BEACON™ HEALTH SYSTEM

BEACON DOWAGIAC HOSPITAL

(formerly known as Ascension Borgess-Lee Hospital)

MEDICAL STAFF BYLAWS

BORGESS-LEE MEMORIAL HOSPITAL.

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BORGESS-LEE MEMORIAL HOSPITAL

MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, Borgess-Lee Memorial Hospital ("Hospital") is a non-profit corporation, organized under the laws of the State of Michigan; and

WHEREAS, Hospital's purpose is to serve as a general acute hospital providing care and education; and

WHEREAS, these Bylaws are adopted in order to provide for the organization of the Medical Staff and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for: (i) Medical Staff operations; (ii) organized Medical Staff relations with the Board and Hospital Administration; and (iii) the organized Medical Staff's relations with its members and applicants. Hospital's Governing Body has delegated to the Medical Staff the responsibility for the quality of medical care in the Hospital and the Medical Staff has agreed to accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body. The cooperative effmis of the Medical Staff, the Chief Operating Officer, and the Governing Body are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the physicians practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

DEFINITIONS

I. The term "Medical Staff" means all duly licensed medical physicians and osteopathic physicians ("Physicians"), and all duly licensed podiatrists, who are privileged to attend patients in the Hospital.

2. The term "Governing Body" or "Board" means the Board of Trustees of the Hospital.

3. The term "MEC" or "Executive Committee" means the Executive Committee of the Medical Staff, unless specific reference is made to the Executive Committee of the Governing Body.

4. The term "Chief Operating Officer" means the administrator appointed by the Governing Body to act on its behalf in the overall management of the Hospital.

5. The term "Practitioner" or "practitioner" means a duly licensed medical physician, osteopathic physician, or a duly licensed podiatrist.

6. The term "Conflict of Interest" means the existence of circumstances where a Medical Staff member's personal interests are or may be adverse to the best interest of Borgess-Lee Memorial Hospital.

7. The term "Medical Staff Year" means the period from the first day of January through the thirty-first day of December each year.

8. The term "Clinical Privileges" or "privileges" means the penmss10n granted to the medical staff members to provide patient care and includes access to those hospital resources (including equipment, facilities and hospital personnel), which are necessary to effectively exercise those privileges.

9. The term "Rules and Regulations" means the Borgess-Lee Memorial Hospital Medical Staff Rules and Regulations.

10. The term "Applicant" or "applicant" means any individually licensed or certified health care provider, including Practitioners and individuals who are applying for membership or reappointment on the Medical Staff, Clinical Privileges, or permission to provide health care services as appropriate at the Hospital.

11. The term "Hospital" means Borgess-Lee Memorial Hospital.

ARTICLE I

NAME

The NAME of this organization shall be, "Medical StaffofBorgess-Lee Memorial Hospital."

ARTICLE II

PURPOSES

The PURPOSES of this organization are:

A. To discharge its duties and responsibilities to monitor medical care in the Hospital, and to make recommendations to the Governing Body regarding quality assessment and improvement.

B. To ensure a high level of professional performance consistent with the applicable standard of practice of each Practitioner authorized to practice in the Hospital by recommending to the Governing Body the appropriate delineation of the clinical privileges that each Practitioner may exercise in the Hospital, and tln·ough an ongoing review and evaluation of each Practitioner's performance in the Hospital.

C. To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill.

D. To provide continuing medical education opportunities to Members of the Medical Staff and individuals with Clinical Privileges to encourage advancement in professional knowledge and skills.

E. To initiate and maintain rules and regulations for self-government of the Medical Staff, consistent with these Bylaws of the Medical Staff and all applicable laws and accreditation standards.

F. To provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by the Medical Staff with the Governing Body and the Chief Operating Officer.

G. To provide a mechanism for accountability to the Board for the delivery and appropriateness of the patient care services, for the professional and ethical conduct of each Member of the Medical Staff and individual with Clinical Privileges, so that patient care provided at the Hospital is maintained at a level of quality and efficiency that is consistent with general recognized standards of care.

H. To serve as the collegial body through which applicants may obtain membership and/or Clinical Privileges at the Hospital, through which the applicants fulfill the obligations of Members of the Medical Staff or individuals with Clinical Privileges, and through which an environment is created that promotes quality and efficient patient care.

I. To participate in the Hospital's quality review and utilization management program through designated peer review activities of the Medical Staff and its committees, as outlined in these Bylaws, including without limitation:

   I. Evaluating each applicant for Medical Staff membership and/or Clinical Privileges through valid and reliable measurement systems based, when appropriate, on objective, clinically sound criteria;

   2. Engaging in the ongoing monitoring of patient care practices;

   3. Evaluating an applicant's credentials for appointment and reappointment to the Medical Staff and for the delineation of Clinical Privileges that may be exercised by each individual applicant in the Hospital; and

   4. Promoting the appropriate use of medical and health care resources at the Hospital for meeting patients' medical, social and emotional needs, consistent with sound health care resource utilization practices.

J. Make recommendations to the Board concerning appointments and reappointments to the Medical Staff, Clinical Privileges and corrective action.

K. To develop and maintain Medical Staff Bylaws and related manuals, rules, regulations, policies and procedures that are consistent with sound professional practices, organizational principles and external requirements such as accreditation standards, and to enforce compliance with them.

L. To participate in the Hospital's long range planning activities, to assist in identifying coinmunity health needs,·and to participate in developing and implementing appropriate Hospital policies and programs to meet those needs.

M. To exercise through its officers, committees and other defined components the authority granted by these Bylaws and the Medical Staff Rules and Regulations to fulfill these responsibilities in a timely and proper manner, and to account thereon to the Board.

ARTICLE III

MEDICAL STAFF MEMBERSHIP

SECTION I. Nature of the Medical Staff Membership

Membership on the Medical Staff of Borgess-Lee Memorial Hospital is a privilege, which shall be extended only to professionally competent physicians and podiatrists who continuously meet the qualifications, standards and requirements set forth in these Bylaws.

SECTION II. Qualifications for Membership

A. General Qualifications.

Each Applicant for appointment or reappointment to the Medical Staff must, at the time of application and initial appointment, and continuously thereafter, demonstrate to the satisfaction of the MEC and the Board, the following qualifications and any additional qualifications and procedural requirements as are set fo1ih within these Bylaws and the Rules and Regulations.

I. Licensure. Current and unlimited license to practice medicine or podiatry issued by the State of Michigan. Applicants and Members must i1runediately disclose to the MEC any restriction, limitation, or disciplinary action regarding their license.

2. DEA/Controlled Substances Registration. Possess a current, valid, United States Drug Enforcement Agency (DEA) number, if applicable.

3. Professional Education and Training. Graduate of an approved medical or podiatric school or school of osteopathic medicine, or be certified by the Educational Council for Foreign Medical Graduates, or have a Fifth Pathway ce1iificate, and have passed the Foreign Medical Graduate Examination in the Medical Sciences, consistent with State of Michigan licensing requirements.

For purposes of this Section, an "approved" school is one fully accredited during the time of the Applicant's attendance by the Liaison Committee on Medical Education, by the America Medical Association, by the American Osteopathic Association, by the Council on Podiatric Medical Education of the American Podiatric Medical Association, by a successor agency to any of the foregoing, or by an equivalent professional organization recognized by the State of Michigan.

4. Board Certification/Admissibility. Board certification in the Applicant's specialty is encouraged. In lieu of Board certification, the.MEC may accept documentation or other information that demonstrates to the MEC that the Applicant or Member has sufficient clinical experience, training, education, and competency that otherwise satisfies this requirement. Determinations of the sufficiency of information shall be determined by the MEC in its sole discretion. Documented clinical experience and competency in the Hospital will be accepted in lieu of Board certification/admissibility or post-graduate training beyond one (1) year for Physicians with Clinical Privileges that were appointed to the Medical Staff prior to 2005.

5. Clinical Performance. Demonstrate recent clinical performance, competence, and utilization practice pattems with an active clinical practice in the area or specialty in which Clinical Privileges are being requested for the purpose of evaluating current clinical competence.

6. Cooperativeness. Demonstrate ability to work with and relate to other members of the Medical Staff, members of other health disciplines, Hospital administration, personnel and employees, the Board, visitors, and the community in general, in a cooperative, professional manner in order to maintain an environment appropriate to quality and efficient patient care.

7. Satisfaction of Membership Obligations. Satisfactory compliance with the basic obligations accompanying membership on the Medical Staff as set forth in these Bylaws, and equitable participation, as determined by the MEC and the Board, in the discharge of obligations specific to each Medical Staff category.

8. Professional Ethics and Conduct. Acceptance of membership on the Medical Staff shall constitute the Medical Staff member's agreement that he/she will abide by (i) the "Code of Ethics" of the American Medical Association or the American Osteopathic Association, whichever is applicable; (ii) the "Ethical and Religious Directives for Catholic Care Services," as the same are appended to and made part of, these Bylaws; and (iii) the Hospital's Bylaws and applicable policies and procedures, these Bylaws and related policies, rules and regulations of the Medical Staff and the Hospital's Corporate Responsibility Program and its Standards of Conduct.

9. Disability. Be free from, or have adequate control over, any physical or mental impairment that would significantly affect his/her ability to practice, including, without limitation, the use or abuse of any type of medicine, substance or chemical, that affects cognitive, motor or communication ability in any manner that interferes with, or has a reasonable probability of interfering with, the individual's performance of Clinical Privileges.

10. Verbal and Written Communication Skills. Ability to read and understand the English language, to communicate in writing and verbally in the English language

in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

11. Professional Liability Insurance. All members of the Medical Staff (other than the Honorary Staff) shall be required to present a current certificate of insurance, and to verify malpractice liability coverage with a minimum of $200,000 per claim and $600,000 annual aggregate. Members will submit annually a certificate of insurance that verifies compliance with this requirement. Should a member in good standing lose his/her malpractice coverage, the provider can maintain privileges, but not exercise those privileges until the required insurance coverage is acquired. Administration will work with the provider to seek coverage through another program.

12. Hospital and Community Need and Ability to Accommodate. In acting on new applications for Membership and Clinical Privileges on applications for changes in Clinical Privileges or in change in Medical Staff category status, the Board may also consider any policies, plans, and objectives formulated by it concerning:

    a. The Hospital's current and projected patient care needs; and

    b. The Hospital's ability to provide the physical, personnel, equipment, and financial resources that will be required if the Applicant is granted Membership and/or Clinical Privileges.

13. Geographic Location. The location will be located within the geographic service area of the Hospital and be close enough to provide timely care for his/her patients, as defined by the Board.

14. Eligibility to Participate in Health Care Programs. The applicant is not excluded of otherwise ineligible to participate in any federal or state health care program, including, without limitation, Medicare and Medicaid.

15. Additional Qualifications. The applicant satisfies any additional qualifications set f01ih elsewhere in these Bylaws or in the Rules and Regulations.

B. Nondiscrimination.

Neither Medical Staff Membership nor Clinical Privileges will be denied on the basis of: age, sex, race, creed, color, national origin, a handicap unrelated to the ability to fulfill patient care and required Membership obligations; or any other criterion unrelated to the delivery of quality and efficient patient care in the Hospital, to professional qualifications, to the Hospital's purposes, needs, and capabilities, or to community need.

C. No Entitlement to Appointment.

1. No individual shall be entitled to appointment to the Medical Staff or to exercise Clinical Privileges merely by virtue of the fact that such individual:

a. Is licensed to practice a profession in this or any other state;

b. Is a member of any particular professional organization;

c. Has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility; or

d. Resides in the geographic service area of the Hospital as defined by the Board.

