Beacon Plainwell Hospital

(formerly known as Ascension Borgess-Pipp Hospital)

Medical Staff Bylaws
Rules & Regulations
Policies

Revised and Approved : June 1990, September 2004, October 27, 2011, July 19, 2016, December 5, 2024

INDEX

BORGESS-PIPP MEDICAL STAFF BYLAWS, RULES, AND REGULATIONS

PREAMBLE

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

ARTICLE I
PURPOSE

The purpose of the Medical Staff shall be:

(a) To discharge those duties and responsibilities delegated to the Medical Staff by the Board of Trustees, to monitor medical care in Borgess-Pipp Hospital, to assure one standard of care for all patients in Borgess-Pipp Hospital, and to make recommendations to the Board of Trustees regarding the evaluation and monitoring of clinical performance.

(b) To establish a Medical Staff organization that will represent the physicians, podiatrists, and dentists in Borgess-Pipp Hospital and provide a means whereby the Medical Staff can participate in the work of Borgess-Pipp Hospital with the Board of Trustees and the Chief Operating Officer.

(c) To initiate and maintain self-government through these Bylaws, Rules and Regulations and to do so in a manner consistent with the Articles and Bylaws of Borgess Medical Center.

(d) To recommend to the Board of Trustees the appointment or reappointment of members of the Medical Staff and clinical privileges of such members, to review and evaluate such clinical privileges, and to recommend to the Board any appropriate action that may be necessary in connection with any member of the Medical Staff in order to maintain at all times a high level of professional performance by all persons authorized to practice in Borgess-Pipp Hospital.

ARTICLE II
DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

1. "Allied Health Professional" or "AHP" means a person, who has been granted clinical privileges or authorization to provide services under these Bylaws as a member of the Auxiliary Staff or the Paramedical Staff. Although AHPs may be credentialed through the Medical Staff system and are granted clinical privileges as either a member of the Auxiliary Staff or the Paramedical Staff, AHPs are not eligible for Medical Staff membership.

2. "Auxiliary Staff" means psychologists, midwives, and other classes of health care professionals approved by the Board, who have been licensed or certified by their respective licensing or certifying agencies, and who desire to provide professional services in Borgess-Pipp Hospital and are granted delineated clinical privileges. Auxiliary Staff are assigned to a specific clinical department.

3. "Board" means the Board of Trustees of Borgess Health, who has overall responsibility for the conduct of the Hospital, including Medical Staff.

4. "Chief Operating Officer" or "COO" means the senior administrator of Borgess-Pipp Hospital or his/her designee.

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 have been granted privileges to treat patients in Borgess-Pipp Hospital or who participate in the Borgess-Pipp Hospital peer review process as a member of the Professional Practice Review Staff as described in Article III.

7. "Paramedical Staff" means Physician assistants, Radiology Practitioner Assistants, Certified Registered Nurse Anesthetists and other classes of health care professionals approved by the Board who have been licensed or certified by their respective licensing or certifying agencies, and who provide professional services only under the supervision of Practitioners who are presently appointed to the Medical Staff of Borgess-Pipp Hospital. This category also includes Nurse Practitioners who are licensed and provide services under a collaborative agreement with a Physician.

8. "Physicians" shall be interpreted to include both doctors of medicine and doctors of osteopathy who are licensed in the State of Michigan.

9. "Practitioner" means all those privileged through the medical staff process.

10. "Professional Practice Review Staff" means physicians, podiatrists, and dentists who are granted Medical Staff membership solely to participate in the professional practice review activities pursuant to the Borgess-Pipp Hospital peer review process, and who are not granted specific clinical privileges.

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. "Posted by Mail" means that written notice has been sent either by ground mail or email.

14. Whenever a personal pronoun is used, it shall be interpreted to refer to persons of either gender.

ARTICLE III
CATEGORIES AND RESPONSIBILITIES OF THE MEDICAL STAFF

1. Categories of the Medical Staff. All appointments to the Medical Staff shall be made by the Board of Trustees. 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 (Category A and Category B). Both Category A and Category B Active Staff shall consist of those physicians, podiatrists, and dentists who have been advanced from the Associate Staff. All Active Medical Staff appointees shall be entitled to vote, hold office, serve on Medical Staff committees, and serve as chairmen of such committees, except as determined otherwise in these Bylaws. They shall be required to attend Medical Staff and Departmental meetings.

   Active Staff members must attend, admit, or be involved in the treatment of at least ten (10) patients each appointment year to provide sufficient clinical experience for a satisfactory evaluation. If there are less than twenty (20) patient care contacts in two (2) years, clinical performance will be based upon the following: (a) letters of reference from three (3) members of the Active Staff at Borgess Medical Center who have knowledge of the appointee's clinical competence and professional behavior; (b) review of consultations provided in the hospital; (c) performance evaluation from other hospitals at which the appointee has privileges; and/or (d) review of office records.

   (i) **Category A** – Category A Active Staff shall consist of only those physicians who have executed a contract with Borgess-Pipp Hospital to serve as attending physicians for long term acute care patients admitted to Borgess-Pipp Hospital shall be granted Category A Active status.

   (ii) **Category B –** Category B Active Staff shall consist of those physicians who do not meet the eligibility criteria for Category A Active Staff and are otherwise eligible for Active Staff status.

   (b) Associate Staff. All newly appointed members of the Medical Staff seeking appointment in Active or Consultative Staff positions must first be appointed to the provisional Associate Staff, except for the initial appointment of Active and Consultative after the adoption of these Bylaws, which, on an individual basis, may be grandfathered from members of the Medical Staff of Borgess Medical Center. All Associate Staff members shall:

   (i) Reside or have a business office within sufficiently close proximity to Borgess-Pipp Hospital or make arrangements that are satisfactory to the

MEC for alternative Practitioner coverage for patients for who he/she is responsible;

(ii) Be a member of the Associate (provisional) staff category for at least two (2) years. This provisional period may be extended for an additional one (1) year should an appointee fail to meet the clinical competency or clinical activity requirements, and;

(iii) Have an evaluator who is appointed by the Department Chief of each of the involved departments and shall be from the Active Medical Staff. The evaluator will review the clinical practice of the Associate Staff member which may include direct observation of patient care activities and/or medical records analysis. The evaluator will provide the department Qualifications Committee with a review of the Associate Staff member's practice at six (6) month intervals during the Associate Staff appointment.

(iv) At the completion of the Associate Staff period (2-3 years), the MEC shall recommend: a) appointment to Active Staff; b) appointment to Consultative Staff; c) appointment to another Staff category; d) Staff appointment with reduction in privileges; or e) no appointment to Medical Staff; and

(v) Attend, admit, or be involved in the treatment of at least ten (10) patients each appointment year to provide sufficient clinical experience for a satisfactory evaluation. If there are less than twenty (20) patient care contacts in two (2) years, clinical performance will be based upon the following: a) letters of reference from three (3) members of the Active Staff at Borgess Medical Center who have knowledge of the appointee's clinical competence and professional behavior; b) review of consultations provided in the hospital; c) performance evaluation from other hospitals at which the appointee has privileges; and/or d) review of office records.

