Beacon Kalamazoo Hospital

(formerly known as Ascension Borgess Hospital)

Medical Staff Bylaws | Rules & Regulations

Approved & Adopted:

Medical Executive Committee- June 11, 2015, October 2022, November 2024
Board of Trustees- November 19, 2015, October 2022, February 2023, November 2024

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PREAMBLE

The Medical Staff is the formal organizational structure through which the benefits of membership on the Staff may be obtained by individual practitioners and by which the obligation of Staff membership may be fulfilled.

MISSION

Borgess Health, as a Catholic health ministry rooted in the values of Ascension Health and its sponsors, is committed to providing holistic, spiritually centered care, which strives to improve the health of individuals in communities we serve with special attention to the poor and vulnerable.

VISION

By putting safety and quality at the core of all we do, Borgess Health will provide health care that is coordinated across the continuum based on meeting the needs and expectations of the patients we serve.

VALUES

We are called to:

- Service of the Poor - generosity of spirit, especially for persons most in need
- Reverence - respect and compassion for the dignity and diversity of life
- Integrity - inspiring trust through personal leadership
- Wisdom - integrating excellence and stewardship
- Creativity - courageous innovation
- Dedication - affirming the hope and joy of our ministry

PURPOSE

The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice within Borgess Health to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Board of Trustees. Specifically, the Medical Staff provides oversight of the quality of care, treatment, and services delivered by Practitioners who are credentialed and privileged through the Medical Staff process. The Medical Staff is also responsible for the ongoing evaluation of the competency of Practitioners who are privileged, delineating the scope of privileges that will be granted to Practitioners, and providing leadership in performance improvement activities within Borgess Medical Center.

AUTHORITY

Subject to the authority and approval of the Board of Trustees, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws.

DEFINITIONS

1. "Board" means the Board of Trustees of Borgess Health, which has overall responsibility for the conduct of the hospital, including Medical Staff.
2. "Calendar Year" means the period from January 1st through December 31st.
3. "Chief Executive Officer" or "CEO" means the "President" of the Borgess Medical Center or his/her designee.
4. "Ethical Religious Directives" or "ERD" means Ethical and Religious Directives for Catholic Health Facilities to which the Hospital and its employees and providers are subject, as referenced in Section 3.2.A.6.
5. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board."
6. "Medical Staff" means all physicians, podiatrists, and dentists who are granted membership by the Board upon the recommendation of the MEC.
7. "Non-Physician Practitioner" or "NPP" means all non-physician practitioners to include Advanced Practice Registered Nurses (APRN), Certified Nurse Midwife (CNM), Physician Assistant (PA), Psychologist, Chiropractors and Social Workers.
8. "Western Michigan University Homer Stryker, MD, School of Medicine" (WMed) is the corporation responsible for the continuing medical education of physicians at Borgess Medical Center.
9. "Physicians" shall be interpreted to include doctors of medicine, doctors of osteopathy, doctors of dental medicine/surgery, doctors of podiatry and doctors of optometry who are licensed in the State of Michigan.
10. "Practitioner" means all those privileged through the Medical Staff process.
11. "Residents" means physicians in basic residency training programs and shall not be appointed to the Medical Staff and shall not be granted specific Clinical Privileges.
12. "Special Notice" means written notice (a) sent by certified mail, return receipt requested; or (b) delivered personally with the affected individual, or his/her designee, signing as proof of receipt; or (c) other written documentation from the individual delivering the notice as to why signature was not obtained.
13. "MSSD" refers to the Medical Staff Services Department located at Borgess Medical Center.
14. "Chief Medical Officer" or "CMO" means the Chief Medical Officer or his/her designee.
15. "Chief of Staff" or "COS" means the Chief of Staff or his/her designee.
16. "Chief of Staff Elect" or "COSE" means the Chief of Staff Elect or his/her designee.
17. "Secretary to the Medical Staff" or "SEC" means the Secretary to the Medical Staff or his/her designee.
18. "Ongoing Professional Practice Evaluation" or "OPPE" refers to the ongoing evaluation and assessment of a Practitioner's clinical competence and professional behavior.
19. "Focused Professional Practice Evaluation" or "FPPE" refers to the focused and time limited evaluation of a Practitioner's competence to perform a specific privilege or privileges.
20. "TJC" means The Joint Commission.

ARTICLE ONE
CATEGORIES OF MEDICAL STAFF

1.1 CATEGORIES

All appointments and reappointments to the Medical Staff shall be made by the Board. All appointees shall be appointed to a specific department, but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws and approved by the Board. All appointments shall be to one of the established categories of the Medical Staff.

A. ACTIVE STAFF

1. Qualifications- Members of this category must actively support the Medical Staff and the health system by contributing to efforts to fulfill Medical Staff functions. Members of this category must be involved in at least fifty (50) patient contacts per year. They shall reside or have a business office within sufficiently close proximity to the health system or make arrangements that are satisfactory to the MEC for alternative practitioner coverage for patients for whom he/she is responsible.

2. Prerogatives- Members will attend Medical Staff/Department meetings of which they are a member and any Medical Staff or hospital education program. Members are eligible to vote on all matters presented to the Medical Staff, or to the department or committee(s) to which they are assigned. Members in this category are eligible to hold office and sit on or be the Chair of any committee in accordance with and qualifying criteria set forth elsewhere in the Medical Staff Bylaws or policies. Members will be responsible for taking call in accordance with their respective departments. Members will participate in, and provide leadership for, the organization wide performance improvement committees and activities.

3. Dues- Members will be required to pay dues on an annual basis by January 31st. Failure to furnish dues will result in voluntary relinquishment of privileges and/or Medical Staff appointment.

B. AFFILIATE STAFF

1. Qualifications- This category is reserved for members who do not meet the eligibility requirements for the active category or choose not to pursue active status, and for members who maintain clinical practice in the hospital service area and wish to follow their patients when they are admitted to the hospital. This category includes practitioners during their first year on the Medical Staff, as well as low volume/no volume practitioners.

2. Prerogatives- Members may attend Medical Staff/Department meetings of which they are a member and any Medical Staff or Hospital education program. Members may

not vote on matters presented to the Medical Staff, or to the department or committee(s) to which they are assigned. Members are not eligible to be an officer of the Medical Staff.

3. Dues- Members will be required to pay dues on an annual basis by January 31st. Failure to furnish dues will result in voluntary relinquishment of privileges and/or Medical Staff appointment.

C. TELE-MEDICINE STAFF

1. Qualifications- This category is reserved for practitioners who solely provide interpretive telemedicine services for Borgess Health.

2. Prerogatives- Members may not vote on matters presented to the Medical Staff, or to the department or committee(s) to which they are assigned. Members are not eligible to be an officer of the Medical Staff.

3. Dues- Members will be required to pay dues on an annual basis by January 31st. Failure to furnish dues will result in voluntary relinquishment of privileges and/or Medical Staff appointment.

D. HONORARY STAFF

1. The Honorary Medical Staff consists of those individuals who, in the judgment of the Chief of Staff and the MEC, are distinguished practitioners whose contributions to Borgess Health or whose recognized professional eminence merit special recognition. Appointees to this category will be nominated by the Chief of Staff or the MEC. Honorary Staff do not hold privileges, nor are they eligible to vote or hold office in the Medical Staff. They are not required to pay dues.

E. RESIDENTS AND FELLOWS

1. Residents or fellows in training in the hospital shall not hold membership on the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the residency/fellowship training program through WMed or other applicable institutions approved by the Board. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows, including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate Medical Staff and hospital leaders.

F. RESIDENT/FELLOW MOONLIGHTER

1. Qualifications- A Resident/Fellow Moonlighter that exercises a limited scope of privileges as determined by the Division/Department Chief and approved by MEC within the department privileges are granted. A Resident/Fellow Moonlighter may not independently admit patients to the hospital.

2. Prerogatives- A Resident/Fellow moonlighter may attend Medical Staff/Department meetings of which they are a member and any Medical Staff or Hospital education programs at the discretion of the department/division chair. Resident/Fellow Moonlighters may not vote on matters to the Medical Staff or to the department or committee(s) to which they are assigned. Resident/Fellow Moonlighters are not eligible to be an officer of the Medical Staff.

ARTICLE TWO
CATEGORIES OF NON PHYSICIAN PRACTITIONER STAFF (NPP) & ADVANCED PRACTICE PROVIDER(APP)

2. 1 CATEGORIES

All appointments and reappointments to the NPP and APP Staff shall be made by the Board. All appointees shall be appointed to a specific department, but shall be eligible for clinical privileges in other departments as applied for and recommended pursuant to these Bylaws and approved by the Board. NPP & APP Staff are ineligible to hold Medical Staff appointment. Furthermore, NPP & APP Staff are not eligible to vote or hold office.

A. NON-PHYSICIAN PRACTITIONER STAFF (NPP)

1. Qualifications- Members of this category must actively support the Medical Staff and the health system by contributing to efforts to fulfill Medical Staff functions. They shall reside or have a business office within sufficiently close proximity to the health system or make arrangements that are satisfactory to the MEC for alternative practitioner coverage for patients for whom he/she is responsible. Members of this category may not admit patients to or discharge patients from the hospital.

2. Prerogatives- Members will attend Department meetings of which they are a member and any hospital education program. Members will be responsible for taking call in accordance with their respective departments if applicable.

3. Dues- Members will be required to pay dues on an annual basis by January 31st.

B. ADVANCED PRACTICE PROVIDER (APP)

1. Qualifications- Members of this category includes physician assistant, advanced practice registered nurse, certified registered nurse anesthetist, certified nurse midwife, nurse practitioners that participate in the management of patients under the supervision, direction or back up of a medical staff member, consistent with the clinical privileges granted to the APP. APP must actively support the Medical Staff and the health system by contributing to efforts to fulfill Medical Staff functions. They shall reside or have a business office within sufficiently close proximity to the health system or make arrangements that are satisfactory to the MEC for alternative practitioner coverage for patients for whom he/she is responsible. Members of this category may not admit patients to or discharge patients from the hospital.

2. Prerogatives- Members will attend Department meetings of which they are a member and any hospital education program. Members will be responsible for taking call in accordance with their respective departments if applicable.

3. Dues- Members will be required to pay dues on an annual basis by January 31st

ARTICLE THREE
APPOINTMENT OF THE MEDICAL STAFF & NON-PHYSICIAN PRACTITIONERS

3.1 QUALIFICATIONS FOR MEMBERSHIP AND/OR CLINICAL PRIVILEGES

A. The credentialing and privileging process involves a series of activities designed to collect, verify and evaluate data relevant to a Practitioner's professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the Medical Staff, and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant's licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established. Professional criteria outlined in these Bylaws are designed to assure the Medical Staff and Governing Body that patients will receive quality care, treatment and services.

B. No practitioner shall be entitled to membership on the Medical Staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization. The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, age, gender, sexual orientation, religion, disability unrelated to the provision of patient care or required medical staff responsibilities, community need, or reasonable objectives of the hospital, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

C. The following qualifications must be met by all practitioners who apply for Medical Staff appointment, reappointment, or clinical privileges:

1. The applicant must demonstrate that he or she has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, optometry, or applicable recognized course of training in a clinical profession that is eligible to hold privileges.

2. The applicant must have a current, valid and unrestricted license as a practitioner that is applicable to his or her profession and provides permission to practice within the state of Michigan.

3. The applicant must have a record that is free of current Medicare/Medicaid sanctions and not be on the Office of Inspector General's (OIG) list of excluded individuals/entities.

4. The applicant must have a record that is free of felony convictions or occurrences that would raise questions of undesirable conduct that could injure the reputation of the Medical Staff or hospital.

5. Physician must be board certified or board eligible and maintain board certification in their respective fields in which a majority of clinical privileges are desired. Boards that Applicants who are applying for appointment and are entering the Medical Staff admitted from an approved training program are allowed (5) five years to acquire Board Certification. Certifying boards must be recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Dental Association (ADA), the American Board of Oral and Maxillofacial Surgery (ABOMS), American Board of Foot and Ankle Surgery (ABFAS) the American Board of Optometry (ABO), The Royal College of Physicians and Surgeons of Canada.

    a. All practitioners who are current Medical Staff members and/or hold privileges as of 1998 and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

    b. All practitioners must maintain parent board certification if their current subsidiary board requires such.

    c. All NPP Staff must maintain board certification in the appropriate Board that is deemed acceptable by the MEC.

6. The applicant must possess a current, valid, and unrestricted Drug Enforcement Administration (DEA) number or Controlled Substance Registration (CSR) number, if applicable.

7. The applicant must abstain from any participation in fee-splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities.

8. The applicant must possess a history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.

9. The applicant must demonstrate his or her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested.

10. The applicant must, on request, provide evidence of physical and mental health that does not impair, with reasonable accommodation, the fulfillment of his or her

Medical Staff responsibilities and the specific privileges requested by and granted to the applicant.

11. The applicant, if granted privileges, who may have occasion to admit an inpatient, must demonstrate his or her capability to provide continuous and timely care to the satisfaction of the MEC and the Board.

12. The applicant must demonstrate current clinical competence within the last 24 months in the area in which he or she seeks clinical privileges.

13. The applicant must request privileges for a service the Board has determined appropriate to provide at the hospital. The Board must also see a need for this service under its Medical Staff development plan.

14. The applicant must provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consulting with the MEC.

C. Only the Board may create additional exceptions to the previous section after consulting with the MEC.

3.2 OBLIGATIONS OF MEMBERSHIP AND/OR CLINICAL PRIVILEGES

A. Each Medical Staff and NPP Staff appointee under the Borgess Health Bylaws must:

1. Comply with these Bylaws, with the Rules and Regulations, and with the policies and procedures set forth by Borgess Health as well as Ascension Health.

2. Consistent with their granted clinical privileges, participate in the on-call coverage of the Emergency Department or in other hospital coverage programs as determined by the MEC and the Board, after receiving input from the appropriate clinical specialty. The Physicians who have clinical privileges in a given service/specialty shall mutually agree on the amount Emergency Department on-call coverage each Physician in that service/specialty will provide in a given month. If all the Physicians in the service/specialty cannot agree on a call schedule that will provide Emergency Department call coverage twenty-four (24) hours a day, seven (7) days a week in a given month, then on-call coverage responsibility will be allocated by the Chief of Staff or designee, department chief, or Chief Medical Officer equally among all the Physicians who have clinical privileges in that service/specialty, up to a maximum of seven (7) days per month per Physician. The Board may at its discretion choose to contract certain on-call services to specific groups of privileged providers, in which case the call schedule may be determined by a physician designee of senior management.