D. Basic Obligations of Medical Staff Membership.

1. By submitting an application for Membership and Clinical Privileges, all applicants to and Members of the Medical Staff, regardless of assigned Medical Staff category, and each applicant for and individual granted Clinical Privileges, agree to continuously satisfy the following basic obligations:

a. Provide his or her patients with medical care that is consistent with recognized standards for quality and efficiency;

b. Abide by these Bylaws, the Rules and Regulations, the Hospital Bylaws, and all applicable standards, policies, and rnles of the Medical Staff and Hospital;

c. Abide by all applicable laws and regulations that govern the practice of medicine, including those requirements unique to a given medical specialty;

d. Discharge such Medical Staff, clinical service, and Hospital functions for which he or she is responsible by assigrnnent, appointment, or election;

e. Complete all medical and other required records for all patients he or she admits or in any way provides care to in the Hospital in accordance with, and within the time frame specified in, these Bylaws, the Rules and Regulations, and any applicable policies of the Medical Staff and/or the Hospital;

f. Provide or arrange for appropriate and timely medical coverage and care for patients for whom he or she is responsible;

g. Assist the Hospital in meeting its commitment and obligation to provide emergency services by taking emergency services call in accordance with policies established by the MEC and the Board;

h. Notify in writing the Chief of Staff and the Chief Operating Officer, together with a statement of all information relevant to the matter within one (I) business day upon the occurrence of the following:

(I) The voluntary or involuntary revocation, surrender, denial, relinquislunent, reduction, non-renewal or suspension· of his/her professional license, DEA registration, malpractice coverage or specialty or subspecialty board certification or eligibility;

(2) The limitation, suspension, revocation or non-renewal of staff membership or Clinical Privileges at any hospital or health care institution;

(3) The initiation of any new malpractice claims or investigation by a State licensing authority or governmental insurance program; and

(4) The suspension, exclusion, sanction, limitation, or other restriction imposed by any government health insurance program such as Medicare or Medicaid.

1. Participate in performance improvement, quality, peer review and utilization management processes and activities of and at the Hospital;

j. Abide by generally recognized standards of professional ethics including, without limitation, the Borgess-Lee/Borgess Health Code of Conduct, and with the Ethical and Religious Directives for Catholic Health Facilities promulgated by the National Conference of Catholic Bishops;

k. Satisfy the continuing education requirements as applicable and as established by the Medical Staff; and

I. Abide by the terms of the Notice of Privacy Practices prepared and distributed to patients of the Hospital, as required by the Federal Patient Privacy Regulations.

2. Failure to satisfy and maintain any of these basic obligations is grounds, as warranted by the circumstances, for non-reappointment or for such other corrective or disciplinary action as deemed appropriate by recommendation of the MEC and final action of the Board pursuant the correction action and fair hearing plan of these Bylaws.

SECTION III. Conditions and Duration of Appointment

A. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments, reappointments, or revocation of appointments, only after there has been a recommendation from the Medical Staff as provided in these Bylaws.

B. All newly appointed members of the Medical Staff seeking appointment in Active or Consulting Staff positions must first be appointed to Provisional Active or Consulting Staff.

C. Appointments to the Active or Consulting Medical Staff shall be for up to two (2) years.

D. All Active staff physicians in Internal Medicine, Surgery, Family Practice and Pediatrics, shall participate in a rotating on-call schedule for urgent or emergency cases.

Effective July 1, 2008, Active staff physicians at age 65 and over, who have been Active members of the Borgess-Lee Memorial Hospital Medical staff for at least 20 years may request to be excused from the requirement to participate in the on-call coverage. Such requests will be directed to the Board of Trustees through the Chief Operating Officer and will be considered by the Board on a case-by-case basis.

E. Appointment to the medical staff shall confer on the appointee only the clinical privileges as have been granted by the Governing Body, in accordance with these Bylaws and the Rules and Regulations.

F. Every application for staff appointment shall be signed by the Applicant and shall contain the Applicant's specific attestation as to the accuracy and completeness of the information provided therein and specific acknowledgement of eve1y Medical Staff member's obligation to provide continuous care and supervision of his/her patients, to abide by the Medical Staff Rules and Regulations, Bylaws, and Medical Staff policies and procedures, and be willing to accept consultation assignments. Misstatements on the factual information provided on the application are grounds for denial of the application.

G. Every applicant will comply and attest to the Borgess Health Corporate Compliance program currently in effect.

H. Every applicant will comply with the applicable requirements of the Michigan Peer Review Organization (MPRO). All physicians with admitting privileges at Borgess-Lee Memorial Hospital shall sign a Medicare Acknowledgement of Receipt of Penalty Notice.

SECTION IV. Representative of Governing Board

The Chief Operating Officer or his/her designee shall be the representative of the Governing Body at meetings of the Medical Staff or committees thereof, and serve in an ex-officio capacity without vote. It shall be the responsibility of the Chief Operating Officer, or his/her designee, to attend meetings of the Medical Staff, and its committees, and the Chief Operating Officer, or his/her designee, shall be an ex-officio member without vote. The Chief Operating Officer shall represent the Governing Body and serve as its liaison to the Medical Staff.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

SECTION I. The Medical Staff

The Medical Staff shall be divided into Active, Provisional Active, Consulting, Provisional Consulting and Honorary categories.

SECTION II. The Active Medical Staff

The Active Medical Staff shall consist of Medical Staff members who are Practitioners who provide or are responsible for the preponderance of medical practice within the hospital and perform all significant Medical Staff organizational and administrative functions. The members of the Active Medical Staff shall:

A. Be located closely enough to the hospital to provide continuous care to their patients;

B. In order to admit to a physician's own service, the geographical restrictions, as stated in the Rules and Regulations, must be met;

C. Attend at least 50% of the Medical Staff and assigned committee meetings;

D. Have full voting privileges and be eligible to hold Medical Staff office; and

E. Active members shall pay annual dues at amounts determined by the Medical Staff.

SECTION III. Provisional Active Medical Staff

The Provisional Active Medical Staff shall consist of Medical Staff members who are Practitioners who are being considered for advancement to the Active Medical Staff.

A. The preceptor associated with the Provisional Active Staff candidate's credentials will evaluate the candidate for Active Staff eligibility by utilizing the approved FPPE format specific for that specialty or those privileges.

B. When the FPPE has been completed by the appropriate preceptor, the Executive Committee shall recommend: a) appointment to Active Staff; b) appointment to Consulting Staff; c)staff appointment with reduction in privileges; or cl) no appointment to Medical Staff.

C. Each member shall be responsible for reporting his/her activity regularly to his/her assigned preceptor. The preceptor shall submit a repot1 on the member's readiness for advancement to the Active Staff to the Executive Committee at the end of the FPPE period described in Article IV, Section III(A) above.

D. In order to admit to a physician's own service, the geographical restrictions, as stated in the Rules and Regulations, must be met.

E. Provisional Active members shall meet geographical location, Emergency Service and meeting requirements as delineated for Active Staff members.

F. Provisional Active members shall be appointed to committee assignments and have voting privileges at committee level, but are not eligible to hold office or act as committee chairperson or vote at Medical Staff meetings,

G. Provisional Medical Staff members shall pay an application fee at the time of applications. This fee will serve as full payment of dues until the beginning of the next medical staff year.

SECTION IV. Consulting Medical Staff

The Consulting Medical Staff shall consist of Medical Staff members who are Practitioners who may have privileges to admit and who treat only occasional patients in the hospital. In order to admit to a physician's own service, the geographical restrictions, as stated in the Rules and Regulations, must be met.

A. Members shall not be eligible to vote or hold office in the Medical Staff organization.

B. Consulting members shall pay annual dues at amounts determined by the Medical Staff.

SECTION V. Provisional Consulting Medical Staff

The Provisional Consulting Medical Staff shall consist of Practitioners who are being considered for advancement to the Consulting Staff. In order to admit to a physician's own service, the geographical restrictions, as stated in the Rules and Regulations, must be met.

A. The preceptor associated with the Provisional Consulting Staff candidate's credentials will evaluate the candidate for Consulting Staff eligibility by utilizing the approved FPPE format specific for that that specialty or those privileges.

B. When the FPPE has been completed by the appropriate preceptor, the Executive Committee shall recommend: a) appointment to Consulting Staff; b) staff appointment with reduction in privileges; or c) no appointment to Medical Staff.

C. Each member shall be responsible for reporting his/her activity regularly to his/her assigned preceptor. The preceptor shall submit a report on the member's readiness for advancement to the Consulting Staff to the Executive Committee at the end of the FPPE period described in Article IV, Section V(A) above.

D. In order to admit to a physician's own service, the geographical restrictions, as stated in the Rules and Regulations, must be met.

E. Privileges and responsibilities shall be as defined in Article IV, Section IV.

SECTION VI. Honora1y Medical Staff

The Honorary Medical Staff shall consist of Physicians who desire and are appointed by the Governing Body to this status and are thus honored by° emeritus positions. These may be Physicians who have retired from active practice or who are of outstanding reputation and have requested transfer to this status. Members of the Honorary Staff shall have no assigned duties, shall pay no dues, shall not have admitting or any other clinical privileges, and shall not hold office, vote or serve on Medical Staff committees.

ARTICLE V

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION I. Application for Appointment

A. All applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall have attached a clear discernible passpmt sized photograph. The application shall be submitted on a form prescribed by the Governing Body after consultation with the Executive Committee. The completed application shall include or require all of the following:

1. Applications for appointment to the Medical Staff and/or clinical privileges shall require detailed information concerning the applicant's current licensure; education and relevant training; experience, ability, and current competence; and evidence of physical ability to perform the requested privileges, including results of tuberculosis testing, and, if available (or required for a specific depmtment), results of rubella titer and hepatitis B titer. Material omissions or misstatements on the completed form(s) will be grounds for summary revocation of the appointment application or appointment and clinical privileges if discovered after the Board has made its determination. All action regarding applications to obtain an appointment application shall be reported to the Chief of Staff.

2. The applicant will be required to present for viewing by Medical Staff office personnel a valid picture ID issued by a state or federal agency (e.g., driver's license or passpo1t).

3. The application shall include the names and complete addresses of at least three physicians, podiatrists, or other practitioners, who have had recent extensive experience in observing and working with the applicant and who can provide adequate information pe1taining to the applicant's current professional competence and character. The references must include: (1) a peer practicing in the same professional discipline as the applicant; (2) the Chief of Staff, a department chair or physician administrator from the most recent facility in which the applicant is practicing or has practiced; and (3) a physician from another specialty who has dealt with the applicant in a consultative situation. For those applicants completing a residency or fellowship, the references must include: (I) the program/fellowship director; (2) a faculty member in the same discipline; and (3) another medical professional reference of choice. The individuals must be able to provide adequate written references pertaining to the following:

a. General medical and/or surgical knowledge;

b. Technical and clinical skills;

c. Clinical judgment;

d. Clinical competence;

e. Practice-based learning and improvement;

f. Patient care (makes appropriate decisions related to patient care);

g. Systems-based practice;

h. Interpersonal and communication skills (ability to work/cooperate with others); and

i. Professionalism (i.e., demonstrates respect and confidentiality in patient/family, hospital personnel and colleague relationship);

4. The application shall also include the following information:

a. Information as to whether the applicant's medical staff appointment or clinical privileges have ever been resigned, denied, revoked, suspended, limited, reduced, or not renewed voluntarily or involuntarily at any other health care facility;

b. Verification of employment, and if applicable, information as to whether or not the applicant's employment by a health care organization has ever been terminated.

c. Information as to whether his or her membership in local, state, or national/professional societies, or his or her license to practice any profession in any state, or his or her narcotic license has ever been suspended, modified or terminated voluntarily or involuntarily. The submitted application shall include a copy of all the applicant's current licenses to practice, as well as a copy of his or her narcotics license, medical or podiatric, and certificates from all post graduate training programs completed;

d. Information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance coverage, and the amount and classification of such coverage;

e. Information concerning the applicant's malpractice claims history;

f. A consent for the release of information from his/her present and past malpractice insurance carriers;

g. Information on the applicant's current physician and mental ability to safely render care to patients;

h. Disclosure of sanctions which prohibit or limit participation or eligibility in federal health care programs, including Medicare and Medicaid or exclusions from participation in federal health care programs, including Medicare and Medicaid;

i. Information as to whether the applicant has ever been named as a defendant in a civil or criminal action and details about any such instance;

J. Information from the National Practitioner Data Bank and from a criminal background check; and

k. Such other information as the MEC or the Board may require.

