BEACON HEALTH SYSTEM

BEACON ALLEGAN HOSPITAL

(formerly known as Ascension Borgess-Allegan Hospital)

MEDICAL STAFF
RULES AND REGULATIONS
BYLAWS

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MEDICAL STAFF RULES & REGULATIONS

Contents List

SECTION 1: ADMISSIONS

Only a member of the Medical Staff who has appropriate privileges may admit a patient to the Hospital. All Practitioners shall be governed by the official admission policies of the Hospital, which shall be formulated jointly by the Medical Executive Committee and the Hospital Board of Trustees.

There is communication among all practitioners involved in a patient’s care, treatment, and services. Under no circumstances will a patient be admitted by a Practitioner in the name of and to the care of another physician without the knowledge and consent of that physician or designee. Authorization may be obtained by telephone.

Practitioners requesting admission for patients shall provide the Hospital with a provisional diagnosis and will give such information as may be required to enable the Hospital to take any necessary action to protect patients already in the Hospital from patients who are, or may become, a source of infection.

A member of the Medical Staff shall be responsible for the medical care and treatment, and services of each patient in the Hospital, for the prompt and accurate completion of the Medical Record, for necessary special instructions, and for transmission of reports regarding the conditions of patients to the referring Practitioner(s) and to the patient’s significant others. Whenever these responsibilities are transferred to another Medical Staff member, a note delineating the transfer of responsibility shall be entered on the Physician’s Order Sheet of the Medical Record.

Admission Priority.
In situations when Hospital beds are limited, patients will be admitted on the basis of the priorities outlined in the “Diversion of Ambulance to Emergency Services and Closed to Inpatient Admissions” policy.

SECTION 2: DISCHARGES

Patients shall be discharged from the Hospital on order of the attending practitioner or designee.

Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient’s Medical Record.

Adequate notice shall be given to Case Management, Food & Nutrition, Patient Education Departments, etc., for patients requiring these services.

SECTION 3: MEDICAL RECORDS

Medical Records are legal documents and are the property of the Hospital.

Medical Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with court order, subpoena, or statue. Records shall not otherwise be removed without the permission of the Hospital President or designee. Unauthorized removal of Medical Records may be grounds for suspension of Medical Staff privileges.

Written consent of the patient/legal representative is required for the release of medical information to persons not otherwise authorized to receive this information by law. Information may not be released from the Medical Record nor copies made thereof except by designated individuals following written guidelines.

READMISSIONS:
When a patient is readmitted or presents for a pre-scheduled appointment or emergency care, all records will be made available for the use of the current attending physician. Upon discharge of the patient, the records shall be returned to the Health Information Management Department.

Exceptions: A previous psychiatric patient admitted to a non-psychiatric unit will have the psychiatric history removed from the record before the charts are sent to the nursing unit. The psychiatric history will be retained in the Department and available to the physician there.

ABBREVIATIONS:
Only those abbreviations approved by the medical staff will be used. ***Those abbreviations on the "Dangerous Abbreviations List" will be avoided.***

AUTHORIZED ENTRIES:
All medical record entries must be legible, complete, dated, timed and authenticated. The author of each entry must be identified and the entry authenticated within 48 hours by the ordering practitioner or another practitioner who is responsible for the care of the patient.

The following personnel are authorized to make entries in the medical record:

- Physicians, Psychiatrists with appropriate medical staff privileges
- Mid-Level Practitioners (CRNA's, Psychologists, NP's, PA's, Nurse Midwives, etc.)
- Registered Nurses, Licensed Practical Nurses, and Unit Technicians
- Case Management Personnel (RN, Social Worker, LPN, etc.)
- Registered Pharmacists
- Registered Respiratory Therapists
- Registered Physical, Occupational and Speech Therapists

- Registered Laboratory and Radiology Technicians
- Registered Dietitians
- Students (of all the above disciplines)

Authorized signature listings will be maintained in the Medical Records Department. (See "Medical Records Policy" – MR101)

CONTENT:

The attending practitioner will be responsible for the preparation of a complete medical record on each inpatient. This record shall include:

. Identification data;

. Medical history, including the chief complaint, details of present illness, relevant past, social, and family histories (appropriate to the age of the patient) and an inventory by body systems;

. A summary of the patient's psychosocial needs, as appropriate to the age of the patient;

. Report of relevant physical examinations;

. Statement of the conclusions or impressions drawn from the admission history and physical examination, including the determination of need for further assessment of nutritional and/or function status, which would result in referrals to a dietician or physical rehabilitation, as appropriate;

. Statement of the course of action planned for the patient while in the hospital and of its periodic review, as appropriate;

Reassessment and revisions to treatment plan;

. Diagnostic and therapeutic orders, including medications ordered and given and any adverse reactions to those medications;

. Evidence of appropriate informed consent;

. Clinical observations, including the results of therapy;

. Daily progress notes;

. Consultation reports;

. Relevant diagnoses during care;

Reports of procedures, tests, and their results;

. Reports of any diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatments, and so forth;

. Records of organ donations and receiving of transplants;

. Referrals to external and/or internal providers or agencies;

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DISCHARGE SUMMARY:

The discharge summary will include the following:

*Reason for hospitalization

*A summary of clinical findings, procedures and treatments

*Condition at discharge

*Instructions to patient/family, including medications prescribed and/or dispensed

*Autopsy results, when performed

A final progress note may be substituted if the patient's LOS is less than 48 hours and minor in nature and/or for normal deliveries and well newborns.

HISTORY AND PHYSICALS:

General Documentation Requirements

(a) A complete medical history and physical (H&P) examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform H&Ps.

(b) The scope of the medical H&P examination will include, as pertinent:
   - i. patient identification;
   - ii. chief complaint;
   - iii. history of present illness;
   - iv. review of systems;
   - v. personal medical history, including medications and allergies; family medical history;
   - vi. social history, including any abuse or neglect;
   - vii. physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses and their likely treatments;
   - viii. data reviewed;
   - ix. assessments, including problem list;
   - x. plan of treatment; and
   - xi. If applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.
   - xii. In the case of a pediatric patient, the history and physical examination report must also include: ;
      - i. length or height; and
      - ii. weight;

H&Ps Performed Prior to Admission

(a) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(b) If a medical H&P examination has been completed within the 30 day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record; however, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

(c) The update of the history and physical examination shall be based upon an examination of the patient and must reflect:
   - i. any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or
   - ii. state that there have been no changes in the patient's condition.

Cancellations, Delays, and Emergency Situations

(a) When the H&P examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operative suites, endoscopy, colonoscopy, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate H&P examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(b) In an emergency situation, when there is no time to record either a complete or an observation H&P, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete H&P examination.

OPERATIVE REPORT:

All surgical procedures performed shall be fully described in writing by the operating surgeon dictated immediately following the procedure. The operative report will include: findings, techniques utilized, specimens removed, postoperative diagnosis and the names of the primary surgeon and assistants. A postoperative progress note may also be completed immediately following the procedure. The operative report is to be authenticated and filed in the record before the patient leaves the OR.

All tissues removed at surgery shall be sent to the hospital pathologist, according to existing hospital policy for such examination as deemed necessary to arrive at a pathology diagnosis. It is the duty of the attending surgeon to make certain that the pathology diagnosis is incorporated into the medical record.

POSTOPERATIVE DOCUMENTATION:

Postoperative documentation will include the following information at a minimum:

*Vital signs and level of consciousness

*Medications and IV fluids prescribed

*Use of blood and blood components if appropriate

*Unusual events or complications

COMPLETED MEDICAL RECORDS:

1. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Chief Executive Officer.
2. The patient's medical record shall be complete within 30 days of discharge including the summary and final diagnosis. Where this is not possible, because of final laboratory or other essential reports that have not yet been received at the time of discharge, the patient's chart will be available in a designated place in the Health Information Management Department until its completion.

INCOMPLETE RECORDS:

Definitions

Incomplete record – record not yet complete, no more than 0 - 30 days post-discharge.

Delinquent record – record not yet complete, 31 days post-discharge.

Procedure

The Health Information Management Department will review incomplete records on a regular basis, preferred weekly.

When a practitioner has a chart that reaches the incomplete stages, verbal and written notification will be given to the practitioner. A copy of the chart deficiency report will be attached to the written notice. This notice will be faxed or hand delivered to the physician's office. Health Information Management staff will also proceed with a follow-up phone call or email to notify the practitioner that he/she is receiving a suspension notice.

As the incomplete chart ages, 4 days prior to the 31st day, a notice will be sent to the practitioner, with a warning that a suspension will occur on the 31st day if the record remains incomplete.
Once a record moves into the delinquent record stage on the 31st day, a suspension notice will be issued signed by the CEO and/or Chief of Staff.

The suspension notice will state that the physician admission privileges will be suspended at 8:00 a.m. the day following issuance of the notice. This notice will too, be faxed or hand delivered to the physician's office with a follow up phone call to the office. Health Information Management staff will also notify the Director of Outpatient Services when a surgeon is involved.

The suspension will take effect at 8:00 a.m. the following morning. All admission privileges will be suspended, including those for elective patients. All elective surgeries will be canceled. The Chief of Service will be responsible for locating a replacement for any call schedule and for notifying the appropriate hospital departments of that change. The suspended practitioner may not admit patients to another practitioner's service without that individual's prior approval. No practitioner will transfer the management of a patient to the service of a suspended practitioner. The suspended practitioner will be expected to care for patients already in the hospital on his/her service.

A notice of the suspension will be sent to Chief of Staff, House Supervisor, Patient Registration, Emergency Department, Director of Outpatient Services, and Case Management.

If a practitioner leaves for vacation during the incomplete record stage without having completed his/her records, Health Information Management staff will issue a suspension letter allowing 72 hours to complete the suspended record(s) upon his/her return. The notice will be faxed or hand delivered to the physician's office. Health Information Management staff will also notify the practitioner by telephone of the impending suspension.

REINSTATEMENT OF PRIVILEGES:
All privileges will be restored as soon as Health Information Management staff have verified completion of the necessary records. Notification of such action will be sent to the appropriate departments.

EMERGENCY PRIVILEGES:
A practitioner may admit and treat patients in situations where his/her specialty is needed in an emergency and his/her privileges have been suspended because of failure to complete medical records. This applies only when another specialist of the type needed is not immediately available.

FILING INCOMPLETE CHARTS:
When a physician leaves incomplete charts due to moving away, death or if a chart has been "lost" and then discovered much later the following are steps to be done prior to filing the chart in the permanent file.

1. If a physician moves, attempts will be made to contact them by phone and then mail to them copies of the records that require signature. The originals will be kept in the record and when the signed copies are received they will be attached to the originals. All copies should be sent by certified mail so that a paper trail can be established.

2. If a physician expires and has incomplete charts, if any other physician on staff participated in the care of the patient and feels comfortable in completing the chart that physician can sign off by stating that they are signing for Dr. ---- who is deceased.

3. When a "lost" record is discovered incomplete if the physician is unable to recall admission they would be asked to dictate something with appropriate caveats, for example, "due to length of time that has passed where record was missing, I cannot recall the details of this visit". This would usually be in the case of ED patients and short stay/observation patients where physician treated them for a short period of time.

If all attempts at contacting the physician to complete the record fail or the physician has expired the record will then be presented to the Medical Executive Committee with an appropriate form (attached) completed. The minutes from the meeting need to reflect the medical record number and date of all charts approved for incomplete filing. This form is then signed by the Service Chief.

In cases where the final diagnosis is missing from an incomplete chart, partners of the physician and Chief of Staff should review record and determine if a final diagnosis can be established using documentation that the chart provides. If so, this should be documented in the record by the Chief of Staff.

When approved by the committee and the appropriate form signed, the incomplete chart can be filed in the permanent file.

(to be put on letterhead)

Record Filed Incomplete

Patient Name: ____

Medical Record # ______________________

Date of Admission/Discharge: _________________________________

Attending Physician: ____

Reasons for filing record incomplete: ____________________________

Listed below are the documents in the record that are incomplete:

It has been approved by (name committee) Committee to file record incomplete. See minutes of __________________.

___________________ ______________________________

Date (who is designated to sign)

SECTION 4: ORDERS

All orders for treatment shall be written clearly, legibly and completely and signed by the ordering practitioner. Only a physician may give verbal/telephone orders. When telephone or verbal orders must be used, they may be accepted by:

*Registered nurses

*Registered pharmacists, for pharmaceuticals only and lab work pertinent to pharmacokinetic dosing service.

*Registered or registry-eligible respiratory therapists only on orders relating to respiratory therapy

*Licensed laboratory technologists, for pertinent tests and/or medications

*Licensed radiology technologists, for radiographic testing

*Physician assistants

*CRNA's, nurse practitioners and nurse midwives

*Physical and occupational therapists only when dealing with those therapies

*Social Worker to assist with discharge planning.

The person will sign his/her name and title, with the name of the practitioner who gave the order.

The ordering practitioner shall authenticate (sign, date and time) all orders within 48 hours. The ordering practitioner shall authenticate verbal and telephone orders for restraint and/or seclusion within 24 hours.

Telephone and verbal orders, when used, will be used infrequently. Telephone and verbal orders must be documented in the patient's medical record, and be reviewed and countersigned by the prescriber as soon as possible. It is acceptable for a covering physician to co-sign the verbal order of the ordering physicians. The signature indicates that the covering physician assumes the responsibility for his/her colleague's order as being complete, accurate and final. It is not acceptable to allow a covering physician to authenticate verbal order for convenience or to make this a common practice.

Standing orders may be approved from time to time by the Medical Staff.

Unless a specific period of treatment is prescribed on the practitioner's orders, there will be an automatic stop order on all orders for antibiotics after 14 days and for all controlled substances after seven (7) days.

ADMINISTRATION OF DRUGS AND BLOOD PRODUCTS

Drugs shall be prepared and blood products and administered according to established policies and procedures and only on orders of those practitioners with privileges to order medications. Drugs and blood products will be administered in accordance with applicable state laws by registered nurses, specially trained LPNs, PA's or NP's, registered laboratory technicians, registered cardiopulmonary technicians, registered radiological technologists and nurse anesthetists.

A formulary system is established by the medical staff.

ADMINISTRATION OF CHEMOTHERAPY OR OTHER HIGH RISK MEDICATIONS

Chemotherapy and other high risk cancer treatment medications may be ordered by a licensed practitioner who is board certified in hematology and/or medical oncology, and with written oversight by the staff hematologist and/or oncologist. Specialty physician certification or oversight is not required when Methotrexate is prescribed for non-oncologic diagnoses.

ADMINISTRATION OF OTHER OUTPATIENT MEDICATIONS

Other outpatient medications, which may be high risk for a patient, can be ordered by a licensed practitioner who is allowed to do this within the scope of his/her license. Examples of these medications include: iron, antibiotics, and biological response modifiers. To enhance patient safety, if the ordering practitioner does not hold admitting privileges, he/she has the option to make arrangements with a physician who holds admitting privileges to admit the patient for treatment and/or supportive care. If these arrangements are not made, the Hospitalist would automatically assume the care of this patient.

ORDERS FROM LICENSED NON-PHYSICIAN PRACTITIONERS

The hospital may provide non-invasive diagnostic services by order of appropriate licensed non-physician practitioners who may or may not have privileges at Allegan General Hospital. This would include such things as midwife orders for laboratory work on OB patients, or chiropractic orders for non-invasive radiology procedures, etc.

ORDERS FROM NON-STAFF PRACTITIONERS

Therapeutic services may be provided by order of appropriate practitioners who may not necessarily have medical staff membership or privileges at Allegan General Hospital. This would include such things as practitioners outside of the AGH geographic area ordering physical therapy for patients in the Allegan area.

SECTION 5. BIRTH AND DEATH CERTIFICATES

It is the responsibility of the attending practitioner to sign birth certificates on newborns and death certificates on patients that have expired. The hospital Health Information Management Department and the funeral home will assist in completion of death certificates.