3. Participate in performance improvement and utilization management processes and activities for Borgess Health.

4. Perform any responsibilities required which may be set forth by the Medical Staff, Borgess Health, Ascension Health, applicable regulatory bodies and state/federal entities.

5. Complete medical records in such a manner that is specified in Article 7.9.

6. Abide by generally recognized standards of professional ethics as required by respective specialty boards, professional societies, Borgess Health, Ascension Health and the Ethical and Religious Directives for Catholic Health Care Services.

7. Satisfy continuing education (CE/CME) requirements prescribed by state regulations and guidelines.

8. Abide by the terms of the Notice of Privacy Practices and distributed to patients as required by the federal patient privacy regulations.

B. A medical history and physical examination must be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery, an interventional diagnostic procedure, or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a Physician or other qualified licensed individual in accordance with state law, Section 13.7 of these Bylaws and hospital policy.

An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery, an interventional diagnostic procedure, or a procedure requiring anesthesia services, when the medical history and physical examination is completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a Physician or other qualified licensed individual in accordance with state law, Section 13.7 of these Bylaws and hospital policy.

A focused history and physical examination and report may be used for outpatient procedures that do not require general anesthesia. The focused history and physical examination must be completed and documented by a Physician or other qualified licensed individual in accordance with state law, section 13.7 of these Bylaws and hospital policy.

3.3 TERMS OF APPOINTMENT

A. Initial appointment and reappointment to the Medical Staff and NPP Staff shall be for a period no longer than 3 years from prior appointment/reappointment. Appointments may only be made after official recommendation by the MEC and final approval by the Board.

ARTICLE FOUR
APPOINTMENT AND REAPPOINTMENT PROCEDURES

4.1 APPLICATION REQUEST PROCEDURE

A. All requests for applications for appointment to the Medical Staff, appointment as a Non-Physician Practitioner and requests for clinical privileges will be forwarded to the MSSD. On receipt of the request, the MSSD will provide the applicant with an application package, which will include a complete set or overview of the Medical Staff Bylaws or a reference to an electronic source for this information. This package will enumerate the eligibility requirements for Medical Staff membership, privileges, and performance expectations for individuals granted Medical Staff membership or privileges.

4.2 PROCESSING APPLICATIONS

A. All individuals and groups acting on an application for staff appointment and/or clinical privileges must do so in a timely manner and in good faith. Except for a good cause, each application will be processed within 180 calendar days. These time periods are deemed guidelines and do not create any right for the practitioner to have an application processed within these time periods. Applications will not be considered complete or process ready until all required documentation, material and components requested by the MSSD are furnished.

4.3 APPLICANT'S BURDEN

A. The applicant for applicant for appointment, reappointment, advancement or transfer, will have the burden of producing complete, accurate, and adequate information for a proper evaluation of qualifications including all requirements specified in the Medical Staff Bylaws and Rules and Regulations, and the Rules and Regulations of the Department in which the applicant is requesting membership, for resolving any doubts about these matters, and of providing any additional information requested by the Chief of Staff or MSSD. This burden may include submission to a medical, psychiatric, or psychological examination, at the applicant's expense, if deemed appropriate by the MEC which may select the examining physician. The applicant's failure to sustain this burden and/or the provision of information containing any misrepresentations or omissions will be grounds for the denial of the application or subsequent termination, suspension or limitation of Medical Staff membership or privileges. The Chief of Staff or MSSD will notify the applicant on any areas of incompletion and/or failure to respond to such information collection or verification efforts within thirty (30) days of receipt of the initial

application, and it will then be the applicant's obligation to obtain all required information. Failure to complete the application and/or to submit any additional requested information within sixty (60) days of a request by MSSD, will be deemed a voluntary withdrawal of the application.

4.4 INITIAL APPOINTMENT PROCEDURE

A. On request, the MSSD will provide to prospective applicants an application package that includes the following:

1. A blank application form with a cover letter outlining membership eligibility criteria.

2. A list of required supporting information.

3. A list of performance expectations for individuals granted Medical Staff membership and/or privileges.

4. A description of responsibilities for Medical Staff members.

5. An overview of the delineation of privileges.

6. Privilege request form(s), including criteria for privileges.

7. A detailed list of requirements the applicant must meet to complete the application.

B. The applicant must complete and sign the application form. By signing this application:

1. The applicant attests to the accuracy and completeness of all information on the application and accompanying documents. The applicant agrees that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges shall lapse effective as soon as notified, without the right to a fair hearing or appeal.

2. The applicant consents to appear for any requested interviews in regard to their application.

3. The applicant authorizes the hospital and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges that have been requested.

4. The applicant consents to hospital and Medical Staff representatives inspecting all records and documents that may be relevant to an evaluation of the following:

    a. Professional qualifications and competence to carry out the clinical privileges requested.
    b. Physical, mental, and emotional health status that is relevant to safely perform requested privileges.

    c. Professional and ethical qualifications.

    d. Professional liability actions, including currently pending claims involving the applicant.

    e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges

5. The applicant releases from liability, promises not to sue, and grants immunity to the hospital, its Medical Staff, and its representatives for acts performed and statements made in connection with the evaluation of the application and his or her credentials and qualifications.

6. The applicant releases from liability and promises not to sue, and grants immunity to all individuals and organizations who provide information to the hospital or the Medical Staff in good faith. This information may include otherwise privileged or confidential information concerning background, experience, competence, professional ethics, character, and physical and mental health to the extent relevant to fulfill requested privileges, emotional stability, utilization practice patterns, and other qualifications for staff appointment and clinical privileges.

7. The applicant authorizes Medical Staff and administrative representatives to release credentialing and peer review information to other hospitals, medical associations, licensing boards, appropriate government bodies, third party payers and other healthcare entities concerned with this practitioner's performance and releases representatives of the hospital from liability for so doing.

8. The applicant acknowledges that they have had access to the Medical Staff Bylaws, including all rules, regulations, policies, and procedures of the Medical Staff, and agrees to abide by their provisions.

C. Notwithstanding these previous sections, if an individual institutes legal action and does not prevail, they shall reimburse the hospital and any member of the Medical Staff named in the action for all costs incurred defending such legal action, including reasonable attorney's fees.

4.5 REAPPOINTMENT PROCEDURE

A. Each Medical Staff practitioner and NPP shall submit an application for reappointment at least 120 days before the expiration date of the practitioner's current appointment. The reappointment application shall:

   1. Include the completion of the application form prescribed by the MSSD.
   2. Require the practitioner to provide the same information and make disclosures in the same manner as the application for initial appointment.

   3. Require the same burden of proof for the practitioner as the initial application.

B. Failure of the MSSD to furnish an application to the practitioner shall not relieve the practitioner from the responsibility to apply for reappointment. Failure to do such shall be deemed a waiver of the right to reappointment and shall constitute a resignation of Medical Staff appointment and/or Clinical Privileges.

4.6 CREDENTIALING & PRIVILEGING APPROVAL PROCESS

A. Complete applications are transmitted to the applicable Department Chair, who reviews the application. Once the Department Chair completes and submits his/her review and recommendation, the application is presented to the Credentials Committee, which then prepares a recommendation and forwards it along with the Department Chair's recommendation to the MEC for review and recommendation and to the Board for final action. The COS may act on behalf of the Credentials Committee on all "clean" applications, as defined below.

4.7 EXPEDITED PRIVILEGING

A. The Board establishes a committee, with a quorum of two board members, consisting of the CEO and COS for the purpose of acting on its behalf for the credentials and privileges of practitioners as well as their reappointments to the Medical Staff of BH between meetings of the Board. Any actions taken by this committee will be reported to, and confirmed by, the Board at its next regularly scheduled meeting. Only applications that are considered to be "clean" qualify for expedited privileging. "Clean" applications are those that:

   1. Do not have any pending/settled malpractice claims.
   2. No licensure or medical staff disciplinary actions or legal sanctions of any kind.
   3. Do not have any derogatory information from peer references.
   4. Do not have any felony or misdemeanor convictions.
   5. Are complete and include all information required by these Bylaws.
   6. No discrepancies or gaps in information received from the applicant or appointee, verifications or references.
   7. Never sanctioned by a third-party payer (e.g., Medicare, Medicaid, private insurance).

8. Request is for privileges consistent with applicant's or appointee's specialty, training, experience, and current competency.
9. Completion of a usual education/training sequence.
10. Unremarkable medical staff/employment history.
11. No concerns raised with recommendations.
12. History of an ability to relate to others in a harmonious, collegial manner.
13. Meet all requirements set forth by these Bylaws.
14. The recommendation of the MEC is not adverse and does not include any limitations.

ARTICLE FIVE
CLINICAL PRIVILEGES

5.1 CLINICAL PRIVILEGES

A. Members of the Medical Staff are entitled to exercise only those delineated clinical privileges specifically granted to them by the Medical Executive Committee and the Borgess Health Board of Trustees in accordance with these Bylaws. All clinical privileges must be requested and processed pursuant to the procedures outlined in Article 4. A mechanism is in place that allows assessment of whether an individual with clinical privileges provides services within the scope of those privileges granted.

B. The Medical Staff will make an objective and evidence-based decision with regard to each request for clinical privileges. Requests for clinical privileges will be evaluated on the basis of the member's education, training, experience, current demonstrated professional competence and judgment, evidence of current proficiency in the hospital's General Competencies; applicant specific information regarding applicant's clinical performance at this hospital and in other settings, comparisons made to aggregate information (when available) about performance, judgment and clinical or technical skills; morbidity and mortality data (when available); current health status; the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate; performance of a sufficient number of procedures to develop and maintain the practitioner's skills and knowledge; and compliance with any specific criteria applicable to the privileges, included in-house training which may be required.

C. Requested privileges will be assessed individually to determine the hospital's needs and ability to support the applicant with respect to the requested privileges, and the applicant's current proficiency with respect to the hospital's General Competencies. Privilege determination may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. The decision to grant or deny a privilege and/or to renew an existing privilege will also be based on peer recommendations which address the applicant's:

1. Medical/clinical knowledge
2. Technical and clinical skills
3. Clinical judgment
4. Interpersonal skills
5. Communication skills
6. Professionalism
7. Health status

D. The hospital's General Competencies include:

1. Patient Care. Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life.
2. Medical/Clinical Knowledge. Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
3. Practice-Based Learning and Improvement. Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.
4. Interpersonal and Communication Skills. Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families and other members of healthcare teams.
5. Professionalism. Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity, and a responsible attitude towards their patients, their profession, and society.
6. Systems-Based Practice. Practitioners are expected to demonstrate both an understanding of the context and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

5.2 TEMPORARY PRIVILEGES

A. Temporary privileges may be granted:

1. To fulfill an important 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 Board

B. When temporary privileges are granted to meet an important patient care, treatment, or service need, the MSSD verifies current licensure and current competence. Such temporary privileges are granted for a time period not to exceed one hundred (120) days.

C. Temporary privileges for applicants for new privileges may be granted while awaiting review and approval by the MEC and the Board upon verification of the following:

1. Current licensure;
2. Relevant training or experience;
3. Current competence;
4. Ability to perform the privileges requested;
5. Any other criteria established by these Medical Staff 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;

9. No subjection to involuntary termination of medical staff membership at another organization; and
10. No subjection to involuntary limitation, reduction, denial or loss of clinical privileges.

D. Temporary privileges are granted by the CEO upon recommendation of the COS.

E. Temporary privileges shall not exceed 120 days.

F. On the discovery of any information or the occurrence of any event of a nature which raises a question about a practitioner's professional qualifications, ability to exercise any interim or temporary privileges granted, or compliance with these Bylaws, Rules and Regulations, requirements of the department, or other requirements, the COS may, after consultation with the Department Chair, deny or terminate any or all of such individual's temporary privileges and or membership. In the event of any such denial or termination, the practitioner's patients in the hospital will be assigned to another practitioner by the COS. The wishes of the patient will be considered, when feasible, in choosing a substitute practitioner. A Practitioner shall not be entitled to the procedural rights afforded by Article VIII of these Bylaws because the practitioner's request for temporary privileges is refused in whole or in part or because all or any portion of the Practitioner's temporary privileges are terminated, not renewed, restricted, suspended, or limited in any way.

5.3 DISASTER PRIVILEGES

A. In the event the Borgess Health emergency management plan is activated, and the health system is unable to manage immediate patient care needs, the CEO, CMO or the COS may grant disaster privileges. Disaster privileges will be granted in accordance with TJC Emergency Management Standard EM.02.02.13.

B. All practitioners providing care to patients will abide by and comply with the entity's emergency management plan.

5.4 EMERGENCY CLINICAL PRIVILEGES

A. Emergency is defined as a condition in which a patient is in imminent danger of serious or permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license and regardless of department, Medical Staff status, or clinical privileges, will be permitted to do, and will be assisted by Borgess Health personnel in doing everything possible to save a patient from such danger. When the emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient or relinquish care to a practitioner duly privileged to assume care for the patient(s).

5.5 MODIFICATION OF CLINICAL PRIVILEGES

A. A practitioner may, at any time, request modification of his/her Medical Staff category or clinical privileges by submitting to the Department Chief, a written application on the prescribed form. Such application is processed pursuant to the procedures set forth in Article 4. Upon the recommendation of the Credentials Committee, the MEC may recommend a change in the clinical privileges, membership category or department assignment(s) of a member. The MEC may also recommend that the granting of additional/modified privileges to a current Medical Staff member be made subject to proctoring.

5.6 NEW PROCEDURES AND TECHNIQUES

A. Requests for clinical privileges to perform either a significant procedure not currently being performed at Borgess Health or a new technique for an existing procedure (new procedure) will not be processed until it has been determined by the Board that (1) the new procedure should be offered by Borgess Health; and (2) criteria to be eligible to request those clinical privileges have been established. Factors that may be considered include, but are not limited to (1) whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients; (2) whether the new procedure is being performed at other similar hospitals and the experience of those institutions; and (3) whether Borgess Health has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure. If it is recommended that the new procedure be offered, the Credentials Committee will appoint a subcommittee to conduct an assessment and consult with internal and/or external experts to develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure; (2) the Departments or Services that should be permitted to offer the new procedure; and (3) the extent of monitoring and supervision that should occur if the privileges are granted. The subcommittee may also develop criteria and/or indications for when the new procedure is appropriate. The subcommittee will forward its recommendations to the Credentials Committee and to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

5.7 EMERGENCY MEDICAL TREATMENT AND LABOR ACT

A. The members of the Medical Staff shall abide by the Medical Center's Rules and Regulations governing Medical Staff responsibilities consistent with the Medical Center's obligation to comply with the provisions of the Emergency Medical Treatment and Labor Act ("EMTALA") and its policy entitled The Screening, Stabilization, and Transfer of Emergency Patients ("EMTALA Policy").