(vi) Be required to attend Medical Staff and Departmental meetings and shall be entitled to serve on Medical Staff committees, but not as chairman of those committees; and

(vii) Not be eligible to vote at Medical Staff and Department meetings but shall be eligible to vote at any committee to which they have been assigned, nor shall they be eligible to hold office.

(c) Professional Practice Review Staff. Professional Practice Review Staff shall consist only of physicians, podiatrists, and dentists who are not members of the Active Staff or Associate Staff, but who participate in the professional practice review activities pursuant to the Borgess-Pipp Hospital peer review process. Professional Practice Review Staff shall not be entitled to hold Medical Staff office, but may serve on Medical Staff committees, and serve as chairmen of

such committees, except as determined otherwise in these Bylaws. Professional Practice Review Staff shall not be granted specific clinical privileges. Only individuals who are members of the Active Staff at Borgess medical Center and individuals appointed to the category in accordance with Article V Section 5 for the purposes of participating in professional practice review activities at Borgess-Pipp Hospital are permitted to be Professional Practice Review Staff members.

(d) Residents. Residents shall consist of residents in basic residency training programs and shall not be appointed to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to perform those services set out in training protocols developed by the applicable training program directors and other appropriate staff and medical school authorities. They shall, in the performance of those services, be subject to all applicable rules and policies of the Medical Staff and Hospital and of the Department and Section under which the services are provided and to the authority of the Department Chief. In all matters of an individual patient's care, Residents are responsible to the private attending practitioner who maintains ultimate decision-making and patient responsibility.

(i) Residents with full (unrestricted) licensure may practice in Borgess-Pipp Hospital outside of the formal residency training hours, provided he/she has been processed for specific clinical privileges without appointment to the Medical Staff. In this circumstance, a Resident's exercise of privileges shall be limited to the performance of those services that he/she is eligible to perform pursuant to training program protocols based on level of experience and competency, and shall be subject to all applicable rules and policies of the Medical Staff and of the Department and Section under which the services are provided and to the authority of the Department Chief and attending physician(s).

2. The responsibilities of the Medical Staff are:

(a) To participate in the performance improvement/quality assessment, quality review, and utilization management activities of Borgess-Pipp Hospital, and to conduct activities required by Borgess-Pipp Hospital to assess, maintain, and improve patient safety, and the quality and efficiency of medical care in Borgess-Pipp Hospital, including without limitation:

(i) Evaluating Practitioner and institution performance through use of a valid measurement system as developed by Borgess-Pipp Hospital based upon clinically sound criteria.

(ii) Monitoring critical patient care practices on an ongoing basis.

(iii) Establishing criteria and evaluating Practitioner credentials for appointment and reappointment to the Medical Staff, Auxiliary Staff, and Paramedical Staff and for identifying the privileges that are granted to Practitioners.

(iv) Initiating and pursuing corrective action with respect to Practitioners when warranted.

(v) Identifying and advancing appropriate use of Borgess-Pipp Hospital resources available for meeting patients' medical, social, and emotional needs, in accordance with sound resource utilization practices.

(vi) To make recommendations to the Board regarding Practitioner appointment and reappointment, including category and department assignments, as well as recommendations to the Board regarding the granting of clinical privileges and corrective action.

(vii) To assist in the development, delivery, and evaluation of continuing medical education and training programs.

(viii) To develop and maintain Medical Staff Bylaws and policies that promotes sound professional practices, organization principles, and compliance with federal and state law requirements; and to enforce compliance with such Medical Staff Bylaws and policies.

(ix) To participate in Borgess-Pipp Hospital's long-range planning activities, to assist in identifying community health needs, and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

(x) To provide oversight in the process of analyzing and improving patient satisfaction.

(xi) Providing leadership and being actively involved in the measurement, assessment and improvement of the following:

- Medical assessment and treatment of patients;
- Use of information about adverse privileging decisions for any Practitioner;
- Use of Medications;
- Use of blood and blood components;
- Operative and other procedures;
- Appropriateness of clinical practice patterns;
- Significant departures from established patterns of clinical practice;
- Patient safety data;
  -Sentinel event date; and

- Use of developed criteria for autopsies.

b. Physicians with appropriate privileges manage and coordinate the patient's care, treatment, and services with other practitioners and Hospital personnel. A doctor of medicine or osteopathy manages and coordinates the care of any patient's psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry, or a clinical psychologist. The Medical Staff provides to patients and their families the information and education necessary for patients and families to be actively engaged in the patient's care and treatment.

3. To fulfill the obligations and appropriately use the authority granted in these Medical Staff Bylaws in a timely manner through the use of Medical Staff officers, committees, and individuals and to account therefore to the Board.

ARTICLE IV
ALLIED HEALTH PROFESSIONALS

1. Auxiliary Staff:

(a) Appointment Procedure:

(i) Each individual applying for Auxiliary Staff membership shall file, with the COO, or his/her designee, an application on a form provided by Borgess-Pipp Hospital. For each Auxiliary Staff category approved by the Board to act in the Hospital, there will be specific qualifications and privileges delineated in the Rules and Regulations or privilege forms. The completed privilege form will be sent to the MEC.

(ii) The involved Department Chief will review each application and make a report to the MEC.

(iii) The MEC shall make a report to the Board of their recommendations for appointment along with written specific delineation of the scope of activities each individual Auxiliary Staff member is permitted to undertake in Borgess-Pipp Hospital.

(iv) Each new Auxiliary Staff member will spend at least two (2) years, but no longer than three (3) years, in a provisional staff position. During the provisional period, an evaluator from the Active Staff will be appointed by the involved Department Chief. The evaluator will review the clinical practice of the provisional Auxiliary Staff member which may include direct observation of clinical activities and record review. At six-month intervals, the evaluator will provide a written review to the MEC.

(v) At the completion of the Auxiliary Staff member's provisional staff interval, the MEC shall recommend to the Board: (1) provisional period be terminated; (2) extension of the provisional period with or without specific proctoring requirements; or (3) modification of requested privileges.

(b) Conditions of Appointment

(i) Appointment as an Auxiliary Staff member is at the discretion of the Board and may be denied by the Board either on its own action or upon recommendation by the MEC; provided however, that the applicant may have the right to appear before the MEC prior to denial of appointment or requested clinical privileges in accordance with Article IV, Section 1, Subsection (d), below.

(ii) Auxiliary Staff members may only engage in acts within the scope of practice or clinical privileges specifically granted by the Board. They shall be located within the geographic service area of Borgess-Pipp Hospital, close enough to fulfill their responsibilities, and to provide timely care for their patients in Borgess-Pipp Hospital.

