership may be present. The decision of the appeal body will be forwarded to the Board for final decision. The APP/Clinical Assistant and the supervising Member will be notified within ten (10) days of the final decision of the Board. If the decision is adverse to the APP/Clinical Assistant, they will not be allowed to reapply for Privileges.

## **7.8 Reporting Requirements**

The CMO or their designee shall be responsible for assuring that the Hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's Privileges are limited, revoked, or in any way constrained, the Hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician, dentist or podiatrist (i.e., an action related to clinical incompetence or misconduct that adversely affects, or could affect, the health or welfare of a patient), which leads to a denial of appointment and/or reappointment; reduction in Clinical Privileges for greater than thirty (30) calendar days; resignation, surrender of Privileges, or acceptance of Privilege reduction either during an investigation or to avoid an investigation.



**Trinity Health Michigan**

**MEDICAL STAFF BYLAWS**

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**Part III: Credentials Procedures**

\_\_\_\_\_, 2022

## Table of Contents

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Section 1.	Medical Staff Credentials Committee	iii-1
Section 2.	Qualifications for Membership and/or Privileges	iii-3
Section 3.	Initial Appointment/Reappointment Procedure	iii-5
Section 4.	Clinical Privileges	iii-9
Section 5.	Provision of Care by Non-Members	iii-14

## **Section 1. Medical Staff Credentials Committee**

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### **1.1 Composition**

Membership of the Medical Staff Credentials Committee shall consist of no less than five (5) Members of the Active Medical Staff who are experienced leaders with a broad representation from the Medical Staff. The COS will appoint the Chair, who must have previous Credentials Committee experience, and the other members of the committee. Strong consideration shall be given to appointing members who are not Department Chairs. Members will be appointed for staggered three (3) year terms. The chair will be appointed for a three (3) year term. The chair and members may be reappointed for additional terms without limit. The CMO and COS may be ex-officio, non-voting members of the committee, but shall not count for quorum purposes. The committee may also invite members, on an as-needed basis, such as representatives from Hospital administration and the Board. As provided in Part I, when dealing with expedited Category 1 requests for routine appointment, reappointment, and Clinical Privileges the Credentials Committee quorum will consist of the committee chair or designee. For all other matters, a quorum will exist when fifty percent (50%) of the voting members are present.

### **1.2 Meetings**

The Medical Staff Credentials Committee shall meet at least ten (10) times per year and on call of the chair or COS. As provided in Part I, Section 1.3, meeting attendance may include meetings conducted via electronic means at the discretion of the Committee chair after due consideration to confidentiality and security issues.

### **1.3 Responsibilities**

- 1.3.1 To review and recommend action on all applications and reapplications for Membership on the Medical Staff including assignments of Medical Staff category;
- 1.3.2 To review and recommend action on all requests regarding Privileges from eligible Practitioners;
- 1.3.3 To review and recommend eligibility criteria for the granting of Medical Staff Membership and Privileges;
- 1.3.4 To develop, review, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;
- 1.3.5 To review, and where appropriate take action on, reports that are referred to it from other Medical Staff committees, Medical Staff or Hospital leaders;
- 1.3.6 To prepare and submit reports and recommendations to the MEC, as directed by the MEC from time to time;
- 1.3.7 To perform such other functions as requested by the MEC.

### **1.4 Confidentiality**

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the Medical Staff and Hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.



1.4.1 The credentials file is the property of the Hospital and will be maintained with strictest confidence and security. The files will be maintained securely in accordance with policies and procedures. Medical Staff and Hospital administrative leaders may access credential files only for appropriate peer review and institutional reasons.

1.5 **APP/Clinical Assistant Credentialing Committee**

The MEC may establish a separate credentialing committee for APPs and Clinical Assistants and delegate functions related to APP and Clinical Assistant credentialing, privileging and eligibility to such committee.