B. The EMTALA Policy requires, among other things, the following:

1. That each patient presenting to the Emergency Department be provided with a medical screening examination within the capability of the Emergency Department to determine whether an emergency medical condition exists;

2. That if it is determined that an emergency medical condition exists, the Medical Center shall provide further medical examination and stabilizing treatment within its capacity, or an appropriate transfer to another medical facility; and

3. That members of the Medical Staff provide on-call service to the Emergency Department in accordance with Sections 3.2 and 13.11.G of these Bylaws, and with protocols approved by the MEC and the CEO, or his/her designee.

C. Qualified Medical Personnel ("QMP") Medical screening examinations may be performed by physicians, registered nurses, advance practice nurses, or physician assistants as follows:

1. Obstetrical Patients. Physicians, registered nurses and advance practice nurses (including certified midwives), who have appropriate training and experience as determined by their department, in accordance with protocols as determined by their department. If a QMP other than a physician or certified nurse midwife determines a woman is in false labor, a physician or certified nurse midwife must certify the diagnosis. How the physician or certified nurse midwife certifies (telephone consultation, or actually examines the patient), the diagnosis of false labor shall be in accordance with department policies and procedures.

2. Dedicated Emergency Department Patients. Physicians, advance practice nurses and physician assistants who have appropriate training and experience as determined by their department, in accordance with protocols as determined by their department.

ARTICLE SIX
RESIGNATIONS, LEAVE OF ABSENCE (LOA) AND PRACTITIONER HEALTH

6.1. RESIGNATIONS

A. Resignations from the Medical Staff shall be submitted in writing to the CEO, CMO, or COS with a courtesy copy to MSSD within forty-five (45) days prior of the scheduled resignation. Upon receipt of said resignation letter, the notification shall be forwarded to the Credentials Committee, MEC and the Board for final approval.

6.2 LEAVE OF ABSENCE (LOA)

A. A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities longer than thirty (30) days if such absence is related to the individual's physical or mental health or to his or her ability to care for patients safely and competently. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the COS stating the reasons for the leave and approximate duration of the leave, which may not exceed one year, except for military service or express permission from the Board. Requests for leaves must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges and has no obligation to fulfill Medical Staff responsibilities. In the event the Board denies a request for a LOA, or when a request for an extension is not granted, the determination of the Board shall be final, and the practitioner will have no recourse to a hearing or appeal.

B. At least (thirty) 30 calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request to be reinstated by sending a written notice to the COS. The practitioner must submit a written summary of relevant activities during the leave if the Credentials, MEC or Board so requests. A practitioner returning from a leave of absence for health reasons if requested must provide a report from his or her physician that answers any questions that the Credentials, MEC or Board may have as part of considering the request for reinstatement. The Credentials and MEC makes a recommendation to the Board concerning reinstatement. The Credentials and MEC review and recommendation, and the Board's determination shall follow the applicable privileging procedures. If the practitioner's current grant of membership and/or privileges is due to expire during the LOA, the practitioner must apply for reappointment, or his or her appointment and/or clinical privileges shall lapse at the end of the appointment period. If the practitioner fails to request reinstatement at the expiration of the LOA, such failure shall be deemed a voluntary resignation of the practitioner's medical staff appointment and clinical privileges. Such voluntary resignation shall not give rise to, and the practitioner shall not be entitled to, any hearing, appeal or other procedural rights afforded by Article XIII of these Bylaws.

6.3 PRACTITIONER HEALTH

A. In order to carry out the obligation of protecting patients from harm, the hospital and the Medical Staff recognize the importance of identifying and managing matters of individual practitioners and NPP personnel health separate from the Medical Staff disciplinary function. Accordingly, the MEC, with the assistance of the CEO, shall implement a process that provides education about Practitioners' health, addresses prevention of physical, psychiatric or emotional illness, and facilitates confidential diagnosis, treatment and rehabilitation of Medical Staff and NPP who suffer from a potentially impairing condition. The purpose of the process is assistance and rehabilitation, rather than discipline, in order to aid Medical Staff and NPP in retaining or regaining optimal professional functioning, consistent with protection of patients. The process shall include the following elements:

1. Education of the Medical Staff, NPP and other Hospital staff about illness and impairment recognition issues. Educational materials and/or informational programs may be utilized for this purpose.

2. An opportunity for self-referral, and/or referral by other Medical Staff, NPP or members of the hospital staff. The Medical Staff shall maintain a list of professional internal or external resources for diagnosis and treatment of the condition or concern, and shall notify the Medical Staff and NPP of the availability of such resources.

3. Confidentiality will be maintained with respect to the practitioner or NPP seeking referral or being referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened.

4. The MEC shall be responsible for evaluation of the credibility of a complaint, allegation or concern regarding a practitioner or NPP and shall be responsible for monitoring of the affected practitioner or NPP until the rehabilitation process is complete.

5. Corrective action may be initiated with respect to a practitioner or NPP at any time his/her physical, mental or emotional condition may potentially impair his/her ability to safety and/or skillfully practice his/her profession. Such action may be initiated in accordance with the provisions of the Bylaws, without any requirement for utilizing the referral resources referred to in this section.

ARTICLE SEVEN
REVIEW OF MEDICAL STAFF MEMBER CONDUCT

7.1 MEDICAL STAFF MEMBER CONDUCT

A. Procedures in this article will be invoked whenever the Physician (or NPP) no longer meets the qualifications for medical staff (or NPP) membership or clinical privileges and whenever it appears the activities, behavior or conduct of any member of the Medical Staff (or NPP):

1. Jeopardizes or may jeopardize the safety, best interests, quality of care, treatment or services of a patient, or the safety or best interests of a visitor, employee or Practitioner;

2. Presents a question regarding the competence, character, judgment, ethics, and stability of personality (including the ability to work cooperatively with others in the provision of patient care, treatment or services), adequate physical or mental health, moral character, or qualification of the member.

3. Violates these Medical Staff Bylaws, Rules and Regulations, the requirements of clinical departments, or Borgess Health policies, including the Provider Handbook, or constitutes conduct that is, or is reasonably probable of being, disruptive to Borgess Health operations or may harm or diminish the community's confidence in Borgess Medical Center or the Medical Staff.

7.2 AUTHORIZATION TO INITIATE

A. The CEO, CMO, COS, Department Chair, or officer of the Medical Staff may request that corrective action be taken or initiated. The COS will apprise the MEC on the request of the investigation. After deliberation, the MEC will determine whether an investigation is warranted and will notify the Medical Staff (or NPP) member of their decision in writing.

7.3 INVESTIGATION

A. An investigation can only begin if the MEC decides that it is warranted via an affirmative vote. In the event the board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

B. The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff. If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as practicable. The committee conducting the investigation shall have the authority to review all documents it considers relevant; interview individuals;

consider appropriate clinical literature and practice guidelines; and use the resources of an external consultant if deemed necessary and such action is approved by the MEC and the CEO.

C. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may subsequently access the results of such exams. The investigating body shall notify the practitioner in question that the investigation is being conducted and give the practitioner an opportunity to provide information in a manner that the investigating body deems appropriate.

D. The meeting between the physician in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing," as that term is used in the hearing and appeals sections of these Bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body or to compel the Medical Staff to engage external consultation.

E. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process, or other action.

7.4 MEC ACTION

A. The MEC will act as soon as it is practical after the conclusion of any investigation. Action taken by the MEC following the conclusion of any investigation may include, but is not limited to, the following actions:

1. No action.

2. Proposed corrective action:

    a. Letter of admonition, reprimand or warning.

    b. Terms of probation including monitoring requirements or specific individual requirements of consultation.

    c. Reduction or revocation of clinical privileges.

    d. Suspension of clinical privileges until completion of specific conditions or requirements.

    e. Limitation of prerogatives related to the practitioner's delivery of safe patient care, treatment, and services.

f. Suspension of Medical Staff Membership for a specific period of time or without limit of time.

g. Revocation of Medical Staff membership.

h. Other actions appropriate to the facts which prompted said investigation.

B. Nothing set forth herein will prevent the MEC from implementing a summary suspension or restriction of privileges at any time, in the exercise of its discretion. Unless the action of the MEC constitutes ground for a hearing as defined in Article 8 of these Bylaws, the action will become effective upon the decision of the Medical Executive Committee.

7.5 BOARD ACTION

A. Recommendation by the MEC or the Board pursuant to Article 7.5, which constitutes grounds for a hearing as set forth in Article 8, will entitle the Medical Staff member to the rights specified in Article 8. In such cases, the COS will give the Medical Staff member written notification of the recommendation, the reasons for the proposed action, and of their right to request a hearing pursuant to the requirements in Article 8. A copy of the Bylaws detailing the hearing rights of the Medical Staff member will also be provided. The Board reserves the right to direct the MEC to investigate or initiate corrective action if deemed appropriate by said Board.

7.6 SUMMARY SUSPENSION

A. In the event a Medical Staff member's conduct is of such a nature as to require immediate action to protect the life of any patient(s) or to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee, or other person present in the health system; to preserve the continued effective operation of the health system; or in response to a willful disregard or gross violation of the Bylaws, Rules & Regulations, or applicable health system policy or procedure, any of the following has the authority to suspend summarily the Medical Staff privileges of such member, effective immediately upon imposition:

1. CEO
2. COS
3. CMO
4. MEC
5. Board

B. The party or body responsible for imposing summary suspension will promptly give oral and written notice thereof to the Medical Staff member as well as all parties delineated in Article 7.7.A.1-5. The notice of suspension to the MEC will constitute a request for corrective action and the procedures set forth in Article 8. All patients empanelled to the suspended Medical Staff member will be assigned to another Medical Staff member by the COS.

7.7 MEC ACTION

A. Within five (5) calendars days after a summary suspension is imposed, the Medical Staff member may request an interview with the MEC. Such interview will not be deemed a "hearing" as that term is set forth in Article 8. The interview will be convened as soon as reasonably possible under all circumstances. The MEC may modify, continue, or terminate the terms of the summary suspension. The MEC will give the Medical Staff member written notice of its recommendation and the reasons therefore with a copy to the parties delineated in Article 7.7.A.1-5. Any action in excess of fourteen (14) calendar days requires a hearing as outlined in Article 8.

7.8 AUTOMATIC RELINQUISHMENT

A. In the following circumstances, the Medical Staff member's privileges and/or membership will be considered relinquished or limited as described, and the action shall be final without a right to hearing. If the Medical Staff member disputes that these circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines whether it is applicable. The MEC will make such a determination as soon as is practicable. The COS may reinstate the Medical Staff member's privileges or membership after determining that the circumstances have been rectified or no longer exist within 60 days of the relinquishment. After 60 days, the practitioner must reapply for membership and/or privileges. In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following actions occur:

1. LICENSURE

    a. Revocation and suspension: Whenever a practitioner's license or other legal credential authorizing him or her to practice in this state is revoked, suspended, expired, or voluntarily relinquished, the practitioner will automatically relinquish his or her Medical Staff membership and clinical privileges as of the date such action becomes effective.

    b. Restriction: Whenever a practitioner's license or other legal credential authorizing him or her to practice is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

    c. Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and

conditions of the probation as of the date such action becomes effective and throughout its term.

2. MEDICARE, MEDICAID, TRICARE, OR OTHER FEDERAL PROGRAMS

    a. Whenever a practitioner is barred from Medicare, Medicaid, Tricare, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the U.S. Department of Health and Human Services Office of the Inspector General's list of excluded individuals/entities will be considered to have automatically relinquished his or her privileges.

3. CONTROLLED SUBSTANCES

    a. Drug Enforcement Agency certificate: Whenever a practitioner's U.S. Drug Enforcement Agency (DEA) certificate or state-controlled substance registration (if applicable) is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

    b. Probation: Whenever a practitioner's DEA certificate or state-controlled substance registration (if applicable) is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

4. MEDICAL RECORD COMPLETION

    a. A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever he or she fails to complete medical records within time frames established by BH Policy 0605. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored when the medical records are completed in compliance with medical records policies.

5. PROFESSIONAL LIABILITY INSURANCE

    a. Failure of a practitioner to maintain professional liability insurance in the amount required by the Board, and sufficient to cover the clinical privileges granted, shall result in immediate automatic relinquishment of a practitioner's clinical privileges. If, within 60 calendar days of the relinquishment, the practitioner does not provide evidence of required professional liability

insurance (including coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The practitioner must notify the Medical Staff services department immediately of any change in professional liability insurance carrier or coverage.

6. MEDICAL STAFF DUES

    a. Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. A practitioner who does not remit such payments within 60 calendar days of receiving written warning of the delinquency shall be considered to have voluntarily resigned membership on the Medical Staff.

7. FELONY CONVICTION

    a. A practitioner who has been convicted of, or pled "guilty" or "no contest" or its equivalent to a felony involving violence, physical or sexual abuse, drug offenses, or insurance/healthcare fraud or abuse in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately on such indictment, conviction, or plea, regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the board or through corrective action, if necessary.

8. FAILURE TO APPEAR

    a. A practitioner, who fails without good cause to appear at a meeting where a special appearance is required, in accordance with these Bylaws, shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

9. FAILURE TO PARTICIPATE

    a. A practitioner who fails to participate in an evaluation of his or her qualifications for Medical Staff membership or clinical privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

10. FAILURE TO ACHIEVE BOARD CERTIFICATION OR MAINTAIN BOARD CERTIFICATION

    a. A practitioner who fails to become board certified or maintain board certification, if applicable, in compliance with these Bylaws will be deemed to have immediately and voluntarily relinquished his or her Medical Staff Appointment and Clinical Privileges (unless an exception is granted by the Board based on a recommendation from the MEC).

11. FAILURE TO EXECUTE RELEASE AND/OR PROVIDE DOCUMENTS

    a. A practitioner who fails to execute a general or specific release and/or provide documents to the president of the Medical Staff or designee on request shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These documents are to help the Medical Staff evaluate the competency and credentialing/privileging qualifications of the practitioner in question. These privileges will be restored when the practitioner provides the executed general or specific release and/or provides the requested documents. Failure to comply within 30 calendar days will be considered a voluntary resignation from the Medical Staff.

12. INCOMPLETE PROCTORING

    a. Failure to comply with Medical Staff proctoring guidelines in the required timeframe.

13. HEALTH SCREENING AND IMMUNIZATIONS

    a. Failure to comply with the BH Policy 1128 on the requirements to maintain annual health screenings and immunizations. BH Policy 0604 mandating Influenza immunizations are also included in this requirement.