SECTION 6: AUTOPSIES

Members of the medical staff are expected to be actively interested in securing autopsies, and will secure autopsies in all cases of unusual death. The hospital pathologist or a Medical Examiner will perform all autopsies. Results of autopsy findings will be utilized in the assessment and improvement of patient care, where applicable. When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within three days. The complete protocol is made part of the record within 60 days, unless the Medical Staff establishes exceptions for special studies.

A. The **Medical Examiner (ME)** should be contacted in all investigations to determine the cause and manner of death in persons who die under the following circumstances:

- sudden or unexpected death;
- accidental or violent death;
- all suicides;
- suspicious circumstances surrounding death;
- deaths resulting in high risk, infectious and contagious diseases;
- deaths as a result of abortion;
- deaths in children that are sudden or unexpected;
- by written order of the prosecuting attorney or the Attorney General;
- are imprisoned or in police custody at time of death;
- fetal death without medical attendance at the delivery;
- when the deceased was last seen by a physician more than 10 days before death and the attending physician can't accurately determine the cause of death;
- when the deceased has not received any medical care during the 48 hours prior to death.
- Known or suspected deaths arising from environmental or occupational hazards.

An autopsy is generally performed/ordered in all of Medical Examiner cases and may be performed with or without the consent of next of kin. (See AGH policy #P-67 for more information.)

B. Non-Medical Examiner Cases - Consent from next of kin is required if a non-medical examiner autopsy is desired. The situation in which an autopsy should be sought include, but are not limited to:

- deaths in which an autopsy would explain unknown or unanticipated medical complications.
- all deaths in which the cause is not known with certainty of clinical grounds.
- Deaths in which the family was concerned regarding the death, where an autopsy would result in reassurance to them.
- death of a patient who participated in clinical protocol trials approved by institutional review boards;
- unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
- unexpected or unexplained deaths that are apparently natural and not subject for forensic medical jurisdiction;
- all obstetric deaths; and, all neonatal and pediatric deaths.

(See AGH Autopsy policies for more information.)

It is not expected that autopsies would results in all indications above. However, it is expected that the medical staff members will consider these indications in the decision process for autopsy.

SECTION 7: CONSULTATIONS

Good medical practice includes the proper and timely use of consultations. Judgment as to the severity of illness involved and the proper diagnosis and treatment rests with the physician responsible for the overall medical care of the patient, subject to the duty of the Medical Staff, the Medical Executive Committee, the Chief of Staff and the Chief of Service to ensure that consultations are requested when needed. The attending Practitioner is responsible for requesting a consultation when indicated.

Except in an emergency, consultation with another qualified physician is required in all cases in which, according to the judgment of the attending practitioner, additional skills and clinical advice or review might be beneficial to the treatment of the patient, including cases in which:

1. Medical stability for surgery is in question.
2. The diagnosis remains obscure after 48 hours, unless otherwise indicated.
3. There is doubt as to the best therapeutic measures to be utilized.
4. The specific skills of other Practitioners are needed because of the unusual complexity of the patient's problem
5. The patient exhibits severe psychiatric symptoms, beyond the scope of the skills and/or privileges of the attending practitioner.
6. Such consultation is requested by the patient/family.
7. The patient has a problem beyond the scope of privileges granted to the Practitioner.

Any qualified Practitioner with clinical privileges in this Hospital may be called for consultation within his/her area of expertise. A consultation with a non-staff Practitioner may be obtained as delineated in these Rules and Regulations.

When consultation is obtained, the responsibility of overall patient care remains with the attending practitioner.

Whenever a suicidal or potentially suicidal patient is seen in the Emergency Department or in the inpatient population, it is recommended that the attending practitioner seek psychiatric consultation for the patient as soon as possible and appropriate.

SECTION 8: OUTPATIENT SERVICES

LABORATORY

Allegan General Hospital laboratory provides defined laboratory hours, staffing, and scope of care information that is necessary for quality patient care. (see Scope of Services Policy). Allegan General Hospital laboratory is staffed and functional 24 hours a day 7 days a week.

Allegan General Hospital laboratory provides:

- All testing must be ordered by a physician. Tests will be preformed at AGH. Tests not available at AGH will be sent to an approved (by Medical Staff) reference lab. All tests will be completed in a timely fashion. It should be noted by a physician if this is a "STAT" test.
- A quality improvement program is established to assess and meet patient's needs.
- Preparing blood and blood products for transfusions.
- All testing at AGH is done by established procedures and in compliance with quality control.

The Laboratory is accredited by a regulatory agency. Procedures preformed include:

1. Obtaining blood specimens.
2. Analyzing blood and body fluids to measure and/or detect physiological or pathological compounds.
3. Culturing body substances to isolate and identify pathogens.

An overseeing pathologist will be the medical director of the Laboratory. The pathologist will determine which tissue specimens require examination (macroscopic and microscopic). These services may be provided via contractual arrangement.

Admission laboratory orders will be at the discretion of the practitioner. Each practitioner who admits patients may request preprinting of standing orders; i.e., pre- and post-partum, newborn care, pre-surgical, ICU, etc. The appropriate Hospital and Medical Staff Committees must approve these.

Outpatient and transfusions need to be ordered by a licensed practitioner who is able to do this within the scope of his/her license. To enhance patient safety, if the ordering practitioner does not hold admitting privileges, he/she has the option to make arrangements with a physician who holds admitting privileges to admit the patient if the patient has an adverse reaction to the transfusion. If these arrangements are not made, the Hospitalist would automatically assume the care of this patient.

RADIOLOGY

Radiological services provided include Diagnostic X-Ray, Ultrasound, Echocardiography, CT, MRI, Nuclear Medicine, Mammography and Bone Density Scanning. (See Scope of Services for Radiology)

The technologists must be proficient in the modality they are utilizing. Ultrasound requires certification in physics, OB and general abdominal work. CT requires hands on experience to master the protocols of the modality. Technologists are encouraged to obtain their certification in CT. Mammography requires certification in mammography and is a state requirement. X-ray requires certification by the ARRT and registry eligible technologists are required to receive their registration within one year of employment. Nuclear Medicine technologists are required to be certified through the ARRT(N) or CNMT.

The Chief of Radiology Service (MD/DO) is appointed by the Medical Staff and serves the Director of Nuclear Medicine and Radiology Services.

During hours when the radiologist is not present, the radiologist on call may be contacted by the attending practitioner for consultation on interpretation of difficult x-rays.

Patients to be admitted for elective surgery are to be given an appointment for their pre-operative work, including laboratory and radiology work, by the physician's office. Outpatients for x-ray, ultrasound, CT and nuclear medicine procedures must have an appointment with the Radiology Department. They should be given a Radiology request form, with the patient's diagnosis and clinical history filled in by the attending physician at the time the appointment is made. The orders for preparation of patient for radiology procedures should be given to them and explained. There should be no modification of prep without notifying the radiologist.

SECTION 9: EMERGENCY DEPARTMENT

The Allegan General Hospital Emergency Department Staff shall undertake the assessment and treatment or referral of all ill or injured persons presenting for care and treatment. In the event of injuries or diseases requiring further care, the patient will be transferred to the appropriate nursing unit in the hospital or another facility following stabilization of his/her condition. The Emergency Department staff does not undertake the routine use of general anesthetics, repair of deep lacerations involving intricate tendon or vascular repair, or the treatment of complicated fractures.

Only licensed independent practitioners with appropriate clinical privileges will perform the medical screening examination and determine care for patients in the Emergency Department. Coverage is provided 24 hours a day. Staffing is by contractual agreement and is at the discretion of Hospital Administration and Board of Trustees with appropriate input from the Medical Staff. Scheduled duty shifts will not exceed 12 hours.

The hospital may, at its discretion, hire full time Emergency Department physicians to work in the Emergency Department; however, the physician on the regular 24 hours rotation will be available for back-up coverage and for admission of any patients requiring same during the 24-hour period for which he/she is assigned. He/she will also cover personally those hours when a full-time Emergency Department staff member is not present.

If a patient is seen by the Emergency Department physician and requires admission to this or another hospital, the physician on back-up call will be contacted for permission to admit the patient or to obtain another physician to take care of the patient. (See “On-Call Physician Support to ED” policy)

Specialty consultation is available at the request of the Emergency Department physician, the attending physician, or by transfer to a designated hospital where more definitive care can be provided.

Blood specimens for alcohol determination may be obtained by the attending physician or designee. No alcohol should be used to prep the skin and the container containing the specimen should be given directly to the law enforcement officer in situations where legal action may be pending.

When a suspected rape case is seen in the Emergency Department by the ED physician or by the physician on 24-hour call, the police should be notified. The physician should collect specimens and follow the rape protocol defined by the Michigan State Police.

THE MEDICAL RECORD:

A medical record is maintained on every patient seeking emergency care. Each time a patient visits the Emergency Department, the following information is entered in the patient's medical record:

1. Time and means of arrival;
2. Pertinent history of the illness or injury and physical finding, including the patient's vital signs;
3. Emergency care provided to the patient prior to arrival;
4. Diagnostic and therapeutic orders;
5. Clinical observations, including the results of treatment;
6. Reports of procedures, tests, and results;
7. Diagnostic impression;
8. Conclusion at the termination of evaluation/treatment, including final disposition, the patient's condition on discharge or transfer and any instructions given to the patient and/or family for follow-up care; and
9. A patient leaving against medical advice.

SECTION 10: SURGICAL AND ANESTHESIA/SEDATION SERVICES

ORGANIZATION

Surgical and Anesthesia/Sedation Services includes the surgical suites, the endoscopy suite, post-anesthesia care unit, preadmission testing, short stay, sterile processing and the anesthesia department.

The Chief of Surgery and Anesthesia/Sedation Services is appointed by the Chief of Staff and Medical Executive Committee bi-annually. The Chief of Surgery and Anesthesia/Sedation Services reports to the Chief of Staff. This role is responsible for the supervision of professional and ethical conduct of the members of the medical staff with privileges in surgical and anesthesia/sedation services as well as the oversight of the anesthesia administration program within Allegan General Hospital. (See AGH Medical Staff Bylaws for a full accounting of all service chief responsibilities.)

PATIENT RESPONSIBILITY

In general, a patient is the responsibility of the operating licensed independent practitioner while in the surgery, endoscopy suite, or other approved locations where anesthesia/sedation is administered. This responsibility includes the supervision of moderate, deep, general or regional anesthesia when administered by an appropriately credentialed individual other than a physician with privileges in anesthesia. This supervision of the certified registered nurse anesthetist (CRNA) shall be considered appropriate as related only to the type and complexity of those surgical privileges the operating licensed independent practitioner has been granted to perform. In the case of a podiatrist, he or she will have independent responsibility for a patient under local anesthetic, but will obtain active medical staff supervision for procedures performed under all other types of anesthesia. In the case of a dentist or oral surgeon, he or she will have independent responsibility for all procedures using local, conscious or moderate sedation, but will obtain active medical staff supervision for procedures under general anesthetic.

A qualified registered nurse may perform circulating duties in the operating room in accordance with applicable policies and procedures.

The operating surgeon is responsible for the patient's immediate postoperative care in the post-anesthesia care unit (PACU). The CRNA may also function as a resource to the PACU staff for anesthesia related concerns. The patient's postoperative status is to be assessed on admission to and discharge from the PACU by the physician or hospital staff.

The operating surgeon is responsible for the postoperative care of the patient, after transfer from the post-anesthesia recovery room to the nursing unit. This responsibility may be transferred to another member of the active staff if approved by the designee physician and properly documented in the form of a specific order on the patient's chart.

SCHEDULING OF PROCEDURES:

Elective procedures will be scheduled through the surgical services scheduling coordinator. The following information must be provided: the patient's name; pre-procedure diagnosis; procedure contemplated; name of physician performing the procedure; the name of any assistant; the type of anesthesia; the approximate length of the procedure; and, whether blood transfusions or x-rays will be required during the procedure.

Ordinarily, elective surgery is not to be scheduled on weekends or official hospital holidays. The usual hours of service will be spelled out more specifically in the hospital Scope of Services. These hours are arbitrary and may be changed at the discretion of the Chief of Surgery and Anesthesia/Sedation Services and/or the Director of Outpatient Services.

Surgeons must be in the suite and ready to commence the procedure at the scheduled time. If a surgeon is repeatedly or flagrantly late, he or she may be referred to the Chief of Surgery and Anesthesia Services and then to Medical Executive Committee or Chief of Staff for corrective action per the medical staff Bylaws

A surgery schedule will be prepared by the scheduling coordinator for the following day and distributed to the following areas: nursing administration; continuing care; appropriate nursing units; radiology; medical records, pharmacy, and registration. This patient information is considered confidential in nature and will not be distributed to any departments that do not need access to it as an essential part of their daily operations, or to any organizations outside of the hospital.

EMERGENCY PROCEDURES:

An emergency procedure is defined as that needed to save life or limb (such as massive hemorrhage or maternal/fetal distress), to prevent irreversible physical damage, or to alleviate intractable pain.

All emergency procedures will be scheduled through the scheduling coordinator during the normal workday, or with the charge nurse/house supervisor at all other times.

Emergency procedures will take precedence over elective cases. If an emergency case delays an already scheduled case, the scheduling surgeon must contact the delayed surgeon. Disagreements over urgency of a particular case will be referred to the Chief of Surgery and Anesthesia/Sedation Services for resolution. The Chief of Staff will prevail if the Chief of Surgery and Anesthesia/Sedation Services is not available for consultation, or is one of those surgeons involved in the dispute. The CEO of the hospital, or designee, will be consulted if both of these efforts fail for any reason.

PREOPERATIVE REQUIREMENTS:

The following preparations must be made and will be reflected in the patient's chart before the patient is allowed to enter the surgical suite:

*Completed history and physical including required content as outlined in detail in Section 3 of these Rules and Regulations.

*Appropriately signed consent form for the procedure, documenting that the informed consent process was carried out by the surgeon to notify the patient or authorized individual of potential risks, benefits, complications and consideration of alternative options. (Also see Informed Consent Policy.)
*Results of any diagnostic testing, as ordered by the provider, based upon the physical condition of each patient.
*Evidence that the laboratory has typed the patient for blood in all cases that are known to be at risk for significant blood loss.
*Evidence that patient has remained NPO since the night before surgery, or the appropriate time period according to minimum criteria –

Clear liquids	2-4 hours
Solid food	6-8 hours
Breast milk	4 hours
Formula	6 hours

These minimum NPO criteria may be waived at the discretion of the operating surgeon and the anesthesia provider if indicated.

The chart need only contain a completed history and physical and appropriately signed evidence of informed consent in the event the patient requires only "local anesthesia" within the surgical suites.

The above requirements may be waived and the chart may contain just a signed surgical consent, as possible, in the event of an extreme surgical emergency (massive hemorrhage, fetal/maternal distress).

PREOPERATIVE ORDERS:

The operating surgeon or designee is responsible for writing preoperative orders. The designee must be a member in good standing of the AGH medical staff. Preoperative orders are to include the following:

1. The wording to appear on the operative permit
2. Appropriate pre-anesthetic medication
3. Type of anesthesia to be used

PRE-ANESTHESIA EVALUATION:

Each patient will have a pre-anesthesia evaluation, an intraoperative anesthesia record, and a post-operative evaluation within 48 hours for inpatients, and according to the approved policy and procedure for outpatients.

OPERATIVE CONSENT:

Written, signed, informed, surgical consent must be obtained prior to any invasive procedure being performed in the surgical or endoscopy suites, except in those situations wherein the patient's life is in jeopardy and suitable signatures can't be obtained due to involvement with a minor or unconscious or incompetent patient, and when consent for the procedure cannot be readily obtained from parents, guardian or another authorized individual. These circumstances must be described in the medical record. (See hospital policies on consent.)

ASSISTANTS IN SURGERY:
The operating surgeon will determine the need for and arrange for an assistant.

SURGICAL TISSUE SPECIMENS:
Surgical tissue specimens will include all tissue and foreign bodies removed from the patient at the time of the procedure unless otherwise specified on the laboratory specimen policy and procedure guidelines.

Surgical specimens must be submitted to the pathologist for proper identification and recording.