## **Section 2. Qualifications for Membership and/or Privileges**

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- 2.1** No Practitioner shall be entitled to Membership on the Medical Staff or to Privileges merely by virtue of licensure, membership in any professional organization, affiliation with a Hospital contracted group, or privileges at any other healthcare organization.
- 2.2** The following qualifications must be met and continuously maintained by all applicants for Medical Staff appointment, reappointment, or Clinical Privileges and all Practitioners granted Membership or Clinical Privileges:
- 2.2.1 Demonstrate that the individual has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, nursing, physician assistant program, dietetics, or applicable recognized course of training in a clinical profession eligible to hold Privileges;
  - 2.2.2 Demonstrate clinical performance consistent with the standards set by the medical staff, and current competence in the Privileges requested;
  - 2.2.3 Have a current valid state or federal license applicable to and/or required for his or her profession, and providing permission to practice within the state of Michigan. The license must be active and permit the Practitioner to practice within the scope of the Privileges being requested;
  - 2.2.4 Is free from current Medicare/Medicaid sanctions and is not on the OIG List of Excluded Individuals/Entities;
  - 2.2.5 Have a record that is free from involuntary termination or other adverse action based on professional competence or conduct at another THM Hospital or voluntary resignation or surrender of Privileges in lieu of such termination within two (2) years;
  - 2.2.6 Have appropriate written and verbal communication skills;
  - 2.2.7 Have appropriate personal qualifications, including consistent observance of ethical and professional standards. These standards include, at a minimum:
    - a. Abstinance from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and
    - b. Demonstrated capacity for acting in a professional, appropriate, and collegial manner with others.
  - 2.2.8 Provide for appropriate, timely, and continuous care of their patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances. This includes alternate coverage by a Member with similar Privileges at this Hospital that can care for the Member's patients when the Member is absent, and meeting proximity of practice requirements that may be established to allow prompt and responsive care for patients in the Hospital and in the community served by the Hospital, or obtaining an exemption to such proximity requirement in accordance with Hospital and Medical Staff policies and procedures.
  - 2.2.9 Be board eligible or board certified (and maintain such certification), in accordance with applicable policies and procedures.
  - 2.2.10 Demonstrate the background, experience, training, current competence, knowledge, judgment, and ability to perform all Privileges requested;

- 2.2.11 Possess a current and valid drug enforcement administration (DEA) number and Michigan Controlled Substance Registration, if applicable;
  - 2.2.12 Upon request, provide evidence of both physical and mental health that does not impair the fulfillment of their responsibilities of Medical Staff Membership and/or the specific Privileges requested by and granted to the applicant. This certification of physical and mental health must be from a clinician acceptable to the Credentials Committee;
  - 2.2.13 Provide evidence of professional liability insurance appropriate to all Privileges requested and of a type and in an amount established by the Board.
- 2.3 The Hospital will also consider the needs of the Hospital and the community it serves, any relevant Hospital contractual obligations, and the availability at the Hospital of adequate facilities and resources to support each Privilege requested, and will consult with the Credentials Committee (or other committee of the Medical Staff determined by the MEC) on such determinations.

## Section 3. Initial Appointment/Reappointment Procedure

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### 3.1 Initial Application

- 3.1.1 **Application Form:** Each application for appointment to the Medical Staff shall be submitted in the format approved by the MEC and Board, and signed by the applicant. The application will elicit information relevant to the qualifications and criteria described in Section 2 above and Part 1, Section 2, shall indicate the Clinical Privileges requested, and shall include the applicant's statement that no health problem exists that could affect the applicant's ability to safely perform the Clinical Privileges requested.
- 3.1.2 **Effect of an Application:** Submission of an application for Medical Staff Membership constitutes the applicant's agreement to be bound by the terms of these Bylaws if the applicant is granted Membership or Privileges, and by the terms of the Bylaws relating to consideration of the application (including Section 4.8) whether or not the applicant is granted Medical Staff Membership.
- 3.1.3 **Applicant's Responsibilities:** The applicant is responsible for producing adequate information for a proper evaluation of the applicant's qualifications and for resolution of any doubts about such qualifications. The applicant shall notify the Medical Staff Office immediately in writing of any change to information contained in his application that occurs while applicant's application is pending. The applicant may be required by the Credentials Committee, MEC or Board to appear for an interview regarding the application or related matters and/or to submit answers to written questions posed by those bodies.
- 3.1.4 **Credentials Verification:** An application is complete when the Hospital has received and verified all information specified in Medical Staff or Hospital policy. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Any time in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for Membership or Privileges, the credentialing process will be terminated and no further action taken, without right to a fair hearing. After the Hospital has verified the applicant's credentials and identity and obtained written peer recommendations and a National Practitioner Data Bank report, the complete application shall be referred to the Division Chair, as applicable, or the Department Chair in which the applicant seeks Medical Staff Membership and/or Clinical Privileges.
- 3.1.5 **Material Omission or Misrepresentation:** Any material omission or misrepresentation by an applicant in connection with their application shall be grounds for return of the application, which shall be deemed a voluntary withdrawal of the application, with no right to any hearing described in Part II.
- 3.1.6 **Department/Division Chair Action:** Where a Division has been established by the MEC, the chair of the Division shall review the applicant's qualifications and submit a written report and recommendation to the Department Chair. The chair of the applicable Department shall review the applicant's qualifications and, if applicable, the recommendation of the Division Chief. The Department Chair may interview the applicant. The Department Chair shall submit a written report and recommendation (as defined in Section 3.1.12) to the Credentials Committee.