5. An application shall be considered complete when information is received from the primary sources regarding the applicant's training, experience, and current competence, as well as information regarding current licensure, malpractice insurance coverage, immune status, and any other information that may be deemed necessary. Information verified from the primary source included Education, Board Ce1iification, and State licensure. Sanction sites including National Practitioner Data Bank, Office of the Inspector General, MI sanctioned provider list, and Excluded Pmiies List System are also verified.

6. The applicant shall have the burden of proof of producing requested information regarding his or her current clinical competence, health status, character and other qualifications, and resolving any doubts about such qualifications, including reasonable evidence of current ability to perform the privileges requested.

7. Such other information as the Governing Body shall request.

B. Within thirty (30) days after receiving all references and other pertinent material, the Chief Operating Officer shall transmit the completed application and all supporting materials to the Executive Committee for evaluation.

C. By applying for appointment to the Medical Staff, each applicant thereby signifies his/her agreement to (i) appear for interviews in regard to the application; (ii) authorizes the Hospital to consult with members of medical staffs of other hospitals with which the applicant has been associated, and with others who may have information bearing on his/her competence, character and ethical qualifications; (iii) consents to the Hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, as well as of his/her moral and ethical qualifications for staff membership and ability to get along with others; (iv) submit to mental or physical examinations by a Practitioner of the Hospital's choice if the Hospital has reason to believe that the applicant may not be able to render care safely to patients as a result of suspected mental or physical conditions; (v) releases from any liability the Hospital and all representatives

of the Hospital and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his/hei credentials; and
(vi) releases from liability all individuals and organizations who provide information to the Hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges including privileged or confidential information. Misstatements on the factual information provided on the application for appointment or reappointment is grounds for denial of the application, or revocation of existing privileges, as determined by the Medical Staff Executive Committee.

D. The application form shall include a statement that the applicant has received and read the bylaws of the Hospital Governing Body, the Medical Staff Rules and Regulations, Bylaws, and the Medical Staff policies and procedures, the Hospital's Corporate Responsibility Program and its Standards of Conduct and that he/she agrees to be bound by the terms thereof, without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of his/her application.

E. Applicants for Medical Staff membership shall be given the following documents:

1. Bylaws and Rules and Regulations of the Medical StaffofBorgess-Lee Memorial Hospital and Hospital Governing Body.

2. Borgess Health Corporate Compliance Introduction.

3. Michigan Peer Review Organization (MPRO) Medicare Acknowledgement of Receipt of Penalty Notice.

4. Code of Ethics (AMA or AOA).

5. The Hospital's Corporate Responsibility Program and its Standards of Conduct.

6. Ethical and Religious Directives for Catholic Health Care Services.

7. Unapproved list of abbreviations for Borgess-Lee Memorial Hospital.

8. Borgess-Lee Memorial Hospital Risk Management Program.

9. Borgess-Lee Memorial Hospital Performance Improvement Program.

10. Borgess-Lee Memorial Hospital Utilization Review Plan.

F. The application shall include an acknowledgment by the applicant of his/her obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within the Hospital for whom he or she has responsibility. The application shall also include a statement that any misrepresentation or misstatement in, or omission from the application, whether intentional or not, may constitute cause or rejection of the application resulting in denial of appointment and/or Clinical Privileges. In the event that an appointment or Clinical Privileges have been granted prior to the discovery of the

misrepresentation, misstatement or omission, such discovery may result m summary dismissal from the Medical Staff.

G. The application shall include a statement that the applicant shall abide by the terms of the Ethical and Religious Directives for Catholic Health Facilities promulgated by the National Conference of Catholic Bishops and to perform no activity prohibited by such directives.

SECTION II. Appointment Process

A. Within 60 days after its receipt of the completed application for membership the Executive Committee shall make a written report to the Board, including its recommendation that the Practitioner be appointed to the Medical Staff, that he/she be rejected for Medical Staff membership, or that his/her application be deferred for fmiher consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by appropriate probationary conditions.

B. Prior to making its report and recommendation, the Executive Committee shall examine the evidence regarding the character, professional competence, qualifications and ethical standing of the Practitioner and shall determine, through information from all sources available to the committee, including an appraisal from those Practitioners and Hospital employees who are familiar with the Applicant's clinical practice and competence, whether the Practitioner has established and meets all of the necessary qualifications for the category of staff membership and the clinical privileges requested by him/her. Privileges may be withheld, among other reasons, due to evidence of forgery, fraud, medical health problems that may impact the applicant's ability to safely render care to patients or unprofessional conduct.

C. When the recommendation of the Executive Committee is to defer the applications for fmiher consideration, it must be followed up within forty-five (45) days with a subsequent recommendation for provisional appointment with specified clinical privileges or for rejection of the application for staff membership.

D. When the recommendation of the Executive Committee is favorable to the Practitioner, the Chief Operating Officer shall promptly forward it, together with all supporting documentation, to the Governing Body.

E. When the recommendation of the Executive Committee is adverse to the Practitioner, either in respect to appointment or clinical privileges, the Chief Operating Officer shall promptly so notify the Practitioner by certified mail, return receipt requested, or by private next day mail. No such adverse recommendations shall be forwarded to the Governing Body until after the practitioner has exercised or has been deemed to have waived his/her rights to a hearing, as provided in Article VIII of these Bylaws.

F. If, after the Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, the Executive Committee's reconsidered recommendation is favorable to the Practitioner, it shall be processed in accordance with

Sub-paragraph D of this Section II. If the Executive Committee's recommendation continues to be adverse, the Chief Operating Officer· shall promptly so notify the Practitioner, by ce1iified mail, return receipt requested, or by private next day mail. The Chief Operating Officer shall also forward the Executive Committee's recommendation and documentation to the Governing Body, but the Governing Body shall not take any action thereon until after the Practitioner has exercised or has been deemed to have waived his/her right to an appellate review as provided in Article VIII of these Bylaws. If a practitioner exercises his/her right to an appellate review as provided in Article VIII of these Bylaws, the report and recommendation of the Hearing Committee, along with the complete hearing record, shall be sent to the Board.

G. At its next regular meeting after receipt of a favorable recommendation by the Executive Committee, the Governing Body, or its executive committee, shall act in the matter. If the Governing Body's decision is adverse to the Practitioner in respect to either appointment or clinical privileges, the Chief Operating Officer shall promptly notify him/her of such adverse decision by ce1iified mail, return receipt requested, or by private next day mail, and such adverse decision shall be held in abeyance until the Practitioner has exercised or has been deemed to have waived his/her rights under Article VIII of these Bylaws and until there has been compliance with Subparagraph Hof this Section II.

H. At its next regular meeting after all of the Practitioner's rights under A1iicle VIII have been exhausted or waived, the Governing Body or its duly authorized committee shall act in the matter. The Governing Body's decision shall be conclusive, except that the Governing Body may defer final determination by referring the matter back to the Executive Committee for fmiher reconsideration. Any such referral back shall state the reason therefore, and shall set a time limit within which the Executive Committee is to make a recommendation to the Governing Body on the matter. At its next regular meeting after receipt of such subsequent recommendation, the Governing Body shall make a decision either to appoint the Practitioner to the staff and grant the requested privileges, or reject him/her for staff membership and/or deny the requested privileges.

I. If the Governing Body's decision will be contrary to the recommendation of the Executive Committee, the Governing Body shall submit the matter to the Fair Hearing Panel described in Article VIII, Section IX.B for review and recommendation and shall consider such recommendation before making its final decision.

J. When the Governing Body's decision is final, it shall send notice of such decision through the Chief Operating Officer to the Chief of the Medical Staff, and by First Class Mail to the practitioner. If the Governing Body's decision is an adverse action, the notice shall be sent as above, and by certified mail, return receipt requested, or by private next day mail to the practitioner.

SECTION III. Reappointment Process

A. Each individual who wishes to be reappointed to the Medical Staff, and/or have his/her Clinical Privileges extended, shall be responsible for completing the reappointment application form approved by the Executive Committee of the Medical Staff and the

Governing Body. The reappointment application shall be submitted to the Chief Operating Officer or his/her designee. Reappointment, if granted, shall be for a period of up to three (3) years.

B. At least forty-five (45) days prior to the final scheduled Governing Body's meeting in the Medical Staff Year, the Executive Committee shall review all pertinent information available regarding each individual whose staff membership and/or Clinical Privileges will expire at the end of the Medical Staff Year for the purpose of determining the Committee's recommendation for reappointments to the Medical Staff and/or for the Clinical Privileges to be granted for the ensuing period, and shall transmit its recommendations, in writing, to the Governing Body. Where non-reappointment or reduction in clinical privileges is recommended, the reason for such recommendation shall be stated.

C. Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted on reappointment, shall he based upon all relevant factors, including verification of current licensure to practice in this State, such member's professional competence and clinical judgment in the treatment of patients, eligibility to pmiicipate in federal health care programs including Medicare and Medicaid, ethics and conduct, attendance at Medical Staff meetings and participation in staff affairs, compliance with the Hospital Bylaws, Hospital's Corporate Responsibility Program and its Standards of Conduct, the Medical Staff Rules and Regulations, Bylaws, and policies and procedures of the Medical Staff, and ability to safety render care to patients. If all attempts to obtain liability insurance have failed or the costs of insurance are prohibitive for the Medical Staff member this requirement of liability insurance may be waived by the Governing Body.

D. Except as otherwise provided for in this Section III, the application for reappointment shall include all the information required by, and shall follow the procedure provided in, Sections I and II of this Article V, including, without limitation, the requirement that the Applicant is required to provide peer recommendations.

E. The procedure provided in Section II of this Atiicle V relating to applications for initial appointment shall be followed with respect to each request for reappointment.

ARTICLE VI

CLINICAL PRIVILEGES

SECTION I. Clinical Privileges Restricted

A. Every individual practicing at this Hospital shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically recommended by the Medical Staff and granted to him/her by the Governing Body, except as provided in Section II, III or IV of this Article VI.

B. Every initial application for staff appointment and every application for reappointment must contain a request for the specific clinical privileges desired by the applicant. All

recommendations for the granting, renewal, reduction or denial of clinical privileges made to the Governing Body shall be based upon all relevant information, including recent training, and, in the case of applicants for reappointment, observation of patient care provided, review of the records of patients treated by the applicant, and review of all records and information from applicable departments of the Medical Staff which evaluate the individual's participation in the delivery of medical care. Other factors to be taken into consideration shall include previously successful or currently pending challenges to any licensure or registration or eligibility to patiicipate in federal health care programs including Medicare and Medicaid, or the voluntary relinquislnnent of such licensure or registration and the individual's clinical and/or technical skills as indicated by the results of quality improvement activities. The applicant shall have the burden of establishing qualifications and competency relating to the clinical privileges requested. The recommendations for privileges may carry with them such requirements for supervision or consultation for such period of time as may be determined necessary.

C. Periodic redetermination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided and review of the records of patients treated in this or any other hospital and all other relevant information.

D. Privileges granted to physicians shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each physician may perform shall be specifically delineated and granted. All surgery patients shall receive a medical appraisal prior to surgery. A physician member of the Medical Staff shall be responsible for submission of a detailed history and physical within the first twenty-four (24) hours of admission, prior to surgery or a procedure that requires sedation, analgesia or anesthesia, and shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. A completed history and physical examination performed within thirty (30) days prior to the day of the admission or procedure must be updated within 24 hours of admission.