In the event of removal of a foreign body such as a bullet, knife blade, etc., which may have been used in an act of violence, the surgeon will properly mark the foreign body so that it may be legally identified at a later date.

All surgical tissue will be transferred promptly, in the appropriate fixative, to the hospital laboratory, accompanied by the surgical pathology slip completed by the operating surgeon.

OPERATIVE REPORT:
An operative report describing preoperative and postoperative diagnosis, procedure performed, specimens removed, name of primary surgeon and assistant, if appropriate and a description of the procedures must be dictated or written immediately following surgery and authenticated by the physician before the patient leaves OR.

If the report has not been dictated the day of surgery, the surgeon's office will be called the business day morning indicating which reports were not completed. The surgeon will be given until the next business day at noon to dictate those reports. If the reports are not completed by that time, all of the surgeons scheduled surgeries will be rescheduled until the reports have been completed.

SURGICAL PRIVILEGES:
Privileges to practice in surgery are subject to review by the Medical Executive Committee and the Board of Trustees. No staff member will exceed his or her privileges on penalty of disciplinary action. The Chief of Surgery and Anesthesia/Sedation Services or designee from the active medical staff who has privileges to perform the specified procedure may assist provisional staff members as deemed necessary by the chief. A staff appointee who is in a proctor status for specified surgery privileges must have the proctor present in order to do a procedure until such time as the proctor validates competence to perform that procedure. A list of current surgical privileges granted to all members of the medical staff will be maintained in Surgical Services. The Perioperative Director is responsible for assuring that the procedures performed do not exceed the scope of delineated surgical privileges except in an extreme emergency. Infractions should be reported immediately to the Chief of Surgery and Anesthesia/Sedation Services.

SURGICAL PATIENTS WITH "NO CODE" ORDERS:

Each time a patient with a “no code” order enters the surgical or endoscopy suites for a procedure, the operating surgeon will discuss the patient’s wishes regarding resuscitation during the procedure and immediately postoperatively with the patient or authorized representative. This discussion must be documented in the medical record.

QUALITY ASSESSMENT AND IMPROVEMENT:

The process – assessment of preoperative judgment, intra-operative skill, and postoperative management – will be included in the hospital’s quality assessment and improvement program, and the findings evaluated along with other factors at the time of reappointment and privilege review. Adverse findings will be evaluated by the Clinical Pathological Conference members and/or the Medical Executive Committee, and appropriate action taken when warranted. The action may involve a restriction of privileges or revocation of staff appointment. Regardless of the action taken, the fair hearing procedures outlined in the Medical Staff Bylaws will be followed as applicable.

SECTION 11: ACUTE CARE UNITS

The Acute Care Committee has the responsibility for general supervision of care provided to critically ill patients including establishment of policies and procedures for same. It will meet bimonthly or more often if deemed necessary to care out this function.

MEDICAL SUPERVISION:

1. The Chief of Medicine will provide medical supervision of the Critical Care and Medical Surgical Units in adherence to the policies and decisions of the Acute Care Committee.
2. The Chief of Medicine responsibilities will include:
   a. Serving as Chairperson or appointing a physician designee to the Acute Care Committee;
   b. Liaison between the CCU and Medical Surgical staff and Medical Staff;
   c. Assistance in the monitoring and evaluation of patient care, with authority to evaluate any patient as needed;
   d. To participate with Clinical Departments in continuing education and performance improvement activities;
   e. Evaluation of the performance and knowledge of medical, para-medical and nursing personnel involved in patient care in the CCU and Medical Surgical Unit and make recommendations to appropriate authorities;
   f. Determination of patient priority if the CCU and Medical Surgical Unit has no available beds and additional patient(s) require admission;
   g. Monitor and assess CCU and Medical Surgical admissions.
3. A designated Hospitalist will assume the Chief of Medicine's responsibilities in his/her absence.

PHYSICIAN'S RESPONSIBILITY:

1. The attending CCU physician must have the appropriate privileges and skills to care for an intensive care patient. Refer to "Care of Patients on Ventilators". Typically this consists of surgeons and internal medicine physicians. Family practice physician can write admission orders, then refer the care of a CCU patient to the Hospitalists care.
2. The attending physician will complete a full history and physical within 24 hours of admission to the CCU and Medical Surgical Unit. Progress notes should be written or dictated (if able to be transcribed the same day) daily. The attending physician is the physician to whose service the patient is admitted.
3. When the attending physician is unavailable, he/she will notify the CCU and Medical Surgical Unit of a back-up physician.
4. The attending physician caring for CCU patients is expected to obtain appropriate specialty consultation in areas of patient care or therapeutic measures that are considered complex, or in which he/she has limited experience, knowledge or privileges. A case is considered complex if it requires:
   a. Swan Ganz, Arterial line, ventilator, temporary or permanent pacemaker;
   b. Complex follow-up beyond Lidocaine;

c. Dopamine or other medications to support blood pressure longer than four hours;
d. Prolonged stay in CCU beyond 72 hours;
e. Progressive chest pain or complex arrhythmia after initial therapy.

5. Rehabilitative services will be given in accordance to the attending physician's orders.
6. If a patient is determined to be in need of restraints, a competent nurse may initiate the restraints with immediate notification to the attending physician. The physician will initiate the orders in accordance with the hospital's restraint policy.

NURSING SUPERVISION:

1. The Director of Inpatient Services will provide nursing supervision with consultation from the Chief Clinical Officer in adherence to hospital policies and procedures.

ADMISSIONS:

1. No patient will be denied admission to CCU or the Medical Surgical Unit if their condition warrants.
2. **Admission criteria for CCU:**
    a. Acute or R/O MI with high probability
    b. Medical diagnosis with acute symptoms
    c. Surgical diagnosis with instability or preexisting severe medical problems
    d. Severe fluid and electrolyte problems
    e. Diabetic acidosis or coma
    f. Trauma with severe or multiple injuries
    g. Uncontrolled or massive hemorrhage

h. Uncontrolled convulsive states

i. Unexplained coma or related to drug overdose

j. Suicide precautions

k. Hypertensive crisis

l. Post CODE-100

m. Uncontrolled sepsis

n. Life threatening arrhythmia

o. Conditions requiring the use of thrombolytic agents, Swan Ganz, Arterial lines, ventilator or temporary pacemakers.

3. **Admission Criteria for Telemetry**:

a. Requirement for arrhythmia detection or follow up

b. Stabilized or T/O MI with low probability

c. Fluid/electrolyte problems requiring cardiac monitoring

d. Syncope known or unknown etiology

e. Chest contusions with undocumented complications

f.

g. Drug toxicity with cardiac status effects

h. Post anesthesia recoveries that occur after regular PACU hours will be temporarily admitted to CCU according to hospital policy.

4. Patients with a□“No CODE-100" orders may be **admitted to the CCU** until their acute situations have been corrected. See DNR policy.

5. The order for admission when **all CCU beds** are occupied is as follows:

a. The admitting physician or the Emergency Department will call the CCU nurse, who will indicate if a CCU bed is available.

b. If no bed is available the CCU nurse will call the physician of the patient who in their judgment could most safely relinquish their bed. The CCU nurse will have available to report the following to this physician:

I. Respiratory status

II. Cardiac status

III. Vital signs

IV. Neurological status

V. Hemodynamic status

VI. Laboratory values

VII. Medications related to cardiac rhythm

c. If the contacted physician(s) or the nurse feels that none of the patients are eligible for discharge, the Chief of Medicine/Hospitalist or designee will make the final decision.

d. Emergency Department patients must be stabilized according to hospital policy prior to transfer to CCU or to another facility.

e. No room accommodations will be held for a patient to go to CCU at a later time.

TRANSFERS TO ANOTHER FACILITY:

1. The CCU and Medical Surgical patient who requires testing or treatment not available at AGH may require transfer to another facility. This may include those being sent to extended care facilities upon discharge. See Transfer policies.

CARE OF PATIENTS ON VENTILATORS

1. Privileges for providing acute and chronic ventilator care must be specifically requested and approved through the usual credentialing procedures.
2. Oversight of respiratory care services is designated to the Chief of Medicine/Hospitalist or designee.
3. A physician with ventilator privileges should be the attending, so care should be transferred to this credentialed physician.
4. Chronic ventilator patients are considered to be those admitted on a ventilator from another facility and not in a state of declining respiratory status
5. Acute ventilator patients are considered to be those requiring ventilator support after admission to the hospital, with a declining respiratory status
6. Hospital policy should be consulted for current protocols regarding the use of chest x-rays and arterial blood gases for ventilator patients.

SECTION 12: INFECTIOUS DISEASES

The Infection Control Committee will meet on a regular basis and make a study of all infections. These shall be divided into three groups: nosocomial, nosohusial, and community acquired.

ISOLATION: When a physician admits a patient with a communicable disease, the physician or the RN on the nursing unit must notify the infection control specialist. If there is any disagreement regarding the type of isolation, apart from Universal Precautions, needed for protection of other patients, the physician and the infection control specialist may confer. If no agreement can be reached, the problem should be referred to a physician member of the Infection Control Committee. If necessary, this can be referred to the entire committee for solution where majority rules. The infection control specialist will refer to the book, “CDC Guidelines for Isolation Precautions in Hospitals” as the policy and procedure manual for this hospital.

INFECTION CONTROL AUTHORITY: The Infection Control Committee shall have the authority to institute any appropriate control measure or study when there is reasonable felt to be a danger to patients or personnel. Program review, education and training, and on-going monitoring of problem areas will occur with the assistance of the medical staff as needed.

SECTION 13: PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

*Physician Assistant: Licensed in the State of Michigan as a PA: current BCLS/ACLS training

*Nurse Practitioner: Masters-prepared nurse with clinical specialty applicable to patients served; licensed in the State of Michigan as a certified NP; current BCLS/ACLS training

1. Each Physician Assistant (PA) and Nurse Practitioner (NP) must have a sponsoring physician willing and able to accept responsibility for, and supervise care provided by the PA or NP.

2. The Sponsoring Physician must signify the acceptance of this responsibility in writing, to accompany the application for membership/privileges. The Sponsoring Physician must also co-sign the application for membership/privileges.

3. The PA or NP cannot be granted privileges not already granted to the Sponsoring Physician.

4. The PA or NP may practice without immediate supervision in primary (non-CCU), and/or urgent care environments. "Immediate" means when the physician is within the hospital or available by telephone.

5. The PA or NP may admit patients to the hospital to the service of the Sponsoring Physician only.

6. All documentation made in the Medical Record (i.e., history and physical, orders, etc.) by the PA or NP must be completed within 24 hours.

SECTION 14: MEDICAL STAFF MINUTES

Medical Staff shall meet in a business session of the whole on the second Tuesday morning of each calendar quarter. Minutes will be kept of each meeting.

There will be an educational meeting once a month on the fourth Tuesday morning. A brief summary of the meeting content along with attendance shall be documented.

SECTION 15: DISASTERS

Members of the medical staff are required to participate in the internal and external disaster plans and drills.

Authority to implement the disaster plan is granted to the Emergency Department Physician and the House Supervisor. The Emergency Preparedness Coordinator or designee will be responsible for coordination of disaster drills and/or situations.

Authority to implement the evacuation of patients from the hospital is granted to the President/designee and Chief of Staff/designee.

SECTION 16: MICHIGAN PEER REVIEW ORGANIZATION (MPRO) QUALITY IMPROVEMENT PROJECTS

The Medical Executive Committee will review final MPRO QI findings according to the following guidelines:

1. The Medical Staff liaison will forward a copy of the findings to the appropriate service chief for his/her review.
2. The service chief will present the findings to MEC at their next meeting along with his/her own findings and opinion of MPRO findings.
3. After review, the committee will decide the course of action to be taken:
    a. MEC does not concur with MPRO findings. No further committee action necessary.
    b. Some validity to MPRO findings. A review will be presented for the general Medical Staff for education purposes.
    c. Some validity to MPRO findings. A review will be presented for the general Medical Staff for education purposes.
    d. MPRO findings valid. Other action to be taken as determined by the committee.
4. All of the above will be documented in the MEC minutes under the performance improvement section, or in executive session as necessary.

SECTION 17: PATIENT AND FAMILY EDUCATION

The Medical Staff will be consulted as necessary in the development and/or provision of Patient and Family Education. Examples of such consultation would include:

1. Family Practice or Internal Medicine for diabetes education.
2. Chief of ED for outpatient instruction.
3. Privileged physicians related to their specialties.

Consultations may be accomplished through direct communication with the appropriate physician or by submission of proposed materials to the Medical Executive Committee.

SECTION 18: INFORMED CONSENT

Evidence of proper informed consent must be present in the medical record. Specific instances in which informed consents are required include, but are not limited to, the following:

1. Inpatient admission and treatment
2. Outpatient treatment
3. Emergency/MedCentre treatment
4. Surgical procedures
5. Minor invasive procedures
6. Invasive radiological procedures
7. Diagnostic HIV testing
8. Release of medical information

9. Discharge against medical advice
10. Blood transfusions
11. High risk therapy/drugs
12. Experimental treatment
13. Refusal of ER screening exam or transfer
14. ECT
15. Administration of psychotropic drugs on the inpatient psychiatric unit.
16. Off label use of medical devices.

Informed consent is the direct communication between patient and physician concerning a proposed course of treatment. It should be based on a clear, concise, and factual explanation of proposed treatments, possible outcomes, and alternatives to therapy.

A valid documentation of informed consent must include a discussion of the following:

. The patient's diagnosis, if known
. Potential benefits and consequences of treatment or procedure
. Potential problems related to recuperation
. Nature/purpose of care to be provided.
. The likelihood of success
. Prognosis if no treatment is rendered.
. Significant alternatives to the treatment/procedure
. The name of the practitioner who has primary responsibility for performing the procedure or treatment
. The right to refuse treatment
. The right to seek another medical or surgical opinion
. Decisionally capacitated patient or designated patient advocate signature.

Hospital policies #S027, S027A and S028 address the specifics of informed consent forms.

SECTION 19: OBTAINING NECESSARY ASSISTANCE/RESOLVING QUESTIONS OF CARE

The Medical Staff recognizes its responsibility to provide immediate/timely intervention when an attending or responsible practitioner is not available or does not respond to nursing or staff requests for patient care assistance. The Medical Staff also recognizes the need to respond when the quality or appropriateness of care being provided to a particular patient is questioned. The purpose of Medical Staff intervention is to assure that necessary care is provided and that preventable adverse patient outcomes are avoided.

If a nurse or other health care provider determines that intervention is necessary, it shall be brought to the attention of the immediate supervisor or the House Supervisor, as appropriate. The supervisor will attempt contact with the attending physician for clarification/action. If the situation is not satisfactorily resolved, the supervisor will make appropriate referral to Medical Staff leadership, IE. The Department Medical Director (if applicable), the Service Chief and/or the Chief of Staff. Medical Staff leadership consulted in these matters is expected to respond in a timely manner. The responding practitioner has authority to review relevant patient information and to act as a consultant or call for a consultation.

It is the responsibility of the responding practitioner to ask the appropriate peer review committee to examine the necessity and adequacy of the intervention and the circumstances which made it necessary. This examination will assist in evaluation of the system that has been provided and in identifying and responding to physician practice problems.

SECTION 20: REVIEW OF RULES AND REGULATIONS

The Medical Staff Rules and Regulations will be reviewed and revised as practices change.

MEDICAL STAFF BYLAWS

Revised/Reviewed Dates:
Revised and Approved: December 18, 2014 , September 2024,

ARTICLE 1: NAME

The name of this organization will be the Ascension Borgess Allegan Hospital Medical Staff.