(iii) Members of the Auxiliary Staff shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice specifically granted by the Board. However, Auxiliary Staff members may serve as non-voting members on committees of the Medical Staff, except the MEC, but shall not be a chairperson of any committee. Auxiliary Staff members shall have no vote in Medical Staff activities. On approval of their respective departments, they may have a collective vote of one on issues that affect only their department. They may not hold office.

(iv) Patients cared for by Auxiliary Staff members shall be under the daily direction and supervision of a physician on the Active or Associate Staff of Borgess-Pipp Hospital. The History & Physical and Clinical Resume may be performed by a member of the Auxiliary Staff provided that he or she has privileges to record such entries into the medical record, as delineated in the Rules and Regulations of the Medical Staff or in the Policies and Procedures Manual of the department to which the Auxiliary Staff member has been assigned.

(v) Each Auxiliary Staff member will carry professional liability insurance in the amounts required by the Board.

(vi) No individual may be a member of the Auxiliary Staff if he/she is excluded involuntarily or otherwise ineligible for participation in any federal health care program, funded in whole or in part, by the federal government, including Medicare and Medicaid.

(c) <u>Reappointment</u>

(i) Auxiliary Staff members will be considered for reappointment at intervals of not greater than three (3) years. Application for reappointment may be obtained from the Medical Staff Office and must be completed and submitted to the Medical Staff Office at least three (3) months prior to the end of the current appointment term. The completed application will be submitted by the Medical Staff Office and to the MEC when complete. The involved Department Chief may review each application and make a report to the MEC.

(ii) The MEC will make recommendations regarding reappointment and specific privileges to the Board.

(iii) Time frames for completing the credentialing and privileging process shall be the same as those set forth in these Bylaws for the Medical Staff credentialing and privileging process.

(iv) Reappointment as an Auxiliary Staff member is at the discretion of the Board and may be denied by the Board either on its own action or upon recommendation by the MEC; provided however, that the applicant may have the right to appear before the MEC prior to denial of appointment or requested clinical privileges in accordance with Article IV, Section 1, Subsection (d), below.

(v) Conditions for appointment (Article IV, Section 1, Subsection (c)(i) through (c)(vi) of these Bylaws) shall also apply to reappointment.

(d) Procedural Rights

(i) In the event that the Board receives a recommendation made by the MEC or the Board determines on its own action to: (A) deny an Auxiliary Staff applicant's initial appointment or requested clinical privileges, to (B) deny an Auxiliary Staff member's reappointment or requested clinical privileges, or (C) deny, limit or terminate an Auxiliary Staff member's clinical privileges, the individual shall be notified of the recommendation or proposed action. The notice shall include a general statement of the reasons for the recommendation or proposed action and, if the reasons are due to the Auxiliary Staff member's clinical competence or quality of care, shall advise the individual that the individual may request a meeting with the MEC prior to final action by the Board, by submitting a written request to the MEC within ten (10) days following the date of the notice.

(ii) If the Auxiliary Staff member requests a meeting with the MEC, the meeting with the MEC (or an ad hoc subcommittee of the MEC authorized by the MEC or its Chair) shall be held within thirty (30) days after the request for a meeting is received.

(iii) The meeting between Auxiliary Staff member and the MEC shall be informal and shall not be considered to be a legal hearing. Neither the Auxiliary Staff member nor the MEC shall be entitled to have legal counsel present for the meeting. However, if the MEC, in its discretion, determines that legal counsel may be present to advise any of the parties during the course of the meeting, legal counsel will not be permitted to examine any of the parties or witnesses during the course of the meeting.

(iv) Following the conclusion of the meeting, the MEC shall forward a written recommendation to the Board. If the MEC recommendation continues to be adverse, the Auxiliary Staff member shall be notified, in writing, and provided the right to submit to the Board a written statement appealing the

MEC recommendation within ten (10) days following the date of the notice. The Board may elect to appoint an ad hoc committee of the Board to review the recommendation of the MEC and any written appeal by the Auxiliary Staff member and to recommend to the Board final action regarding the MEC recommendation. The decision of the Board shall be final.

(v) Nothing in this Article IV, Section 1, Subsection (d) prohibits the Medical Director, an officer of the Medical Staff, the Department Chief in which the Auxiliary Staff member exercises privileges or any standing committee or subcommittee of the Medical Staff, the COO, or the Board or the chair thereof from immediately suspending an Auxiliary Staff member's appointment, reappointment or clinical privileges without following the procedures set forth herein, if in good faith, the suspension is necessary to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee, or other person present in the Hospital; to preserve the continued effective operation of the Hospital; or in response to a willful disregard or gross violation of the Bylaws, Rules & Regulations, or applicable Hospital policy or procedure. If the reasons for such suspension are due to the Auxiliary Staff member's clinical competence or quality of care, the Auxiliary Staff member shall be afforded the procedural rights set forth in Article IV, Section 1, Subsection (d); provided, however, that in lieu of the procedure in Article IV, Section 1, Subsection (d)(i), the written suspension notice provided to the Auxiliary Staff member will advise that the individual may request a meeting with the MEC prior to final action by the Board by submitting a written request to the MEC within ten (10) days following the date of the suspension notice.

3. Paramedical Staff:

(a) <u>Appointment Procedure</u>

(i) To the extent the Board permits such Paramedical Staff to act in Borgess-Pipp Hospital, the MEC shall recommend to the Board the scope of each such individual's activities within Borgess-Pipp Hospital.

(ii) No such individual shall provide medical services in Borgess-Pipp Hospital as a Paramedical Staff unless and until the MEC has received sufficient information about the qualifications of that individual to permit the MEC to recommend the scope of activities the individual will be permitted to undertake in Borgess-Pipp Hospital. The form providing this information shall be prepared by the supervising physician and signed by both the supervising physician and the individual.

(iii) Each individual applying for Paramedical Staff membership shall file, with the Medical Director, or his/her designee, an application on a form provided by the Hospital. The completed application and qualifications form described in Article IV, Section 2, Subsection (a)(3) will be sent to MEC.

(iv) The appropriate Department Chief will review each application and associated forms and make a recommendation to the MEC.

(v) After receiving the appropriate reports, the MEC shall recommend to the Board a written delineation of the scope of activities each Paramedical Staff member is permitted to undertake in Borgess-Pipp Hospital. The Paramedical Staff member may conduct activities in Borgess-Pipp Hospital pursuant to the approved delineation only so long as the Paramedical Staff member's designated supervising physician remains a member of the Active Staff and agrees to such supervisory designation.

(vi) Time frames for completing the credentialing and privileging process shall be the same as those set forth in these Bylaws for the Medical Staff credentialing and privileging process.

(b) Conditions of Appointment

(i) Appointment as a Paramedical Staff member is at the discretion of the Board and may be denied by the Board either on its own action or upon recommendation by the MEC; provided however, that the applicant and/or his/her supervising physician may have the right to appear before the MEC prior to such denial in accordance with Article IV, Section 2, Subsection (d), below.

(ii) Paramedical Staff shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice specifically granted by the Board.