14. FAILURE TO RESPOND TO CALL

    a. The on-call physician shall respond to the initial call and be on-site within thirty (30) minutes thereof. An individual who refuses or fails to respond within the requisite amount of time to provide the necessary stabilizing treatment of an emergency medical condition, active labor or consult will be reported to the Corporate Compliance Officer and the MSSD.

ARTICLE EIGHT
HEARING AND APPELLATE REVIEW PROCEDURES

8.1 RIGHT TO HEARING Except as otherwise specifically provided in these Bylaws, the recommendations set forth in Subsection A of this Section shall, if deemed adverse pursuant to Subsection B of this Section, entitle the Practitioner thereby affected to a hearing. Procedural rights set forth in this Article VIII also apply to NPPs.

A. Recommendations or actions.

1. Denial of initial appointment or subsequent reappointment.

2. Suspension in excess of fourteen (14) days if suspension is related to competence or conduct; or revocation of Medical Staff (or NPP) appointment.

3. Denial of requested privileges.

4. Suspension in excess of fourteen (14) days if suspension is related to competence or conduct or revocation of privileges.

5. Terms of probation resulting in a limitation on previously exercised privileges.

6. Individual application of, or individual change in, mandatory consultation requirement resulting in a limitation on previously exercised privileges.

B. When deemed adverse. A recommendation or action listed in Subsection A of this Section shall be deemed adverse only when it has been:

1. Recommended by the MEC; or

2. Taken by the Board contrary to a favorable recommendation by the MEC.

C. Actions which do not give right to hearing. Notwithstanding the provisions of Subsections A and B, above, no action described in this Subsection C shall constitute grounds for or entitle the Practitioner to request a hearing.

1. An oral or written reprimand or warning.

2. The denial, termination, or suspension of temporary or emergency privileges.

3. Imposition of a probationary period with retrospective or concurrent review of cases provided that such probationary period does not otherwise limit the Practitioner's ability to exercise his/her privileges.

4. Denial of requested privileges because the Practitioner failed to satisfy the basic qualifications or criteria of training, education, or experience established for the granting of privileges for a specific procedure or procedures.

5. Ineligibility for Medical Staff appointment or reappointment or the privileges requested because a Department has been closed or there exists an exclusive contract limiting the performance of the specialty with which the Practitioner is associated or the privileges which the Practitioner has requested to one (1) or more Practitioners.

6. Termination of or the inability to exercise privileges either in whole or in part because the Medical Center has determined to close a Department or grant an exclusive contract limiting the performance of privileges within the specialty in which the Practitioner practices to one or more Practitioners.

7. Termination of the Practitioner's employment or other contract for services unless the employment contract or services contract provides otherwise.

8. Ineligibility for Medical Staff appointment or requested privileges because of lack of facilities, equipment, or because the Medical Center elected not to perform, or does not provide, the service which the Practitioner intends to provide or the procedure for which privileges are sought.

9. Suspension, or revocation of Medical Staff appointment or privileges as provided in Section 7.8.

10. Voluntary suspension or relinquishment of privileges or Medical Staff appointment when professional competence or conduct is not at issue.

11. Voluntary suspension or relinquishment of privileges or Medical Staff appointment which is not in return for the Medical Staff or Board refraining from conducting an investigation based upon professional competence or conduct.

12. Suspension of privileges, either in whole or in part, or suspension of Medical Staff appointment, for not more than fourteen (14) days during which time an investigation is being conducted to determine the need for further action.

13. Any other action which does not relate to the competence or professional conduct of a Practitioner.

8.2 NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A. A Practitioner against whom an adverse action has been taken or recommended pursuant to Section 1 of this Article shall be given Special Notice by the CEO of such action. The notice shall:

1. Advise the Practitioner of the nature of and reasons for the proposed action, including a concise statement of the Practitioner's alleged acts or omissions, a list of the specific or representative patient records in question (if applicable), and/or a concise statement of any other reasons or subject matter forming the basis for the adverse action which is the subject of the hearing.

2. Advise the Practitioner that he or she has thirty (30) days after receiving the notice within which to submit a request for hearing on the proposed action.

3. Provide a summary of the Practitioner's rights in the hearing as provided in this Article.

4. State that if the Practitioner fails to request a hearing in the manner and within the time period prescribed, such failure shall constitute a waiver of the right to a hearing and to an appellate review on the issue that is the subject of the notice.

8.3 REQUEST FOR HEARING

A Practitioner shall have thirty (30) days after his/her receipt of a notice pursuant to Section 2 of this Article to file a written request for a hearing. Such request shall be delivered to the CEO by Special Notice.

8.4 WAIVER BY FAILURE TO REQUEST HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 3 of this Article, waives any right to such hearing and to any appellate review to which he/she might otherwise have been entitled. The adverse recommendation and/or action shall thereafter be presented to the Board for final decision.

8.5 RIGHT TO ONE HEARING AND APPELLATE REVIEW

Notwithstanding any other provision of this Article to the contrary, no Practitioner shall be entitled as a matter of right to more than one (1) hearing and (1) appellate review on any matter for which there is a hearing right. Adverse recommendations or actions on more than one (1) matter may be consolidated and considered together or separately as the MEC or Board shall designate in their sole discretion.

8.6 HEARING REQUIREMENTS

A Notice of Time and Place for Hearing. Upon receipt from a Practitioner of a timely and proper request for hearing the CEO shall deliver the same to the Chief of Staff if the request for hearing was prompted by an adverse recommendation of the MEC, or to the chair of the Board if the request for hearing was prompted by an adverse recommendation or action of the Board. The Chief of Staff or the chair of the Board,

as applicable, shall promptly schedule and arrange for a hearing. At least thirty (30) days prior to the hearing, the CEO shall send the Practitioner by Special Notice a "Notice of Adverse Recommendation and/or Action" setting forth the time, place, and date of the hearing, which date shall be not less than thirty (30) days after the date of the notice. Provided, however, that a hearing for a Practitioner who is under summary suspension, at the request of the Practitioner, shall be held as soon as the arrangements may be reasonably made provided that the Practitioner agrees to a waiver of the thirty (30) day advance notice time requirement. The notice shall further provide a summary of the Practitioner's rights according to these Bylaws.

B. Witnesses and Documents. The notice shall further include a list of witnesses (if any) expected to testify at the hearing in support of the proposed action as well as a time frame under which the Practitioner must notify the MEC, or Board, as applicable, of his/her list of witnesses. Admissibility of testimony to be presented by a witness not so listed shall be at the discretion of the presiding officer. The notice may further provide a schedule for exchange of documents. It shall further state that to the extent that documents intended to be used at the hearing have not yet been exchanged or names of witnesses not exchanged, in whole or in part, such exchange shall occur not later than five (5) days prior to the scheduled date for commencement of the hearing to the extent possible.

C. Conduct of Hearing. If the adverse action that is the subject of the hearing was recommended by the MEC, the hearing shall be held before a hearing officer or hearing committee as determined by the Chief of Staff. If the adverse recommendation or action was taken by the Board, the chair of the Board shall determine whether the hearing shall be held before a hearing officer or a hearing committee. The hearing officer and/or hearing committee shall be appointed by either the Chief of Staff or the chair of the Board, as applicable. The decision as to whether to utilize a hearing officer or a hearing committee shall be in the sole discretion of the body whose actions triggered the hearing.

D. Appointment of Hearing Officer. The hearing officer may be a Practitioner, attorney, or other individual qualified to conduct the hearing. The hearing officer is not required to be a member of the Medical Staff. The hearing officer shall not be in direct economic competition or otherwise have a conflict of interest with the Practitioner involved in the hearing.

8.7 APPOINTMENT OF HEARING COMMITTEE

A. By Chief of Staff. A hearing committee appointed by the Chief of Staff shall consist of at least three (3) members, who shall have the same qualifications as a hearing officer. One member shall be designated as chair by the Chief of Staff.

B. By Board chair. A hearing committee appointed by the Board chair shall consist of at least three (3) persons. One of the members shall be designated as chair by the Board chair. At least one (1) member of the committee shall be a physician, who may or may not be a member of the Medical Staff.

C. Service on Hearing Committee. A Practitioner or Board member shall be disqualified from serving on a hearing committee if he/she participated in initiating, investigating, or evaluating the underlying matter at issue, is in direct economic competition, or otherwise has a conflict of interest with the Practitioner involved in the hearing. All members of the hearing committee shall be required to objectively consider and decide the case in good faith.

D. Presiding Officer. An individual qualified to conduct hearings may be designated as the presiding officer for a hearing to be heard by the hearing committee. Such individual may, but need not be, a member of the hearing committee.

8.8 HEARING PROCEDURE

A. Forfeiture of Hearing. A Practitioner who requests a hearing pursuant to this Article but who fails to appear at the hearing without good cause, as determined by the hearing committee or hearing officer, as applicable, shall forfeit his or her rights to such hearing and to any appellate review to which he or she might otherwise have been entitled.

B. Presiding Officer. The hearing officer, the chair, or the individual designated pursuant to Subsection 8.7 D above, shall be the presiding officer. He/she shall act to maintain decorum and to assure that all participants in the hearing process are provided 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, procedure, and the admissibility of evidence.

C. Representation. The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a member of the Medical Staff in good standing, by a member of his/her professional society, or by an attorney. The MEC or the Board may appoint a member of the Medical Staff in good standing or Board member, as applicable, or an attorney to represent it at the hearing to present the facts in support of its adverse recommendation or action, and to examine witnesses; provided, however, that if an attorney is chosen, then a member of the triggering body shall also be present to provide testimony on behalf of such body.

D. Rights of Parties. During the hearing, each party may:

1. Call, examine and cross-examine witnesses.

2. Introduce any relevant evidence, including exhibits.

3. Question any witness on any matter relevant to the issues that are the subject of the hearing.

4. Impeach any witness.

5. Offer rebuttal of any evidence.

6. Have a record made of the hearing in accordance with Section 8.7 H.

7. Submit a written statement at the close of the hearing.

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

E. Procedure and Evidence. At the hearing, the rules of law relating to examination of witnesses or presentation of evidence need not be strictly enforced, except that oral evidence shall be taken only on oath or affirmation. The hearing officer or hearing committee, as applicable, may consider any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs regardless of whether such evidence would be admissible in a court of law. Prior to or during the hearing, any party may submit memoranda concerning any procedural or factual issue, and such memoranda shall be included in the hearing record.

F. Information Pertinent to Hearing. In reaching a decision, the hearing committee or hearing officer, as applicable, shall be entitled to consider any pertinent material contained on file in the Medical Center, and all other information that can be considered, pursuant to the Medical Staff Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for privileges. The hearing committee or hearing officer, as applicable, may, at any time, take official notice of any generally accepted technical or scientific principles relating to the matter at hand and of any facts that may be judicially noticed by the Michigan courts. The parties to the hearing shall be informed of the principles or facts to be noticed, and the same shall be noted in the hearing record. Any party shall be given the opportunity, upon timely request, to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the hearing officer or committee.

G. Burden of Proof. The triggering body shall present its evidence first establishing the basis for its action. It shall also have the right to present rebuttal witnesses following the presentation of the Practitioner's case. The Practitioner has the burden of proof by clear and convincing evidence to establish that the adverse recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn there from are arbitrary, capricious, or unreasonable.

H. Record of Hearing. A record of the hearing shall be kept of sufficient accuracy that an informed and valid judgment can be made 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 or hearing officer, as applicable, shall arrange for a court reporter to transcribe the hearing. Upon request, the Practitioner shall be entitled to obtain a copy of the record at his/ her own expense.

I. Postponement. Prior to the beginning of the hearing, the Chief of Staff, in discussion with the hearing officer and/or hearing committee, shall determine whether requests for postponement of a hearing should be granted. The presumption shall be that the hearing will go forward on its scheduled date in the absence of a showing of good cause and only if the request is made as soon as is reasonably practical. Once the hearing has begun, the hearing officer and/or hearing committee shall be responsible for determining whether any continuances should be granted based upon the same standard.

J. Presence of Hearing. Committee Members and Vote. If a hearing committee is appointed. a majority of the hearing committee shall be present at all times during the hearing and deliberations. If a committee member is absent from any part of the proceedings, the presiding officer in his/her discretion may rule that such member be excluded from further participation in the proceedings or recommendations of the committee.

K. Recesses and Adjournment. The hearing committee or hearing officer, as applicable, may recess the hearing and reconvene it without additional notice if the committee or officer deems such recess necessary for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. When presentation of oral and written evidence is complete, the hearing shall be closed. The hearing committee/officer shall deliberate outside the presence of the parties and at such time and in such location as is convenient to the committee. Upon receipt of the transcript of the proceedings or closing written briefs, whichever occurs later, the hearing shall be adjourned.

8.9 REPORT AND FURTHER ACTION

A. Hearing Officer/Committee. Within thirty (30) days after final adjournment of the hearing, the hearing committee/officer shall report in writing its findings and recommendations with specific references to the hearing record and other documentation considered and shall forward the report along with the record and other documentation to the body whose adverse recommendation or decision occasioned the hearing.

B. Final Recommendation/Action. Within twenty (20) days after receipt of the report, the triggering body shall consider the same and affirm, modify. or reverse its recommendation or action in the matter. The recommendation/action shall be transmitted, together with the hearing record, the report of the hearing committee/officer, and all other documentation considered to the Chief Executive Officer.

8.10 NOTICE AND EFFECT OF RESULT

A. Notice. The Chief Executive Officer shall promptly send a copy of the decision to the Chief of Staff, to the Board and, by Special Notice to the affected Practitioner.

B. Favorable Recommendation. If the MEC's recommendation is favorable to the Practitioner, the Chief Executive Officer shall promptly forward it, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the MEC's decision in whole or in part or by referring the matter back to the MEC for further consideration. Any such referral shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take action. The Chief Executive Officer shall promptly send notice to the affected Practitioner informing him or her of each action taken pursuant to this Subsection. A favorable determination shall become the final action of the Board, and the matter shall be considered closed.

C. Effect of Adverse Recommendation/Result. If the recommendation of the MEC or of the Board continues to be adverse to the affected Practitioner, the notice required by Subsection 8.10 A shall inform the affected Practitioner of his /her right to request an appellate review by the Board as provided in Section 8.12.

8.11 INITIATION AND PREREQUISITES OF APPELLATE REVIEW

A. Request for Appellate Review. A Practitioner shall have fifteen (15) days after receiving notice of his/her right to request an appellate review to submit a written request for such review. Such request shall be directed to the Board in care of the Chief Executive Officer by Special Notice. If the Practitioner wishes an attorney to represent him/her at any appellate review appearance permitted under this Section 8.11, his/her request for appellate review shall so state. The request should also state whether the Practitioner wishes to present oral arguments to the appellate review body.