SECTION II. Temporary Privilege

A. There are two circumstances in which temporary privileges may be granted. The circumstances for which the granting of temporary privileges is acceptable are: (I) to fulfill an impotiant patient care, treatment or service need; and (2) when an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the MEC and the governing body. Temporary privileges to meet an important care need, and temporary privileges for applicants for new privileges awaiting review and approval by the MEC, may be granted upon verification of the following: (1) current licensure; (2) relevant training and experience; (3) current competence; (4) ability to perform the privileges requested; (5) other criteria required by these Bylaws; (6) a query and evaluation of the National Practitioner Data Bank information; (7) a complete application; (8) no current or previously successful challenge to licensure or registration; and (9) no subjection to involuntary termination of Medical Staff membership or Clinical Privileges at any other health care facility or organization. As

used in these Bylaws, the Chief Operating Officer shall be deemed to be the authorized designee of the chief executive officer.

B. Upon receipt of a complete application for Medical Staff membership from an appropriately licensed Practitioner, the Chief Operating Officer may, upon the basis of information then available which may be reasonably relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the Chief of Staff, grant temporary admitting and clinical privileges to the applicant for no more than 120 days, but in exercising such privileges, the applicant shall act under the supervision of the Chief of Staff or other member of the Active Medical Staff to which he/she is assigned. In the absence of the Chief Operating Officer, the person designated to act on his/her behalf is authorized to grant temporary privileges.

C. Temporary clinical privileges may be granted by the Chief Operating Officer for the care of a specific patient to a Practitioner who is not an applicant for membership in the same mam1er and upon the same conditions as set fmih in sub-paragraph A of this Section II, provided that there shall first be obtained such Practitioner's signed acknowledgment that he/she has received and read copies of the Medical Staff Bylaws, Rules and Regulations, Hospital's Corporate Responsibility Program and its Standards of Conduct, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary clinical privileges.

D. The Chief Operating Officer may permit a Practitioner serving as a locum tenens for a member of the Medical Staff to exercise temporary clinical privileges for a period not to exceed 120 days, providing all of his/her credentials have first been approved by the Chief of Staff.

E. Special requirements of supervision and repo1iing may be imposed by the Chief of Staff on any Practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Operating Officer if the Practitioner fails to comply with such special conditions.

F. The Chief Operating Officer may at any time, with concurrence of the Chief of Staff, terminate a Practitioner's temporary privileges, effective as of the discharge from the Hospital of the Practitioner's patient(s) then under his/her care in the Hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the Practitioner or Hospital operations would be significantly disrupted by the continuation of said Practitioner's temporary privileges, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Section I1 A of Article VII of these Bylaws, and the same shall be immediately effective. The Chief of Staff shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patient(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of such substitute practitioner.

G. Neither denial of a request for temporary privileges nor termination of temporary privileges entitles the Practitioner to a hearing of appellate review.

SECTION III. Emergency Privileges

In the case of emergency, any member of the Medical Staff, to the degree permitted by his/her license and regardless of staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such staff member must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or he/she does not desire to request privileges, the patient shall 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, permanent harm would 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 that clanger.

SECTION IV. Emergency Disaster Clinical Privilege

In the event the Hospital's emergency disaster or management plan is activated, and the Hospital is unable to manage immediate patient care need, the Chief Operating Officer, the Chief of Medical Staff, or a designee may (but is not required to) grant emergency disaster clinical privileges. The individual who grants disaster clinical privileges shall be responsible to ascertain that the practitioner granted such privileges is duly licensed in his or her profession, as evidenced by one of the following: (a) a current picture hospital ID card; (b) a current license to practice and a valid picture ID issued by a state, federal or regulatory agency; (c) identification as a member of a Disaster Medical Assistance Team; (cl) identification indicating that the individual is authorized by a governmental entity to render patient care in disaster circumstances; or
(e) presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity and profession.

The individual practitioner will be assigned duties, as needed, under the direction of the Chief of Staff, or a member of the Medical Staff designated by the Chief of Staff. The individual's status as an emergency disaster clinical provider shall be evident throughout the emergency situation.

A credentialing process for individuals granted emergency disaster clinical privileges will be undertaken at the earliest possible time using the process outlined in Article III Medical Staff Membership, IV Categories of the Medical Staff, V Procedure for Appointment and Reappointment, and VI Clinical Privileges in these Bylaws.

SECTION V. Allied Health Privileges

A. Defined: Generally, Allied Health Professionals are individuals, other than physicians or podiatrists who:

1. Are qualified by training, experience, and current competence in a discipline which the Medical Staff recommended and the Governing Body has approved to allow to practice in the Hospital, and either;

2. Have a recognized, but limited scope of health care practice and are permitted by license and by Hospital policy to provide services independently in the Hospital,

i.e., without the direction or immediate supervision of a physician (Independent Allied Health Personnel); or

3. Function in a medical support role to a physician; and

4. Are eligible to participate in federal health care programs including Medicare and Medicaid.

B. Categories of Allied Health Professionals currently authorized to function in the Hospital:

Pursuant to policy adopted by the Governing Body, the following are the only categories of independent Allied Health Professionals:

I. Psychologist

Pursuant to policy adopted by the Governing Body, the following are the only categories of physician-directed Allied Health Professionals:

I. Social Worker

2. Certified Registered Nurse Anesthetist

3. Physician's Assistant

4. Nurse Practitioner

5. Certified Nurse Midwife

C. All Allied Health Personnel who wish to perform duties in the Hospital relating to patient care must make application on a prescribed form. The completed application shall be submitted to the Executive Committee for review and recommendation and to the Governing Body for final action. The applicant shall specify privileges requested within the guidelines, if any, established in the Rules and Regulations and meet any qualification so stipulated in the Rules and Regulations. This specification of privileges shall be covered by the right of hearing or appeal.

D. Terms and Conditions of Affiliation.

An Allied Health Professional shall be subject to an initial probationary period, formal periodic review and disciplinary procedures as are determined for his/her category. An Allied Health Professional is entitled to the procedural due process rights provided in the Fair Hearing Plan for Medical Staff members and applicants. The quality and efficiency of the care provided by Allied Health Personnel within any clinical unit shall be monitored and reviewed as part of the regular Medical Staff and/or Hospital quality review program.

E. Prerogatives and Obligations of Allied Health Professionals:

1. Prerogatives are to exercise such clinical privileges as are specifically granted consistent with any limitations stated in the Medical Staff Bylaws, the Rules and Regulations, and any other applicable Medical Staff or Hospital policies; service on committees when so appointed and with vote when so specified by the appointing authority; attend, when invited, clinical, scientific, and education meetings of the Medical Staff or clinical services; exercise such other prerogatives as may be accorded Allied Health Personnel in general or specific categories of Allied Health Professionals.

2. Obligations are *to:*

a. Provide patients with care at the level of quality and efficiency generally recognized as appropriate by the Medical Staff and Governing Body and required at the Hospital.

b. Each Allied Health Professional shall retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services and, when necessary, shall arrange, or alert the primary attending physician of the need to arrange, a suitable alternative for such care and supervision.

c. Patticipate when requested in quality review program activities and in discharging such other functions as may be required from time to time.

d. When requested, attend clinical and education meetings of the staff and of the service and other clinical units with which he/she is affiliated.

e. Fulfill any special requirements in the Medical Staff Bylaws respective to privileges held, i.e., attendance at meetings or conferences scheduled as a result of issues or concerns arising out of quality of care review.

f. Abide by the Medical Staff Bylaws and related manuals, the Rules and Regulations, the Hospital Bylaws, the Hospital's Corporate Responsibility Program and its Standards of Conduct, the Ethical and Religious Directives for Catholic Health Care Services, and all other standards, policies and rules of the Medical Staff and Hospital.

g. Prepare and complete in timely fashion those pottions of patient's medical records documenting services that he/she provided.

F. Reappointment of Allied Health Professionals.

All Allied Health Professionals must be recommended by the Medical Staff and reappointed by the Governing Body biannually in order to continue to provide services at the Hospital. They will follow the same procedure for reappointment as set forth in Article V, Section Ill. Reappointment is at the discretion of the Governing Body. Decisions by the Governing Body are covered by the procedural due process provisions of these Bylaws.

SECTION VI. Telemedicine Privileges

A. Telemedicine is the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications.

B. Applicants based at distant sites whose practice at the Hospital will be limited to Interpretive Telemedicine only may apply for telemedicine privileges through one of the following mechanisms, as selected by the Medical Executive Committee either for the individual or for a designated class of applicants All licensed independent practitioners who are responsible for the patient care, treatment and services via a telemedicine link are credentialed and privileged to do so at the originating site, according to standards MS.06.01.03 through MS.06.01.13 of the Joint Commission.

1. The originating site's medical staff may use a copy of the distant site's credentialing information for privileging purposes rather than directly obtaining primary source verification of the information supplied by the applicant if all the following requirements are met:

   a. The distant site is Joint Commission accredited hospital or ambulatory care organization.

   b. The practitioner is privileged at the distant site for those services to be provided at the originating site.

   c. The originating site has evidence ofan internal review of the practitioner's performance of these privileges, and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment and services for use in privileging and pe1fonnance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Conunission that result from telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners or staff at the originating site.

   d. The application packet includes a list of all privileges granted to the licensed independent practitioner by the distant site and an attestation signed by the distant site indicating that the packet is complete, accurate and up-to-date.

2. If the distant site is not Joint Commission accredited hospital or ambulatory care organization, applicants will submit the same application required of all applicants for Medical Staff Membership or Clinical Privileges, to be processed pursuant to the application process described in these bylaws.

C. The MEC shall recommend which clinical services are appropriately delivered through a telemedicine link and are consistent with commonly accepted quality standards.

ARTICLE VII

CORRECTIVE ACTION

SECTION I. Procedure

A. Whenever the activities or professional conduct of any Practitioner with clinical privileges are likely to be detrimental to patient safety or to the delivery of quality patient care, or disruptive to Hospital operations, a written request for corrective action against said Practitioner may be submitted to the Executive Committee. The Executive Committee shall notify said Practitioner of the written tequest for corrective action. A copy of such shall be sent to the Practitioner.

B. Corrective action may be requested by the Chief of Staff, any officer of the Medical Staff, the Chairperson of any Medical Staff committee, the Chief Medical Officer, or the Chief Operating Officer. The written request shall include supportive reference to specific activities or conduct which constitute the grounds for the request.

C. Within seven (7) days after its receipt of a request for corrective action, the Executive Committee shall designate a member of the Medical Staff and/or Ad Hoc Committee consisting of a minimum of three (3) Practitioners to investigate the matter. This investigation shall occur and a written report shall be submitted to the Executive Committee within fifteen (15) days of the Executive Committee's request.

D. The Practitioner with respect to whom the request for corrective action has been made shall be given an opportunity to meet with the investigating Member of the Medical Staff and/or the Ad Hoc Committee before the completion of the investigation.

The right to a hearing may be forfeited if the affected practitioner fails, without good cause, to appear.

E. The Executive Connnittee shall meet and determine the action to be taken within fifteen (15) days of its receipt of the rep01i of the investigating Member of the Medical Staff or the Ad Hoc Committee. The Practitioner involved shall be invited to make an appearance before the Executive Committee prior to any adverse action being taken by that Committee. This appearance shall not constitute a hearing but shall be preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of such appearance shall be maintained by the Executive Committee. Notice of results of the Executive Committee's deliberations will be communicated to the Practitioner from the Executive Committee through written notice or through the use of certified mail, return receipt requested.