(iii) Each new Paramedical Staff member will spend at least two (2) years, but no longer than three (3) years, in a provisional staff position. During the provisional period, an evaluator from the Active Staff will be appointed by the involved Department Chief. The evaluator will review the clinical practice of the provisional Paramedical Staff member which may include direct observation of clinical activities and record review. At six-month intervals, the evaluator will provide a written review to the MEC.

(iv) Any activities permitted by the Board to be done in Borgess-Pipp Hospital by Paramedical Staff shall be done only under the direct supervision of his/her designated physician supervisor as defined by Michigan law. ("Direct supervision" does not require the actual physical presence of the

physician supervisor for each instance of care rendered by the Paramedical Staff member, unless otherwise required by federal or state law.) Should any Borgess-Pipp Hospital employee or staff who is licensed or certified by the state have any question regarding the clinical competence or authority of the Paramedical Staff either to act or to issue instructions outside the physical presence of the physician supervisor in a particular instance, such Borgess-Pipp Hospital employee or staff has the right to require that the individual's physician supervisor validate, in a timely fashion, the order of the Paramedical Staff member. Any act or instruction of the Paramedical Staff member shall be delayed until such time as the Borgess-Pipp Hospital employee or staff can be certain that the act is clearly within the scope of the Paramedical Staff member's activities as permitted by the Board. At all times, the supervising physician will remain responsible for all acts of any of his/her supervised Paramedical Staff member within Borgess-Pipp Hospital.

(v) The number of Paramedical Staff acting as agents of one physician, as well as the acts they may undertake, shall be consistent with applicable federal and state statutes and regulations, the Rules and Regulations of the Medical Staff and the policies of the Board of Trustees.

(vi) It shall be the responsibility of the Paramedical Staff member and the physician supervising the Paramedical Staff member to assure that his or her Paramedical Staff member has professional liability insurance in amounts required by the Board that covers any activities in Borgess-Pipp Hospital and furnish evidence of such to Borgess-Pipp Hospital so that it can be ascertained that such professional liability insurance covers activities of the Paramedical Staff member in Borgess-Pipp Hospital and such Paramedical Staff member shall conduct activities in Borgess-Pipp Hospital only while such coverage is in effect.

(vii) Notwithstanding any insurance carried by the Paramedical Staff member or his/her employer, other than Borgess-Pipp Hospital, the employer of the Paramedical Staff member shall indemnify, defend, and hold Borgess-Pipp Hospital harmless from all claims, loss, damage, or injury of any kind or character (including, without limitation, Borgess-Pipp Hospital's attorneys' fees and costs of defense) to any person or property arising from the performance of services by the Paramedical Staff member or caused by or arising from any act or omission of the Paramedical Staff member.

(viii) No individual may be a member of the Paramedical Staff if he/she is excluded involuntarily or otherwise ineligible for participation in any federal health care program, funded in whole or in part, by the federal government, including Medicare and Medicaid.

(c) Reappointment

(i) Not more than every two (2) years, the Paramedical Staff member may be considered for reappointment. Applications for reappointment may be obtained from the Medical Staff Office and must be completed and submitted back to the Medical Staff Office at least three (3) months before the end of the current appointment term. Using the same guidelines as for appointment (Article IV, Section 2, Subsection (a)(i) through (a)(v) of these Bylaws), the Board will consider the request for reappointment.

(ii) Reappointment as a Paramedical Staff member is at the discretion of the Board and may be denied by the Board either on its own action or upon recommendation by the MEC; provided however, that the applicant may have the right to appear before the MEC prior to such denial in accordance with Article IV, Section 2, Subsection (d), below.

(iii) Conditions for appointment (Article IV, Section 2, Subsection (b)(i) through (b)(viii) of these Bylaws), shall also apply to reappointment of the Paramedical Staff member.

(d) Procedural Rights

(i) In the event that the Board receives a recommendation made by the MEC or the Board determines on its own action to: (A) deny a Paramedical Staff applicant's appointment; (B) deny a Paramedical Staff member's reappointment; or (C) terminate a Paramedical Staff member's appointment or reappointment, the individual shall be notified of the recommendation or proposed action. The notice shall include a general statement of the reasons for the recommendation or proposed action and, if the reasons are due to the Paramedical Staff member's clinical competence or quality of care, shall advise the individual that the individual may request a meeting with the MEC prior to final action by the Board, by submitting a written request to the MEC within ten (10) days following the date of the notice.

(ii) If the Paramedical Staff requests a meeting with the MEC, the meeting with the MEC (or an ad hoc committee of the MEC authorized by the MEC or its Chair) shall be held within thirty (30) days after the request for a meeting is received.

(iii) The meeting between Paramedical Staff member and the MEC shall be informal and shall not be considered to be a legal hearing. The Paramedical Staff member's supervising physician and the Paramedical Staff member shall both be permitted to attend the meeting. Neither the Paramedical Staff member, the supervising physician, nor the MEC shall be entitled to have legal counsel present for the meeting. However, if the

MEC, in its discretion, determines that legal counsel may be present to advise any of the parties during the course of the meeting, legal counsel will not be permitted to examine any of the parties or witnesses during the course of the meeting.

(iv) Following the conclusion of the meeting, the MEC shall forward a written recommendation to the Board. If the MEC recommendation continues to be adverse, the Paramedical Staff member shall be notified, in writing, and provided the right to submit to the Board a written statement appealing the MEC recommendation within ten (10) days following the date of the notice. The Board may elect to appoint an ad hoc committee of the Board to review the recommendation of the MEC and any written appeal by the Paramedical Staff member and to recommend to the Board final action regarding the MEC recommendation. The decision of the Board shall be final.

(v) Nothing in this Article IV, Section 2, Subsection (d) prohibits the Medical Director, an officer of the Medical Staff, the Department Chief in which the Paramedical Staff member exercises privileges or any standing committee or subcommittee of the Medical Staff, the COO, or the Board or the chair thereof from immediately suspending a Paramedical Staff member's appointment, reappointment or clinical privileges without following the procedures set forth herein, if in good faith, the suspension is necessary to reduce the substantial likelihood of injury or damage to the health or safety of any patient, employee, or other person present in Borgess-Pipp Hospital; to preserve the continued effective operation of Borgess-Pipp Hospital; or in response to a willful disregard or gross violation of the Bylaws, Rules & Regulations, or applicable Borgess-Pipp Hospital policy or procedure. If the reasons for such suspension are due to the Paramedical Staff member's clinical competence or quality of care, the Paramedical Staff member shall be afforded the procedural rights set forth in Article IV, Section 2, Subsection (d); provided, however, that in lieu of the procedure in Article IV, Section 2, Subsection (d)(i), the written suspension notice provided to the Paramedical Staff member will advise that the individual may request a meeting with the MEC prior to final action by the Board by submitting a written request to the MEC within ten (10) days following the date of the suspension notice.