Ascension Borgess Allegan

ARTICLE 2: PURPOSES

The purposes of this organization are:

1. To provide all patients admitted or treated at the Hospital with compassionate and respectful care consistent with the standards of medicine practiced in the community and commensurate with Hospital and community resources.
2. To serve as the collegial body through which individual Practitioners may obtain membership prerogatives and clinical privileges at the Hospital to provide clinical services to patients.
3. To assist in providing a program of continuing education for all Practitioners and Affiliate Staff designed to keep them informed of pertinent new developments in the diagnostic and therapeutic aspects of patient care and to refresh them in various aspects of their basic medical and specialty education. Determination of educational activities will be based, at least in part, upon the type and nature of care provided by the hospital, and the findings of performance improvement activities.
4. To increase the probability of desired patient outcomes and reduce the probability of undesired outcomes, given the current state of medical knowledge for all practitioners, through participation in performance improvement activities, including but not limited to: education of patients and their significant others; coordination of care with other practitioners and personnel; and, accurate, timely and legible completion of medical records.
5. To make recommendations to the Governing Body concerning appointments and reappointments to the Medical Staff, including membership categories and service assignments, clinical privileges, specified services for Affiliate Staff, and corrective actions where indicated.
6. To develop, administer, and recommend amendments to these Bylaws of the Medical Staff.
7. To enforce compliance with the Bylaws, policies, and all appropriate state and federal laws.
8. To positively influence the management of the Hospital in order to improve services provided to all patients.
9. To represent the medical staff through participation in any hospital deliberation affecting medical staff responsibilities.
10. To ensure licensed independent practitioner members of the organized medical staff are designated to perform the oversight activities of this medical staff.
11. The organized medical staff has a mechanism to ensure that patients receive appropriate care, treatment, and services from a licensed independent practitioner who has been credentialed through the medical staff process during the entire length of stay at Ascension Borgess Allegan Hospital.
12. The organized medical staff participates in the measurement, assessment, and improvement of processes:

- Education of patients and families
- Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient.
- Accurate, timely, and legible completion of patient's medical records.
- Findings of the assessment process that is relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence.
- Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and governing body.

ARTI CLE 3: MEDICAL STAFF COMMUNICATION WITH GOVERNING BODY

3.1 Effective communication between the Medical Staff and the Governing Body is achieved through written and oral reports from the Medical Staff through the Medical Executive Committee and the Chief of Staff at the Governing Body meetings. The Chief of Staff and/or any Medical Staff member appointed to the Governing Body will represent the Medical Staff at the Governing Body meetings.

3.2 Effective communication between the Governing Body and the Medical Staff is achieved through written and oral reports from the Governing Body through the Chief of Staff and the Medical Executive Committee. The Hospital President may express **concerns/views of the Governing Body to the Chief of Staff for communication to the** Medical Executive Committee and the Medical Staff.

ARTICLE 4: MEDICAL STAFF MEMBERSHI P

4.1 Nature of Medical Staff Membership

Membership on the medical staff of the Ascension Borgess Allegan Hospital is a privilege, which **will be extended only to professionally competent practitioners who continuously meet** the qualifications, standards and requirements set *forth* in these bylaws.

4.2 Qualifications for Membership

The members of the Medical Staff who are responsible for the oversight of quality of **care, treatment, and services are licensed independent practitioners. Only practitioners who can provide evidence of current Michigan licensure, relevant training/experience in** their preferred specialty, current competence, acceptable health status, adherence *to* medical ethics, and ability to work with others, to assure the Medical *Staff* and Governing Body that any patient treated by him or her in the hospital will be given a high quality of medical care, treatment, and services will be qualified for membership on the Medical *Staff.* Gender, race, creed and national origin will not be used in granting or denying Medical Staff membership or clinical privileges.

Acceptance of membership on the Medical Staff will constitute *the* staff member's agreement to the following:

a. To strictly abide by the principles of Medical Ethics of the American Medical **Association or the American Association of Osteopathic Physicians and Surgeons,** whichever is applicable, and Chiropractic Medicine, Podiatry or Dentistry as the same are appended to and made a part of these bylaws.

b. **Acknowledgment of responsibility to provide continuous care for one' s own patients.**

c. Agreement to strictly abide by the Medical Staff bylaws, rules and regulations. Said agreement is outlined in the Medical Staff application form. The signature of the **applicant on this form constitutes acceptance and is required for membership and privileges.**

Ascension Borgess Allegan

Effective 10/01/03, all new physician applicants to the medical staff must also meet one of the following qualifications:
*Current certification, board eligible, and active participation in the examination process leading to certification in their specialty within five years of completion of residency or fellowship in their specialty; or
*Current participation in an ACGME – or AOA- accredited postgraduate residency program in their specialty and successful completion of at least two years of that program.

d. Compliance with Hospital Policies

Medical Staff members agree to comply with all Corporate bylaws, policies, procedures, and practices of Ascension Borgess Allegan Hospital as well as with its Medical Staff bylaws, rules and regulations, and policies. These would include, but not be limited to, the HIPAA Privacy and Security Regulations, and the Corporate Compliance Program of Ascension Borgess Allegan Hospital. Where there is conflict between a term(s) in the corporate documents and a term(s) in the Medical Staff documents, the Medical Staff term(s) shall prevail, providing the prevailing term(s) are lawful, otherwise the lawful term(s) prevail.

e. Participation in Hospital's Organized Health Care Arrangement

Medical Staff members may participate in the Hospital's HIPAA Organized Health Care Arrangement (OHCA) while providing care within the Hospital. If a Medical Staff member chooses to do so, then he or she shall adhere to the OHCA's Joint Notice of Privacy Practices. If a Medical Staff member refuses to participate in the OHCA, then the Member shall provide each patient that he or she treats at Ascension Borgess Allegan Hospital with a copy of that Member's HIPAA Notice of Privacy Practices.

4.3 Conditions and Duration of Appointments/Clinical Privileges

The Governing Body, based upon Medical Staff recommendations, in accordance with these bylaws, grants initial Medical Staff membership and delineated clinical privileges. In the event of unwarranted delay on the part of the Medical Staff, the Governing Body **may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from** reliable sources other than the Medical Staff. Initial appointments and clinical privileges **will be provisional for a period of one year. Reappointments and privilege renewals will** be made for a period not to exceed three Medical Staff years. Appointment to the Medical Staff will confer on the appointee only such clinical privileges as have been granted by the Governing Body, in accordance with these bylaws.

In the granting of privileges to physicians applying to the Ascension Borgess Allegan Hospital Medical Staff, consideration will be given to the need for such physicians and their specialties in the hospital's service area.

Unless specifically excused by the Executive Committee, Active Staff members will be expected to fulfill all functions and responsibilities of said membership.

Individuals in administrative positions who desire membership and/or privileges are subject to the same procedures as all other applicants. Contracted staff (physicians or other licensed independent practitioners) and telemedicine practitioners are subject to the same procedures as well.

ARTICLE 5: CATEGORIES OF THE MEDICAL STAFF

5.1 The Medical Staff
The medical staff will be divided into active, consulting, courtesy, honorary, and affiliate **categories.**

5.2 The Active Staff
5.2-1 Qualifications
The active staff will consist of practitioners who, in the best judgment of the Medical Executive Committee, are located in sufficient proximity to the Hospital to provide continuous care to their patients. They regularly admit patients to and are regularly involved in the care of AGH inpatients or outpatients. They have satisfactorily completed their designated time on the provisional staff.

5.2-2 Prerogatives and obligations
a. Admit patients without limitation and exercise such clinical privileges as are granted.
b. Vote on all matters presented at general and special meetings of the Medical Staff, **any committee thereof and clinical service of which they are a member, and to** otherwise participate in all Medical Staff affairs.
c. Hold office in the organization, service or any committee if so elected or appointed.
d. Assist in the clinical, administrative and quality management work conducive and necessary to the professional and efficient operation of the Hospital.
e. Attend regular Medical Staff and committee meetings, as deemed appropriate by the Chief of the Service.
f. Pay membership dues and other fees that may become due.
g. Take emergency department call for his/her specialty as assigned.

5.2-3 Limitations
a. Active staff members will be expected to maintain a minimum of 13 admissions, outpatient procedures or inpatient consultations per year or be actively involved in medical staff activities.
b. After two consecutive years in which a member of the active staff fails to regularly care for patients in the hospital or be regularly involved in medical staff functions, that member will be automatically transferred to another appropriate category.

5.3 The Courtesy Medical Staff

5.3-1Qualifications

The courtesy staff will consist of practitioners who:

a. Meet the basic qualifications for membership

b. Are located closely enough to the Hospital or clinic to provide continuous care to his/her patients.

c. Admit not more than 12 patients per year to the hospital.

d. Are members of the Active or Provisional Staff of another hospital where he/she **actively participates in patient care and performance improvement activities.**

e. Has satisfactorily completed appointment in the provisional category.

5.3-2 Prerogatives

Except as otherwise noted, the courtesy medical staff member will be entitled to:

a. Admit up to12 patients per year to the hospital and exercise such clinical privileges as have been granted.

b. Attend medical staff and service meetings in a non-voting capacity.

c. Courtesy staff members will not be eligible to hold office in the medical staff, but may **serve on committees, as a voting member if so desired and appointed.**

5.3-3 Limitations

Courtesy staff that regularly admit patients or regularly care for patients at the hospital, upon review by the Medical Executive Committee, will be obligated to seek appointment to the active staff.

5.4 The Consulting Medical Staff

5.4-1 Qualifications

The consulting staff will consist of practitioners who:

a. Meet the general qualifications for membership.

b. Possess adequate clinical and professional expertise in their specialty.

c. Do not qualify for membership as an active or courtesy staff member.

d. Have satisfactorily completed appointment in the provisional category.

5.4-2 Prerogatives

Except as otherwise noted, the consulting staff may:

a. Be called as a consultant by members of the medical staff in regard to patients on **whom their special skills may be useful.**

b. May not admit patients to AGH or assume medical responsibility for any hospitalized patient.

c. Attend meetings of the medical staff and service but will not be eligible to vote at such meetings or to hold office in the medical staff. They may serve on committees as voting members if so desired and appointed.

5.5 The Provisional Medical Staff

5.5-1 Qualifications

The provisional staff will consist of members who:

a. Meet the general qualifications for membership.

b. Are newly appointed members of the medical staff.

5.5-2 Prerogatives

The provisional staff member will be entitled to:

a. Admit patients and exercise clinical privileges as granted. Applicants requesting Honorary or Consulting staff membership will not be permitted to admit patients.

b. Attend meetings of the medical staff and department and vote at same.

c. Be appointed to committees.

d. Will not be eligible to hold office in the medical staff organization.

5.5-3 Observation of Provisional Staff Members

Each provisional staff member will be subject to a period of observation by a designated proctor(s). The observation will serve to evaluate the member's competence in the exercise of clinical privileges initially granted and overall eligibility for continued staff membership and advancement within staff categories. Observation may include, but not be limited to concurrent or retrospective chart review, mandatory consultation and/or direct observation.

5.5-4 Terms of Provisional Staff Status

A member shall remain as provisional staff for a period of 12 months unless that status is extended by the Medical Executive Committee for an additional period of up to six months.

5.5-5 Action at Conclusion of Provisional Staff Status

If a provisional staff member has satisfactorily demonstrated the ability to effectively exercise clinical privileges initially granted and appears qualified for continued medical staff membership, the member will be eligible for placement in the active, courtesy, or consulting staff as appropriate, upon recommendation of the Medical Executive **Committee.**

In all other cases, the appropriate Service Chief will advise the Medical Executive Committee, which will recommend to the Board of Trustees regarding a modification or **termination of clinical privileges and membership.**

5.6 The Honorary Staff

5.6-1 Qualifications

The honorary staff will consist of and be offered to those medical staff members who **meet the general qualifications for membership but who are no longer active in clinical** practice at the Hospital and whose past association with and service to the Hospital warrant recognition by continued membership on its medical staff. Approval for this membership status may include physicians who no longer hold active medical l **licensure, certifications, etc., but who requested this change in status while good** standing and who served Ascension Borgess Allegan Hospital with a minimum of 10 years of longevity.

5.6-2 Prerogatives

a. The honorary staff member will not be granted clinical privileges nor care for AGH inpatients or outpatients.

b. The honorary staff member may attend meetings in a non-voting capacity.

c. The honorary staff member may not hold office.

d. Will not be required to serve in a provisional capacity.

5.7 The Affiliate Staff

5.7-1 Qualifications

The Affiliate Staff will consist of non-physician healthcare providers, including mental **health practitioners, who:**

a. Meet the general membership qualifications for medical staff

b. Are located closely enough to the Hospital and clinics to assure that continuous quality care is provided to patients.

c. Are regularly involved in the care of AGH inpatients and/or outpatients.

5.7-2 Prerogatives

Members of the Affiliate Staff will be able to:

a. Exercise such clinical privileges as granted.

b. Attend meetings of the medical staff and assigned service.

c. Will not be eligible to vote or hold office in the medical staff organization.

d. Will be eligible for fair hearing procedures.

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ARTICLE 6: PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

6.1 Application for Appointment

Upon request, eligible applicants will be given an application for appointment to the Medical Staff, privilege request form(s), and a detailed list of requirements for completion of the application. A copy of the Medical Staff Bylaws, Rules and Regulations and applicable policies/procedures will also be provided.

Qualifications necessary to be recommended for appointment by the governing board includes:

- Individual character;
- Individual competence;
- Individual training;
- Individual experience; and
- Individual judgment.

For the application process, it is the applicant's responsibility to provide the following documentation to be considered a complete application:

- A completed, signed application form and request for privileges. This will include signed consent to inspect all records and documents pertinent to the application;
- A copy of current State licensure, Controlled Substance License, and, where applicable, DEA number or certificate if no license is required;
- A certificate of current professional liability insurance from a company licensed by the State of Michigan. Limits of liability will be in accordance with those stipulated by the Ascension Borgess Allegan Hospital Board of Trustees;
- Verification of completion of an approved residency, training program, or other educational curriculums;
- Verification of experience related to the privileges requested, including current statistical and quality information of procedures/admissions/diagnosis treated within requested time frame;
- Verification of board status, board admissibility, or board certification i.e. copies of certificates or letters from appropriate specialty boards;
- Evidence of continuing medical education in accordance with licensure requirements;
- Evidence of TB testing results or risk assessment completion if TB is positive to follow frequency of hospital 's (Employee TB Detection) policy;
- Information regarding the following, if applicable:
    - Previously successful or currently pending challenges to any licensure or registration, or voluntary or involuntary relinquishment of such Licensure or registration, including DEA;
    - Previously successful or currently pending challenges, voluntary or involuntary, termination, limitation, reduction, withdrawal of application for or denial of membership and/or clinical privileges at another hospital or licensed health care facility;
    - Involvement in a professional liability action or claim, previous or pending.
    - Documentation as to the applicant's health status;

- o Relevant practitioner-specific data are compared to aggregate data, when applicable;
  - Morbidity and mortality data, when applicable.
  - Three letters of recommendation sent directly to the Medical Staff Office (MSO) from persons who have recently worked with the applicant and directly observed professional performance over a **reasonable period of time and who can and will provide reliable** information regarding current clinical ability, any effects of health status on privileges being requested, ethical character and ability to **work with others. References must be from individuals practicing in** a professional discipline similar to the applicant.

Upon receipt of a completed signed application, the applicant will be sent a letter of acknowledgment by the MSO. The letter of acknowledgment will further detail any **remaining documentation that must be submitted to complete the credentials file and** begin the 60-day application process as stipulated by the medical staff bylaws.
Upon receipt of a completed application, the MSO will seek to verify its contents and collect additional information as follows:

***Completed administrative and clinical reference questionnaires from all** significant past practice setting for the previous ten years.
***Verification of licensure status in all current or past states of licensure.**
A statement of physical and mental ability to perform specific privileges requested.
Information from the National Practitioner Data Bank.
Information from the AMA or AOA.
***Verification of Board Certification.**
NOTE: Verification of information will be with the primary source whenever feasible. In the event of undue delay in obtaining required information the MSO will request assistance from the applicant. No initial appointment/clinical privileges will be granted until all information is available and verified.

When complete as outlined above, the applicant's file will be presented to the **appropriate service chief.**

The applicant will be notified when a clinical interview with the Medical Executive Committee (MEC) has been scheduled, if required. Results of the interview will be placed in the applicant's file.

The applicant's file will be reviewed by the MEC as soon as possible but not later than its next regularly scheduled meeting. The Committee reserves the right to request additional documentation of competency/education if the **privileges requested are not within the usual confines of a particular service. This may include use of outside consultants as necessary. The signature of the** chairperson of the MEC (Chief of Staff) on the sign-off sheet will indicate approval of the Committee.