- 3.1.7 **Credentials Committee Action:** The Credentials Committee shall review the applicant's qualifications. The Credentials Committee may also interview the applicant. The Credentials Committee shall submit its written report and recommendation, along with the Department Chair's report and recommendation, to the MEC.
- 3.1.8 **MEC Action:** Upon receipt of the report of the Credentials Committee, the MEC shall review the reports of the Credentials Committee and Department Chair and other relevant information. The MEC shall submit its written report and recommendation to the Board. If the MEC disagrees with the recommendation of the Credentials Committee, the MEC shall also deliver to the Board a copy of the reports and recommendations of the Credentials Committee and the Department Chair.
- 3.1.9 **Board Action:** The Board has final authority for all appointments to the Medical Staff and for granting Clinical Privileges. It is the Hospital's and Medical Staff's goal that applications typically be acted on by the Board within 60 days after the application is complete, recognizing however that a longer period may be needed in some cases, for example, to evaluate an applicant's credentials or to complete any applicable hearing process under Part II. Clinical Privileges are determined in accordance with Article IV. The Board shall either (1) adopt the recommendation of the MEC, or (2) refer it back to the MEC for further consideration with a statement of the reason(s) for such action. If an application is referred back, the MEC shall again make a written report and recommendation to the Board, which shall consider the recommendation before taking final action on the application.
- 3.1.10 **Adverse Recommendations:** If the MEC makes an Adverse Recommendation or the Board makes a preliminary Adverse Recommendation with respect to an application, a physician, dentist and podiatrist applicant may request a hearing to the extent available under Part II, Section 4. If an applicant who is the subject of a preliminary Adverse Recommendation does not make a timely request for a hearing or is not entitled to a hearing, the application is considered to have been withdrawn and shall not receive further consideration. If a decision is unfavorable with respect to scope of Clinical Privileges only, an applicant who either does not timely request a hearing or is not entitled to a hearing, will be deemed to have requested only those Clinical Privileges the Board is willing to grant.
- 3.1.11 **Reapplication:** An individual whose application for Medical Staff Membership is deemed withdrawn pursuant to Section 3.1.5 or 3.1.10 or whose application is denied shall not be eligible to reapply to the Medical Staff for a period of two (2) years from the date of withdrawal or denial, as applicable, unless the Board specifies otherwise.
- 3.1.12 **Reports and Recommendations:** As used in this Article, "written report and recommendation" means a written recommendation regarding Medical Staff appointment and, if appointment is recommended, Staff category, Clinical Privileges to be granted, and any special conditions to be attached to the appointment, with the reasons for any unfavorable recommendation stated in writing.
- 3.1.13 **Expedited Credentialing:** A completed Category 1 initial application, as defined in Medical Staff policy, may be processed in an expedited manner in accordance with Medical Staff policy, after review and action by the following: Department Chair, credentials chair acting on behalf of the Credentials Committee, two (2) members of the MEC, one of which

must be the COS or designee, acting on behalf of the MEC as provided in Part I, Section 7.4.2, and a Board committee consisting of at least two (2) individuals.