ARTICLE V
APPOINTMENT TO THE MEDICAL STAFF

1. Qualifications for Appointment

(a) Appointment to the Medical Staff is a privilege which may be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. All individuals practicing medicine (including podiatry and dentistry) in Borgess-Pipp Hospital, unless excepted by specific provisions of these Bylaws, must first have been appointed to the Medical Staff or have been granted clinical privileges. Appointment to the Professional Practice Review Staff shall be in accordance with Article V, Section 5.

(b) Every Practitioner who applies for or holds a Medical Staff appointment or clinical privileges must, at the time of application and appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Board that he/she meets all of the following qualifications for appointment and/or clinical privileges and any other qualifications and requirements as set forth in these Bylaws, Rules and Regulations, and Medical Staff policies:

(i) Be currently licensed to practice medicine in the state of Michigan, and if appropriate hold a current, valid DEA registration;

(ii) Be located close enough to provide timely care for his/her patients, as defined by the Board;

(iii) Not excluded or otherwise ineligible for participation in any federal health care program, funded in whole or in part, by the federal government, including Medicare and Medicaid;

(iv) Possess current, valid professional liability insurance coverage in amounts set by the Board;

(v) Can document his/her background, experience, training and current clinical competence;

(vi) Can document his/her adherence to the ethics of his or her profession, his or her good reputation and character, and his or her ability to work harmoniously with others;

(vii) Be free from, or have adequate control over, any physical or mental impairment that would significantly affect his/her ability to practice, including, but not limited to, use or abuse of any type of medicine, substance or chemical that affects cognitive, motor or communication ability in any manner that interferes with, or has reasonable probability of

interfering with the qualifications for appointment or clinical privileges such that patient care is, or is likely to be, adversely affected; and

(viii) Meet any additional qualifications set forth elsewhere in these Bylaws, Rules & Regulations, and Medical Staff policies.

(ix) Every Practitioner who applies for or holds a Medical Staff appointment or clinical privileges must immediately notify the Medical Director, in writing, as soon as the Practitioner becomes aware that he or she has failed, or may fail, to meet qualifications and requirements as set forth in these Bylaws, Rules and Regulations, and Medical Staff policies, including but not limited to, information that the Practitioner may be excluded or otherwise ineligible for participation in any federal health care program.

(c) Board Certification

(i) All applicants to the Medical Staff since 1998 must be currently board certified or become Board certified within five (5) years of first admission to the Medical Staff, regardless of any gap of time in Medical Staff appointment or privileges. 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"), or the American Board of Podiatric Surgery ("ABPS"). Each Medical Staff Department or Division has a corresponding Board certificate recognized by ABMS, AOA, ADA, ABOMS, or ABPS. This subsection (i) does not apply to any Medical Staff members with appointment prior to 1998.

(ii) As of May 2007, the applicant must become Board certified in each of the Medical Staff Departments or Divisions in which a majority of the clinical privileges are desired. Failure to do so within the time set forth above will result in voluntary relinquishment of privileges in that particular Medical Staff Department or Division. Failure to attain any board certification(s) within the time set forth above will result in voluntary relinquishment of all privileges and voluntary resignation of Medical Staff appointment at the expiration of the appointment in which the member fails to meet this requirement. Extenuating circumstances relevant to failure to attain Board certification may be considered on a case-by-case basis.

(iii) Medical Staff members on or admitted to the Medical Staff beginning November, 2007 must maintain board certification as defined by the rules and regulations of the appropriate board with the ABMS, AOA, ADA, ABOMS, and the ABPS. In the case of subspecialty certification, maintenance of the parent board certification will not be required as long as

the subspecialty board certification is maintained, so long as this does not violate any requirements of the appropriate certifying board. However, applicable board certification must be maintained in each Medical Staff Department or Division in which clinical privileges are desired. For example, a general board certificate in Internal Medicine and a subspecialty certificate in Gastroenterology must both be maintained to retain clinical privileges in both general Internal Medicine and Gastroenterology (a Division of Internal Medicine); however, in order to retain privileges in Gastroenterology only, maintenance in the general board certificate in Internal Medicine would not be required, unless required by the certifying board.

(iv) Failure to maintain board certification in a subspecialty will result in voluntary relinquishment of privileges within that Department or Division. Failure to maintain any board certification will result in voluntary relinquishment of all privileges and voluntary resignation of Medical Staff appointment at the expiration of the appointment period in which the member fails to meet this requirement. Extenuating circumstances relevant to failure to maintain board certification may be considered on a case-by-case basis.

(d) No individual shall be entitled to appointment to the Medical Staff or exercise clinical privileges in Borgess-Pipp Hospital merely by virtue of the fact that (i) he or she is licensed to practice medicine in this or any state, (ii) he or she is a member of any particular professional organization, or (iii) he or she had in the past, or currently has, Medical Staff appointment or privileges in another hospital.

(e) No individual shall be denied appointment on the basis of sex/gender, national origin, race creed, religious affiliation, or protected disability.

2. Obligations of Appointment

(a) Each Practitioner granted appointment to the Medical Staff, or who holds clinical privileges under these Bylaws must:

(i) Provide his/her patients with generally recognized professional services consistent with the recognized standards of his/her area of practice;

(ii) Comply with these Bylaws, Rules and Regulations, and policies of the Medical Staff; Borgess-Pipp Hospital policies and rules; Borgess-Pipp Hospital's Corporate Compliance program; and state and federal laws;

(iii) Participate in the Emergency Department call coverage in accordance with the Medical Staff Rules and Regulations or policies, including acceptance

of those patients referred through the Emergency Department call coverage schedule regardless of the patient's insurance coverage or ability to pay;

(iv) Participate in performance improvement and utilization management processes and activities at Borgess-Pipp Hospital.

(v) Perform any Medical Staff, committee, and Hospital functions for which he/she is responsible;

(vi) Complete medical records and other records in such manner and within the time period required by Borgess-Pipp Hospital for all patients he/she admits or in any way provides care for in Borgess-Pipp Hospital or outpatient facilities. The medical record must include a history and physical examination performed and documented by a member of the Medical Staff, House Staff, Auxiliary Staff or an authorized member of the Paramedical Staff within the first twenty-four (24) hours of admission, prior to surgery procedure that requires sedation, analgesia, or anesthesia. A complete History and Physical examination performed within thirty (30) days prior to the day of the admission or procedure must be updated within twenty-four (24) hours of admission but prior to the procedure and authenticated by a practitioner qualified to perform the History and Physical with signature, time, and date. If there are no changes to the H&P as written, it is acceptable to document a note stating that the H&P has been reviewed, that the patient has been examined, including notation about the heart and lung exam, and that there have been no significant interval changes. Any changes in the History or Physical examination must be documented and authenticated in the update;

(vii) Abide by generally recognized standards of professional ethics;

(viii) Satisfy the continuing education requirements as applicable and as established by the Medical Staff; and

(ix) Abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

(b) A Practitioner's failure to satisfy any of the aforementioned qualifications or obligations may be grounds for denial of Medical Staff membership or clinical privileges, reduction in Medical Staff category, restriction or revocation of clinical privileges, or other corrective action as determined in a final action of the Board pursuant to these Bylaws.