B. Waiver by Failure to Request Appellate Review. A Practitioner who fails to request an appellate review in accordance with Subsection (a) of this Section waives any right to such review.

C. Notice of Time and Place for Appellate Review. Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review. At least ten (10) days prior to the date of the appellate review, the Chief Executive Officer shall advise the Practitioner, by Special Notice, of the time,

place, and date of the review, and whether oral arguments will be permitted. The appellate review body may extend the time for the appellate review for good cause if the request is made as soon as is reasonably practicable.

D. Appellate Review Body. The Board shall determine whether the appellate review shall be conducted by the Board as a whole or by a committee composed of three (3) or more members of the Board appointed by the chair of the Board. If a committee is appointed, one (1) of its members shall be designated as chair by the Board chair. To the extent possible, the appellate review body shall include a Practitioner (who may also be a Board member).

8.12 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/officer, the hearing committee/officer's report. and all subsequent results and actions thereof. The appellate review body also shall consider any written statements submitted pursuant to Subsection B of this Section and such other materials as may be presented and accepted under Subsections D 2 and 3 of this Section.

B. Written Statements. The appellate review body shall set a date by which written statements must be submitted to it (through the Chief Executive Officer) and to the opposing party. The Practitioner's statement should describe the fact, conclusions, and procedural matters with which he or she disagrees, and the reasons for such disagreement. The body whose adverse action occasioned the review should discuss the basis upon which it believes its recommendation/action should be upheld and may submit a written statement in support of its action. The time limits provided in this paragraph may be waived by the appellate review body in its sole discretion.

C. Oral Arguments. The decision to permit oral arguments shall be in the sole discretion of the appellate review body. The body shall further decide what time limits, if any, should be placed upon the arguments, and whether the arguments will be presented separately or with representatives of both parties in the room.

D. Conduct of the Appellate Review.

1. The chair of the appellate review body shall preside over the appellate review, including determining the order of procedure, making all required rulings, and maintaining decorum during all proceedings.

2. The appellate review body may, at its discretion, allow the parties or their representatives to appear and make oral statements. Parties or their representatives appearing before the review body must answer questions posed to them by the review body.

3. If a party wishes to introduce new matters or evidence not raised or presented during the original hearing and not otherwise reflected in the record, the party may introduce such information at the appellate review only if expressly permitted by the review body in its sole discretion and only upon a showing by the party requesting consideration of the information that it could not have been discovered in time for the initial hearing. Prior to introduction of such information at the review, the requesting party shall provide, to the appellate review body and the other party, a written, substantive description of the information.

E. Presence of Members and Vote. A majority of the review body shall be present at all times during the review and deliberations. If a review body member is absent from any part of the review or deliberations, the chair of the review body, in his or her discretion, may rule that such member be excluded from further participation in the review or deliberations or in the recommendation of the review body.

F. Recesses and Adjournments. The appellate review body may recess the review proceeding and reconvene the same without additional notice if it deems such recess necessary for the convenience of the participants or to obtain new or additional evidence or consultation required for resolution of the matter. When oral statements (if allowed) are complete, the appellate review shall be closed. The review body shall then deliberate outside the presence of the parties at such time and in such location as is convenient to the review body. The appellate review shall be adjourned at the conclusion of those deliberations.

G. Action Taken. The appellate review body may recommend that the Board affirm, modify, or reverse the adverse recommendation/action or, in its discretion, may refer the matter back to the hearing committee/officer for further review and recommendation to be returned to the appellate review body within ten (10) days and in accordance with its instructions. Within five (5) days after receipt of such response, the review body shall then make its recommendation to the Board.

H. Final Decision of the Board. Within thirty (30) days after receipt of the appellate review body's recommendation, the Board shall reach its proposed decision. If this decision is contrary to the MEC's last recommendation, the Board of Trustees shall refer the matter to the Joint Conference Committee prior to issuing notice of its final decision. This committee shall make its recommendation to the Board within fifteen (15) days. The Board of Trustees shall then make its final decision. The Board's final decision shall be immediately effective, and the matter shall not be subject to any further referral or review. The Chief Executive Officer will promptly send notice of the final decision to the affected Practitioner by Special Notice, and to the Chief of Staff.

I. Reporting. The Chief Executive Officer shall report any final action taken by the Board pursuant to these Bylaws to the appropriate authorities as required by law and in accordance with applicable Medical Center procedures regarding the same.

8.13 GENERAL PROVISIONS

A. 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 Article, he/she shall be deemed to have voluntarily waived all rights to which he or she might otherwise have been entitled with respect to the matter involved.

B. Exhaustion of Remedies. Any Practitioner applicant or member of the Medical Staff must exhaust the remedies afforded by this Article before resorting to any form of legal action.

C. Release. By requesting a hearing or appellate review under these Bylaws, a Medical Staff member or applicant agrees to be bound by the provisions of these Bylaws relating to immunity from liability.

D. Representation by Counsel. At such time as the Practitioner, Medical Executive Committee, or Board is represented by legal counsel, then all notices required to be sent herein may be served upon legal counsel, and the requirement that such notices be sent by Special Notice is hereby waived; rather, such notices may be sent by regular first class U.S. mail.

ARTICLE NINE
LEADERSHIP OF THE MEDICAL STAFF

9.1 MEDICAL STAFF OFFICERS

A. Officers of the Medical Staff shall include:

1. Chief of Staff
2. Chief of Staff Elect
3. Secretary to the Medical Staff
4. Immediate Past Chief of Staff

9.2 QUALIFICATIONS OF OFFICERS

A. Officers must be members of the Active category in good standing for five (5) years and be actively involved in patient care in the health system. They must have previously served in a significant leadership position on a Medical Staff (e.g., Department Chair, Committee Chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have participated in Medical Staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the health system, and have excellent administrative and communication skills. The Medical Staff leadership will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria.

9.3 ELECTION OF OFFICERS

A. The leadership shall offer at least one nominee for each available position. Nominations must be announced and the names of the nominees distributed to all members of the Active Medical Staff at least thirty (30) calendar days prior to the election.

B. A petition signed by at least 30% of the members of the Active staff may add nominations to the ballot. The Medical Staff must submit such a petition to the COS at least fourteen (14) calendar days prior to the election for the nominee(s) to be placed on the ballot. The leadership must determine if candidates meet the qualifications in the section of the Bylaws that address qualifications of officers before they can be placed on the ballot.

C. New officers shall be elected at least one month prior to the expiration of the term of the current officers. Only members of the Active category shall be eligible to vote. The MSSD will determine the mechanisms by which votes may be cast, subject to the approval of the MEC. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the members' voting choices. No proxy voting will be permissible. The nominee with the greatest

number/majority of votes will be elected. In the event of a vote without a clear winner, the MSSD will make arrangements for repeat votes until one candidate receives the majority of all votes cast.

9.4 REMOVAL OF OFFICERS

A. The Medical Staff may remove any officer if at least 75% of the Active staff members sign a petition advocating such action. The petition must be followed by an affirmative two-thirds vote of those Active staff members casting ballot votes. Members can also be removed for conduct or statements that damage the health system, its goals, or programs or for an automatic or precautionary suspension of clinical privileges that lasts more than thirty (30) calendar days. After consulting with the Joint Conference Committee, the Board will determine if members have failed in their duties.

9.5 TERM OF OFFICE

A. All officers serve a term of two years. They shall take office in the month of January. An individual may not be re-elected for two successive terms, unless there is a 75% majority vote in support of a successive term by the MEC with formal approval by the Board.

9.6 VACANCIES OF OFFICE

A. The MEC shall fill vacancies of office during the Medical Staff year, except the office of the COS. If there is a vacancy in the office of the COS, the COSE serves the remainder of the term.

9.7 RESPONSIBILITIES OF OFFICERS

A. Chief of Staff shall be responsible for:

1. Enforcing the Medical Staff Bylaws, Rules and Regulations, implementing sanctions when indicated, and ensuring compliance with procedural safeguards where corrective action has been warranted.

2. Performing oversight of the Medical Staff clinical activities within the health system including quality improvement, credentialing and privileging, patient safety, and utilization management.

3. Serves as chair of the MEC and calling, presiding and being responsible for the agenda of all meetings thereof.

4. Developing and implementing methods for Medical Staff Performance Improvement activities within the health system, including quality assurance, credentialing and privileging, and utilization management.

5. Serving as an ex-officio member of all other Medical Staff committees, without vote, unless so designated by the Bylaws of the Medical Staff.

6. Working collaboratively with the health system administration and the Board in all matters of mutual concern within the health system.

7. Representing the Medical Staff to the Board, outside licensing and accreditation committees, and the public.

8. Appointing, in consulting with the MEC, the members of all Medical Staff committees and designating the Chairs of committees, unless otherwise provided for by these Bylaws.

9. Communicating and representing the opinions, needs, and grievances of the Medical Staff to the MEC, CEO and Board.

10. Retains the ability to appoint associate COS as may be necessary to fulfill the tasks of the Medical Staff after approval by the MEC.

11. Being a spokesperson for the Medical Staff in external professional and public relations.

12. Serves as liaison to the Board, WMED, Graduate Medical Education Committee and the outside licensing or accreditation agencies.

13. Review and enforce compliance with standards of ethical conduct and professional demeanor among the members of the Medical Staff in their relations with each other, the Board, health system, health system management, other professional and support staff and the community served.

14. The COS or the COSE, if the COS is unavailable, may perform any of the duties of any Department Chair or Chair of any Medical Staff committee, if such individual is unavailable or otherwise fails to perform in their necessary duties.

B. Chief of Staff Elect shall be responsible for:

1. Assumes all duties and authority of the COS in the absence of the COS.

2. Serves as a voting member of the MEC.

3. Serves as ex-officio member of all Medical Staff committees, without vote, unless so designated by the Bylaws of the Medical Staff.

C. Secretary to the Medical Staff shall be responsible for:

1. Chairing the Peer Review Committee as a voting member.

2. Calling and arranging for all meetings of the Medical Staff and the MEC.

3. Serving as Medical Staff Treasurer and reports monthly to MEC.

4. Perform such duties upon the request of the COS and COSE to help fulfill responsibilities for the aforementioned officers.

D. The Immediate Past Chief of Staff shall:

1. Serve as a consultant to the COS and COSE, as requested, and assists in fulfilling the responsibilities of the officers.

9.8 ADMINISTRATIVE OFFICERS

A. Administrative Officers of the Medical Staff shall include:

1. Chief Medical Officer

9.9 QUALIFICATIONS OF ADMINISTRATIVE OFFICERS

A. Administrative Officers must be members of the Active category in good standing for five (5) years and be actively involved in patient care in the health system or any health system deemed acceptable. They must have previously served in a significant leadership position on a Medical Staff (e.g., Department Chair, committee Chair), indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have participated in Medical Staff leadership training and/or be willing to participate in such training during their term of office, have demonstrated an ability to work well with others, be in compliance with the professional conduct policies of the health system, and have excellent administrative and communication skills. All administrative officers shall be appointed to the Medical Staff by the Board.

9.10 GENERAL DUTIES OF ADMINISTRATIVE OFFICERS

A. The CMO shall have administrative responsibility for the overall direction and coordination of medical affairs for Borgess Health. They shall be responsible to the President/CEO, serving in the capacity of senior medical executive for Borgess Health, and shall assist the COS and the MEC. The CMO shall be concerned with medical-administrative and medical-legal aspects of patient care provided in the health system and with matters affecting the quality of patient care.

ARTICLE TEN
COMMITTEES OF THE MEDICAL STAFF

10.1 COMMITTEES

A. Medical Staff Committees will include, but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of Clinical Services and Divisions, meetings of Committees established under this Article, and meetings of special or ad hoc committees(bylaws and infectious diseases) created by the Medical Executive Committee, by the Clinical Services, or by the Committees described below. The Committees described in this Article will be the Standing Committees of the Medical Staff.

10.2. MEDICAL EXECUTIVE COMMITTEE

A. The MEC shall be a standing committee consisting of the following voting members: officers/administrative officers of the Medical Staff and Department Chiefs and a WMED representative mutually agreed upon between WMED Dean and ABH Chief of Staff. The chair of MEC will be the COS. The CEO and CNO will be ex-officio members without vote.

10.3 DUTIES OF MEC

A. The duties of the MEC, as delegated by the Medical Staff, shall be to:

1. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff Bylaws and provide oversight for all Medical Staff functions.

2. Coordinate the implementation of policies adopted by the Board.

3. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, department assignments, clinical privileges, and corrective action.

4. Report to the Board and to the staff the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities.

5. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members, including collegial and educational efforts and investigations when warranted.

6. Make recommendations to the Board on medical, administrative, and hospital management matters.

7. Update the Medical Staff on issues concerning the licensure and accreditation status of the hospital.

8. Participate in identifying community health needs and setting hospital goals and implementing programs to meet those needs.

9. Review and act on reports from Medical Staff committees, departments, and other assigned activity groups.

10. Formulate and recommend Medical Staff rules and policies and procedures to the Board.

11. Request evaluations of practitioners privileged through the Medical Staff process when there is doubt about an applicant or member's ability to perform privileges he or she has requested or currently holds.

12. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures

13. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital.

14. Oversee the portion of the corporate compliance plan that pertains to the Medical Staff.

15. Hold Medical Staff leaders, committees, and departments accountable for fulfilling their duties and responsibilities.

16. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws.

17. Act on behalf of the Medical Staff between meetings of the Medical Staff within the scope of its responsibilities as defined by the Medical Staff.

10.4 FREQUENCY OF MEC MEETINGS

A. The MEC shall meet at least ten (10) times per year or more often if necessary to transact pending business.

10.5 REMOVAL FROM MEC

A. Officers or department chairs that are involuntarily/voluntarily removed from their positions in accordance with these Bylaws will automatically lose their membership on the MEC.

10.6 CREDENTIALS COMMITTEE

A. The Credentials Committee shall consist of the COS, COSE, SEC, the two (2) previous COS and CMO. The COS may appoint one or more members-at-large to serve on the committee for a period of time determined by the COS. The Chairman shall be the current COS. The CMO will sit without vote unless in the event of a tie.

10.7 DUTIES OF CREDENTIALS COMMITTEE

A. The duties of the Credentials Committee, as delegated by the Medical Staff, shall be to:

1. To review the qualifications and credentials of all applicants for appointment to the Medical Staff, NPP Staff and clinical privileges.

2. To make recommendations to the MEC for appointment to all categories of the Medical Staff, NPP Staff and clinical privileges.

3. To establish uniform standards as the basis for granting those privileges to perform procedures by members of different departments.

4. The Chairman of the Credentials Committee, or his/her designee, shall be available to meet with the Board or its applicable committee on all recommendations that the Credentials Committee may make.