F. The action of the Executive Committee in response to a request for corrective action may include, but is not limited to, the following recommendations:

1. Reject corrective action request.

2. Issue a warning, a letter of admonition, or a letter of reprimand.

3. Impose individual requirements of training, retraining or continuing education.

4. Recommend reduction, suspension or revocation of clinical privileges for fifteen (I 5) or less days.

5. Recommend reduction, suspension or revocation of clinical privileges for fifteen (15) or more days.

6. Recommend a change in Medical Staff category.

7. Recommend suspension or revocation of Medical Staff membership.

G. If the Executive Committee takes any of the actions listed in F-1 through F-3 above, the actions shall take effect immediately without action of the Board and without the right of hearing or appeal. A report of the action taken and reasons therefore shall be made to the Board through the Chief Operating Officer and the action shall stand unless modified by the Board. In the event the Board determines to consider modifying the action of the Committee and such modifications would reduce or suspend clinical privileges, or revoke or suspend staff appointment, the Board shall so notify the individual, through the Chief Operating Officer, and shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights provided in Article VIII.

H. Any recommendation by the Executive Committee to take any of the actions listed in F-4 through F-7 above shall entitle the affected Practitioner to the procedural rights provided in the Fair Hearing Plan (Article VIII of these Bylaws).

I. The Chairperson of the Executive Committee shall promptly notify the Chief Operating Officer in writing of all requests for corrective action received by the Executive Committee and shall continue to keep the Chief Operating Officer fully informed of all action taken in connection therewith.

SECTION II. Summary Suspension

A. Grounds.

1. The Chief of Staff, or in his/her absence, a member of the Medical Staff Executive Committee, in conjunction with the Chief Operating Officer, the Chief Medical Officer or a member of the Executive-Finance Committee of the Board, or the Chief Operating Officer, or the Chief Medical Officer with the advice and counsel of the Chief of Staff or other member of the MEC, shall each have the authority to summarily suspend all or any portion of the clinical privileges of a Medical Staff member or other individual if such action is in the best interest of patient care or safety or the continued effective operation of the Hospital. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.

2. Such summary suspension shall become effective immediately upon imposition shall immediately be reported in writing to the Chief Operating Officer, or, in

his/her absence, his/her designee and shall remain in effect unless or until modified by the Chief Operating Officer or the Board.

B. Executive Committee Procedure.

The individual who exercises his/her authority under Subsection A of this Section II to summarily suspend clinical privileges shall i1mnediately report his/her action to the Chairperson of the Executive Committee. The Executive Committee shall proceed in accordance with Article VII, Section I, Subsections D through I.

C. Care of Suspended Individual's Patients.

Immediately upon the imposition of a summmy suspension, the Chief of Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's patients still in the Hospital at the time of suspension until such time as they are discharged. The wishes of the patient shall be considered by the Chief of Staff in the selection of a substitute. It shall be the duty of the Chief of Staff and the MEC to cooperate with the Chief Operating Officer in enforcing all suspensions.

SECTION III. Other Actions

A. Failure to Complete Medical Records.

The elective and emergency admitting and clinical privileges of any individual shall be voluntarily relinquished without right to access the fair hearing rights set forth in A1iicle VIII hereof for failure to complete medical records after notification by the Medical Records Department of such delinquency. Such relinquishment shall continue until all the records of the individual's patients are no longer delinquent. Failure to complete the medical records that caused relinquishment of clinical privileges after six (6) months from relinquishment of privileges shall constitute a voluntary relinquishment of clinical privileges and resignation from the Medical Staff.

B. Action by State Licensing Agency or Federal Health Care Program.

Action by the appropriate state licensing agency or a federal health care program, including Medicare and Medicaid, terminating, revoking or suspending an individual's professional licensure, certification or registration or eligibility to participate in federal health care programs, including Medicare and Medicaid, shall result in automatic relinquishment of all Hospital clinical privileges as of that date, without right to access the fair hearing rights set forth in Article VIII hereof, until the matter is resolved to the satisfaction of the Hospital, and the license restored.

C. Failure to Provide Required Documentation.

If a Practitioner fails to provide, on a timely basis, requested documentation of qualifications (such as evidence of current malpractice insurance) required under Article V or VI, the Practitioner's application will be deemed automatically withdrawn, or the Practitioner's Medical Staff membership and clinical privileges shall automatically be

relinquished, as applicable, without right to access the fair hearing rights set forth in A1ticle VIII hereof.

D. Procedure for Leave of Absence.

1. Persons appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Board of a definitely stated period of time not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation of Medical Staff appointment and clinical privileges without right to access the fair hearing rights set forth in A1ticle VIII hereof, unless an exception is made by the Board.

2. Requests for leaves of absence shall be made to the MEC, and shall state the beginning and ending dates of the requested leave. The MEC shall transmit the request, together with its recommendation, to the Chief Operating Officer for action by the Board.

3. At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement summarizing his/her professional activities during the leave of absence with the Chief Operating Officer, and obtaining approval by the MEC and the Board.

ARTICLE VIII

FAIR HEARING PLAN

SECTION I. Definitions

The following definitions, in addition to those following the Preamble of these Medical Staff Bylaws, shall apply to the provisions of the Fair Hearing Plan:

A. "Appellate Review Body" means the group designated pursuant to Section VII.D of this Plan to hear a request for appellate review properly filed and pursued by a Practitioner.

B. "Hearing Committee" means the committee appointed pursuant to Section IV.C of this Plan to hear a request for a bearing properly filed and pursued by an Affected Practitioner,

C. "Parties" means the Affected Practitioner and the body upon whose adverse action a hearing or appellate review request is predicated.

D. "Affected Practitioner" means the Practitioner who requested the hearing or appellate review.

SECTION II. General Provisions

A. Hearing Officer Appointment and Duties.

The use of a hearing officer to preside at a hearing is optional. The use and appointment of such officer shall be determined by the Chairperson of the Board, in consultation with the Chief of Staff. The Hearing Officer shall act in an impartial manner as the presiding officer of the hearing and shall not be entitled to vote. No person who is in direct economic competition with the Affected Practitioner shall be appointed as Hearing Officer.

B. Waiver.

If at any time, after receipt of notice of an adverse recommendation, action or result, the Affected Practitioner fails to make a required request or appearance or otherwise fails to comply with this Fair Hearing Plan, he/she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he/she might otherwise have been entitled under these Bylaws with respect to the matter involved.

C. Number of Reviews.

Notwithstanding any other provision of these Bylaws, no practitioner shall be entitled as a right to more than one hearing and appellate review with respect to an adverse recommendation or action.

D. Release.

By requesting a hearing or appellate review under the Fair Hearing Plan, the Affected Practitioner agrees to be bound by the provisions of Atticle XIII (Immunity from Liability) of these Bylaws in all matters relating thereto.

SECTION III. Initiation of Hearing

A. Recommendations or Actions.

The following recommendations or actions shall, if deemed adverse pursuant to Section III.B, entitle the practitioner affected thereby to a hearing:

1. Denial of initial staff appointment.

2. Denial of reappointment.

3. Suspension of staff membership.

4. Revocation of staff membership.

5. Denial of requested advancement in staff category.

6. Reduction in staff category.

7. Limitation of admitting prerogatives.

8. Denial ofrequested clinical privileges.

9. Reduction in clinical privileges.

10. Suspension of clinical privileges.

11. Revocation of clinical privileges.

B. When Deemed Adverse.

A recommendation or action listed in Section III.A above shall be deemed adverse action only when it has been:

1. Recommended by the Executive Committee; or

2. Taken by the Board contrary to a favorable recommendation of the Executive Committee under circumstances where no right to hearing existed.

C. Notice of Adverse Recommendation or Action.

The Chief of Staff shall be responsible for giving prompt written notice, including a summary of the reasons for the action, of an adverse recommendation of decision to the Affected Practitioner, delivered in person or by certified mail, return receipt requested. Such written notice shall advise the individual of his/her right to request a hearing in accordance with the procedures described herein.

The written notice of hearing rights shall also include:

1. A statement of the acts or omissions with which the Practitioner is charged.

2. A list of specific or representative charts being questioned, if any.

3. A summary of the rights and procedures to which the Practitioner is entitled.

4. In addition, upon request, the Medical Staff member shall be provided with the relevant records of the meetings or other materials underlying the recommendation(s) or decision of the Executive Committee or the Board.

D. Request for Hearing.

The Affected Practitioner may request a hearing by written notice to the Chief of Staff delivered by certified mail, return receipt requested, within 30 days from the Practitioner's receipt of the notice of hearing rights described in Section III-C above.

E. Waiver by Failure to Request a Hearing.

The failure of the Practitioner to request a hearing to which he/she is entitled within the time and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled

on the matter, and the adverse recommendation/action shall thereupon become effective against the Practitioner. Thereafter, the procedures set forth in A11icle V, Section II, and Paragraphs I through K of these bylaws shall be followed.

SECTION IV. Hearing Prerequisites

A. Notice of Time and Place for Hearing.

The Chief of Staff or Vice Chief shall notify the Affected Practitioner by certified mail, return receipt requested, of the place, time and date of the hearing, which date shall be at least 30 days after the Practitioner's receipt of the notice.

B. Statement of Charges.

The notice of hearing required by Section IV.A shall contain a concise statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation of action which is the subject for the hearing.

C. Appointment of Hearing Committee.

1. Matter Initiated By Medical Staff.

A hearing occasioned by an Executive Committee recommendation pursuant to Section III.B shall be conducted by a Hearing Committee appointed by the Chairperson of the Board, on the recommendation of the Chief of Staff, and composed of three (3) members of the Medical Staff. Members of the Hearing Committee must be members of the Active Medical Staff or Consulting Medical Staff. One of the members so appointed shall be designated as Chairperson, unless a Hearing Officer is appointed. The Hearing Committee shall consider any evidence relevant to the issues before it. The committee will make its determinations based on administrative or Medical Staff policies in effect at the time of the relevant conduct of the Affected Practitioner.

2. Matter Initiated By Governing Body.

A hearing occasioned by an adverse action of the Governing Body pursuant to Section III.B shall be conducted by a hearing connnittee appointed by the president of the Board and composed of five (5) persons. At least two (2) Medical Staff members shall be included on this committee. One of the appointees to the committee shall be designated as chairperson, unless a Hearing Officer is appointed.

3. Service on Hearing Connnittee.

No person, who served on the Ad Hoc Committee, shall be appointed to the Hearing Committee. A Medical Staff or Board member shall not be disqualified from serving on a Hearing Committee merely because he/she otherwise

participated in initiating or investigating the underlying matter at issue or because he/she has heard of the case or has knowledge of the facts itivolved or what he/she supposes the facts to be. No person who is in direct economic competition with the Affected Practitioner shall be appointed to the Hearing Committee.

4. There shall be at least a majority of members of the Hearing C01mnittee present when the Hearing Committee meets or when the committee conducts a hearing session, and no member shall vote by proxy. If a committee member is unable or fails to fulfill his/her duties, the Chairperson of the Board in consultation with the Chief of the Medical Staff may appoint a successor.

5. The personal attendance of the Affected Practitioner shall be required. A Practitioner who fails without good cause, as determined by the Hearing Committee, to appear and proceed at such hearing shall be deemed to have waived his/her rights and to have accepted the adverse recommendation or decision involved, and the same shall thereupon become and remain in effect as provided in this Article VIII.

6. Each member of the Hearing C01mnittee who participates in making the Committee's recommendation must ce1iify that he/she has reviewed the record of any sessions not attended.

SECTION V. Heal'ing Pl'ocedul'e

A. List of Witnesses.

If either party, by notice, requests a list of witnesses, then each party within 10 days of such request shall furnish to the other a written list of the names and addresses of the individuals so far as is then reasonably known, who will give testimony or evidence in support of that pmiy at the hearing, and the names and addresses of additional witnesses as soon as procured. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other Party.

B. Presiding Officer.

Either the Hearing Officer, if one is appointed pursuant to Section II.A, or the Chairperson of the Hearing Committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law and the admissibility of evidence.