The Chief of Staff or designee will present a summary of the applicant's file and recommendations from the service chief and the Medical Executive Committee to the Board of Trustees (or its appropriate subcommittee) at its next regularly scheduled meeting. The signature of the Board Secretary will indicate approval by the Board of Trustees provisionally appointing the applicant with specified privileges to the indicated category of the Medical Staff. The new appointee will be notified in writing of the action of the Board of Trustees. Any pertinent information regarding appointment to the Medical Staff will be forwarded ormade available to the appointee at this time.

All initial appointments and privileges being provisional, individuals with the status are subject to review by the chief of the respective service(s) for a period of 12 months. At the termination of the 12-month provisional staff period, a report of clinical activities (number, type and outcome) will be prepared for the service chief. The chief will then evaluate the appointee's clinical competence and will render a report of such to the MEC. The report may:

A Recommend awarding of full staff status.

8. Recommend termination of appointment.

C. Recommend a six-month continuation of provisional status for either:

1. Failure to admit or otherwise provide services to a minimum of 25 patients; or

2. Inconclusive data demonstrating clinical competence.

D. Recommend full privileges with exception of individual procedures, which would **be provisional.**

<u>6.2 Procedure for Reappointment/Privilege Renewal</u>

At least 120 days prior to the expiration of each Medical Staff appointee's term of **appointment or expiration of clinical privileges, a reappointment information form with** a copy of existing privileges will be sent to the appointee. If the reappointment information is not returned within 15 days, reminder notifications will be sent All reapplications not returned within 90 days will be considered as voluntary resignations from the staff. Those individuals will not be afforded the fair hearing process but will be immediately eligible to formally apply for initial appointment. All returned documents will be reviewed and verified as needed. The MSO will compile a summary of clinical activity for each appointee due for reappointment. Appropriate **hospital staff will review all pertinent Medical Staff Committees minutes/studies as well as findings of Performance Improvement activities and prepare a summary of findings** for each practitioner requesting reappointment (see EVIDENCE OF REAPPRAISAL & REAPPOINTMENT).

The completed file will be sent to the chief of the clinical service for review. A peer from the AGH medical staff, in good standing, will review files belonging to the service chiefs and chief of staff. The chief will review privilege requests. If privileges are outside of the specialty being requested, additional documentation of **competency/education may be requested. The service chief and/or MEC may utilize outside consultants as necessary. The service chief will prepare and present a recommendation to the MEC at its next regularly scheduled meeting**

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The MEC reserves the right to request additional documentation of competency/education if the privileges requested are not within the usual confines of **the service.**

The Chief of Staff or designee will present a summary of the applicant's file, along with the MEC's recommendation to the Board of Trustees (or its appropriate subcommittee) at its next regularly scheduled meeting. The Board of Trustees (or an appropriate subcommittee) will formulate the Board of Trustee's decision regarding reappointment and/or the granting of clinical privileges after considering the **recommendations from the MEC and reviewing pertinent materials. Decisions may** include:

1. Continuation of full staff status, with or without revision of privileges,
2. **Termination of appointment/privileges,**
3. **Provisional status, or**
4. **Provisional status for certain privileges**

The AGH Medical Staff encourages all physician members to become board certified in their specialty. Effective 10/01/03, all physician members of the medical staff who do not meet one of the following qualifications will be subject to the reappointment **process on an annual basis:**

1. Currently certified or actively participating in the examination process leading to certification in their specialty

2. Currently participating in an ACGME- or AOA-accredited postgraduate residency program in their specialty.

<u>6.3 Reappointment Process</u>

The qualifications necessary to be recommended to the governing board for appointment includes:

- **Individual character;**
- Individual competence;
- **Individual training;**
- **Individual experience; and**
- Individual judgment

For the reappointment application process the following documentation necessary to complete a request for reappointment will consist of the following:

A A completed, signed reappointment information form and privilege request form.

8. A current copy of State Licensure and, where applicable, DEA number.

C. A certificate of current professional liability insurance.

D. Information regarding the following, when applicable:

•Previously successful or currently pending challenges to any **licensure or registration, or voluntary or involuntary relinquishment of such licensure or registration, including DEA.**

***Previously successful or currently pending challenges, voluntary or**

involuntary, termination, revocation, limitation, reduction or denial of membership and/or clinical privileges at any hospital or licensed health care facility.

*Involvement in a provisional liability action or claim, previous or pending.
*Evidence of CME credits related to type and nature of care provided and any relevant findings of performance improvement activities, by presentation of any combination of the following:

- Individual listing of Continuing Education Credits
- Copies of Continuing Education Certificates
- Copies of recognized awards earned through Continuing Education credits

*Documentation as to the applicant's health status;
*Relevant practitioner-specific data are compared to aggregate data, when applicable;
*Morbidity and mortality data, when applicable.
*Peer recommendations.

E. Findings from ongoing monitoring of professional performance, judgment and clinical skills
F. Summary of clinical activity including number and types of patients treated
G. Compliance with bylaw requirements
H. Results of performance improvement findings
I. Information from the National Practitioner Data Bank
J. Evidence of review of all information by the following:
*Service Chief
*Medical Staff Executive Committee
*Board of Trustees
K. Practitioners do not practice outside the scope of their privileges.

NOTE: Peer recommendations will be obtained from practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice. If there are no peers (practitioners in the same professional discipline as the appointee/applicant on the MEC), a reference letter or a documented telephone conversation about the appointee/applicant from a peer on the Hospital Medical Staff or from outside the hospital who is knowledgeable about the appointee/applicant's competency will be solicited by the Chief of Staff. Podiatrists, dentists and oral surgeons will be required to provide a completed reference letter from a peer.

6.4 Contracted Staff Appointment Reappointment
Contracted staff (physician or other LIP) is subject to the same procedures for membership and delineated clinical privileges as other medical staff members, as outlined in these bylaws.

6.5 Affiliate Staff Appointment Reappointment
Subject to same procedures as are applicable to Medical Staff reappointment. An affiliate health professional will also be required to obtain a personal letter of recommendation from a peer concerning clinical competence or submit a copy of a recent performance evaluation.

6.6 A member may be removed, or privileges restricted by the Governing Body upon recommendation of the Medical Executive Committee. In instances where there is doubt about an applicant's ability to perform the privilege requested, criteria related directly to **quality of care provided and peer recommendations will be considered in this decision.**

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ARTICLE 7: CLINICAL PRIVILEGES

7.1 Clinical Privileges Defined

Each practitioner granted clinical privileges will be entitled to exercise only those clinical privileges specifically granted by the Governing Body, except as provided in these Bylaws.

Every application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests will be based upon: The applicant must demonstrate his/her medical competency by providing relevant information, i.e. proof of: relevant education, training and **experience; current licensure status; current demonstrated competence; current health status; references; treatment outcomes, conclusions from performance improvement** data, and other relevant information, including an appraisal by the appropriate Medical Staff Service. The applicant will have the burden of establishing or reestablishing **qualifications and competency as deemed necessary by the Medical Executive** Committee (MEC) or the Governing Body.

Periodic renewal or revision of clinical privileges will be processed through the MEC and Board of Trustees.

7.1 (a) Clinical Privileges for Dentists, Podiatrists and Chiropractors. The scope and extent of surgical procedures that each podiatrist or dentist may perform will be **specifically delineated and granted in the same manner as other surgical privileges.** Surgical procedures performed by podiatrists or dentists will be under the overall approval of the Chief of Surgery. Medical procedures performed by Chiropractors shall be under the overall supervision of the Chief of Family Practice. All podiatry, dental, and chiropractic patients will receive the same basic medical appraisal as patients admitted to other surgical services.

An active member of the Medical Staff will be responsible for admission evaluation, history and physical, and for the care of any medical problems that may be present at the time of admission or that may arise during hospitalization/treatment and will determine the risk and effect of the proposed surgical procedure on the total health status of the patient. The podiatrist, dentist, or chiropractic will be responsible for the part of their patients' history and physical exam that relates to podiatry, dentistry, or **chiropractic medicine.**

7.2 **Temporary privileges**

Subject to the following, temporary privileges may be granted by the CEO, with the concurrence of the Chief of Staff and Service Chief, to a practitioner for a stated and limited period of time not to exceed 90 days:

Temporary privileges are granted for the following special situations:

1. To fulfill an important patient care need, for example:

- A practitioner on the medical staff becomes ill or takes a leave of absence and a licensed independent practitioner would need to cover his/her practice until he/she returns (locum tenens).
- An outside practitioner needs temporary privileges to help manage a patient with a specific medical problem. The outside practitioner brings expertise that the medical staff of Ascension Borgess Allegan Hospital does not have.
- At reappointment, if failure to allow the practitioner to continue to provide care would result in a problem meeting an important care need.

2. When an applicant with a complete, clean application is awaiting review and approval by the MEC and Governing Board. All information normally collected/verified must be obtained and evaluated before a decision regarding privileges can be made, including, but not limited to the following:

The applicant has:

a. Completed the application
b. no current or previously successful challenge to licensure or registration
c. not been subject to involuntary termination of medical staff membership or privileges at another organization.

not been subject to involuntary limitation, reduction, denial or loss of clinical privileges. In both of the circumstances the information required in #3 below must be obtained and evaluated before a decision regarding privileges can be made.

3 Temporary privileges for new applicants may be granted while awaiting review and approval by the organized medical staff upon verification of the following:

- A complete application
- Primary source verification of current licensure indicating no current or previous successful challenges to license or registration, or restrictions, sanctions, limitations or probations.
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges
- Current competence
- Relevant training or experience
- Ability to perform the privileges requested
- Current and appropriate amount of professional liability insurance coverage
- Malpractice history, including pending activity
- At least two (2) positive references from responsible medical peers regarding the applicant's competence, training, and ability to perform the requested privileges including their physical and mental ability -in writing, if possible or verbal with documentation of discussion.

- A National Practitioner Data Bank query
- Written agreement from the practitioner to abide by bylaws, rules and regulations and facility policies.

Circumstances in which temporary privileges will not be granted in the above **situations are as follows:**

1. the licensed independent practitioner fails to provide all information necessary to the processing of his/her reappointment in a timely manner.
2. Failure of the hospital staff, with reasonable diligence, to verify performance data and information in a timely manner.
3. **Also, if other care providers are available to meet the important patient care** need, temporary privileges will not be granted.

These privileges may be granted to a practitioner who is sponsored by an active staff **member for the purpose of assistance in a locum tenens manner of the sponsor's** practice for a period of less than 60 days. Applicants for privileges under the clause **must provide full documentation of their health status, licensure, board certification,** state and federal narcotics registration, medical school graduation and residency completion, and malpractice insurance. All documentation will be verified with the primary source whenever possible. The sponsoring physician, at the completion of the practitioner's temporary privileges shall assume patient care and record keeping **responsibility.**

Limited temporary privileges may be granted to a qualified practitioner who is assisting an Active staff member in a specific surgical/medical procedure. Documentation of competence in the specific procedure is required through the completion of an application for privileges describing the nature of the specific procedure, as well as evidence of licensure, medical school graduation, residency completion, specialty **board certification, federal narcotics registration and malpractice insurance. All required documentation will be verified with the primary source whenever possible.**
He or she must also be a member in good standing of another medical staff and **provide the names of two professional references.**

Temporary privileges may be granted to students from accredited institutions and **physicians in training, commensurate with their level of training and then only under** the supervision of a physician on the active staff, with clinical privileges at least equal to those granted on a temporary basis. Documentation of affiliation with the program at the accredited institution will be required.

Special requirements of supervision and reporting may be imposed by the appropriate **service chief on any practitioner granted temporary privileges. Temporary privileges** may be terminated by the Hospital President upon notice of any failure by the practitioner **to comply with such special conditions or for any reason deemed in the** best interest of the Hospital or Medical Staff.

The Hospital President may at any time, upon the recommendation of the Chief of Staff, terminate temporary privileges effective as of the discharge from the hospital of the physician's patient(s) then under care. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the physician, the termination may be imposed by any person entitled to impose a summary suspension pursuant to these bylaws. The Chief of Staff will assign a member of the medical staff to assume responsibility for the care of the patient(s) until they are discharged from the hospital. The wishes of the patient(s) will be considered **in selection of substitute practitioners.**
Failure to grant temporary, locum tenens or limited temporary privileges shall not entitle the affected practitioner to the procedural rights afforded by these bylaws.

7.3 **Emergency Privileges**
In the case of an emergency, any member of the Medical Staff, to the degree permitted by one's license and regardless of clinical privileges or Medical Staff status, will be permitted and expected to do everything possible to save the life of a patient or to save a patient from serious harm, using every facility of the hospital available, **including a request for any consultation deemed necessary or desirable.**

When the emergency situation no longer exists, said members must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or are not desired the patient will be assigned to an appropriate member of the Medical Staff.

For the purpose of this section, an emergency is defined as a condition in which serious or permanent harm could result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to this harm or **danger.**

7.4 **Interim Appointment and Privileges**
If recommended by the service chief, completed and verified applications may be processed as set forth in this section so long as they meet the following **conditions:**

A. The applicant has successfully completed a residency in the specialty for which privileges are requested, with a consistent and satisfactory training record **and no disciplinary actions or conditions imposed during training.**

B. The applicant has not changed permanent practice locations more than three **times in the past ten years.**

C. There are no negative or questionable recommendations, and all have been returned in a timely fashion.

0. There have been no malpractice cases within the past two years. Any claims **activity is reasonable in light of his or her specialty.**

E. There are no pending or past investigations or disciplinary actions from any hospital or licensing agency.

F. The applicant has an unremarkable medical staff/employment history.

G. The applicant has submitted a reasonable request for clinical privileges based on experience, training, and competence and is in compliance with applicable criteria.

H. The applicant reports an acceptable health status.
I. The applicant has never been sanctioned by a third-party payer (e.g. Medicare, Medicaid, etc.).
J. The applicant has never been the subject of a criminal conviction.
K. The applicant's history shows an ability to relate to others in a harmonious, collegial manner.
L. No questions have been raised by either the service chief or any other member of the medical staff.

As part of the process of making a recommendation, the service chief may meet with the applicant to discuss the application, qualifications and clinical privileges requested. The service chief will then prepare a report and forward it to the chief of staff. The report will recommend the membership and clinical privileges be granted.

The chief of staff, acting on behalf of the Medical Executive Committee, will review the report and recommendation made by the service chief. If he or she approves, the recommendation will be forwarded to the hospital president.

The Chief Executive Officer, acting on behalf of the Board, may grant the individual an interim appointment to the medical staff and interim clinical privileges for a period of 60 days.

In the event the service chief, the Chief of Staff or the Chief Executive Officer has any questions about the applicant, the questions will be noted, and the matter will be referred to the full Medical Executive Committee for further review **and action.**

A report regarding all applicants who are granted interim appointment and privileges will be forwarded to the Medical Executive Committee for review and confirmation and to the Board for final action.

7.5 **Temporary Privileges during a Disaster**
For the purpose of this Section, a "disaster" is defined as an uncontrolled or **unforeseen occurrence in the community that causes large numbers of injured or** sickened persons.

1. Temporary Disaster Privileges may be granted providing:
- **The emergency management plan has been activated.**
- There is not adequate staff to provide emergent care to all the patients presenting at the hospital.
- **Physicians and other professionals volunteer to provide care.**

2. The chief executive officer or his/her designee, or the chief of medical staff **may approve temporary disaster privileges during a national or state emergency** (disaster) situation.