10.8 FREQUENCY OF CREDENTIALS COMMITTEE MEETINGS

A. The Committee will meet monthly, but may meet more frequently or be canceled as determined by the Chief of Staff.

10.9 PEER REVIEW COMMITTEE

A. The Peer Review Committee shall consist of the SEC and nine (9) members from the Medical Staff to be appointed on an alternating schedule by the COS and approved by the MEC. Members will serve a minimum of two (2) years . The CMO shall serve as ex-officio member without vote. The Committee Chair will be the current SEC. The immediate past SEC will serve on the committee.

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

2. Fosters a culture that promotes a commitment to continually improving the quality of patient care and services and reducing healthcare errors.

3. Assessing and prioritizing process improvement projects.

4. To ensure the utilization of peer review assessments to improve patient care and safety.

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

6. To create and maintain the process for practitioner feedback.

7. To make recommendations for individual practitioner performance improvement action plan.

10.10 FREQUENCY OF PEER REVIEW COMMITTEE MEETINGS

A. The Committee will meet monthly, but may meet more frequently or be canceled as determined by the Chairperson.

10.11 PHARMACY, THERAPEUTICS & DRUG USAGE COMMITTEE

A. The Pharmacy, Therapeutics, and Drug Usage Committee shall consist of at least two (2) representatives from the Department of Medicine and six (6) other physicians including one each from the Departments of Pediatrics, Surgery and Family Practice. In addition, one representative each from nursing service and hospital management shall be appointed to the committee by the CEO or designee. The CEO or designee shall appoint appropriate representatives of the hospital pharmacy as ex-officio members of the committee.

10.12 DUTIES OF THE PHARMACY, THERAPEUTICS & DRUG USAGE COMMITTEE

A. The duties of the Pharmacy, Therapeutics & Drug Usage Committee shall be to:

1. Ongoing review of the appropriateness of empiric and therapeutic use of drugs through the analysis of individual or aggregate patterns of drug practice including high risk or high use drugs, or those used in high risk clinical situations;

2. Developing and recommending to the MEC and the Board procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic materials.

3. Reviewing all significant untoward drug reactions;

4. Maintaining a formulary or drug list;

5. Evaluating and, if appropriate, approving protocols concerned with the use of investigational or experimental drugs,

6. Reviewing the appropriateness, safety and effectiveness of the prophylactic, empiric and therapeutic use of antibiotics and other drugs in the hospital.

7. Developing and recommending to the Medical Staff Executive Committee and hospital senior management policies and procedures for minimizing drug errors.

10.13 FREQUENCY OF PHARMACY, THERAPEUTICS & DRUG USAGE COMMITTEE

B. The Committee will meet monthly, but may meet more frequently or be cancelled as determined by the Chairperson.

10.14 JOINT CONFERENCE COMMITTEE

A. The Joint Conference Committee is a Board committee shall serve as the body for resolution if there is a conflict between the MEC and the Board. The Joint Conference Committee is not meant to be a voting or deciding body. Rather, its purpose is to make recommendations to the Board or MEC.

B. The members of the Joint Conference Committee shall comply with the policies of the Board of Trustees and Medical Staff, including policies with respect to conflict of interests and confidentiality.

10.15 MEDICAL STAFF COMMITTEES

A. The committees of the Medical Staff shall consist of those committees established by these Bylaws and such other committees as may be established by the MEC with the approval of the CEO. There shall be established such joint hospital/Medical Staff committees as the MEC and the CEO shall agree upon to address such issues as infection control, performance improvement, utilization review, pharmacy and therapeutics, and other administrative and clinical issues as may be required by TJC or otherwise. The specific membership and duties of joint Hospital/Medical Staff committees shall be established by the MEC subject to the approval of the CEO. The scope, membership and duties of Committees may be revised, and committees may be merged or terminated, by the MEC with the approval of the CEO. Members of joint committees shall be those practitioners appointed by the COS, subject to the approval of the CEO, and those representatives or employees of the hospital appointed by the CEO with the approval of the COS.

10.16 QUORUM REQUIREMENTS

A. MEC, Credentials, and Medical Staff Peer Review Committee shall require 30% of voting members. Department meetings or Medical Staff committees other than those listed previously require 25% of voting members present

10.17 ATTENDANCE REQUIREMENTS

A. Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Members of the MEC, Credentials, and Peer Review Committee are expected to attend at least 75% of the meetings held annually. Failure to attend may result in suspension or relinquishment of committee slot at the discretion of the COS.

10.18 MINUTES

A. Minutes will be kept of all required meetings of the Medical Staff, the MEC, Credentials and Peer Review Committees, and will be filed with the MSSD.

ARTICLE ELEVEN
CLINICAL ORGANIZATION OF THE MEDICAL STAFF

11.1 CLINICAL DEPARTMENTS

A. The Medical Staff of Borgess Medical Center is organized into clinical departments. The current departments are as follows:

1. Anesthesiology
2. Clinical Pharmacy
3. Critical Care
4. Emergency Services
5. Family Medicine
6. Internal Medicine
7. Obstetrics & Gynecology
8. Pathology
9. Pediatrics
10. Psychiatry
11. Radiology
12. Surgery

B. Clinical departments may be created, eliminated, subdivided, or combined in accordance with changes in Borgess Health with concurrence of the MEC and Board.

11.2 CLINICAL DEPARTMENT RESPONSIBILITIES

A. Each clinical department is charged with the responsibility for implementing and conducting specific monitoring review and evaluation activities that contribute to the preservation and improvement of the quality of safe patient care, treatment and services provided in the service. To carry out this responsibility, each department shall:

1. Establish guidelines for the granting of specific clinical privileges within the department.

2. Development of recommendations regarding the need for pertinent continuing education programs that reflect the type and nature of services offered by Borgess Health and the findings or performance improvement activities.

3. Overseeing of members' adherence to the Medical Staff Bylaws, Polices, Rules and Regulations, requirements of the department, sound principals of clinical practice and regulations designed to promote patient safety.

4. Regularly assess professional performance, patient safety, professional conduct, and patient complications as determined by the Department.

11.3 DEPARTMENT CHAIR SELECTION

A. The selection of all Department Chairs will be made by the CMO upon recommendation of the COS and an interview panel selected by the COS and CMO. All Department Chairs will be presented for final approval by the Board.

11.4 DEPARTMENT CHAIR RESPONSIBILITIES

A. Each Department Chair will be accountable to the COS and CMO and must:

1. Determine and manage the clinically related and administrative activities within their clinical department.

2. Where department rules and regulations are desired, will be accountable for the development and implementation of those rules and regulations, ensuring that they support the overall performance improvement directly pertaining to professional medical care within their department. Such development will be approved by a majority of the Medical Staff members of the department with submission to MEC for final approval.

3. Develop and implement department programs for orientation of new members, credentials review and privilege delineations for initial appointment and reappointment, continuing medical education, utilization review, concurrent evaluation of practice, and retrospective evaluation of practice (OPPE and FPPE).

4. Recommend to the Medical Staff the criteria for privileges that are relevant to the care provided in the Department.

5. Be responsible for implementation within the department of actions taken by the Board and the MEC.

6. Assess and make recommendations to the CEO, CMO or COS of any off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

7. Be responsible for the establishment, implementation and effectiveness of orientation and continuing education of all practitioners in the department and collaborate with the medical directors in the teaching, education and research program in the department.

8. Continuously assess and improve the quality of care, treatment of services, and maintain the quality improvement programs as appropriate.

9. Communicate to the appropriate authorities as required in these Bylaws, the department's recommendations concerning appointment, reappointment, delineation of clinical privileges, and disciplinary action with respect to members of the department.

10. Recommend a sufficient number of qualified and competent persons to provide care, treatment, or services.

11. Develop and implement policies and procedures that guide and support the provision of care, treatment and services.

12. Make recommendations to the COS and CMO concerning the space and other resources needed by the department.

13. Perform such other duties commensurate with their office as may be assigned by the COS, CMO, or the Board.

11.5 DEPARTMENT CHAIR REMOVAL

A. The Medical Staff may remove a Department Chair if at least 75% of the MEC staff members sign a petition advocating such action. Department Chairs can also be removed for conduct or statements that damage the health system, its goals, or programs or for an automatic or precautionary suspension of clinical privileges that lasts more than thirty (30) calendar days. After consulting with the MEC, the Board will determine if members have failed in their duties.

ARTICLE TWELVE
PROFESSIONAL PRACTICE REVIEW

12.1 FOCUSED PROFESSIONAL PRACTICE REVIEW (FPPE)

A. Focused Professional Practice Evaluation (FPPE) is the process whereby the Medical Staff evaluates privilege specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the hospital. FPPE is also used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. FPPE is the time limited period during which the Medical Staff evaluates and determines the practitioner's professional performance.

B. FPPE is implemented for all initially requested privileges, whether from a new applicant or from an existing privileged practitioner seeking a new privilege. Focused professional practice evaluation FPPE must be consistently implemented in accordance with the criteria and requirements developed by the Medical Staff. The Medical Staff shall develop a FPPE process that is clearly defined and includes:

1. A method for conducting performance monitoring of the requested privileges from applicant.

2. A method for determining the duration of performance monitoring, generally three (3) months.

3. The triggers that indicate the need for performance monitoring.

4. The results of the FPPE will be reviewed by the applicable Department Chair, the CMO, and the MEC, and kept in the practitioner's quality file held in the MSSD.

5. Any decision to extend the period of performance monitoring to further assess current competence is based on the evaluation of a Practitioner’s current clinical competence, practice behavior and ability to perform the requested privilege(s).

C. Information for FPPE may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of the patient. Relevant information resulting from the focused evaluation process is integrated into performance improvement activities, consistent with the hospital's policies and procedures that are intended to preserve the confidentiality of the information.

D. If a practitioner’s conduct or clinical competence is brought into question, a FPPE may be implemented to adequately address concerns that have arisen. The FPPE may be implemented upon recommendation by the Credentials Committee, Peer Review Committee, MEC, CMO, COS, or the applicable Department Chair. The parameters of the FPPE will be defined by the aforementioned committee or party. The practitioner

undergoing the FPPE will be notified of such action and circumstances surrounding the action.

12.2 ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

A. Ongoing Professional Practice Evaluation (OPPE) allows the hospital to identify professional practice trends that impact on quality of care and patient safety. The criteria used in the hospital's OPPE include, as applicable:

1. Review of operative and other clinical procedures performed and the outcomes;
2. Patterns of blood and pharmaceutical usage;
3. Requests for tests and procedures;
4. Length of stay patterns;
5. Morbidity and mortality data;
6. Practitioner's use of consultants; and
7. Other relevant data and criteria as determined by the applicable Clinical Department.

The specific criteria and data used in a practitioner's OPPE is determined **by** the applicable Clinical Department.

B. The information used in the OPPE may be acquired through:

1. Periodic chart review;
2. Direct observation;
3. Monitoring of diagnostic and treatment techniques; and
4. Discussions with other individuals involved in the patient care, including other physicians and nursing and administrative personnel.

C. All practitioners, whether appointed to the Medical Staff or NPP Staff, will be subject to OPPE. The OPPE will be conducted by the applicable Department Chair, their designee or by the Peer Review Committee or other Medical Staff Monitoring Committee. Review of the OPPE will be conducted by the CMO and on completion placed in the practitioner’s quality file held in the MSSD. The criteria and process for renewing privileges, or granting additional privilege(s), to a practitioner with a record of

professional performance at the hospital includes the review and consideration of all of the practitioner's OPPE data.

12.3 PROCTORING & INITIAL PRIVILEGES

A. Each member will complete such proctoring (Focused Professional Practice Evaluation – FPPE) as may be required by the Clinical Department. Medical Staff members who change Medical Staff categories to one of greater clinical responsibility, or who are granted additional privileges, must also complete a period of proctoring as assigned by the Department Chair and approved by the Credentials Committee. Proctoring will be performed by a member in good standing of the Medical Staff of BH, with privileges in the specialty area being proctored. Each Clinical Department will establish proctoring guidelines, a term of, and process for, proctoring. Proctoring Policy and guidelines are subject to approval by the Credentials Committee.

ARTICLE THIRTEEN
RULES & REGULATIONS

13.1 RULES & REGULATIONS

A. The Medical Staff is responsible to the Borgess Health, Clinics, and Board for the professional medical care performed at Borgess Health and the quality of medical care rendered. In accordance with the Bylaws of the Medical Staff, the following Rules and Regulations pertaining to professional care are hereby adopted. Individual Clinical Departments may adopt Department-specific Rules governing both practice in the Department and the professional medical care to be rendered by members of the Department. These documents are complementary.

13.2 PATIENT TYPES AND ADMISSION OF PATIENTS

A. Patient encounters at Borgess Health are categorized as: inpatient, emergency, and outpatient. These are based on the service provided as well as on specific regulatory requirements such as the Medicare Conditions of Participation.

1. Inpatient: A person who has been admitted to the hospital for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient if formally admitted to a licensed inpatient bed with the expectation of remaining overnight, even if it later develops that the patient can be discharged before midnight.

2. Emergency: The provision of emergency medical care in specifically designated areas of the hospital which is staffed and equipped at all times to provide prompt care for any patient presenting urgent medical problems.

3. Outpatient: A person who has not been admitted to the hospital as an inpatient and who is not receiving emergency services but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital.

4. Hospitalized Episodes for Outpatients

    a. Ambulatory Care Procedure: Outpatient procedures those are generally invasive, including same-day surgeries, angiograms, bronchoscopies, and endoscopies.

    b. Observation: Those services furnished on the hospital's premises, including the use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition in order to determine the need for a possible admission to the hospital as an inpatient.

5. Other Outpatient Episodes/Services

   a. Clinic Visits: Encounters during which diagnoses and other related information are provided by the physician who performs the examination or who is overseeing the activities of an Advanced Practice Professional.

   b. Diagnostic and Treatment Services: Services such as laboratory and radiological studies, chemotherapy, radiation therapy, and physical therapy, which are performed based on the order of a qualified physician (may be a practitioner not appointed to the Medical Staff but is licensed to practice in Michigan) who is also responsible for providing the patient's diagnosis and other clinical justification for the test or therapy.

   c. Referred Specimen Services: Services rendered when a specimen is sent by an external (Borgess Health or non-Borgess Health) physician's office, hospital, or other institution for evaluation or consultation when the patient does not present to Borgess Health for service.