### **3.2 Procedure for Reappointment**

**3.2.1 Reappointment Application:** Each Member who desires reappointment to the Medical Staff shall submit a timely, signed and complete reappointment application to the Hospital in accordance with Medical Staff policy on a form approved by the MEC and Board. The application will indicate the Medical Staff category and Clinical Privileges requested. If a timely and complete reappointment application is not submitted, the Member's Medical Staff Membership and Clinical Privileges will expire at the end of the current term of appointment. The reappointment application will require submission of information that will allow a determination of whether the Member meets the ongoing qualifications for Medical Staff Membership and for requested Clinical Privileges, including providing reasonable evidence of current ability to perform capably the Clinical Privileges requested and information concerning any changes in the Member's qualifications since his last (re)appointment. A Member who does not comply with the Board Certification requirements stated in Section 2.2.9, if applicable, is not eligible for reappointment.

**3.2.2 Reappointment Criteria:** The reappointment process will include evaluation of:

- a. The Member's professional performance and judgment.
- b. The Member's current Clinical and technical skills and competence to perform the Clinical Privileges requested, as measured in part by the results of the Hospital's performance improvement activities and ongoing professional practice evaluation, and as assessed by the applicable Department Chair.
- c. Professional ethics and conduct, including compliance with the Bylaws and rules, and working relationships with others at the Hospital.
- d. Current appraisal of the Member's physical and mental ability to perform the Privileges and practice quality patient care.
- e. Participation in continuing education.
- f. Compliance with activity requirements applicable to the Medical Staff category requested by the Member.
- g. All information supplied in the Member's reappointment application.

**3.2.3 Processing Reappointment Applications:** Applications for reappointment shall be processed in the same manner as initial applications, using the procedures described in relevant portions of Part III, Section 3.1 of these Bylaws, except interviews of the applicant are not routinely required. The consequences of failure to complete or follow Bylaw requirements during the reapplication process shall be identical to the consequences of failure to complete or follow requirements during initial application for Membership and Clinical Privileges.

- 3.2.4 **MEC Input Required:** The Board will not take action on an application for reappointment without first seeking the recommendation of the MEC with respect to the application.
- 3.2.5 **Board Action:** The Board shall take final action on applications for reappointment and renewal of Clinical Privileges, except that no final action may be taken with respect to any Member as to whom an Adverse Recommendation or decision has been made who has not either waived or completed the fair hearing process provided for in Part II, if applicable.
- 3.2.6 **Expedited Credentialing:** A completed Category 1 reappointment application, as defined in Medical Staff policy, may be processed in an expedited manner in accordance with Medical Staff policy, after review and action by the following: Department Chair, credentials chair acting on behalf of the Credentials Committee, two (2) members of the MEC, one of which must be the COS or designee, acting on behalf of the MEC as provided in Part I, Section 7.4.2, and a Board committee consisting of at least two (2) individuals.

## Section 4. Clinical Privileges

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### 4.1 Delineation of Clinical Privileges

- 4.1.1 **Clinical Privileges Are Required:** Each Practitioner shall exercise only those Clinical Privileges granted to the Practitioner by the Board upon recommendation of the MEC, except as otherwise permitted by Sections 4.5 and 4.6.
- 4.1.2 **Criteria:** Requests for Clinical Privileges shall be evaluated on the basis of the factors and categories of information listed in Sections 2, 3.2.2 and Part I, Section 2. Privilege determinations shall take into account pertinent information concerning clinical performance obtained from other sources, especially from other institutions and health care settings where the Practitioner has exercised clinical privileges. The Practitioner has the burden of establishing his qualifications and competency in the Clinical Privileges the Practitioner requests. The Clinical Privileges available within a Department and the specific qualifications required for each Privilege shall be recommended by the Department Chair and approved by the MEC and Board.
- 4.1.3 **Dentists and Oral Surgeons:** An oral surgery patient may be admitted by an Oral Surgeon Member who has admitting Clinical Privileges. A Member who has history and physical Clinical Privileges shall perform the required history and physical exam of a dental or oral surgery patient. In all cases a Physician Member shall be responsible for the care of any medical problem that is present at the time of admission or that arises during hospitalization, and shall be identified in the medical record by the Oral Surgeon/Dentist at the time of admission.
- 4.1.4 **Podiatrists:** A Member who has history and physical Clinical Privileges shall perform the required history and physical exam of a podiatric patient. In all cases a Physician Member shall be responsible for the care of any medical problem that is present at the time of admission or that arises during hospitalization, and shall be identified in the medical record by the Podiatrist at the time of admission.
- 4.1.5 **Non-Members:** Clinical Privileges may be granted to Non-Members pursuant to Sections 4.4 and 4.6 and Article V. Non-Members may not be granted admitting Clinical Privileges, except as otherwise permitted by Sections 4.4 and 4.6. A non-Member may participate in the care of patients, including performance of histories and physicals, only in accordance with the scope of Clinical Privileges granted to the non-Member.