(c) No person who is voluntarily or involuntarily excluded, debarred, or otherwise prohibited from participation in any state or federal health care reimbursement

program shall be granted Medical Staff, Auxiliary Staff or Paramedical Staff membership or clinical privileges.

3. Terms of Appointment

(a) Initial appointment and reappointments to the Medical Staff shall be granted by the Board. The Board shall act on appointments and reappointments, or revocation of appointments only after there has been recommendation from the MEC as provided in these Bylaws, provided that in the event the MEC does not act within ninety (90) days of receipt of a completed application, the Board may act without such recommendation on the basis of documented evidence of the applicant's or Member's professional and ethical qualifications obtained from reliable sources.

(b) Initial appointment and reappointment shall be for a period not to exceed three (3) years. Reappointment may be granted prior to the end of an existing appointment term if necessary for purposes of coordination of the staggering or batching of appointments in particular departments.

(c) Appointment to the Medical Staff shall confer on the Practitioner only such clinical privileges as have been granted by the Board in accordance with these Bylaws.

4. Conditions of Initial Provisional Appointment

(a) All initial appointments to the Medical Staff involving direct patient care activities, regardless of the category of the Staff to which the appointment is made, and all initial clinical privileges, shall be provisional for a period of at least two (2) years from the date of the appointment, and may be extended for up to an additional year. The provisional period of appointment shall be the time spent on the Associate Staff. During the term of this provisional appointment, the person receiving the provisional appointment shall be evaluated by the chief of the department or departments in which he or she has clinical privileges, and by the relevant committees of the Medical Staff and the Board as to his or her clinical competence and as to his or her general behavior and conduct in Borgess-Pipp Hospital. The chief of the involved department(s) will select an evaluator from the Active Staff to assist in the provisional period evaluation. Continued appointment after the provisional period shall be conditioned upon an evaluation of the factors to be considered for reappointment set forth in Article VI, Section 4 (d) of these Bylaws.

5. Appointment to the Professional Practice Review Staff

(a) Appointment to the Professional Practice Review Staff without clinical privileges may be granted by the COO or his designee to a physician or other LIP if the COO or the MEC has identified a need for an individual to perform professional practice review. An applicant for membership on the Professional Practice Review Staff

will provide the COO with documentation that he or she is a member in good standing of the Active Staff at Borgess Medical Center or, if not a current member of the Active Staff at Borgess Medical Center, with written information (via curriculum vitae) regarding his/her education, training, experience supporting that he or she is qualified to provide professional practice review. If the applicant is not a current member of the Active Staff at Borgess Medical Center, the COO or his or her designee will perform an NPDB inquiry, confirm that the applicant holds an unrestricted license to practice medicine in the State of Michigan (or other applicable state) and that the applicant is not excluded or otherwise ineligible for participation in any federal health care program, funded in whole or in part, by the federal government, including Medicare and Medicaid. Initial appointment and continuation of appointment to the Professional Practice Review Staff shall be solely at the discretion of the COO. An individual shall not be entitled to the procedural rights afforded by Article IX of these Bylaws because the applicant's request for appointment to the Professional Practice Review Staff is denied, or such membership is not renewed, or is revoked or terminated in any way.

ARTICLE VI
APPLICATION, APPOINTMENT AND REAPPOINTMENT PROCEDURES

1. Initial Appointment Applications

(a) Applications for initial appointment to the Medical Staff and/or for clinical privileges may be obtained from the Medical Staff Office.

(b) Applications for initial appointment to the Medical Staff and/or for clinical privileges shall be in writing, signed by the applicant, and shall have attached a clear, discernable, passport size photograph. The application shall be submitted on forms prescribed by the Board after consultation with the MEC and shall require detailed information concerning the applicant's current licensure; education and relevant training; experience, ability, and current competence; and evidence of physical ability to perform the requested privileges. Material omissions or misstatements on the completed form(s) will be grounds for summary revocation of the appointment application or appointment and clinical privileges if discovered after the Board has made its determination. All action regarding applications to obtain an appointment application shall be reported to the COO and to the Medical Director.

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

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

(i) general medical and/or surgical knowledge;

(ii) technical and clinical skills;

(iii) clinical judgment;

(iv) clinical competence;

(v) patient care (makes appropriate decisions related to patient care);

(vi) interpersonal and communication skills (ability to work/cooperate with others);

(vii) professionalism (i.e., demonstrates respect and confidentiality in patient/family, hospital personnel and colleague relationships);

(e) The application shall also include the following information:

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

(ii) Verification of employment, and if applicable, information as to whether or not the applicant's employment by a healthcare organization has ever been termination.

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

(iv) Information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company, and the amount and classification of such coverage;

(v) Information concerning the applicant's malpractice claims history;

(vi) A consent for the release of information from his/her present and past malpractice insurance carriers;

(vii) Information on the applicant's current physical and mental ability to safely render care to patients;

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

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

(x) Information from the National Practitioner Data Bank and from a criminal background check; and

(xi) Such other information as the MEC or the Board may require.

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

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

(h) Applicants for initial appointment to the Medical Staff shall be given the following documents: (i) A copy of the Bylaws, Rules and Regulations of the Medical Staff of Borgess-Pipp Hospital; (ii) Medical Staff policies; (iii) Principles of Medical Ethics (AMA); (iv) Ethical and Religious Directives for Catholic Health Care Services; (v) Regulations of the departments in which the applicants expect to admit patients, if any; (vi) Borgess-Pipp Hospital confidentiality statement; and Borgess-Pipp Hospital Notice of Privacy Practices; and (vii) Medical Staff Expectations.

2. Undertakings: Every application for appointment shall be signed by the applicant and shall contain:

(a) The applicant's specific acknowledgment of his/her obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients within Borgess-Pipp Hospital for whom he or she has responsibility;

(b) By applying for clinical privileges and/or appointment (includes initial appointment and reappointment) to the Medical Staff, Auxiliary Staff, or Paramedical Staff, each applicant thereby signifies his or her willingness to appear for interviews in regard to his or her application, authorizes Borgess-Pipp Hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated, and with others who may have

information bearing on his or her current clinical competence to perform the clinical privileges requested, character and ethical qualifications, and adverse actions, and consents to Borgess-Pipp Hospital's inspection of all records and documents pertinent to his or her licensure, specific training, experience, current clinical competence, and ability to perform the privileges requested. Upon request, a specific authorization for this purpose shall be signed by the applicant and submitted with the application.

(c) A statement that the applicant has received and had an opportunity to read a copy of the Bylaws, Rules and Regulations, and policies of the Medical Staff as are in force at the time of his or her application.

(d) A statement that any misrepresentation or misstatement in, or omission from the application whether intentional or not, may constitute cause for rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment or clinical privileges has been granted prior to the discovery of misrepresentation, misstatement, or omission, such discovery may result in summary dismissal from the Medical Staff.