13.3 ADMISSION CRITERIA

A. Patients may be admitted to the hospital as inpatients, accepted for outpatient hospital registration, or accepted for observation services or ambulatory care procedures only by a qualified member of the Medical Staff who has been granted the privilege to admit patients to the hospital or order procedures in accordance with state law and criteria for standards of medical care established by the Medical Staff. All patients must be under the direct care or supervision of a member of the Medical Staff.

   a. Only those practitioners authorized in accordance with the Bylaws of the Medical Staff may admit patients to the hospital. The patient's attending physician will execute, or cause to be executed, all physician responsibilities related to the admission and discharge of patients from the Hospital.

   b. The admit order must specify the admission type: (a) Observation, (b) Outpatient Surgery, or (c) Inpatient.

   c. A change in admission type requires a new order; however, a patient's status cannot change from Inpatient to Observation.

   d. Except in emergencies, no patient may be admitted to the hospital without a recorded provisional diagnosis. In the case of an emergency, a diagnosis must be recorded as soon as possible.

   e. Patients who are treated at Borgess Health for diseases diagnosed on the basis of histological sections or the morphological assessment of fine needle aspirates, bone marrow aspirates, or peripheral blood, and when the proposed treatment depends on the interpretation of these specimens, must have such diagnoses confirmed by a

Medical Staff member with Pathology privileges, before initiation of therapy, except when urgent therapy is indicated. If the pathology specimens cannot be obtained because they have been destroyed, no longer exist, or have been irrevocably lost or cannot be obtained through reasonable efforts, this should be documented in the medical record.

f. It is the responsibility of the Medical Staff member to report all cases of reportable diseases in accordance with Borgess Health Procedures and Policies.

13.4 MEDICAL RECORDS

A. A medical record consists of medical information that is specific to the patient, that is pertinent to the patient's care and treatment, and that is in the custody of the Hospital's Health Information Management Services Department. The information contained in the medical record, and any other patient-specific information, must be treated in accordance with all applicable legal and ethical rules related to the confidentiality of patient medical information.

1. Access- Access to confidential materials by members of the Medical and other staffs of the Hospital, Hospital employees, and others is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, Medical Staff credentialing, approved research, educational pursuit, or other specifically authorized activity.

2. Required Medical Record Elements- Elements required in a medical record include identification data; appropriate comprehensive history and physical examination; reports and consultations; clinical laboratory, radiology and other special reports; provisional diagnosis; medical or surgical treatments; operative reports; anesthesiology records; pathological findings; progress notes; final diagnosis; discharge notes; clinical summary; autopsy report; and other pertinent information such as Patient Advance Directives and Consent Forms.

3. Documentation Rules-

    a. Unless otherwise stated in these Rules and Regulations, the content, form, nomenclature, permitted abbreviations, and timeliness requirements of all portions of and entries in the patient's medical record must be as stated in the Hospital's Policies and Procedures governing medical records.

    b. Entries must be legible and authenticated by the individual making the entry. Authentication is defined as written or electronic signature, timed and dated.

c. The attending physician is responsible for the timely preparation and completion of the patient Medical Record. Medical Record entries must be authenticated within thirty (30) days following the patient's discharge.

d. Medical student entries must include identification of student status and be counter-signed by a supervising physician.

e. All entries must be dated and timed. Entries that are time sensitive in the delivery or documentation of care should be timed using the 24 hour clock. The following entries must be timed using 24 hour clock:

1. Orders
2. Post-operative note immediately following surgery
3. Forms that specify a time documentation requirement
4. Administration of medications
5. Restraint and/or seclusion application and removal
6. Emergency Room log of patient arrival, discharge
7. Anesthesia note immediately prior to induction
8. Date format shall reflect month/day/year

f. Symbols and abbreviations may not be used on the face sheet or in the final diagnosis, but may be used within the medical record when approved by the Medical Staff. A list of permitted and ***not*** permitted symbols and abbreviations has been approved by the Medical Staff. Use of not approved symbols and abbreviations has the potential to negatively impact patient care. No order for medications will be completed if the order contains a symbol or abbreviation on the not permitted list until the physician has been contacted for order clarification. The Pharmacy and Therapeutics Committee and the Medical Record Committee will monitor compliance with these requirements.

g. A clinic note should be entered into the medical record or dictated for each visit or consult within 48 hours of the encounter.

h. All clinic visit documentation must conform to the Centers for Medicare and Medicaid Services (CMS) 95 or 97 Documentation Guidelines for Evaluation and Management Services regardless of payer.

i. Orders:

1. Orders for ancillary and diagnostic services must include the diagnosis (ICD code) and, as necessary, other appropriate information about the patient's diagnosis, or the sign(s) or symptom(s) providing the justification for the service/treatment. An order for medication must comply with the Medical Staff's approved Policies and Procedures which govern the content of, and nomenclature and abbreviations permitted and not permitted in medication orders, both generally and for specific types of medications.

2. For treatment orders, an explanation must be provided as appropriate.

j. Documentation of phone consultations must be included in the legal medical record.

k. All clinical e-mail correspondence with patients must be maintained with the legal, medical record. This should include the patient's initial question and the clinical response.

l. Summary lists must be initiated by the third visit to a primary care provider.

1. Patients receiving continuing Primary Care at Borgess Health will have summary lists in their medical record. The summary lists will contain major and ongoing medical diagnosis/conditions, history of major surgical and invasive procedures, allergies, ongoing medications, and date of last revision. The summary lists will be maintained as part of the permanent medical record.

2. The summary lists will be revised when the medical condition/diagnosis changes, medications are discontinued or changed, the patient has undergone additional surgical procedures and/or when there is a change in allergy status.

m. Education and instructions provided to the patient and family should be documented in the record.

13.5 CONSENT AND DISCLOSURE

A. Informed Consent

1. Unless an emergency exists, no care or treatment may be rendered to any patient in the Hospital, Emergency Department, or Clinics without a written consent signed by the patient or his/her properly designated representative. In an emergency situation, when immediate services are required to alleviate or prevent severe pain, disability, or death, and the patient lacks capacity to give consent for the services required, the physician recommending treatment to the patient must follow Hospital policies and procedures regarding obtaining consent from a properly designated representative, such as a surrogate, or providing treatment pursuant to the emergency exception if applicable. Except in an emergency situation as defined above, proper informed consent is a prerequisite to any procedure or treatment that is considered complex based on medical judgment, and includes, but is not limited to the following situations:
    a. Operative procedures
    b. Invasive procedures that have the potential for serious risks and adverse reactions

c. Blood transfusions or other use of blood products
d. Planned use of moderate sedation
e. Electroconvulsive therapy

B. The informed consent discussion should include at least information about the specific procedure or treatment, the reasonably foreseeable risks and benefits of the treatment, and the reasonable alternatives for care and treatment. In all surgical procedures, the physician in whose name the permission for the operation is obtained must participate in person or as a member of the operating team and must be present during the critical portion(s) of the procedure. Such participation may not be delegated without the informed consent of the patient or the patient's properly designated representative.

13.6 RESEARCH

A. Any research project conducted in the hospital or clinics involving human subjects must be approved by the Administrative Panel on Human Subjects in Medical Research (the Investigational Review Board or "IRB") that is formally recognized by Borgess Health.

1. The Medical Staff Member who is participating as a Principal Investigator in a research protocol involving human subjects is responsible for submitting the research protocol for approval to the IRB of Borgess Health and complying with all IRB requirements relating to the provision of care and treatment of a patient under an approved research protocol.

2. All research projects must be conducted in accordance with the Medical Staff Policy on Clinical Research and any applicable Borgess Health policy. Confidentiality is maintained in accordance with Borgess Health HIPAA Research policy.

13.7 PATIENT ASSESSMENT

A. History & Physical (H&P) Requirements must be documented by a member of the Borgess Health Medical Staff or a NPP with the appropriate privileges.

1. A H&P examination must be completed no more than 30 days before or 24 hours after inpatient or outpatient admission. If the H&P was completed within 30 days before admission, an updated examination must be completed and documented within 24 hours after admission.

2. The H&P must be completed for every patient prior to surgery, or a procedure requiring anesthesia services, except in emergencies. In all cases, except for emergencies, the H&P or update must be completed and documented before the surgery or procedure takes place, even if that surgery occurs less than 24 hours after admission or registration.

3. The H&P shall include, at minimum, the following components and any other information deemed to be relevant by the examining provider:

    a. Chief Complaint
    b. History of Present Illness
    c. Relevant past medical, surgical, social, and family history
    d. Medications and Medication Allergies
    e. Review of Systems
    f. Physical Examination
    g. Assessment Including Provisional Diagnosis
    h. Treatment Plan

4. The H&P update shall indicate that the H&P was reviewed, the patient was examined, any changes that have occurred, or that "no changes" have occurred in the patient's condition. In the case of a surgical update, it shall also confirm that indications for the procedure are still present.

5. In addition to the H&P requirements above, patients undergoing sedation or anesthesia care must also have a Pre-Anesthesia Assessment. The assessment is performed and documented prior to the induction of sedation/anesthesia and considers data from other assessments.

6. The H&P requirement does not apply for Emergency Surgery; however an H&P must be documented as soon as possible after surgery.

7. A focused history and physical examination and report may be used for outpatient procedures and should include the following information:
    a. Chief complaint or reason for the admission or procedure;
    b. A description of the present illness;
    c. Past medical history, including current medications, allergies, and current diagnoses;
    d. A review of systems relative to the procedure planned;
    e. Relevant physical findings, including an evaluation of the cardiac and respiratory systems;
    f. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

13.8 PLANNING CARE, TREATMENT AND SERVICES

A. Orders

1. All orders for treatment must be in writing or entered into the electronic medical record, dated and timed, and signed by the issuing practitioner, and should include the issuing practitioner's pager number. Orders written by an individual who is not a Medical Staff member or NPP authorized to enter orders must be cosigned by the supervising physician prior to implementation.

    a. Verbal/Telephone Orders

        1. Verbal/telephone orders may be issued by members of the Medical Staff or NPP authorized to write orders to licensed nursing personnel (RN's) and registered pharmacists. Verbal/telephone orders appropriate to their discipline may be given to any licensed physical therapist, occupational therapist, speech-language pathologist, registered laboratory technologist, registered MRI technologist, registered nuclear medicine technologist, registered sonographer, registered x-ray technologist, or dietician.

        2. Verbal/telephone orders may be issued only if the circumstances are such that an immediate order is required and it would be impractical for the prescriber issuing the order to do so in writing.

        3. Verbal/telephone orders are appropriate in the following situations:

            a. Emergency
            b. If person placing the order is physically unavailable
            c. If the physician/clinician is performing a procedure

        4. The ordering provider must identify themselves and the nurse will read back their name as a part of the order transcription process.

        5. Prescribers must remain on the telephone to allow the receiver of the order to write out the complete order and for the receiver to read it back to the prescriber.

        6. The ordering physician or designee must sign, and write the date and time of signing, all verbal and telephone orders at the time of the next visit. Members of a Physician Team may cosign verbal/telephone orders for any other members of that team if they are sufficiently familiar with the clinical circumstances and appropriateness of the order.

B. Medications

1. An order for medication must comply with the Medical Staff approved Medication Policies and Procedures which govern the content of abbreviations and nomenclature permitted in medication orders, both generally and for specific types of medications.

2. Complete medication orders must include the name of the drug, dosage, frequency of administration, route of administration, date, time, and signature of the prescriber. There should be a documented diagnosis, condition, or indication for each medication ordered.

3. Orders documented by medical students must be reviewed and counter-signed by a physician prior to implementation.

4. Upon transfer of the patient to the Operating Room, all medication orders are canceled and must be rewritten. It is not acceptable to write a statement such as "Resume all medications orders"; complete orders for each medication must be documented. If there is a change in Department (e.g. Medicine, Surgery) and/or the physician responsible for the patient, all orders for the patient must be reviewed by the new Department and/or physician, and reaffirmed or discontinued via order documented in the patient's chart.

5. Only those drugs listed in the Borgess Health Drug Formulary may be administered to inpatients or those employed for purposes of direct therapeutic benefit to a particular patient in an emergency, when approved by the Chief of Staff or the Chief's designee, or those brought by or with the patient to BH. Investigational drugs may be used in accordance with applicable State and federal laws and regulations as well as policies adopted by the Pharmacy and Therapeutics Committee.

6. Medication ordering and administration must comply with all the Medication Administration Requirements Procedures such as using patient specific information, monitoring the effects of the medications, not using Borgess Health unapproved abbreviations, etc.

7. The Physician is responsible for ensuring that an indication or diagnosis is present in the medical record for every medication prescribed.

13.9 PROVIDING CARE, TREATMENT AND SERVICES

A. A hospitalized patient must be seen by the attending physician or the appropriate covering physician or the provider delegated by the attending and/or supervising physician at least daily or more frequently as required by the patient's condition or circumstances.

B. A progress note must be documented on each patient daily in sufficient detail to allow formulation of a reasonable picture of the patient's clinical status at the time of observation.

C. Follow-Up on Outpatient Test

1. An attending physician who orders medical tests on a Borgess Health outpatient must ensure that the results of such tests are reviewed by a physician or appropriated NPP no later than 2 business days after those results appear in the electronic medical record (or are made available via fax, mail or other means).

D. Consultations

1. Requesting consultations shall be the responsibility of the attending or treating physician and should be requested when the attending physician requires assistance in the care of the patient. The physician requesting the consultation shall be responsible for documenting the reason for the consultation and contacting the consultant. It is expected that practitioner to practitioner communication occurs under most circumstances. The consultation shall contain evidence of a review of the patient's record, findings as a result of an examination of the patient, and the consultant's opinion and recommendations. All consultations require date and time the report was dictated or handwritten and the signature of the consultant.

2. Patients who exhibit significant psychiatric illness with acute exacerbation of symptoms or new onset of symptoms while hospitalized will be referred for an evaluation by a psychiatrist on the Medical Staff. Patients with alcohol/drug abuse/intoxication/dependence will be referred for psychiatric evaluation if the attending physician believes management of the patient is beyond his/her scope of practice. Consultation will involve diagnostic evaluation, acute management suggestions and assistance, and referral for outpatient treatment as indicated.

E. Operative Care of Patients

1. A post-operative note must be documented immediately following surgery or a procedure (inpatient or outpatient) that requires anesthesia, or deep or moderate sedation before the patient is transferred to the next level of care. The report should contain:
   a. Name of Primary Surgeon
   b. Name of Primary Surgeon Assistant (if any)
   c. Post-Operative/Procedure Diagnosis
   d. Procedure Description
   e. Procedure findings
   f. Estimated blood loss
   g. Specimen/tissue removed or altered
   h. Signature, date and time

A complete procedure report must also be entered into the electronic health record within 24 hours.