### 4.2 Privilege Modification

- 4.2.1 **Privilege Increase:** A Member may request an increase in Clinical Privileges during the term of his appointment by submitting a written request in accordance with Medical Staff Policy. Any such request will be processed using substantially the same procedures as for a request for reappointment.
- 4.2.2 **Privilege Decrease:** A Member may request a decrease in Clinical Privileges during the term of his appointment by written request to the Credentials Committee. The Credentials Committee shall promptly notify the MEC and the Board of any Privilege reduction request that it approves.



### 4.3 Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation

- 4.3.1 **Focused Professional Practice Evaluation:** Clinical Privileges granted to initial applicants and additional Clinical Privileges granted in connection with reappointment or a mid-appointment request for additional Clinical Privileges shall be subject to Focused Professional Practice Evaluation as provided in Medical Staff policy. In addition, each Practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through OPPE or other processes.
- 4.3.2 **Ongoing Professional Practice Evaluation:** The Medical Staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing Privileges, to revise existing Privileges, or to revoke an existing Privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of Practitioner's current clinical competency.

### 4.4 Temporary Clinical Privileges

- 4.4.1 **Types of Temporary Clinical Privileges:** Temporary Clinical Privileges may be granted in the following circumstances:
- a. **Pendency of Application:** An applicant with a complete application for Staff appointment (or, in the case of an applicant for APP, Clinical Assistant or House Physician status, a complete application for Clinical Privileges) may be granted temporary Clinical Privileges in accordance with Section 4.4.2 during the pendency of the application or for up to 120 calendar days, whichever is shorter. An applicant is eligible for temporary Clinical Privileges under this Section only if the applicant is not/has not been subject to licensure sanction, adverse action on medical staff membership or privileges at another facility, or any other disqualifying criteria specified in Medical Staff policy.
  - b. **Important Patient Care, Treatment, or Service Need:** Temporary Privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such Privileges, the organized Medical Staff verifies current licensure and current competence.
- 4.4.2 **Procedures:** A Practitioner may be granted temporary Clinical Privileges by the Hospital President or designee, upon the recommendation of the Chief of Staff or designee, and the Credentials Committee Chair or designee. Practitioners who hold temporary Clinical Privileges are not Members. Temporary Clinical Privileges shall be granted only (a) when the information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, competence and judgment to exercise the Clinical Privileges requested, (b) after the Practitioner has provided evidence of professional liability insurance as required by the Board, and (c) after the Practitioner's license has been verified. Temporary Clinical Privileges must be for a specified time period, consistent with the time limits stated in this Section.
- 4.4.3 **Supervision:** Practitioners granted temporary Clinical Privileges shall be subject to the supervision of the Chair of the Department to they are which assigned and, in the case of a

Practitioner who is not a Physician, Dentist, or Podiatrist, shall be under the supervision of an identified Member. Practitioners granted temporary Clinical Privileges shall comply with these Bylaws and other documents that apply to other Practitioners. A Practitioner is not entitled to the procedural rights afforded in Part II of these Bylaws because their request for temporary Privileges is refused or because all or any part of their temporary Privileges are terminated or suspended unless the decision constitutes an Adverse Recommendation and triggers the right to a hearing in accordance with Part II, Section 4.

#### **4.5 Emergency Clinical Privileges**

In case of emergency, any Practitioner who holds Clinical Privileges and any Member is permitted to do everything possible within the scope of his license to save the life of the patient or to save the patient from serious harm, regardless of Clinical Privileges or Staff category. For the purpose of this section, an “emergency” is defined as a condition in which serious, permanent harm may result to the patient or in which the life of the patient is in immediate danger, and any delay in administering treatment might add to that danger.

#### **4.6 Disaster Clinical Privileges**

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

#### **4.7 Effect of Contracts on Clinical Privileges**

It is recognized that certain clinical activities at the Hospital may be operated under exclusive contracts. The right to provide services within those clinical areas shall be controlled by the specific agreements to which the Hospital is a party. Individuals granted Clinical Privileges pursuant to these Bylaws shall not be deemed to have obtained the right to exercise those Clinical Privileges in a manner contrary to the Hospital’s contractual arrangements.