(a) The responsible individual is not required to approve disaster privileges **and will make privileging decisions on a case-by-case basis at his or her discretion.**

(b) The individual may grant disaster privileges upon review and evaluation of any of the following:

- A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in **emergency circumstances, such authority having been granted by** a federal, state, or municipal entity.
- Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

3. Under these extreme circumstances, the hospital shall be permitted to grant **temporary disaster privileges to a licensed independent practitioner of known** reputation and quality that holds medical staff membership at another fully accredited institution. The granting of such privileges will be timely and will **require minimal documentation.**

4. The approved volunteer practitioner providers will wear a "Volunteer Provider" nametag and will be paired off with medical staff members, preferably members of the same specialty. The approved volunteer must practice under the direction **of an existing medical staff member.**

5. The Medical Staff Coordinator or designee will begin the credentials **verification process as soon as the immediate situation is under control following** these bylaws directives for granting temporary privileges to fulfill an important patient care need. Every effort will be made to verify medical license and **malpractice insurance coverage before granting emergency disaster privileges.**

6. Emergency temporary privileges will be terminated once the disaster situation **subsides.**

7.6 Delivery of Telemedicine

Telemedicine as the term is used in federal regulations means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the patient either simultaneously (in real time), as in tele ICU services, or non-simultaneously (after the fact interpretation of diagnostic tests), as with teleradiology services.

Licensed independent practitioners (LIP) who are responsible for care, treatment**, and services of the patient via telemedicine link are subject to three** options for the credentialing and privileging process:

1 – they are subject to the credentialing and privileging process of the originating site (Ascension Borgess Allegan Hospital) alone;

2 – they are subject to the credentialing and privileging process of the distant-site hospital (another Medicare participating hospital) if Ascension Borgess Allegan Hospital (AGH) executes a written contract with the distant- site hospital where AGH can rely on the distant-site hospital's credentialing and privileging decision as allowed by the Centers for Medicaid and Medicare Services (CMS) Conditions of Participation Section 485.616 - Agreements; or

3 – they are subject to the credentialing and privileging process of the distant-site telemedicine entity if AGH executes a written contract with the distant-site telemedicine entity where AGH can rely on the distant-site telemedicine entity's credentialing and privileging decision as allowed by the CMS Conditions of Participation Section 485.616 - Agreements.

Any decision to execute a written contract with a distant-site hospital or distant-site telemedicine entity will be made at a regular or special meeting of the Medical Executive Committee with approval by the Governing Body only.

Evidence of an internal/external review of the practitioner's performance of these privileges is requested from the practitioner's primary site in assisting the practitioner's quality of care, treatment, and service he/she is privileged and for **performance improvement. At a minimum, this information may include adverse** outcomes related to sentinel events considered reviewable by the Joint Commission **that result from the telemedicine services provided, and complaints** about distant site LIP from patients, other practitioners, or staff at AGH. All information received will be kept under the Michigan Quality Review Laws.

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ARTICLE 8: CORRECTIVE ACTION

1. DISCRETIONARY INTERVIEW PRIOR TO CORRECTIVE ACTION

Nothing in these Bylaws shall prevent Medical Staff officers, Members of the Medical Staff or the administrative staff of the Hospital from informally **investigating possible causes for corrective action, interviewing the involved practitioners and attempting to resolve all such matters without resort to formal corrective action. Informal counseling is expected and encouraged, but not** required. It is hoped that formal requests for corrective action will not ordinarily **be used until and unless informal methods have failed.**

A practitioner whose privileges have been summarily suspended is entitled to a hearing and appeal, providing the summary suspension is deemed adverse, as set forth in Article Fifteen.

2. CRITERIA FOR INITIATION

Any person may provide information to the Chief Executive Officer or Medical **Executive Committee about the conduct, performance, or competence of its** Members. When reliable information indicates a Member may have exhibited acts, demeanor, or conduct reasonably likely to be:

- detrimental to staff, visitor or patient safety, the delivery of quality patient care within the Hospital or the orderly functioning of the Hospital or Medical Staff:
- **unethical;**
- contrary to the Hospital Bylaws or Policies and Procedures, or the Medical Staff Bylaws and Rules and Regulations:
- in violation of state or federal law, or below applicable professional **standards, a request for an investigation or action against such Member** may be initiated by the Chief Executive Officer or designee, the Chief of Staff, or the Medical Executive Committee.
- **The above also applies in those instances where a Member's habitual over-utilization of services, beyond the requirements of quality of care, and after educational efforts to provide change have failed, results in** continual substantial monetary loss to the Hospital under the Medicare or Medicaid programs or from other third-party payors or managed health **care plans.**

3. INITIATION

A request for an investigation must be in writing, must be submitted to both the Medical Executive Committee and Chief Executive Officer, and must be supported by reference to specific activities or conduct alleged including witnesses, incident reports, medical records, or other documentation known and available to the person bringing the request. If the Medical Executive Committee initiates the request, it shall make an appropriate recording of the reasons.

4. INVESTIGATION

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. It is at this time that a formal investigation for purposes of the Health Care Quality Improvement Act begins. The Medical Executive Committee shall use its best efforts to complete the investigation within thirty (30) days. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate Medical Staff committee, standing or ad hoc. If the investigation is delegated to a committee other than the Medical Executive Committee, **such committee shall proceed with the investigation in a prompt manner and** shall forward a written report of the investigation to the Medical Executive Committee as soon as appropriate follow up is completed. The report may **include recommendations for appropriate corrective action. The Member** shall be notified in writing that an investigation is being conducted. In addition, the Member shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The committee investigating the matter may, but is not obligated to, conduct **interviews with persons involved; however, such investigation shall not** constitute a "hearing" as that term is used in Article Fifteen and *at the* ***committee's sole discretion a*** **Member's legal counsel *may* be permitted to** attend, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever **action may be warranted by the circumstances, investigative process, or** other action.

5. MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as possible after the conclusion of the investigation, the Medical **Executive Committee shall act which may include, without limitation:**

(a) Determining no corrective action be taken and, if the Medical Executive Committee determines there was not credible **evidence for the complaint in the first instance, document** final disposition and maintain all information in the Member's credential peer review file;

(b) Deferring action for a reasonable time where circumstances warrant;

(c) Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude **department managers from issuing information, written or oral warnings, outside of the mechanism for corrective action. In the event such letters are issued, the affected** Member may make a written response which shall be placed in the Member's confidential peer review file;

(d) Imposing terms of probation or recommending special limitation upon continued Medical Staff membership or **exercise of Clinical Privileges, including without limitation, requirements for co-admission, mandatory consultation, or monitoring;**

(e) Recommending reduction, modification, suspension or revocation of Clinical Privileges;

(f) Recommending reductions of membership status or limitations of any prerogatives directly related to the Members delivery of patient care;

(g) Recommending suspension, revocation or probation of Medical Staff membership; or

(h) taking other actions deemed appropriate under the **circumstances.**

6. <u>SUBSEQUENT ACTION</u>

(a) If the medical staff member in question concurs with the recommendations of the Medical Executive Committee, or if **the recommendations of the Medical Executive Committee are deemed non-adverse, then the recommendations shall** be implemented, there will be no further actions taken and this process will be considered finalized, subject to any statutory reporting requirements.

(b) If the medical staff member does not concur with the above **recommendations, and adverse corrective action is** recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of **Trustees.**

(c) The recommendation of the Medical Executive Committee shall become final action when approved by the Board of **Trustees unless the Member is entitled to and requests a hearing, in which case the final decisions shall be** determined as set forth in Article Fifteen.

7. <u>SUMMARY RESTRICTION OR SUSPENSION</u>

A. CRITERIA FOR INITIATION

Whenever a Member's conduct appears to require that immediate action 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, or safety of any **patient, prospective patient, or other person, or Is so disruptive as to threaten the** orderly function of the Hospital, the Chief Executive Officer, Chief of Staff and

Medical Executive Committee acting as a peer review committee may summarily restrict or suspend the staff Clinical Privileges of such Member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the Chief Executive Officer or designee shall promptly give written notice to the Member. The summary 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. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another Member by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute Member.

B. MEDICAL EXECUTIVE COMMITIEE

Within fifteen (15) calendar days after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request, the Member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the Member, constitute a "hearing" within the meaning of Article Fifteen, and at the committee's sole discretion a Member's legal counsel may be permitted to attend, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event, it shall furnish the Member with notice of its decision.

C. PROCEDURAL RIGHTS

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, the Member shall be entitled to the procedural rights afforded by Article Fifteen.

8. AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the Member's Privileges or membership may be suspended or limited as described, which action shall be final without a right to hearing or further review, pursuant to Article Fifteen, where a bona fide dispute exists as to whether the circumstances have occurred, at the member's written request, but upon the sole discretion of the Medical Executive Committee, an informal review may take place in the manner described in subsection 8.7(b) above.

1. LICENSE

(a) **Revocation and Suspension:** Whenever a Member's license or other legal credential authorizing practice in this State is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(b) Revocation and Suspension: Medical Staff membership and clinical privileges shall be automatically revoked or suspended whenever a member fails to maintain the minimum amount of professional liability insurance as required in Section 6.1.

(c) Restriction: Whenever a Member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at the Hospital which 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.

(d) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his/her membership status and 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.

(e) Sanction by Medicare or Medicaid.

2. CONTROLLED SUBSTANCES

(a) Whenever a member's Michigan Controlled Substance License and/or DEA Certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective throughout its term.

(b) Probation: Whenever a member's Michigan Controlled Substance License and/or DEA Certificate is subject to probation, the member'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.

9. FAILURE TO SATISFY SPECIAL APPEARANCE REQUIREMENT

Where the Medical Executive Committee has requested that a member attend a meeting that involves a corrective action against the member, and such notice to the member includes time, date, place, and purpose of the request, the member must attend. If the member fails to attend without good cause, then, at the sole discretion of the individual in charge at the meeting, he or she may convene the meeting and carry on business for the purpose in which it was convened as if the member had attended.

10. MEDICAL RECORDS

Members of the Medical Staff are required to complete medical records within such reasonable time as shall be prescribed by the Medicare Conditions of Participation for Hospitals, the Michigan Department of Community Health, and Joint Commission Accreditation of Healthcare Organizations (JCAHO). A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief Executive Officer, Chief of Staff, or his/her designee, or the Medical Executive Committee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means on-call **service for the emergency room, scheduling surgery, assisting in surgery,** consulting on Hospital cases, and providing professional services within the Hospital **for future patients. Bona fide vacation or illness may constitute an** excuse subject to approval by the Medical Executive Committee or Chief of Staff. **Members whose privileges have been suspended for delinquent records may** admit patients, but only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff, or his/her designee. See Section 3 of the Medical Staff Rules & Regulations.

11. MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as possible after action is taken or warranted as described in this Article, the Medical Executive Committee shall convene to review and consider **the facts and may recommend such further corrective action as it may deem** appropriate following the procedures set forth above.

<u>ARTICLE 9: OFFICERS</u>

<u>Officers of the Medical Staff</u>

The officers of the Medical Staff will be:

A. Chief of Staff
B. Vice Chief of Staff-Secretary-Treasurer

<u>Qualifications of Officers</u>

Officers must be members of the Active Medical Staff and a licensed M.D. or **D.O. at the time of nomination and election and must remain members in good** standing during their term of office. Failure to maintain such status will immediately **create a vacancy in the involved office.**

<u>Nomination of Officers</u>

The Chief of Staff will appoint a nominating committee of at least two individuals (including him or herself) to develop a slate of nominees, with at least one name for each officer position. Nominations may also be made from the floor during the **election process.**

<u>Election of Officers</u>

Officers will be elected at the annual meeting of the Medical Staff to be held in December of each year. Only members of the active Medical Staff will be eligible to vote. A 51% majority vote is required for election.

<u>Terms of Office</u>

All officers will serve a two-year term from their election date or until a successor is elected. Officers will take office on the first day of the Medical Staff year which **is a calendar year.**

<u>Vacancies in Office</u>

The Medical Staff will fill vacancies in office during the Medical Staff year. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff will serve out the remaining term. If necessary, the new Chief of Staff will appoint a replacement for the Vice Chiefs office that will be reviewed and ratified at the next Medical Executive Committee meeting. If there is a vacancy in the Vice Chief of Staff's office, the Chief of Staff will appoint a replacement that will be reviewed and ratified at the next Medical Executive Committee meeting.

<u>Duties of Officers</u>

The Chief of Staff will serve as the Chief Medical Administrative Officer and will:

A. **Coordinate the activities and concerns of the Hospital President in** all matters of mutual concern within the Hospital with the Medical Staff;
B. Account to the Governing Body, in collaboration with the Medical Executive Committee, for the quality and efficiency of clinical services and professional performance within the Hospital and for the effectiveness of patient care monitoring and Quality

Management activities delegated to the Medical Staff;

C. Appoint Medical Staff representatives to Medical Staff and Hospital committees, and Service Chiefs. The Chief of Staff will have the ultimate and final responsibility for the selection of such **representatives; Communicate and represent the opinions, policies,** concerns, needs, and grievances of the Medical Staff to the Governing Body, Hospital President, Medical Staff, and other **officials;**

E. Assume responsibility for enforcement of the medical staff bylaws, fair hearing, and rules and regulations for the implementation of **sanctions where these are indicated, for the medical staff's** compliance with procedural safeguards in all instances where **corrective action has been requested against a practitioner;**

F. Call, preside at, and be responsible for the agenda of all general **medical staff meetings;**

G. Serve as chairperson of the Medical Executive committee and an **ex- officio member of all other medical staff committees and/or** functions;

H. Receive and interpret the policies of the governing body to the medical staff and report to the governing body on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care

I. Act as spokesperson for the medical staff in its external professional and public relations; and

J. Assume responsibility for the educational activities of the medical staff.

<u>The Vice Chief-Secretary-Treasurer,</u> in the absence of the Chief of Staff, will assume all the duties and have the authority of the Chief of Staff. The Vice Chief will:

A. Be a member of the Executive Committee of the Medical Staff;

B. Will automatically succeed the Chief of Staff if the latter fails to **serve for any reason.**

C. **Perform other duties as ordinarily pertain to said office.**

<u>Removal of Officers</u>

The officers of the Medical Staff may be removed during their term of office by the Governing Body acting upon its own initiative or by a two-thirds vote by secret ballot of the Active Medical Staff, such votes to be taken at a special meeting called for that purpose.

Permissible grounds for removal of Medical Staff officers include, but are not limited to:

A. **Failure to perform the duties of the office as described in these** Bylaws; or failure to continuoulsy satisfy the qualifications of the office.

ARTICLE 10: ORGANIZATION

10.1 Organization of Services

The Medical Staff is organized with the following Services and Sections:

A. Internal Medicine
   i. Psychiatry
B. Family Practice
   i. Pediatrics Section
C. Surgery
D. Emergency Medicine
E. Radiology
F. Pathology

10.2 Medical Staff Service Chiefs

Each chief will be board certified in [his or her service] a specialty relevant to responsibilities in the service, or board-eligible, if applicable, and anticipating certification within 18 months of appointment. The Medical Executive Committee, **on an individual basis, will evaluate exceptions to determine comparable** competence. Each chief will also be qualified by relevant experience and demonstrated ability for the position. The Chief of Staff will appoint each Service Chief for a two-year term. No such appointment will be effective until it has been reviewed and ratified by the Executive Committee of the Medical Staff when a Service Chief position is vacated during the year or during their January meeting (after the officers have been elected in December).

Removal of a service chief during a term of office may be initiated by two-thirds majority vote of all active staff members of the service, but no such removal will be effective unless and until it has been ratified by the Executive Committee of the Medical Staff.

10.3 Functions of Service Chiefs

The Chief of each service is responsible for the ongoing, effective operation of **the service and for assessing and improving its activities. This encompasses not** only the internal functioning, but also the integration of each service into the overall functioning of the hospital.

Each Chief will, within his or her own service:

1. Establish, together with the medical staff and administration, the type and scope of services required to meet the needs of the patients and the hospital;
2. Participate in every phase of the administration of the service through **cooperation with hospital staff and administration in matters affecting** patient care, including personnel, supplies, special regulations, quality **improvement programs, standing orders and techniques, space and other resources;**
3. Develop and implement policies and procedures that guide and support

4. Be responsible for enforcement of the Hospital Bylaws and the Medical Staff Bylaws, Rules and Regulations;
5. Recommend to the medical staff criteria for clinical privileges in the service;
6. Recommend clinical privileges for each member in the service;
7. Carry out continuous surveillance of the professional performance of all individuals with clinical privileges in the service and report regularly to the Medical Executive Committee;
8. Continuously assess and improve the quality of care provided within the service;
9. Assist in the orientation and continuing education of all staff;
10. Assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by the service or organization.
11. Assist in the integration of the department or service into the primary functions of the organization.
12. Assist in the coordination and integration of interdepartmental and intradepartmental services.
13. Make recommendations for a sufficient number of qualified and competent persons to provide the appropriate care, treatment, and service.
14. Assist with the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services.
15. Assist with the maintenance of quality improvement, risk management and patient safety programs within the department or service, as appropriate.
16. Make recommendations for space and other resources needed by the department or service.