C. Representation.

The Affected Practitioner shall be entitled to be represented at the hearing by an attorney or other person of his or her choice to examine witnesses and present the case. The Affected Practitioner shall inform the Chief Operating Officer in writing of the name of

that person at least 10 days prior to the date of the hearing. The Chief Operating Officer shall appoint a representative, who may be an attorney, to support the recommendations that gave rise to the hearing and to examine and cross-examine witnesses at the hearing.

D. Rights of Parties.

During a hearing, each of the pmiies shall have the right to:

1. Call and examine witnesses;

2. Introduce relevant evidence;

3. Cross-examine any witness on any matter relevant to the issue;

4. Impeach any witness; and

5. Rebut any evidence.

If the Affected Practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

E. Procedure and Evidence.

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, during the hearing, be entitled to submit memoranda concerning any issue of law or fact and such memoranda shall become a part of the hearing record. The presiding officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation.

F. Burden of Proof.

When a hearing relates to action described in Section III.A (5), (8) or (9), the Affected Practitioner shall have the burden of proving that the adverse recommendation or action lacks any factual basis or that such basis or the conclusion drawn there from are arbitrary and capricious. Otherwise, the body whose adverse recommendation or action occasioned the hearing, shall have the initial obligation to present evidence in suppmi thereof, but the Affected Practitioner shall thereafter be responsible for suppo1iing his/her challenge to the adverse recommendation or action by clear and convincing evidence that the recommendation/action lacks any factual basis or that such basis or the conclusions drawn there from are arbitrary or capricious.

G. Record of Hearing.

A record of the hearing shall he kept that is of sufficient accuracy to permit an informed and valid judgment by any group that may later be called upon to review the record and

render a recommendation or decision in the matter. The Hearing Committee may select the method to be used for the making the record, siich as court rep01ier or electronic recording unit. The Affected Practitioner shall be entitled to obtain a copy of the hearing record upon payment of reasonable costs of producing the copy.

H. Postponement.

Request for postponement of a hearing shall be granted by the Hearing C01mnittee only if the committee determines good cause exists.

I. Recesses and Adjournment.

The Hearing Committee may recess the hearing and reconvene the same without additional notice for the convenience of the pmiicipants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral or written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusions of its deliberations, the hearing shall be declared finally adjourned.

SECTION VI. Hearing Committee, Report and Further Action

A. Hearing Committee Rep01i.

Within ten (IO) days after final adjounm1ent of the hearing, the Hearing Committee shall make a written repoti of its findings and recommendations on the matter and shall fo1ward the same, together with the hearing record and all other documentation considered by it, to the body whose adverse recommendation or decision caused the hearing. The Hearing Committee shall be supported by reference to the hearing record and the other documentation considered by the committee. The Chief Operating Officer shall send a copy of the Hearing Committee's repo1i to the Affected Practitioner.

B. Action on Hearing Committee Report.

Within ten (10) working days after its receipt of the repo1i of the Hearing Connnittee, the Executive Committee or the Board, as the case may be, shall consider the same and affirm, modify, or reverse its reconnnendation or action in the matter. It shall transmit the result and a statement of reason(s) for the result, together with the hearing record, the report of the Hearing Committee and all other documentation considered, to the Chief Operating Officer.

C. Notice and Effect of Result.

I. Notice.

The Chief Operating Officer shall promptly send a copy of the result to the Affected Practitioner by special notice and to the Board.

2. Effect of Favorable Result.

a. Adopted **by the Board.**

If the Board's decision pursuant to Section VI.B following consideration of the results of the hearing is favorable to the Affected Practitioner, such result shall become the final decision of the Board and the matter shall be considered finally closed.

b. Action **by the Executive Committee.**

If the Executive Committee's recommendation pursuant to Section VI.B following consideration of the results of the hearing is favorable to the Affected Practitioner, the Chief Operating Officer shall promptly forward the recommendation, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the Executive Committee's recommendation in whole or in part, or by referring the matter back to the Executive Committee for fmiher reconsideration. Any such referral back shall state the reasons therefore and set a time limit within which the Executive Committee is to make a recommendation to the Board. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The Chief Operating Officer shall promptly send the Affected Practitioner special notice informing him/her of each action taken to pursuant to this Section VI.C (b). Favorable action shall become the final decision of the Board, and the matter shall he considered finally closed. If the Board's action is adverse in any of the respects listed in Section III.A, the special notice shall inform the practitioner of his/her right to request an appellate review of the Board decision as provided in Section VII.A of this Plan.

3. Effect of Adverse Result.

If the recommendation/action of the Executive Committee or of the Board pursuant to Section VI.B following consideration of the results of the hearing continues to be adverse to the Affected Practitioner in any of the respects listed in Section III.A, the Chief Operating Officer shall promptly send the Affected Practitioner special notice of said recommendation/action which will inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section VII.A of this Plan.

SECTION VII. Initiation and Prerequisites of Appellate Review

A. Request for Appellate Review.

A Practitioner shall have ten (10) working days following his/her receipt of a notice pursuant to Section Vl.C.2 (b) or VJ.C.3 to file a written request for appellate review. Such request shall be delivered to the Chief Operating Officer either in person or by certified or registered mail and may include a request for a copy of the record of the Hearing Committee.

B. Waiver by Failure to Request Appellate Review.

A practitioner who fails to request an appellate review within the time and in the manner specified in Section VII.A waives any right to such review. Such waiver shall have the same force and effect as that provided in Section III.E.

C. Notice of Time and Place for Appellate Review.

Upon receipt of a timely request for appellate review, the Chief Operating Officer shall deliver such request to the Board. Within ten (10) working days after receipt of such request, the Board shall schedule and arrange for an appellate review which shall occur not less than ten (I 0) working days nor more than twenty (20) working days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may reasonably be made, but no later than ten (I 0) working days from the date of receipt of the request for review. At least five (5) working days prior to the appellate review, the Chief Operating Officer shall send the Practitioner special notice of the time, place and date of the review. The time for the appellate review may be extended by the appellate review body for good cause.

D. Appellate Review Body.

The Board shall determine whether the appellate review will be conducted by the Board as a whole or by an appellate review committee composed of at least three (3) members of the Board appointed by the Chairperson. If a committee is appointed, one (I) of its members shall be designated as chairperson.

SECTION VIII. Appellate Review Procedure

A. Nature of Proceedings.

The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Committee, that the Hearing Committee's report, and all subsequent actions thereon. The appellate review body shall also consider the written statements submitted pursuant to Section VIII.C and such other materials as may be presented and accepted under Sections VIII.D and VIII.E.

B. Presiding Officer.

Either the chairperson of the appellate review body or his/her designee shall preside over the appeal hearing, if any, determine the order of the procedures, ensure that all participants, if any, in the hearing have a reasonable oppo1tunity to present oral and documental), evidence, rule on any issues or questions that might arise, set deadlines for the submission of written documentation or the like, maintain decorum and ensure that all parties present their positions promptly and without unnecessary delay and that no party abuses its rights and privileges tinder this Section VIII.

C. Written Statements.

The Affected Practitioner shall submit a written statement detailing the findings of fact, coi1clusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review body through the Chief Operating Officer at least three (3) working days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Executive Committee of the Medical Staff or by the Board, and if submitted, the Chief Operating Officer shall provide a copy thereof to the Practitioner prior to the scheduled date of the appellate review.

D. Oral Statements.

The appellate review body, in its sole discretion, may allow the pmiies or their representative to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him by any member of the appellate review body.

E. Recesses and Adjournment.

The appellate review body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

F. Action Taken.

Within ten (10) working days of completion of the appellate review, the appellate review body shall recommend in writing that the Board affirm, modify or reverse the adverse result or action taken by the Executive Committee or by the Board pursuant to Section Vl.C.2 (b) or VI.C.3.

G. Conclusion.

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section VIII have been completed or waived.

SECTION IX. Final Decision of the Board

A. Board Action.

Within ten (10) working days after receipt of the appellate review body's report, the Board shall render its final decision in the matter in writing and shall send notice thereof to the Practitioner by special notice, to the Chief of Staff, and to the Executive Committee. If this decision is in accord with the Executive Committee's last reconnnendation in the matter, if any, it shall be immediately effective and final. If the

Board's action has the effect of changing the Executive Committee's last such recommendation, if any, the Board may refer the matter to a Fair Hearing Panel as provided in Section IX.B, in which case the Board's action on the matter following receipt of the Fair Hearing Panel recommendation shall be immediately effective and final.

B. Fair Hearing Panel Review.

Within ten (10) working days of its receipt of a matter referred to it by the Board pursuant to the provisions of this Plan, a Fair Hearing Panel of equal numbers of the Medical Staff and Board members shall convene to consider the matter and shall submit its recommendation to the Board. The Fair Hearing Panel shall be composed of a total of seven members selected in the following manlier:

1. Three (3) Medical Staff members - Chief of Staff, Vice Chief of Staff, Secretary-Treasurer;

2. Three (3) members of the Board, appointed by the Chairperson; and

3. The Chairperson, who will vote in the event of a tie.

ARTICLE IX

OFFICERS

SECTION I. Officers of the Medical Staff

The officers of the Medical Staff shall be:

A. Chief of Staff;

B. Vice Chief of Staff; and

C. Secretary-Treasurer.

SECTION II. Qualifications of Officers

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

SECTION III. Election of Officers

A. Officers shall be elected at the annual meeting of the Medical Staff. Only members of the Active Medical Staff shall be eligible to vote.

B. The Nominating Committee shall consist of members of the Active Medical Staff appointed by the Chief of Staff. The committee shall offer one or more nominees for each office.

C. Nominations may also be made from the floor at the time of the arnrnal meeting.

D. If there are tln·ee or more candidates for a single, office and no candidate receives a majority of the votes cast, there will be successive balloting and the name of the candidates receiving the fewest votes will be omitted from each successive ballot until a majority vote is obtained by one candidate.

SECTION IV. Term of Office

All officers shall serve a one-year term from or until a successor is elected. Officers shall take office on the first day of the Medical Staff year.

SECTION V. Vacancies in Office

Vacancies in office during the Medical Staff year, except for the Chief of Staff, shall be filled by vote of the Active Medical Staff. If there is a vacancy in the office of Chief of Staff, the Vice Chief of Staff shall serve out the remaining term.

SECTION VI. Removal from Office

At least 25% of the Active Medical Staff members must sign a petition stating the grounds for removal. After the petition is submitted to the Executive Committee, which detennines that it is valid in form, the matter is then brought to a vote at a special meeting of the Medical Staff. Two-thirds of the Active Medical Staff may recommend by vote the removal of an officer of the Medical Staff to the Board for concurrence.

Grounds for removal shall include, but not be limited to, mental or physical impairment, and the inability or failure to perform the duties and responsibilities of the office.

SECTION VII. Duties of Officers

A. Chief of Staff. The Chief of Staff shall:

I. Serve as the chief administrative officer of the Medical Staff in all matters of mutual concern within the hospital;

2. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

3. Serve on the Executive Committee;

4. Serve as an ex officio member of all other Medical Staff committees without vote;

5. Be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staffs compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

6. Appoint committee members to all standing, special, and multidisciplinary Medical Staff committees;

7. Communicate the views, policies, needs and grievances of the Medical Staff to the Governing Body and to the Chief Operating Officer;

8. 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 responsibility to monitor the quality of medical care furnished at the Hospital;

9. Be responsible for the educational activities of the Medical Staff;

10. Be spokesman for the Medical Staff in its external professional and public relations.

B. Vice Chief of Staff.

In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. He/she shall automatically succeed to the Chief of Staff if the latter fails to serve for any reason.

C. Secretary-Treasurer.

The Secretary-Treasurer shall keep accurate and complete minutes of all Medical Staff meetings, call Medical Staff meetings on order of the Chief of Staff, attend to all correspondence, and perform such other duties as ordinarily pertain to his/her office.

SECTION VIII. Chief Medical Officer

The Chief Medical Officer shall by a physician appointed to the Medical Staff by the Board after recommendation by the MEC in the marmer of initial appointment and reappointment provided for in these Bylaws.