#### **4.8 Conditions to Clinical Privileges**

The provisions of this Section are express conditions to any Practitioner’s application for, and exercise of, Clinical Privileges at the Hospital. By applying for Clinical Privileges and/or Medical Staff Membership, the Practitioner accepts these conditions with respect to the processing and consideration of his application, whether or not Membership/Clinical Privileges are granted, and with respect to all activities relating to Membership/Clinical Privileges granted.

- 4.8.1 **Release of Liability:** The Practitioner absolutely releases the Hospital, the Medical Staff, and any of their representatives, from any liability relative to any communication, recommendation or action, concerning the Practitioner’s qualifications or conduct and evaluation thereof, whether in connection with the Practitioner’s initial application for Clinical Privileges/Medical Staff Membership or any subsequent activities relating to the Practitioner’s Clinical Privileges/Medical Staff Membership. This release also extends to third parties that furnish information described in this Section, including otherwise privileged or confidential information, to the Medical Staff, the Hospital, or their representatives.

- 4.8.2 **Authorize Communication:** The Practitioner authorizes the representatives of the Medical Staff and Hospital to consult with other hospitals, medical associations, licensing boards and other organizations and individuals who may have information bearing on the Practitioner's character, conduct, ethics, physical and mental health, competence and other qualifications (collectively, "Qualifications"), and authorizes said individuals and organizations to provide information to representatives of the Medical Staff and Hospital.
- 4.8.3 **Authorize Document Inspection:** The Practitioner consents to representatives of the Medical Staff and Hospital inspecting all records and documents relevant to an evaluation of the Practitioner's qualifications.
- 4.8.4 **Authorize Release of Information:** The Practitioner authorizes representatives of the Hospital and the Medical Staff to consult with and provide other hospitals, medical associations, licensing boards, and other organizations and individuals concerned with provider performance and the quality of patient care with any relevant information regarding the Practitioner.
- 4.8.5 **Confidentiality of Professional Practice Review Material:** The Practitioner agrees to maintain the confidentiality of all Hospital professional practice review materials.
- 4.8.6 **Health Status:** The Practitioner agrees to submit to mental and physical examination and testing (including drug, alcohol and infection screens) by a health professional or at a facility satisfactory to the MEC, Credentials Committee, or Board, if requested in order to determine that the Practitioner's current physical or mental health does not threaten or interfere with his ability to practice safely. The results of such examination and testing shall be submitted directly to the body that requested them or the body's designee.

#### 4.9 Telemedicine Privileges

Telemedicine Privileges are limited to those services the MEC, acting for the Medical Staff, has approved for telemedicine delivery. Requests for telemedicine Privileges at the Hospital that includes patient care, treatment, and services will be reviewed by the MEC and will be processed through one of the following mechanisms:

- 4.9.1 The Hospital fully privileges and credentials the Practitioner; OR
- 4.9.2 The Hospital privileges Practitioners using credentialing information from the distant site if the distant site is a Medicare participating hospital or telemedicine entity and the information is then processed through the routine Medical Staff credentialing and privileging process. The distant-site Practitioner must have a license that is issued or recognized by the State of Michigan; OR
- 4.9.3 The Hospital accepts the credentialing and privileging decision from the distant site if all of the following requirements are met:
  - a. The distant site is a TJC accredited hospital or ambulatory care organization or is a Medicare participating hospital or telemedicine entity;
  - b. The Hospital has a written agreement with the distant site which satisfies the requirements of the Medicare Hospital Conditions of Participation;

- c. The Practitioner is privileged at the distant site for those services to be provided at this Hospital and the Practitioner has a license that is issued or recognized by the State of Michigan; and
- d. The Hospital has evidence of the distant site's internal review of the Practitioner's performance of these privileges and the Hospital sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by the The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent Practitioner from patients, licensed independent practitioners, or staff at the Hospital.