10.4 Assignment to Services

The Executive Committee will, after consideration of the recommendation of the medical service chief, recommend initial service assignment for all Medical Staff members and for all other approved practitioners with clinical privileges.

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ARTICLE 11: MEDICAL STAFF COMMITTEES

11.1 Medical Executive Committee

Composition: The Medical Executive Committee will be a standing committee and will consist of the following: The Chief of Staff; the Vice Chief of Staff/Secretary Treasurer; The Chiefs of Medicine, Surgery, Family Practice, Pathology, Radiology and Emergency Medicine Services. The Hospital President and CEO, Chief Clinical Officer, the Chief Quality, Risk and Compliance Officer, and the Medical Records Manager will be ex-officio members without a vote. No medical staff member actively practicing in the hospital will be ineligible for membership on the MEC solely because of his or professional discipline or specialty. A majority of voting members on the MEC will be fully licensed physician members of the active staff.

Functions: The Medical Executive Committee (MEC) is delegated primary authority over activities related to the functions of self-governance of the medical staff and over activities related to the functions of performance improvement of the professional services provided by individuals with clinical privileges. It is empowered to act for the medical staff as a whole in the intervals between medical staff meetings. Specific functions include:

A. Makes recommendations directly to the governing body regarding:
   1. The medical staff's structure
   2. The mechanism used to review credentials and to delineate individual clinical privileges
   3. Recommendations for individual medical staff membership
   4. Recommendations for individual delineated clinical privileges
   5. Participation of the medical staff in performance improvement activities
   6. The mechanism by which medical staff membership may be terminated
   7. The mechanism for fair hearing procedures.
   8. The clinical services are appropriately delivered by the LIP through telemedicine linkage.
   9. The therapeutic dietary manual will be reviewed and approved thought the MEC.
   10. Medical staff representatives participate in the institutional plan and budgeting processes.

B. Receive and act upon reports and recommendations from medical staff committees, clinical services and assigned activity groups.

C. Provide leadership in the design of mechanisms for medical staff **performance improvement, including medical assessment/treatment of patients, use of medications, use of blood and blood components, use of operative and other procedures,** efficiency of clinical practice patterns and significant departures from established patterns of clinical practice.

Meetings: Will be monthly, or more often as needed
Minutes: Will be kept of all meetings, documenting conclusions, **recommendations and actions taken.**

11.2 Acute Care Committee

The Acute Care Committee is formed for the purpose of monitoring and evaluating the care provided to acutely ill patients in order to facilitate continued **improvement in that care. The committee will review policies and procedures, peer review cases, and make recommendations as appropriate to the Medical** Staff at their monthly meetings. The Acute Care Committee will include the Service Chiefs of Internal Medicine, Family Practice, Pediatrics, and Emergency Department and a physician member of Surgical Services. Hospital personnel will serve on the committee as determined by the committee itself. Minutes of all Acute Care meetings will be forwarded to the Medical Executive Committee. Quality care issues concerning Medical Staff will also be forwarded to the **Medical Executive Committee for action and follow-up.**

11.3 Pharmacy and Therapeutics Function

This function will be coordinated by the medical staff (one physician appointed by the Chief of Staff), the Chief Pharmacist and a hospital representative. The scope of this function will include: the development and approval of policies and procedures relating to the acquisition, storage, handling, and distribution of drugs and diagnostic testing materials; the development and maintenance of the Hospital Drug Formulary including changes as appropriate; the evaluation and **approval of protocols relating to the use of investigational or experimental drugs** in the hospital, including the use of approved drugs for non-approved indications; the development of a definition of a significant drug reaction and the review of all **such reactions; and, measurement of medication processes related to prescribing/ordering, preparing/dispensing, administering, and monitoring the** effects of drugs on patients. Activities and findings will be reviewed and reported **directly to the Performance Improvement and Medical Executive Committees.**

11.4 Medical Education

This function will be coordinated by the Medical Records Manager, who will be responsible for analyzing the changing needs of the hospital's medical education and library services. These activities will include deletion of outmoded material as well as the accusation of new material.

- **Hospital -sponsored educational activities are offered.**

- **These activities relate, at least in part, to the type and nature of care,** treatment, and services offered by the hospital.
- The organized medical staff helps prioritize hospital-sponsored continuing **education.**
- **Education is based on the findings of performance improvement activities.**

11.5 Medical Ethics Committee

The team will assist in the resolution of conflicts in care decisions as they might arise between the organization, the physician, the patient and/or surrogate decision **maker. These decisions may involve admission, treatment, discharge, withholding resuscitative services and foregoing or withdrawing life-sustaining** treatment. The Chief of Staff will appoint at least one physician participant whowill serve as the Team Leader. An alternate physician appointee is **recommended for vacation coverage, or when the Team Leader is not readily** available.

11.6 Performance Improvement Committee

The Performance Improvement Committee has the function to review quality, patient safety, risk management, case management, pharmacy and therapeutics, and forms review oversight throughout the hospital. A physician representative will be included, in addition to the Chief of Staff, as necessary. The medical staff designates the Performance Improvement Committee to provide **leadership in activities related to patient safety, risk management, quality measuring by assessing, improving processes, implementing and monitoring strategies to reduce medical errors. The Utilization Plan is reviewed at this committee.**

11.7 Surgeon's Council

The Surgeon's Council is composed of the physicians who are privileged to perform surgery at this hospital. The purpose of this committee is to monitor and**evaluate the care provided to patients who undergo surgery and/or an invasive procedure. The committee will review policies and procedures and make** recommendations as appropriate to the Medical Staff at their regular meetings.

11.8 Invasive Procedure/Transfusion Review Committee

The Invasive Procedure/Transfusion Review Committee are composed of the chief of surgery services, a pathologist as assigned, and members of the hospital surgery and laboratory staff. The purpose of these committees is to monitor and evaluate the care provided to patients who undergo an invasive procedure, and **transfusions and other blood products. This committee will review policies and procedures, peer review cases, and make recommendations as appropriate to** the Medical Staff at their regular meetings.

11.9 Liaisons to Hospital Committees

*The Chief of Staff will appoint physician members to the following hospital committees:

*Safety/Employee Health: one physician advisor, if necessary
***Infection Control: one physician advisor**

Minutes from all of these committees will be forwarded to the Medical Executive **Committee for review. When findings from any committees/functions relate to** the performance of an individual with medical staff membership or privileges, the **MEC will determine their use in peer review, ongoing monitoring and evaluation of the individual practitioner's competence.**

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ARTICLE 12: MEDICAL STAFF

12.1 Regular Meetings

Regular meetings of the Whole will be held on the second Tuesday of March, June, September and December. An educational meeting of the Medical Staff will be held on the fourth Tuesday of each month. The meeting in December will be the staff meeting at which election of officers for the ensuing period will be conducted. The Medical Executive Committee will, by standing resolution, designate the time and place for all regular staff meetings. Notice of the original **resolution and any changes will be given to each member of the staff in the** same manner as provided in Section 2 of this Article XII for notice of a special **meeting.**

12.2 Special Meetings

Special meetings of the Medical Staff may be called at any time upon order of the Chief of Staff or the Hospital President, or upon request of any five members of the staff. Notice of such special meeting will be given to the members of the staff at least two days prior to said meeting; such notice may be given by telephone to the business officer of the members.

12.3 Quorum

Voting members present will constitute a quorum for purposes of conducting medical staff business. The Chief of Staff or designee may table a vote if **representation is deemed insufficient.**

12.4 Attendance Requirements

To promote continuous improvement in the quality of patient care and service, attendance at meetings of the Whole is strongly encouraged as a mechanism for communication, performance improvement, education and other peer activities.

12.5 Agenda

The Chief of Staff in cooperation with Hospital Administration will determine the order of business at a regular meeting of the Whole.

The agenda at special meetings will include reading of the notice calling the meeting and transaction of business for which the meeting was called.

ARTI CLE 13: COMMITTEE AND SERVICE MEETINGS

13.1 Regular Meetings
Committees and services may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

13.2 Special Meetings
A special meeting of any committee or service may be called by or at the request of the chairperson of chief thereof, by the Chief of the Medical Staff, or by 113 of the group's members, but no less than two.

13.3 Notice of Meetings.
Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution will be given to each member of the committee or service at least three days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting will be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on hospital records, with postage thereon prepaid. The attendance of a member at a meeting will constitute a waiver of notice of such meeting.

13.4 Quorum
The voting members present will constitute a quorum for purposes of conducting medical staff business. The chairperson or other medical staff member may table the vote if representation is deemed insufficient.

13.5 Manner of Action
The action of a majority of the members present at a meeting at which a quorum is present will be the action of a committee or service. Action may be taken without a meeting by unanimous consent in writing setting forth the action so taken, signed by each member entitled to vote thereat.

13.7 Minutes
Minutes of each regular and special meeting of a committee or service will be prepared and will include a record of the attendance of members and vote taken on each matter. The presiding officer will sign the Minutes and copies thereof will be promptly submitted to the attendees for approval and, after such approval is obtained, forwarded to the Executive Committee. Each committee and service will maintain a permanent file of the Minutes of each meeting.

13.8 Attendance Requirements
Members of all committees and active staff members in each service must attend at least 60% of all meetings (including the executive committee) in each calendar year. The failure to meet annual attendance requirements, unless excused by the committee chairperson, service chief, or stipulated by the MEC,

may be grounds for corrective action leading to revocation of Medical Staff **membership in the same manner and to the same effect as provided in article** 12, section 4 of these bylaws. Committee chairpersons will report such failures to **the Executive Committee for action.**

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ARTICLE 14: **IMMUNITY FROM LIABILITY**

The following will be express conditions to any practitioner's application for, or exercise of, clinical privileges at this hospital:

First, that any act, communication, report, recommendation, or disclosure with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, will be privileged to the fullest extent permitted by law.

Second, that such privilege will extend to members of the hospital's Medical Staff and of its Governing Body, its other practitioners, its President and his representatives, and to third parties who supply information to any of the **foregoing authorized to receive, release, or act upon the same. For the purpose** of this Article Fourteen, the term Third Parties means both individuals and **organizations from which information has been requested by an authorized** representative of the Governing Body, the Medical Staff or the President.

Third, that there will, to the fullest extent permitted by law, be absolute immunity **from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information would otherwise be** deemed privileged.

Fourth, that such immunity will apply to all acts, communications, reports, **recommendations, or disclosure performed or made in connection with this or** any other health care institution's activities related, but not limited to:

- **A. Applications for appointment or clinical privileges,**
- **B. Periodic reappraisals for reappointment of clinical privileges,**
- **C. Corrective action, including summary suspension,**
- D. Hearings and appellate review,
- **E. Medical care evaluations,**
- **F. Utilization reviews and,**
- **G. Other hospital, service or committee activities related to quality patient care and interprofessional conduct.**

Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this Article Fourteen may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly **have an effect on patient care.**

Sixth, that the furtherance of the foregoing, each practitioner will upon request of the hospital execute releases in accordance with the tenor and import of Article **Fourteen in favor of the individuals and organizations specified in Paragraph** 2, subject to such requirements, including those of good faith, absence of malice and exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the state.

Seventh, That the consent, authorizations, releases, rights, privileges and immunities provided by Article Six of these bylaws for the protection of this **hospital's practitioners, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, will also be** fully applicable to the activities and procedures covered by this Article Fourteen.

ARTICLE 15: HEARING AND APPELLATE REVIEW

PROCEDURE PREAMBLE

The Board of Trustees, Medical Staff, and any committees and/or agents thereof, in order to conduct professional peer review activity, hereby constitute themselves as peer review and professional review committees as defined by the Michigan Peer Review Act and the Health Care Quality Improvement Act of 1986. Such committees or agents hereby claim all privileges and immunities *afforded* to them by said federal and state statutes. The purpose of this Article is to provide a mechanism through which a fair hearing, and appeal *are* provided to all professional healthcare providers having privileges or applying for privileges at the Hospital. These procedures are intended to comply with the Health Care Quality Improvement Act of 1986 and the Michigan Peer Review Act. As such, any action taken pursuant to this Article shall be in the reasonable belief that such was in the furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality medical care in the Hospital), only after a reasonable *effort* has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any professional health care provider involved, and only in the reasonable belief that the action was warranted by the facts known after a reasonable *effort* has been made to obtain the facts.

15.1 GENERAL PROVISIONS

1. EXHAUSTION OF REMEDIES

If adverse action described in Article VI is taken or recommended, the applicant or Member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

2 APPLICATION OF ARTICLE

(a) For purposes of this Article, the term "Member" may include "applicant" as it may be applicable under the circumstances.

(b) Under Article 8 of these Bylaws, circumstances may arise in which an initial hearing is provided by the Board of Trustees. In such cases, the procedures set forth herein for hearings before the hearing committee ("Hearing Committee") shall generally apply to hearings before the Board of Trustees, except as reasonably modified by the Board of Trustees. Circumstances may also arise when an appeal is made to an ad hoc Committee as established by the Board of Trustees and Medical Executive Committee in which case the procedures applicable to appeals to the Board of Trustees shall apply, except as reasonably modified by the ad hoc Committee.

(c) Members who are directly under contract with the Hospital in a **capacity where the contracted services require membership on the Medical Staff, such as medical-administrative capacity or in** closed departments shall be subject to the procedural rights specified in these Medical Staff bylaws, except as may be modified by contract with the Hospital.

15.2 GROUNDS FOR HEARING

1. RECOMMENDATIONS OR ACTIONS

Except as otherwise specified in these Bylaws, any one (1) or more of the following actions or recommended actions shall be deemed an actual or **potential adverse action and constitute grounds for a hearing upon timely and** proper request:

(a) Denial of Medical Staff membership;
(b) Denial of requested advancement in staff membership status, **or category;**
(c) Denial of Medical Staff reappointment;
(d) Involuntary change of Medical Staff category except an administrative change Article 8;
(e) Suspension, restriction, or termination of membership status;
(f) Revocation of Medical Staff membership;
(g) Denial or restriction of requested Clinical Privileges, excluding **temporary Privileges (unless such denial of temporary Privileges acts as a denial of an application for membership);**
(h) Involuntary reduction of current Clinical Privileges;
(i) Suspension of Clinical Privileges for a period of longer than fourteen (14) days;
U) Termination or revocation of all Clinical Privileges for a period of longer than fourteen (14) days;
(k) Involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status); or
(l) Suspension or limitation of the right to admit patients or of any **other membership prerogative directly related to the Member's provision of patient care.**

2. WHEN DEEMED ADVERSE

A recommendation or action by the Medical Staff, including without limit those listed in Section 15.2-1 is adverse only when it relates to a **Member's professional competence or conduct; is in or may be in** effect for a period in excess of fourteen (14) days and has been:

(a) Recommended by the Medical Executive Committee; or

(b) Taken by the Board under circumstances where no prior right to request a hearing existed.

3. WHEN DEEMED NON-ADVERSE

All other recommendations or actions by the Medical Staff shall not be **deemed adverse and shall not give rise to a hearing under this,** including:

(a) Probation. The Medical Executive Committee may impose the following terms of probation on a Member without giving rise to the right to a hearing or appeal pursuant to this Article:

1) Required physical examination and reports on the Member by a practitioner chosen by the Medical **Executive Committee; and**

2) Required psychological and/or psychiatric examinations and reports on the Member by a practitioner chosen by the Medical Executive Committee.