(e) A statement that the applicant will:

(i) refrain from fee splitting or other inducements relating to patient referral;

(ii) refrain from delegating responsibility for diagnosis or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

(iii) refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

(iv) seek consultation whenever appropriate;

(v) abide by generally recognized ethical principles applicable to his or her profession.

(vi) provide continuous care and supervision as needed to all patients in Borgess-Pipp Hospital for whom he/she is responsible;

(vii) accept committee assignments and such other duties and responsibilities as shall be assigned by the Borgess-Pipp Hospital Board and Medical Staff.

(f) An agreement to abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops and to perform no activity prohibited by said Directives.

(g) An attestation that the applicant is not currently excluded from any federal health care benefit program.

(h) Statement that, if granted staff membership and/or clinical privileges, the applicant shall abide by the Hospital Bylaws, Rules, and Regulations, Hospital Corporate Responsibility Program and Standards of Conduct, and the Medical Staff Bylaws, Rules, and Regulations, and policies and procedures.

(i) To the fullest extent permitted by law, the individual shall release from any and all liability, and extend absolute immunity to Borgess-Pipp Hospital, its authorized representatives and any third parties, with respect to any acts, communications or documents, recommendations or disclosure involving the individual concerning the following:

(i) Applications for appointment (including reappointment) and/or clinical privileges, including temporary privileges;

(ii) Evaluations concerning reappointment or changes in clinical privileges;

(iii) Proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanctions;

(iv) Summary suspension;

(v) Hearings and appellate reviews;

(vi) Medical care evaluation;

(vii) Utilization review;

(viii) Other activities relating to the quality of patient care or professional conduct;

(ix) Matters or inquiries concerning the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or

(x) Any other matter that might directly or indirectly have an effect on the individual's competence, on patient care or on the orderly operation of this or any other hospital or health care facility. The foregoing shall be privileged to the fullest extent permitted by law. Such privilege shall extend to the hospital and its authorized representatives, and to any third parties.

(j) In the event a separate authorization is not provided, the individual specifically authorizes Borgess-Pipp Hospital and its authorized representatives to release

such information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges. Before releasing the above stated information, notification of the applicant for Staff membership is required, except for information released to Borgess-Pipp Hospital or any of its related or affiliated entities, which the individual specifically acknowledges may be released without formal request.

3. Processing Initial Application

(a) The completed application for Medical Staff appointment shall be submitted by the applicant to the Medical Staff Office. After collecting references and other information or materials deemed pertinent as required by these Bylaws, the Medical Staff Office shall determine the application to be complete and transmit the application and all supporting materials to the Chairman of the MEC for evaluation. It is the responsibility of the applicant to ensure that his/her application is complete, including adequate responses from references. An incomplete application will not be processed.

(b) Upon receipt of the completed application for appointment, the Chairman of the MEC, or his/her designee, shall inform the chief of each department in which the applicant seeks clinical privileges of the pending applications, furnish a copy of the application to each chief concerned, and request recommendations.

(c) Medical Executive Committee. The MEC shall review the application, the supporting documentation, the reports and opinions from the Department Chief(s), and any other relevant information available to it to examine the evidence of the character, professional competence, qualifications, prior behavior and ethical standing of the applicant, and shall determine, through information contained in references given by the applicant and from other sources available to the Committee, whether the applicant has established and meets all of the necessary qualifications for the staff category and clinical privileges requested. In addition, any current Medical Staff member shall have the right and responsibility to appear in person before the MEC to discuss in private and in confidence any concerns he/she may have about the applicant.

(i) Recommendations by the MEC may be subject to a physical and mental examination of the applicant by a physician or clinician acceptable to the MEC to determine whether the applicant can safely render care to patients, and the results of such examination shall be made available to the MEC and any other individual or body involved in the credentialing and privileging process.

(ii) As part of the process of making its recommendations, the MEC shall have the right to require the applicant to meet with it to discuss any aspect of his/her application, his qualifications, or requested and his clinical privileges.

(d) The MEC shall vote on the application and, on the basis thereof, shall either defer action on the application for further consideration or prepare a written report with recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Medical Staff appointment, Department and Division affiliation(s), and clinical privileges. The MEC may take any of the following actions:

(i) Defer Action: A decision by the MEC to defer any action on the application must be revisited, except for good cause, within thirty (30) days, or its next regularly scheduled meeting, with subsequent recommendations as to approval or denial of, or any special limitations on, Medical Staff appointment, category of Medical Staff appointment, Department or Division affiliation, scope of clinical privileges, and provisional period. The COO shall promptly send the applicant written notice of a decision to defer action on his/her application.

(ii) Favorable Recommendation: If the MEC makes a favorable recommendation regarding all aspects of the application and clinical privileges, the MEC shall promptly forward its recommendation, together with all supporting documentation, to the Board.

(iii) Adverse Recommendation: If the MEC's recommendation is adverse to the applicant, the COO shall inform the applicant by Special Notice of the recommendation, and the applicant shall then be entitled to the procedural rights as provided in Article IX of these Bylaws. No such adverse recommendation shall be required to be forwarded to the Board until after the applicant has exercised or has been deemed to have waived his or her right to a hearing as provided in Article IX of these Bylaws.

(e) The Board may take any of the following actions:

(i) Favorable MEC recommendation: The Board may adopt or reject any portion of the MEC's recommendation that was favorable to an applicant or refer the recommendation back to the MEC for additional consideration, but must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent recommendation must be made. If the Board's action is favorable, the action shall be effective as its final decision. If the Board's decision is adverse to the applicant, the Board shall so notify the applicant by Special Notice, and the applicant shall be entitled to the procedural rights provided in Article IX of these Bylaws.

(ii) Without benefit of MEC recommendation: If the MEC fails to make a recommendation within the time required, the Board may, after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, make its own determination using the same type

of criteria considered by the MEC. If the Board's decision is adverse to the applicant, the Board shall so notify the applicant by Special Notice, and the applicant shall then be entitled to the procedural rights provided in Article IX of these Bylaws.

(iii) Adverse MEC recommendation: If the Board is to receive an adverse MEC recommendation, the COO shall withhold the recommendation and not forward it to the Board until after the COO notifies the applicant by Special Notice of the adverse recommendation and the applicant's rights to the procedural rights provided in Article IX of these Bylaws, and the applicant either fully exercises or waives such rights.

(f) The Board, through the Chief Operating Officer, shall give notice of its final decision to the applicant and to the Medical Director. The Medical Director, or his/her designee, shall, in turn, transmit the decision to the Department Chief of each Department concerned. A decision and notice to appoint shall include: the Medical Staff category to which the applicant is appointed; the Department and Division to which he or she is assigned; the privileges he or she may exercise; the length of the provisional period; and any special conditions attached to the appointment.