## Section 5. Provision of Care by Non-Members

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### 5.1 Advanced Practice Professionals and Clinical Assistants

- 5.1.1 **Assignment, Supervision and Compliance:** Although responsible to the Medical Staff and the Board, Advanced Practice Professionals and Clinical Assistants are not Members of the Medical Staff. Each APP and Clinical Assistant may furnish patient care at the Hospital only within the limits of the Clinical Privileges granted to them in accordance with these Bylaws, except as otherwise permitted by Sections 4.4 and 4.6. Each APP and Clinical Assistant acts under the overall supervision of an identified Supervising Member approved by the Board, acting on the recommendation of the Medical Executive Committee. The APP or Clinical Assistant shall immediately notify the Chief of Staff in writing if the APP's supervisory arrangement with the Supervising Member ends. An APP or Clinical Assistant may not be granted Clinical Privileges that exceed those of the APP's or Clinical Assistant's Supervising Member. The Hospital may grant Clinical Privileges that are less extensive than the scope of activities an APP or Clinical Assistant is licensed to perform. APPs and Clinical Assistants shall comply with these Bylaws, the rules and regulations, and any Medical Staff or Hospital policy intended to govern their activities.
- 5.1.2 **Qualifications:** APPs and Clinical Assistants must possess a license or registration to practice their profession in the state of Michigan, if applicable. Applications for initial, renewed, increased and decreased Clinical Privileges will be processed using the procedures and criteria set forth in Articles III and IV (subject, however, to procedures in accordance with Part II, Section 7.7) to the extent applicable to the APP's/Clinical Assistant's profession. Requests for Privileges by APPs and Clinical Assistants may be reviewed by a separate APP and Clinical Assistant credentialing committee established by the MEC and in accordance with Hospital and Medical Staff policies and procedures.
- 5.1.3 **Meeting Attendance:** APPs/Clinical Assistants may attend meetings of the Medical Staff and/or their Department at the request of their Supervising Member and subject to the approval of the individual presiding at the meeting. If so permitted to attend a meeting, APPs/Clinical Assistants may not vote, nor may they otherwise participate unless requested by the committee chair or other individual presiding over the meeting.
- 5.1.4 **Suspension and Termination:** An APP's/Clinical Assistant's Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Part II) in the same manner as a Member of the Medical Staff (subject, however, to the procedures in accordance with Part II, Section 7.7), as well as in accordance with the terms of any written contract the APP/Clinical Assistant may have with the Hospital and, in the case of a Hospital-employed APP/Clinical Assistant, in accordance with any applicable Hospital policy.

### 5.2 House Physicians

- 5.2.1 **Assignment, Supervision and Compliance:** Although responsible to the Medical Staff and the Board, House Physicians are not Members of the Medical Staff. Each House Physician may furnish patient care at the Hospital only within the limits of the Clinical Privileges granted to him in accordance with these Bylaws, except as otherwise permitted by Sections 4.4 and 4.6. Each House Physician acts under the overall supervision of the

Chair of the Department to which assigned. When participating in the care of a patient admitted to the Hospital, the House Physician shall work under the supervision of the attending Member. House Physicians shall comply with these Bylaws, the rules and regulations, and any Medical Staff or Hospital policy intended to govern their activities.

- 5.2.2 **Qualifications:** House Physicians must possess a full license to practice allopathic or osteopathic medicine in the state of Michigan (e.g. not a limited license that restricts practice to activities within the scope of graduate medical education program). Applications for initial and renewed Clinical Privileges will be processed using the procedures and criteria set forth in Articles III and IV excluding those relating to Board Certification and Eligibility. The Board grants or denies Clinical Privileges to prospective House Physicians, upon recommendation of the MEC.
- 5.2.3 **Meeting Attendance:** House Physicians may attend meetings of the Medical Staff and/or their Department at the request of their Department Chair and subject to the approval of the individual presiding at the meeting. If so permitted to attend a meeting, House Physicians may not vote, nor may they otherwise participate unless requested by the committee chair or other individual presiding over the meeting.
- 5.2.4 **Suspension and Termination:** A House Physician's Clinical Privileges may be suspended, revoked, or not renewed (including action pursuant to Part II) in the same manner as a Member of the Medical Staff, as well as in accordance with the terms of any written contract governing the House Physician's services to the Hospital and, in the case of a Hospital-employed House Physician, in accordance with any applicable Hospital policy.

### 5.3 Physician Re-Entry

A Practitioner who has not provided patient care within the past two (2) years who requests Clinical Privileges at the Hospital must comply with the Practitioner re-entry requirements defined in Hospital or Medical Staff policies and procedures.