(b) Reprimand or Warning. The Medical Executive Committee **may discuss a request for corrective action against a Member** with a reprimand or warning to the Member without giving rise to any right to a hearing or appeal. Such a reprimand or **warning shall be made part of a Member's peer review file for internal use only but shall not be reported as substantive corrective action to the Medical Licensing Board or to any Peer Review Committee or others making inquiry regarding the** Member. Such a reprimand or warning shall be considered in the nature of instruction and guidance to the Member rather **than as any form of punishment.**

(c) Action pending investigation. When a restriction or suspension is for a period of less than fourteen (14) days or during a **period in which an investigation is being conducted to determine the need for professional review action.**

(d) Voluntary reduction of clinical privileges. A voluntary reduction **of clinical privileges for reasons of personal preference.**

(e) Any action that detrimentally relates to an affiliate staff (section 5.7) or honorary member (section 5.6) medical staff **status or a member's emergency clinical privileges (section** 7.3) or is an automatic suspension or limitation (section 8.8) **is deemed non-adverse.**

15.3 Right to Hearing and to Appellate Review

When any practitioner receives notice of a recommendation of the Executive Committee that, if ratified by decision of the Governing Body, will adversely affect appointment to or status as a member of the Medical Staff or exercise of clinical privileges, he or she will be entitled to a hearing before an ad hoc committee of the Medical Staff. If the recommendation of the Executive Committee following such hearing is still averse to the affected practitioner, he or she will be entitled to an appellate review of the Governing Body before the Governing Body makes a final decision on the matter.

When any practitioner receives notice of a decision by the Governing Body that will affect appointment to or status as a member of the Medical Staff or exercise of clinical privileges, and such decision is not based on a prior adverse recommendation by the Executive Committee of the Medical Staff with respect to which there is entitlement to a hearing and appellate review, there will be entitlement to a hearing by a committee appointed by the Governing Body, and if such hearing does not result in a favorable recommendation, to an appellate review by the Governing Body, before the Governing Body makes a final decision on the matter.

All hearings and appellate reviews will be in accordance with the procedural safeguards set forth in this Article Fifteen to assure that the affected practitioner is accorded all rights to which he is entitled.

Physicians in a medico-administrative position; i.e., physicians compensated by the hospital for administrative duties, will, if needed, be subject to disciplinary action in the following manner. The Hospital President and Board of Trustees will handle all matters relating to compensated administrative physician services. All other physician matters are handled according to the policies and procedures as outlined in the Medical Staff Bylaws, Rules and Regulations.

15.4 Request for Hearing

The Hospital President will be responsible for giving prompt written notice of an adverse recommendation or decision to any affected practitioner who is entitled to a hearing or to an appellate review, by certified mail, return receipt requested. The President will:

A. Advise the applicant of the right to a hearing or an appellate review pursuant to this Article Fifteen;

B. Specify that the applicant will have seven days following the date of receipt of such notice within which to request a hearing or an appellate review;

C. State that failure to request a hearing or an appellate review within the specified time period will constitute a waiver of the right to the same;

D. State that upon receipt of the request, the applicant will be notified of the date, time and place for the hearing or appellate review and

E. Advise the applicant of the right to review the hearing record and **report, if any, and to submit a written statement in his or her own** behalf as part of the appellate procedure.

The failure of a practitioner to request a hearing described by these Bylaws within the time and in the manner herein provided will be deemed a waiver of rights to such a hearing and to any appellate review to which might otherwise be allowed in the matter. The failure of a practitioner to request an appellate review allowed by these Bylaws within the time and in the manner herein provided will **be deemed a waiver of rights to such an appellate review on the matter.**

When the waived hearing or appellate review relates to an adverse recommendation of the Executive Committee of the Medical Staff or of a hearing **committee appointed by the Governing Body, the same will thereupon become** and remain effective against the practitioner pending the Governing Body's **decision on the matter. When the waived hearing or appellate review relates to** an adverse decision by the Governing Body, the same will thereupon become **and remain effective against the practitioner in the same manner as a final** decision of the Governing Body provided for in this Article Fifteen. In either of such events, the President will promptly notify the affected practitioner of his or her status by certified mail, return receipt requested.

15.5 Notice of Hearing

Within seven days after receipt of a request for hearing from a practitioner entitled to the same, the Executive Committee or the Governing Body, whichever is appropriate, will schedule and arrange for such a hearing and will, through the President, notify the practitioner of the time, place and date so scheduled, by certified mail, return receipt requested. The hearing date will be not less than seven days, nor more than 30 days from the date of receipt of the request for **hearing; provided, however, that a hearing for a practitioner who is under suspension which is then in effect will be held as soon as arrangements** therefore, may reasonably be made, but not later than 14 days from the date of receipt of the practitioner's request for hearing.

The notice of hearing will report in concise language the acts or omissions with which the practitioner is charged, a list of specific or representative charts being **questioned, and/or the other reasons or subject matter that was considered in making the adverse recommendation or decision.**

15.6 Composition of a Hearing Committee

When a hearing relates to an adverse recommendation of the Executive Committee, such hearing will be conducted by an ad hoc hearing committee of not less than three members of the Medical Staff appointed by the Chief of Staff **in consultation with the Executive Committee, and one of the members so**

appointed will be designated as chairperson. No staff member who has actively participated in the consideration of the adverse recommendation will be appointed a member of this hearing committee unless it is otherwise impossible to select a representative group due to the size of the Medical Staff.

When a hearing relates to an adverse decision of the governing Body that is contrary to the recommendation of the Executive Committee, the Governing Body will appoint a hearing committee to conduct such hearing and will **designate one of the members of this committee as chairman. At least one** representative from the Medical Staff will be included on this committee.

15.7 Conduct of Hearing

There will be at least a majority of the members of the hearing committee present when the hearing takes place, and no member may vote by proxy.

An accurate record of the hearing must be kept. The mechanism will be established by the ad hoc hearing committee and may be accomplished by use **of a court reporter, electronic recording unit, and detailed transcription or by the taking of adequate Minutes.**

The personal presence of the practitioner for whom the hearing has been scheduled will be required. A practitioner who fails without good cause to appear **and proceed at such hearing will be deemed to have waived the right in the** same manner as provided in this Article Fifteen and to have accepted the **adverse recommendation or decision involved, and the same will thereupon become and remain in effect.**

Postponement of the hearing beyond the time set forth in these Bylaws will be made only with the approval of the ad hoc hearing committee. Granting of such postponements will only be for good cause shown and at the sole discretion of the hearing committee.

The affected practitioner will be entitled to be accompanied by and/or represented at the hearing by a member of the Medical Staff in good standing or by a member of the local professional society.

Either a hearing officer, if one is appointed, or the chairperson of the hearing committee or his designee, will preside over the hearing to determine the order **of procedure during the hearing, to assure that all participants in the hearing** have a reasonable opportunity to present relevant oral and documentary evidence**, and to maintain decorum.**

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs

will be considered, regardless of the existence of any common law or statutory rule that might make evidence inadmissible over an objection in civil or criminal will be considered, regardless of the existence of any common law or statutory rule that might make evidence inadmissible over an objection in civil or criminal action. The practitioner for whom the hearing is being held will, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure **or of fact and such memoranda will become a part of the hearing record.**

In reaching a decision, official notice may be taken by the hearing committee, either before or after submission of the matter for decision, of any generally accepted technical or scientific matter relating to the issues under consideration at the hearing and of any facts which may be judicially noticed by the courts of the state where the hearing is held. Participants in the hearing will be informed of the matters to be noticed and those matters will be noted in the record of the hearing. The practitioner for whom the hearing is being held will be given the **opportunity, on request, to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be** determined by the hearing committee. The committee will also be entitled to consider any pertinent material contained on file in the hospital, and all other **information that can be considered in connection with applications for** appointment to the Medical Staff and for clinical privileges pursuant to these Bylaws.

The Executive Committee, when its action has prompted the hearing, will appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. The Governing Body, when its action has prompted the hearing**, will appoint one of its members to represent it at the hearing, to present the facts in support of its adverse decision and to examine witnesses. It will be the obligation of such representative to present appropriate evidence in support** of the adverse recommendation or decision, but the affected practitioner will **thereafter be responsible for supporting any challenge to the adverse** recommendation or decision by an appropriate showing that the charges or grounds involved lack any factual basis or that such basis or any action based **thereon is arbitrary, unreasonable or capricious.**

The affected practitioner will have the following rights: to call and examine witnesses**, to introduce written evidence, to cross-examine any witness on any** matter relevant to the issue of the hearing, to challenge any witness and to rebut **any evidence. If the practitioner does not testify in his or her own behalf, he or** she may be called and examined as if under cross-examination. The hearing **committee may order that oral evidence is taken only on oath or affirmation** administered by any person entitled to notarize documents in the state where the hearing is held.

The hearings provided for in the Bylaws are for the purpose of resolving, on an **intra professional basis, matters bearing on professional competency and** conduct. Accordingly, neither the affected practitioner, nor the Executive Committee of the Medical Staff or the Governing Body, will be represented at

any phases of the hearing procedure by an attorney at law unless the hearing committee, in its discretion, permits both sides to be represented by counsel. The foregoing will not be deemed to deprive the practitioner, the Executive Committee of the Medical Staff, or the Governing Body, of the legal counsel in **connection with preparation of the hearing or for a possible appeal. A hearing** officer, if utilized, may be an attorney at law. The use of a hearing officer to preside is optional. A hearing officer, if used, should be experienced in presiding at and conducting hearings. He may be permitted to participate in the deliberations and to act as an advisor, but he may not vote.

The hearing committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing will be closed. The **hearing committee may thereupon, at a time convenient to itself, conduct its** deliberations outside the presence of the practitioner for whom the hearing was **convened.**

Within seven days after the final adjournment of the hearing, the hearing committee will make a written report and recommendation and will forward the same together with the hearing record and all other documentation to the Executive Committee or to the Governing Body, whichever appointed it. The **report may recommend confirmation, modification, or rejection of the original adverse recommendation of the Executive Committee or decision of the** Governing Body. Thereafter, the procedure to be followed will be as provided in Article Six of these Bylaws.

15.8 Appeals to the Governing Body.

Within seven days after receipt of a notice by an affected practitioner of an adverse recommendation or decision made or adhered to after a hearing as above provided, the practitioner may, by written notice to the Governing Body delivered through the administrator by certified mail, return receipt requested, **request an appellate review by the Governing Body. Such notice may request** that an appellate review be held only on the record on which the adverse **recommendation or decision is based, as supported by the practitioner's written** statement provided for below or may also request that oral argument be permitted **as part of the appellate review. If such appellate review is not requested within seven days, the affected practitioner will be deemed to have** waived his right to the same, and to have accepted such adverse **recommendation or decision, and the same will become effective immediately as provided in this Article Fifteen.**

Within seven days after receipt of such notice of request for appellate review, a specified date, including a time and place for oral argument if such has been requested, will, through the President, by written notice sent by certified mail, return receipt requested, be sent to the affected practitioner. The date of the

appellate review will not be less than 14 days, nor more than 30 days, from the date of receipt of the notice of request for appellate review, except that when the practitioner requesting the review is under a suspension which is then in effect, such review will be scheduled as soon as the arrangements for it may reasonably by made, but not more than 14 days from the date of receipt of such **notice.**

The appellate review will be conducted by the Governing Body or by a duly appointed appellate review committee of the Governing Body of not less than three members.

The affected practitioner will have access to the report and record (and transcription, if any) of the ad hoc hearing committee and all other material **favorable or unfavorable, that was considered in making the adverse** recommendation or decision. The practitioner will then have seven days to submit a written statement on his or her own behalf, in which those factual and **procedural matters with which he or she disagrees, and the reasons for such** disagreement, will be specified. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and the legal **counsel may assist in its preparation. Such written statements will be submitted** to the Governing Body through the President by certified mail, return receipt requested, at least seven days prior to the scheduled date for the appellate review. A similar statement may be submitted by the Executive Committee of the Medical Staff or by the chairman of the hearing committee appointed by the Governing Body, and if submitted, the President will provide a copy thereof to the practitioner at least seven days prior to the date of such appellate review by certified mail, return receipt requested.

The Governing Body or its appointed review committee will act as an appellate **body. It will review the record created in the proceedings, and will consider the** written statements submitted, for the purpose of determining whether the adverse **recommendation or decision against the affected practitioner was justified and was not arbitrary or capricious. If oral argument is requested as part** of the review procedure, the affected practitioner will be present at such appellate review, will be permitted to speak against the adverse recommendation **or decision, and will answer questions put forth by any member of the appellate** review body. The Executive Committee or the Governing Body, whichever is appropriate, will also be represented by an individual who will be permitted to speak **in favor of the adverse recommendation or decision and who will answer** questions put forth by any member of the appellate review body.

New or additional matters not raised during the original hearing or in the hearing committee report, not otherwise reflected in the record, will only be introduced at **the appellate review under unusual circumstances, and the Governing Body or** the committee thereof appointed to conduct the appellate review will in its sole **discretion determine whether such new matters will be accepted.**

If the Governing Body conducts the appellate review, it may affirm, modify or reverse **its prior decision, or, in its discretion, refer the matter back to the Executive Committee of the Medical Staff for further review and recommendation** within seven days. Such referral may include a request that the Executive Committee of the Medical Staff arrange for a further hearing to resolve specified **disputed issues.**

If the appellate review is conducted by a committee of the Governing Body, such committee will, within seven days after the scheduled or adjourned date of the appellate review, either make a written report recommending that the Governing **Body affirm, modify or reverse its prior decision, or refer the matter back to the** Executive Committee for further review and recommendations within seven days. Such referral may include a request that the Executive Committee of the Medical Staff arranges for a further hearing to resolve disputed issues. Within **seven days after receipt of such recommendation after referral, the committee** will make its recommendation to the Governing Body as above provided. The appellate review will not be deemed to be concluded until all of the **procedural steps provided in this Section 6 have been completed or waived.**

Where permitted by the hospital Bylaws, all action required of the Governing Body may be taken by a committee of the Governing Body duly authorized to **act.**

<u>15.9 Final Decision by Governing Body</u>

Within fourteen days after the conclusion of the appellate review, the Governing Body will make its final decision in the matter and will send notice thereof to the Executive Committee and, through the President, to the affected practitioner, by **certified mail, return receipt requested. If this decision is in accordance with the** Executive Committee's last recommendation in the matter, it will be immediately effective and final, and will not be subject to further hearing or appellate review. If this decision is contrary to the Executive Committee's last such **recommendation, the Governing Body will appoint an ad hoc joint conference committee for further review and recommendation within 14 days and will** include in such notice of its decision a statement that a final decision will not be made until the ad hoc joint conference committee's recommendation has been received. At its next meeting after receipt of the ad hoc joint conference committee**'s recommendation, the Governing Body will make its final decision** with liking effect and notice as first above provided in this Section 7.

Notwithstanding any other provisions of these Bylaws, no practitioner will be **entitled as a right to more than one hearing and one appellate review on any** matter which will have been the subject of action by the Executive Committee of the Medical Staff, or by the Governing Body, or by a duly authorized committee of the Governing Body, or by both.

15.1O External Reporting of Final Actions

If there is a final adverse decision by the Governing Body, notification will be made to the Michigan State Licensing Authority and the National Practitioner Data Bank as required by law.

ARTICLE 16: RULES AND REGULATIONS

The medical staff will adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Governing Body. These will relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations will be a part of these Bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without **previous notice or at any special meeting on notice, by a two-thirds vote of those** present of the Active Medical Staff. Such changes will become effective when approved by the Governing Body.

ARTICLE 17: REVIEW OF THE BYLAWS

Bylaws will be reviewed and revised as necessary to reflect current practice with respect to medical staff organization and functions.

ARTICLE 18: AMENDMENTS TO THE BYLAWS

These Bylaws may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff. A proposed amendment will be sent to all members of the Active Staff at least 72 hours prior to the voting time. To be adopted, an amendment will require some two-thirds vote of the Active Medical Staff present. Amendments so made will be effective when approved by the Governing Body. Neither the Medical Staff nor the Board of Trustees may amend the bylaws unilaterally.