A. General Duties.

The Chief Medical Officer shall have administrative responsibility for the overall direction and coordination of medical affairs for the Hospital. He/she shall be responsible to the President/CEO of the Hospital, serving in the capacity of the senior medical executive for the Hospital, and shall assist the Chief of Staff and the MEC. The Chief Medical Officer shall be concerned with medical-administrative and medical-legal aspects of patient care provided in the Hospital and with matters affecting the quality of patient care.

B. Specific Duties.

I. Maintain continuity of medical planning for the development of the Hospital, and assist in detennining operational goals to meet current and future patient care needs;

2. Assist the Chief of Staff and the MEC in matters pe1taining to the Medical Staff and represent their concerns in organizational decision-making;

3. Serve as an ex officio member of all Medical Staff committees, including the MEC, and a voting member of any committee where official appointment is made by the Chief Operating Officer or the Board;

4. Work in conjunction with Medical Staff officers and committees to assure:

   a. Compliance with the standards of the Joint Commission;

   b. Efficient utilization of Hospital diagnostic and therapeutic facilities;

   c. Oversight of efforts to integrate quality improvement and quality measurement into physician perfonnance; and

   d. That indicated changes in the Bylaws or Rules and Regulations of the Medical Staff are brought to the attention of the MEC and the Medical Staff.

5. Oversee Medical Staff governance, credentialing, and peer review activities in concert with Board policies and processes, and the Medical Staff Bylaws.

6. Prepare an annual report of Medical Staff goals and objectives for presentation to theMEC.

7. Review appropriate hospitalized patient communication and provide guidance to the Hospital's patient representative.

8. Assist administration in the preparation of the annual operating budget for the Hospital, including specific responsibility for developing Medical Staff input on:

   a. New patient care program development, including deletion, revision and expansion;

   b. New medical equipment priorities;

   c. Patient care criteria; and

   d. Selection of general medical supplies.

9. Serve as liaison and public relations officer in appropriate medical matters with the local medical community, organized medical societies, and appropriate community organizations.

ARTICLEX

COMMITTEES

SECTION I. Executive (Credentials and Bylaws) Committee

A. The Executive Committee shall consist of the Medical Staff officers. A representative of Administration and the Chief Medical Officer, or his/her designee, shall serve as an ex-officio members.

B. Medical Staff Credentialing.

1. The Executive Committee shall report to the Board all matters relating to credentialing, i.e., appointments, reappointments, staff categorization, clinical privileges, and corrective action for final approval.

2. The functions of credentialing are to review results of the credentialing and performance improvement review as indicated for the purposes of application for appointment or reappointment to the Medical Staff. Criteria for privileges are developed and :functions are perforated under Article V of these Bylaws.

C. Bylaws and Rules and Regulations of the Medical Staff.

1. The Executive C01mnittee shall provide for the review of the Bylaws and Rules and Regulations of the Medical Staff.

2. The Executive Committee's recommended revisions of the Bylaws and Rules and Regulations of the Medical Staff are acted upon by the Medical Staff and presented to the Board for final approval.

D. The Executive Committee will meet as often as indicated.

SECTION II. Committee Meetings

A. Regular Meetings.

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

B. Special Meetings.

A special meeting of any committee may be called by, or at the request of, the Chairperson thereof, by the Chief of Staff, by one-third of the group's other members, but not less than two (2), or by the Chief Medical Officer, or his/her designee.

C. Notice of Meetings.

Written notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution, shall be given to each member of the committee

not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The notice of a special meeting must state the business to be transacted.

D. Quorum.

A majority of the Medical Staff members ofa committee shall constitute a quorum at any meeting.

E. Manner of Action.

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee.

F. Rights of Ex-Officio Members.

Persons serving under these Bylaws as ex-officio members of a committee shall have all the rights and privileges of regular members, except they shall not be counted in determining the existence of a quorum and may not vote.

G. Minutes.

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and a copy thereof shall be promptly submitted to the attendees and forwarded to the Executive Collllllittee. Each committee and service shall maintain a permanent file of the minutes of each meeting.

H. Attendance Requirements.

Each committee member shall be required to attend not less than fifty percent 50% of all meetings of his/her committee in each year. The failure to meet the foregoing atmual attendance requirements, unless excused by the committee chairperson for good cause shown, shall be grounds for removal from that committee and shall be considered in making Medical Staff reappointment decisions.

SECTION III. Functions of Committees

A. Functions of Committees - Generally. Consistency in quality of patient care by all individuals with delineated Clinical Privileges is accomplished by establishing practice standards, by routine and regular monitoring, and by compiling inter-depmtmental quality assessment improvement screening activities for identification and correction of substandard practices. Quality improvement and utilization review, including the establishment of practice standards, routine and regular monitoring, and interdepartmental quality assessment improvement screening activities are the function and responsibility of the Medical Staff as a whole, and of each of the following committees. The committees shall provide for the timely review and evaluation of the medical necessity for admission, and the appropriateness and duration of stays and

professional services rendered, and shall have as their objectives both the maintenance of high quality patient care and assurance of appropriate and efficient utilization of available resources and services, discharge practices, and shall work toward proper continuity of care upon discharge. The committees shall review and evaluate the quality of medical care rendered to patients within its respective scope of practice, and repo1i these findings and recommendations to the Executive Committee.

B. Infection Control/ Pharmacy and Therapeutics Committee.

1. The Infection Control / Pharmacy and Therapeutics Committee is a hospital-wide committee which shall consist of a Chairperson, as appointed by the Chief of Staff, Medical Staff members as assigned by the Chief of Staff, a hospital pathologist, a representative of Administration, the Hospital's Chief Nurse Officer, the Infection Control Nurse, a Pharmacist, a representative of Microbiology, a representative of the Hospital's quality staf£1department, and the Chief Medical Officer, or his/her designee.

2. The Infection Control / Pharmacy and Therapeutics Committee shall meet at least quarterly.

3. The functions oflnfection Control shall include, but not be limited to:

   a. Reporting and reviewing of infection among patients and personnel for monthly review.

   b. Promotion of prevention and c01Tective program to minimize the hazards of infection.

   c. Trending of the rate or spread of infection.

   d. Surveillance of hospital infection potential.

   e. Discussion and/or action on matters of Infection Control as indicated or requested by the Executive Committee or Administration.

   f. Review of antibiotic therapy.

   g. Review of blood utilization.

   h. Periodic review of the policies, procedures and standing orders that govern the provision oflnfection Control Services.

   i. Peer review will be performed monthly by the Pathologist, the Infection Control Nurse or assistant and reported to the Quality Improvement Committee.

4. The functions of Phannacy and Therapeutics shall include, but not he limited to:

a. Surveillance of drug utilization.

b. Evaluate drugs for the inclusion in the hospital Formulary.

c. Provide periodic review of policies, procedures and standing orders governing the distribution, storage, utilization and safety of medications.

d. Prevent the unnecessary duplication of compounds and/or drugs.

e. Establish the standards for the utilization and control of investigational/experimental drugs.

f. Review all significant untoward drug reactions.

g. Peer review will be performed monthly by the Pharmacist, or other members of the committee as necessary. Reporting of results will be at the Quality Improvement Committee.

C. Quality Improvement Committee.

1. The Quality Improvement Committee shall consist of all of the members of the Active Medical Staff. A representative of Administration, the Hospital's Chief Nurse Officer, and the Chief Medical Officer, or his/her designee, shall serve as ex-officio members.

2. The committee shall meet at least at least quarterly.

3. The functions of the Quality Improvement Committee shall include, but not be limited to:

a. Review of medical records to determine compliance with reasonable standards of usefulness, historical validity and realistic documentation of medical events, including:

(1) Condition of the patient.

(2) Progress of the patient during hospitalization.

(3) Therapy provided to the patient and results thereof

(4) Identification of responsibility for all actions taken.

(5) Completeness to meet the criteria of medical comprehension of the case.

(6) Discharge review to determine the promptness, pertinence, adequacy and completeness thereof.

b. Utilization Management studies to evaluate the appropriateness of admission, length of stay, discharge practices, use of medical and hospital services, specifically:

(1) How under-utilization and over-utilization of se1vices affects the quality of care provided at the hospital.

(2) Study patterns of care, relating to the specific length of stay by disease specific categories.

(3) Development of criteria related to the above.

(4) Proper continuity of care upon discharge.

c. Review of selected quality of care issues presented.

4. Peer review of selected screens shall be done monthly by the members of the Quality Improvement Committee.

5. Quality of care issues can be addressed by the Chief of Staff, the Chief Medical Officer or the Quality Improvement Committee, and recommended actions can be made at their own level to the Practitioner prior to an implementation of the Corrective Action Plan by the Medical Staff.

6. Quality review issues and the results of quality improvement activities will be communicated to the Board on a regular basis.

D. Peer Review Committee. The Peer Review Committee shall consist of all members of the Active Medical Staff. A representative of Administration and the Chief Medical Officer, or his/her designee, shall serve as ex-officio members.

1. The committee shall meet at least qumterly.

2. Duties of the Peer Review Committee shall be:

a. To insure compliance with Medical Staff Peer Review Policy;

b. To oversee the process for ongoing evaluation of individuals granted privileges using all appropriate and relevant sources of performance data available;

c. To assess the performance of all individuals granted privileges;

d. To ensure utilization of peer review assessments to improve patient care and safety;

e. To establish the specific indicators and targets to be used for evaluation and keep Medical Staff informed of same;

f. To perform ongoing monitoring of practitioner performance based on defined rate and rule indicators and evaluate the collected data that falls outside of the accepted targets;

g. To perform specific case reviews brought forth as defined in the Medical Staff Peer Review Policy;

h. To create and maintain the process for practitioner feedback;

i. To make recommendations for individuals practitioner performance improvement action plan;

j. To oversee the education process for individual performance improvement;

k. To perform timely follow-up of individual performance improvement; and

l. To ensure that pertinent practitioner performance data is forwarded for timely review by the Executive Committee.

3. Review Entity. This Medical Staff Peer Review Committee constitutes only one part of the Hospital's duly appointed peer review committee. In addition to this Medical Staff Peer Review Committee, the Hospital's duly appointed peer review committee includes, but is not limited to, the entire Medical Staff, the Board, the Executive Committee, the quality committees of the Hospital and the Medical Staff, and the administrative offices of the Hospital and the Medical Staff that process Practitioner applications.

E. Committee of the Whole.

I. The Medical Staff acting as a Committee of the Whole, on a rotating basis, shall consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of the medical care and treatment provided to patients.

2. The functions of the Medical Staff acting as a Committee of the Whole, on a rotating basis, shall include, but not be limited to:

a. Routine monitoring of the care, treatment and professional medical services furnished at the Hospital, as well as the routine monitoring of Special Care Services and the Hospital's education department.

b. Screening for identification of substandard practice.

c. Timely review and evaluation of services rendered.

d. Review for the appropriate and efficient utilization of available facilities and services.

e. Review for appropriate discharge practice and continuity of care upon discharge.

f. Periodic review of the policies, procedures and standing orders that govern the provision of care at the Hospital.

g. Continuing peer review of the professional performance of all Practitioners and other individuals with Clinical Privileges. Such peer review will be evaluated monthly and reported to the Quality and Improvement Committee and to the MEC.

3. Develop the criteria for Clinical Privileges at the Hospital.

4. Transmit to the Executive Committee any and all reports requested by the Executive Committee concerning: (i) requests for appointment and/or reappointment to the Medical Staff, and (ii) the delineation of Clinical Privileges.

5. Assist in the preparation of such annual repotts, including budgetary planning pertaining to emergency, surgical, anesthesia, pathology, medical, pediatric and radiology services, as may be requested by the Chief Operating Officer or the Governing Body.