13.10 COORDINATING CARE AND TREATMENT

A. Discharge/Death

1. Patients may be discharged only on the order of the responsible physician or NPP. It is the responsibility of the attending physician, dentist, or podiatrist to plan discharge in a timely and coordinated fashion. The responsible practitioner is obligated to communicate to a referring doctor all appropriate medical information and provide the same information to any institution or agency to which a patient is referred following discharge from the hospital. For patients who have been in the hospital for a period of more than 48 hours, the patient's discharge summary should either be documented in the medical record or dictated within 48 hours of discharge. For patients with a stay less than 48 hours the final progress note may serve as the discharge summary and must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care. All inpatient deaths must have a death summary regardless of length of stay. The discharge or death summary must be completed by the discharging practitioner within fourteen (14) days of discharge.

2. If a patient leaves Borgess Health against medical advice, this must be documented in the patient's medical record and the patient should be asked to sign the appropriate release form.

3. Discharge Summary

    a. The discharge summary can be directly entered in the electronic health record or dictated for transcription.

    b. The content of the discharge summary should be consistent with the rest of the record and includes:

        1. Admitting date and reason for hospitalization
        2. Discharge date
        3. Final diagnoses
        4. Succinct summary of significant findings, treatment provided and patient outcome
        5. Documentation of all procedures performed during current hospitalization and complications (if any)
        6. Condition of patient upon discharge and to where the patient is discharged
        7. Discharge medication, follow-up plan, and specific instructions given to the patient and/or family, particularly in relation to activity, diet, medication, and rehabilitation potential

4. Death Summary

    a. The Death Summary is entered in the electronic health record or dictated for transcription.

    b. The content of the death summary should be consistent with the rest of the record and includes:

        1. Admitting date and reason for hospitalization
        2. Date of Death
        3. Final diagnoses
        4. Succinct summary of significant findings, treatment provided and patient outcome
        5. Goals of Care – if patient was placed on
        6. DNR/palliative/comfort/hospice care status
        7. Documentation of all procedures performed during current hospitalization and complications (if any)

5. Patient Death

    a. In the event of death, the patient must be pronounced dead by a licensed physician or registered nurse. The physician pronouncing the death is responsible for determining whether the death is reportable to the County Coroner's Office and must make such reports in accordance with the applicable Michigan laws. The body may not be released from Borgess Health until an appropriate entry by a licensed physician has been made and signed in the patient's medical record. Policies with respect to the release of bodies must conform to Michigan law.

13.11 RULES PERTAINING TO SPECIFIC PATIENT SITUATIONS

A. Autopsy

1. Unless otherwise required by the Coroner, an autopsy may be performed only with a written consent, signed in accordance with applicable law. In the event of a patient death in the hospital, the physician/Department is expected to attempt to obtain permission to perform an autopsy from the appropriate legally authorized person.

2. Autopsies are performed by the Borgess Health Pathology Department. The Medical Staff, and specifically the attending physician, should be notified of the time and place an autopsy is performed. The complete post-mortem report should be made part of the medical record within three (3) months.

B. Suicidal Patient

1. For the protection of patients, the Medical and Nursing Staffs, and Borgess Health, the following standards are to be met in the care of the patient who is determined to be potentially suicidal:

    a. Psychiatric consultation must be obtained immediately (or as soon as the patient's condition permits if the suicide attempt has rendered him/her unconscious) after a patient has threatened suicide or made a suicide attempt.

    b. Prior to the consultation, the physician in charge of the care should evaluate the type of immediate care the patient requires and write the appropriate orders.

    c. If a patient's medical history or symptoms suggest a problem with alcohol and/or other drugs, the attending physician is encouraged to seek information and/or consultation regarding alcohol and drug treatment services to assist with detoxification, referral to community resources or treatment sources, and other support.

C. Organ and Tissue Donation

1. Members of the Medical Staff and NPP Staff are expected to follow the BMC Policy 4127.

D. Tissue Specimens

1. All tissue specimens that are clinically relevant to the indication for the procedure during which they were removed, or to subsequent therapy, must be examined by a Medical Staff member with privileges to examine such specimens at Borgess Health to the extent necessary to arrive at a tissue diagnosis. The findings of that examination must be documented by the Medical Staff member in the patient's medical record.

E. Transfer of Patient

1. If the attending physician transfers the care of a patient to another Borgess Health Medical Staff member, the transferring attending physician should clearly document the transfer of responsibility in the medical record to the accepting attending physician.

F. Clinical Department Policies and Procedures

1. Each Clinical Department may develop policies and procedures to be administered routinely to all patients admitted to their Service. This does not preclude the Medical Executive Committee from adopting similar policies regarding procedures to be

administered to all patients admitted to the Hospital. Where clinical department and Medical Staff rules appear inconsistent, Medical Staff rules will supersede service rules.

G. Emergency Services

1. The provision of emergency medical services occurs through the Emergency Department of Borgess Health, which is organized and directed by a member of the Medical Staff who is trained and experienced in Emergency Medicine. The Emergency Department is staffed by members of the Medical Staff.

2. A medical record must be kept for every patient and becomes part of the Borgess Health legal medical record.

3. A Medical Staff member may determine the need to transfer a patient to another medical facility. This must be done in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA) guidelines and the practitioner making the determination must complete and sign all forms related to the transfer including a transfer statement.

    a. On call physicians will respond in person to emergency consultation requests within 30 minutes if on call in-hospital and within 60 minutes if on call outside the hospital. Longer response times are acceptable if agreeable to the requesting physician. In specialties (e.g., radiology, pathology) where direct examination of the patient is often not clinically indicated, the physician must view the relevant images, specimens or other clinical materials within the specified time limits

H. Conflict of Care Resolution

1. All members of the health care team have a duty to advocate for the patient through the organizational chain of command when they have concerns about a patient's care. The chain of command involves administrative and clinical lines of authority which are established to ensure effective conflict resolution in patient care situations. In all cases, the final authority in the chain of command on patient care decisions rests with the COS or the COS designee.

I. Supervision of Medical Students

1. All medical students are under the supervision of the Medical Staff. Members of the Medical Staff exercise that supervision under the guidelines established by the Graduate Medical Education Program from the respective educational institution. However, supervising members of the Medical Staff are responsible for the patient care, treatment, services, safety and quality, and documentation activities of the medical students they supervise. The Graduate Medical Education Committee must provide regular reports of the activities of the Graduate Medical Education Program

to the Medical Executive Committee, which will communicate this report to the Board.

13.12 CONFIDENTIALITY

A. The members of the Medical Staff, NPP Staff associated with the Medical Staff, and their respective employees and agents, must maintain the confidentiality, privacy and security of all Protected Health Information in records maintained by Borgess Health or by business associates of Borgess Health, in accordance with any and all privacy and security policies and procedures adopted by Borgess Health to comply with current federal, state and local laws and regulations, including, but not limited to, the HIPAA Privacy Regulations. Protected Health Information may not be requested, accessed, used, shared, removed, released, or disclosed except in accordance with Borgess Health's health information privacy policies and applicable law. Medical record information about a patient whom a Medical Staff member is treating can be furnished by the Medical Staff member to any health care provider within the facility who has responsibility for that patient's care. This applies to general patients, psychiatric patients, and substance abuse patients as defined by the Health Insurance Portability and Accountability Act of 1996.

B. All electronic data pertaining to the medical care of individual patients is a part of the legal medical record and confidential to the same extent as other Borgess Health medical records. Passwords used by a member of the Medical Staff to access Borgess Health computers may be used only by such member, who may not disclose the password to any other individual (except to authorize security staff of the computer system). The use of a member's passwords is equivalent to the electronic signature of the member. The member may not permit any practitioner, resident, or other person to use his/her passwords to access Borgess Health computers or computerized medical information. Any misuse may, in addition to any sanctions approved by the Medical Staff and/or the Board regarding security measures, be a violation of state and federal law and may result in denial of payment under Medicare.

C. Each member of the Medical Staff agrees to maintain as confidential all information and documents related to patients' condition or treatment, peer review, performance improvement and evaluation, risk management, utilization review, and other information related to the evaluation of the provision of health care, or actions or conduct of health care providers. Failure to maintain the confidentiality of confidential information shall be grounds for immediate suspension and/or termination of Medical Staff membership and clinical privileges.

13.13 CONFLICT RESOLUTION

A. Each staff member in the Active category may challenge any rule, regulation, policy, or procedure established by the MEC through the following process:

1. The staff member submits to the COS their challenge to the rule or policy in writing, including any recommended changes to the rule or policy.

2. At the MEC meeting that follows such notification; the MEC shall discuss the challenge and determine if it will change the rule or policy.

3. If changes are adopted, they will be communicated to the Medical Staff. At such time, each Medical Staff member in the Active category may submit written notification of any further challenge(s) to the rule or policy to the COS.

4. In response to a written challenge to a rule or policy, the MEC may, but is not required to, appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.

5. If a task force is appointed, the MEC will take final action on the rule or policy based on the recommendations of the task force.
6. Once the MEC has taken final action in response to the challenge, with or without recommendations from a task force, any Medical Staff member may submit a petition signed by 75% of the members of the Active category requesting review and possible change of a rule, regulation, policy, or procedure.

13.14 IMMUNITY

A. Each representative of the Medical Staff and/or BH, acting pursuant to these Bylaws will be exempt, to the fullest extent permitted by law, from liability to an applicant or Medical Staff member for damages or other relief for any action taken, or statements or recommendations made within the scope of his/her duties, or for providing information concerning any person who is or has been an applicant to or member of the Staff, or who did or does, exercise clinical privileges or provide services at BH.

13.15 COMMUNICATION AND EMAIL

A. The members of the Medical Staff and NPP Staff associated with the Medical Staff will insure to provide a valid business address and email address to the MSSD to be used for communication of Medical Staff business, and to notify the MSSD of any changes to the business or email address.

B. Electronic communication for matters of patient care, business, quality and other administrative purposes is recognized as the official means of communication between the Medical Staff and BH.

13.16 RULES & REGULATIONS

A. Except with respect to adoption and amendment, the Rules & Regulations stated in this Article 13 shall be deemed to be the Rules & Regulations of the Medical Staff and a part of the Bylaws. For the purposes of adoption and amendment, this Article THIRTEEN shall be deemed to be the Rules & Regulations of the Medical Staff.

ARTICLE FOURTEEN
GENERAL PROVISIONS

14.1 RULES & POLICIES

A. These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Board. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions, including, but not limited to, procedures for implementing the Medical Staff standards may be set out in Medical Staff or Department Rules, or in policies adopted or approved as described below.

14.2 GENERAL MEDICAL STAFF RULES & REGULATIONS

A. Subject to the approval of the MEC and Board, the Medical Staff shall initiate and adopt such Rules & Regulations as it may deem necessary and shall periodically review and revise its Rules & Regulations to comply with current Medical Staff practice. New Rules & Regulations or changes to the Rules & Regulations (proposed Rules & Regulations) may emanate from any responsible committee, department, Medical Staff officer, or by majority voting members of the Medical Staff. Additionally, hospital administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on hospital operations and feasibility.

14.3 DEPARTMENT RULES & REGULATIONS

A. Subject to the approval of the MEC and Board, each department shall formulate its own Rules for conducting its affairs and discharging its responsibilities. Additionally, hospital administration may develop and recommend proposed department Rules, and in any case should be consulted as to the impact of any proposed department Rules on hospital operations and feasibility. Such Rules shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules or other policies.

14.4 MEDICAL STAFF POLICIES

A. Subject to the approval of the MEC and Board, policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules & Regulations. New or revised policies (proposed policies) may emanate from any responsible committee, department, Medical Staff officer, or by majority voting members of the Medical Staff. Proposed policies shall not be inconsistent with the Medical Staff or hospital Bylaws, Rules & Regulations or other policies, and upon adoption shall have the force and effect of Medical Staff Bylaws.

14.5 CONFLICT RESOLUTION

A. If there is a conflict between the Bylaws, Rules & Regulations, and/or policies, the Bylaws shall prevail.

ARTICLE FIFTEEN
ORGANIZED HEALTH CARE ARRANGEMENT

15.1 ORGANIZED HEALTH CARE AGREEMENT (OHCA)

A. BH, together will all members of the Medical Staff, NPP Staff, Residents, Fellows (collectively, for the purposes of this Article Fifteen only, BH Staff), constitutes an Organized Health Care Arrangement (OHCA) under the HIPAA Privacy Regulations. Accordingly, BH and BH Staff will issue a joint notice of privacy practices, as permitted under the HIPAA Privacy Regulations, and each member of the Medical Staff and NPP Staff will abide by the terms of this joint notice with respect to Protected Health Information he or she may receive in connection with his or her participation in professional activities of the OHCA. BH and the Medical Staff and NPP Staff may share Protected Health Information with each other as necessary to carry out treatment, payment or health care operations functions relating to the OHCA.

ARTICLE SIXTEEN
ADOPTION & AMENDMENT OF BYLAWS

16.1 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

A. The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Board, which approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Board. Additionally, hospital administration may develop and recommend proposed Bylaws, and in any case should be consulted as to the impact of any proposed Bylaws on hospital operations and feasibility.

B. Amendments to these Bylaws shall be submitted for vote upon the request of the MEC or upon receipt of majority vote by the Medical Staff members. Amendments submitted upon receipt of the voting Medical Staff members shall be provided to the MEC.

16.2 AMENDMENT & ADOPTION MECHANISM

A. Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:

1. The affirmative vote of a majority of the Medical Staff members voting on the matter by mailed or electronic secret ballot, provided at least fourteen (14) days advance written or electronic notice, accompanied by the proposed Bylaws and/or alterations, has been given; and

2. The approval of the Board, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Board in writing, and shall be forwarded to the COS, the MEC and the Bylaws Committee.

16.3 TECHNICAL AND EDITORIAL CORRECTIONS

A. The MEC shall have the power to approve technical corrections, such as reorganization or renumbering of the Bylaws, or to correct punctuation, spelling or other errors of grammar expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the MEC. After approval, such corrections shall be communicated to the Medical Staff and to the Board. Such corrections are effective upon adoption by the MEC; provided however, they may be rescinded by vote of the Medical Staff or the Board within 60 days of the date of adoption by the MEC. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or rules and regulations.

16.4 URGENT AMENDMENT TO RULES & REGULATIONS

A. The MEC and the Board may adopt such provisional amendments to these Rules & Regulations that they deem necessary for legal or regulatory compliance. After adoption, the MEC will communicate these provisional amendments of the Rules & Regulations to the organized Medical Staff for its review. If the Medical Staff approves of the provisional amendment, the amendment will stand. If the Medical Staff does not approve of the provisional amendment, this will be resolved using the Joint Conference Committee. If a substitute amendment is then proposed, it will follow the usual approval process.