SECTION IV. Joint Conference Committee

Not later than the first regular meeting following the Annual Meeting of the Board, the Chairperson of the Board shall appoint a Joint Conference Committee, which shall serve as a liaison among the Board, Hospital Administration and the Medical Staff. This Committee is represented by three (3) Trustees appointed by the Chairperson of the Board; three (3) representatives of Hospital Administration recommended by the Chief Operating Officer, including the Chief Medical Officer, or his/her designee; and three (3) representatives of the Medical Staff recommended by the Chief of Staff. The Chairperson of the Joint Conference Committee shall be rotated among the three (3) groups of committee members on an annual basis.

The Joint Conference Committee shall meet as often as deemed necessary. Length of term for each participant shall be one (1) year. All Committee participants shall have equal voting privileges. The Joint Conference Committee shall transmit written reports of its activities to the Executive Committee and to the Governing Body.

The Joint Conference Committee shall conduct itself as a forum for the discussion of matters of hospital policy and practice, especially those pertaining to efficient and effective liaison among the Governing Body, Hospital Administration and the Medical Staff. The Joint Conference Committee shall discuss any relevant matter proposed by the members. The Committee shall also review and make recommendations to the Board relative to any matter assigned to it for review.

ARTICLE XI

MEDICAL STAFF MEETINGS

SECTION I. Meetings

A. The regular meetings of the Medical Staff shall be bi-monthly, January through November. These meetings shall include a report of all committees, administrative report and a review of administrative and medical staff issues, and action on repotis of the medical staff minutes, administrative repo1i and individually submitted items. The Chief Medical Officer, or his/her designee, shall attend all regular and special meetings of the Medical Staff.

B. The annual meeting of the Medical Staff shall be the last meeting before the end of the Medical Staff Year. At this meeting, officers for the ensuing year shall be selected.

C. The Medical Staff shall meet at any time at the request of the Chief of Staff, or the Chief Medical Officer, or his/her designee. Written or printed notice stating the place, day and hour of any such special meeting of the Medical Staff shall be delivered either personally or by mail to each member of the Active Staff not less than three (3), nor more than seven (7) days before the date of such meeting, by, or at the direction of, the Chief of Staff.

D. A majority of the Medical Staff shall constitute a quorum.

E. The Medical Staff will meet bi-monthly as a committee of the whole with the following duties:

I. Serve as liaison mechanism between the Medical Staff and hospital administration. The Chief Operating Officer (or his/her designee), the Chief Medical Officer (or his/her designee) shall serve, and the Chief Nurse Officer may serve, as ex-officio members of the co111lllittee without vote.

2. Receive and act on reports and recommendations of the medical staff committees, Hospital committees, and assigned activity groups.

3. Implement the approved policies of the Medical Staff.

4. Fulfill the Medical Staffs responsibility for the quality and appropriateness of the medical care rendered to patients in the Hospital and the effectiveness of the Quality Improvement and Utilization Management activities including evaluation and revisions of such activities.

5. Initiate and pursue corrective action when warranted in accordance with Medical Staff Bylaws' provisions, including termination of membership.

6. Inform the Medical Staff of the Joint Commission accreditation program and the accreditation status of the hospital.

7. Be responsible for the teaching, education and research programs in the Hospital.

SECTION II. Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, the Executive Committee of the Medical Staff or by the Chief Medical Officer, or at the request of the Chief Operating Officer or the Board, or at the request of not less than one-fourth of the members of the Active Medical Staff, by filing a written request with the Chief of Staff that, within ten (10) days of the filing of such request, a special meeting of the Medical Staff be called. The Executive Committee shall designate the time and place for any such special meeting. Written or printed notice stating the place, day and hours of any such special meeting of the Medical Staff shall be delivered either personally or by mail to each member of the Active Staff not less than three (3), nor more than seven (7), days before the date of such meeting, by, or at the direction of, the Chief of Staff.

SECTION III. Quorum

The presence of a majority of the Active Medical Staff at any regular or special meeting shall constitute a quorum for purposes of amendment of these Bylaws, Rules and Regulations, and for all other actions.

SECTION IV. Attendance Requirements

A. All members of the Active Medical Staff shall be required to attend all of the scheduled staff meetings. Less than 50% attendance at these meetings in any one-year will be considered ground for suspension by the Staff.

B. Reinstatement of members of the Active Staff whose staff membership was suspended because of absence from meetings, may be made on application, the procedures being the same as in case of original appointment.

ARTICLE XII

IMMUNITY FROM LIABILITY

SECTION I. Immunity

By applying for Medical Staff membership and/or privileges at the Hospital, the applicant automatically agrees to the following:

A. Any act, communication, report, recommendation, or disclosure with respect to such applicant, performed or made in good faith and without malice, by or at the request of an authorized representative of this or any other health care facility, shall be privileged to the fullest extent permitted by law.

B. The releases and immunity contained in this Atiicle XII extend to the Hospital and to any member of this Hospital's Medical Staff and of its Goveming Body, to its other Practitioners, to its Chief Operating Officer and his/her representatives, and to third parties who supply information to any of the foregoing. For the purposes of this Article XII, the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Goveming Body or the Medical Staff.

C. There shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure described in this Article XII, even where the information involved would othe1wise be deemed privileged.

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

I. Applications for appointment or clinical privileges;

2. Periodic reappraisals for reappointment or clinical privileges;

3. Corrective action, including summary suspension;

4. Hearings and appellate reviews;

5. Quality Improvement activities;

6. Utilization Management reviews, and

7. Other Hospital, service or committee activities related to quality care or interprofessional conduct.

E. The acts, communications, reports, recommendation and disclosures referred to in this Aliicle XII may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional health or stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care or the effectiveness of Hospital operations.

F. In furtherance of the foregoing, each Practitioner and other applicant or individual with Clinical Privileges shall, upon request of the Hospital, execute releases in accordance with the tenor and import of this Article XII in favor of the individuals and organizations specified in Paragraph B, subject to such requirements as may be applicable under the laws of this State; provided, however, that the effectiveness of the releases and commitments made pursuant to this Article XII shall not be dependent on execution of the releases described in this Paragraph F.

G. The consents, authorizations, releases, rights privileges and immunities provided by Sections I and II of Article V of these Bylaws for the protection of this Hospital's Practitioners, other Hospital officials and personnel, and third parties in connection with applications for initial appointment, shall be fully applicable to the activities and procedures covered by this Article XII.

SECTION II. Confidentiality

A. Requests for information relating to current or past Medical Staff members, will be given to the Chief Operating Officer for response. Administration will seek input from the

Chief of Staff for response relative to clinical performance, and Hospital will provide the information ·to the requesting organization

B. Verification of Medical Staff status may be handled administratively.

C. Information with respect to a specifically identified Practitioner that is submitted, collected or prepared by any representative of this Hospital or any other health care facility, organization or medical staff for the purpose of achieving and maintaining the quality of patient care shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative or the Practitioner or used in any way, except as permitted or provided herein and in Medical Staff and Hospital policies.

D. Such confidentiality shall also extend to information of like kind that may be provided to the Hospital by third parties.

E. This information shall not become part of any patticular patient's file or general Hospital records.

ARTICLE XIII

ORGANIZED HEALTH CARE ARRANGEMENT ("OHCA")

A. The Medical Staff shall patticipate in the Borgess-Lee Memorial Hospital's Organized Health Care Arrangement ("OHCA"), as that OHCA is more particularly described in Borgess-Lee Memorial Hospital's Joint Notice of Privacy Practices, and to abide by the terms of the Joint Notice of Privacy Practices with respect to patient information created or received by the Medical Staff as part of its pmticipation in the OHCA.

B. Individual members of the Medical Staff shall participate in Borgess-Lee Memorial Hospital's OHCA, as described in Borgess-Lee Memorial Hospital's Joint Notice or Privacy Practices, and to abide by the terms of the Joint Notice of Privacy Practices with respect to patient in formation created or received by the individual members of the Medical Staff as part of his/her participation in the OHCA.

C. The Medical Staff and its individual members shall comply with applicable state and federal laws, rules and regulations, as well as Hospital policies and procedures, including but not limited to confidentiality and privacy laws, regulations, policies and procedures.

D. The Medical Staff and its individual members shall indemnify the Hospital, its directors, officers, employees, agents and representatives from and against any claims, losses, damages, verdicts, judgments, actions, fines, penalties or injuries incurred as a result of an action or inaction by the Medical Staff or individual member that is found or alleged to be a violation of the Health Insurance Portability and Accountability Act or regulations promulgated there under.

E. Any individual member of the Medical Staff who does not agree to pmticipate in the Hospital's OHCA and who is a "covered entity" under the Health Insurance Pmtability

and Accountability Act of 1996 ("HIPAA") shall agree to provide to individuals a copy of the member's Notice of Privacy Practices as i·equired by HIPAA.

ARTICLE XIV

EMERGENCY MEDICAL TREATMENT AND LABOR ACT

The Hospital is obligated to comply with the provisions of the Emergency Medical Treatment and Labor Act (EMTALA) and has adopted the Screening, Stabilization and Transfer of Emergency Patients policy to implement the requirements of EMTALA. In brief, the policy requires:

A. Each patient that presents to the Emergency Department shall be provided a medical screening examination within the capability of the Emergency Department to determine whether an emergency medical condition exists.

B. If it is determined that an emergency medical condition exists, the Hospital shall provide further medical examination and stabilizing treatment within its capacity, or an appropriate transfer to another medical facility.

C. Members of the Medical Staff shall provide on-call service to the Emergency Depaiiment in accordance with protocols approved by the Medical Staff Executive committee and the Chief Operating Officer or his designee. Medical Staff obligations relating to on-call service shall be more specifically delineated in applicable Rules and Regulations.

The members of the Medical Staff shall abide by the Hospital's policies and Rules and Regulations governing Medical Staff responsibilities under this A1iicle.

ARTICLE XV RULES

AND REGULATIONS

The Medical Staff shall 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 shall 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 shall be a part of these Bylaws, except that they may be amended or repealed at any regular meeting of the Active Medical Staff at which a quorum is present and without previous notice, or at any special meeting at which a quorum is present, by a two-thirds vote of those Active Medical Staff members present. Such changes shall become effective when approved by the Governing Body.

ARTICLE XVI

REVIEW

The Medical Staff Bylaws and Rules and Regulations are reviewed by the Executive Committee biannually to assure that they are appropriate.

ARTICLE XVII

AMENDMENTS

Notice of all proposed amendments to these Bylaws shall be given at a regular meeting of the Medical Staff. The proposed amendments shall be presented to the Executive Committee, which shall report at the next regular meeting of the Medical Staff. Vote ofa two-thirds majority of the Active Medical Staff members present at the meeting is required to adopt the amendments. Amendments so adopted shall be effective when approved by the Governing Body.

ARTICLE XVIII

ADOPTION

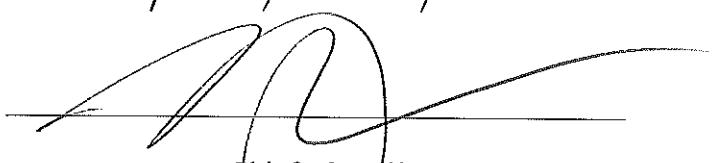
These Bylaws, together with the appended Rules and Regulations, may be adopted at any regular or special meeting of the Active Medical Staff and shall replace any previous Bylaws, Rules and Regulations, and shall become effective when approved by the governing body of the Hospital.

BORGESS LEE MEMORIAL HOSPITAL
Borgess Health
MEDICAL STAFF BYLAWS

These amended **MEDICAL STAFF BYLAWS** of Borgess-Lee Memorial Hospital were duly:

Approved by the Borgess-Lee Memorial Hospital Medical Staff on

April 8, 2014



Chief of Staff
Borgess-Lee Memorial Hospital

Approved and Adopted by the Borgess-Lee Memorial Hospital Board of Trustees on:
April 15, 2014

Chairman Board of Trustees
Borgess-Lee Memorial Hospital