(g) All individuals and groups required to act on an application under this Section must do so in good faith and, except for good cause, complete their actions within a reasonable time period such as:

Individual/Group	**Time**
MEC designee (collection/verification)	60 days
MEC (after receipt of completed application)	30 days
Board of Trustees	Next regular meeting.

These time periods are considered guidelines and do not create any rights for a Practitioner to have an application processed within these precise periods; provided, however, that this provision shall not apply to the time periods contained in the provision of Article IX. When Article IX is activated by an adverse recommendation or action as provided herein, the time requirements set forth therein shall govern the continued processing of the application.

(h) If an applicant's file remains incomplete ninety (90) days after the initial application for appointment, or more than thirty (30) days after any request that the applicant provide additional information, the applicant will be deemed to have withdrawn his/her application for appointment. The COO shall notify the applicant that the application is deemed to have been withdrawn, and that the applicant shall not be entitled to a hearing or any other procedural rights with

respect to such application. Thereafter, the applicant will need to submit a new application for appointment and privileges.

4. Reappointment

(a) No later than three (3) months prior to the date of expiration of a Practitioner's appointment, the COO shall cause the Practitioner to be notified of the upcoming expiration date. No later than sixty (60) days before the expiration date, the Practitioner must furnish to the MEC designee the following reappointment materials in writing and on a form approved by the Board:

(i) All information necessary to bring his/her file current regarding the information required by these Bylaws, including all current licensure and specialty board certification information, controlled substance registration, professional liability insurance coverage, the status of other institution affiliations, pending or completed disciplinary actions, and ability to exercise the privileges being requested.

(ii) A record of continuing medical and/or professional training and education completed outside of Borgess-Pipp Hospital during the preceding appointment period.

(iii) A list of all requested privileges.

(iv) Any requests for Medical Staff category or Department assignment changes, with the basis for the requested changes.

(b) Failure of a Practitioner to provide complete and accurate information, without good cause, shall be deemed grounds for denial of reappointment to the Medical Staff. The Practitioner whose appointment is so terminated is entitled to the procedural rights provided in Article IX.

(c) The MEC, (or its designee for this purpose, the Medical Staff Office), shall verify the information provided on the reappointment application, query the same data banks and programs as with an initial application appointment, and notify the Practitioner of any deficiencies, inadequacies, or verification problems. The Practitioner then has the burden of producing adequate information and resolving any doubts about the information.

(d) The MEC (or its designee for this purpose, the Medical Staff Office), shall consider and retain all relevant information regarding the Practitioner's professional and collegial activity, performance, and conduct in Borgess-Pipp Hospital for inclusion in each Practitioner's credentials or peer review file, as appropriate. Such information shall include, but not be limited to, the following:

(i) Findings of Department quality assessment and utilization review activities demonstrating patterns of patient care and utilization.

(ii) Continuing education activities and participation in other internal training.

(iii) Clinical activity at Borgess-Pipp Hospital.

(iv) Previously successful or currently pending challenges to the Practitioner's licensure, sanctions imposed or pending, and other problems related to the Practitioner's practice or professional conduct at Borgess-Pipp Hospital.

(v) Ability to exercise the privileges requested, with or without a reasonable accommodation.

(vi) Records of attendance at required Medical Staff and Hospital meetings.

(vii) Performance as a Medical Staff officer, Department Chief, committee member, or committee chair.

(viii) Participation in on call Emergency Trauma Center ("ETC") coverage, if applicable.

(ix) Compliance with requirements related to the preparation of medical records (including requirements regarding timeliness, legibility, and accuracy.

(x) Ability to work cooperatively with other Practitioners, Hospital personnel, and the Board.

(xi) General character of relationship with patients and Borgess-Pipp Hospital.

(xii) Ability to comply with all applicable Medical Staff Bylaws; Medical Staff Rules & Regulations; Hospital policies and procedures; and Hospital Compliance Plan.

(xiii) Voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction or loss of privileges at any other hospital, ambulatory surgery center, or other health care entity.

(xiv) Ability to practice in an efficient manner taking into account the patient's medical needs; the facilities, services, and resources available; and generally recognized utilization standards.

(xv) Any other relevant information that could affect the Practitioner's status and privileges at Borgess-Pipp Hospital, including any activities of the

Practitioner at other health care entities and his/her clinical practice outside Borgess-Pipp Hospital.

(e) The Department Chief(s) of each Department in which a Practitioner has privileges or has requested privileges must evaluate the information contained in the Practitioner's file to assess the Practitioner's continuing satisfaction of the qualifications contained in these Bylaws and whether the requested Medical Staff category, Department, Division, and clinical privileges are appropriate. Each applicable Department Chief shall send to the MEC a written report regarding the Practitioner's professional performance, judgment, and clinical and/or technical skills. This evaluation can include procedures performed and their outcomes and can be based on, but not limited to, pertinent results of review of operative and other procedures, medication usage, blood usage, medical records, mortality rates, utilization management, and risk management data. Any such criteria should be uniformly applied and documented in the credential or peer review files. The written report shall include the Department Chief's opinion with respect to, any special limitations on, reappointment, and privileges, including any limitations or restrictions.

(f) The MEC shall review the Practitioner's file, the Department Chief(s) report(s), and any other relevant information available to the MEC, and shall either defer action on the reappointment or prepare a written report with recommendations for, and any special limitations on, reappointment or non-reappointment and Medical Staff category, Department and Division assignment, privileges, and length of the provisional period, if any.

(g) The final determinations regarding reappointment applications shall follow the process set forth in Sections 3(e) and 3(f) of this Article.

(h) The time periods addressed are guidelines for accomplishing the reapplication process. If this process has not been completed by the end of the appointment term due to Borgess-Pipp Hospital's delay, the Practitioner may be eligible for reappointment for a limited period of time, pending completion of the process. If the delay is due to the Practitioner's failure to provide information included in Section 4(a) of this Article, the Practitioner's appointment ends on the expiration date as provided in Section 4(b) of this Article. Any limited reappointment under this provision is not intended to (and shall not) create a right of automatic reappointment any further period of any future term(s).

(i) The Practitioner may, either in connection with reappointment or at any other time, request modification of his/her Medical Staff category, Department or Division assignment, or privileges by submitting a written application the COO on the prescribed form. An application for modification shall be processed in the same manner as an application for reappointment, including an updated verification of licensure and query of the NPDB.

5. Expedited Credentialing. The Chair of the MEC and applicable Department Chief, together with a representative of the Medical Staff Office, will review each completed application and any associated additional information, and will categorize the application according to the criteria set forth in this Section. Completed applications meeting Category I criteria may be processed through the expedited review process. All other applications, including applications meeting Category II criteria, will be managed through the routine review process. The decision to manage an application through the expedited review process is totally discretionary on the part of Borgess-Pipp Hospital. No applicant has any entitlement to have his/her application processed other than through the routine review process.

(a) Category I Applications reflect the following:

(i) All requested information and has been returned promptly.

(ii) No concerns raised with recommendations.

(iii) No discrepancies or gaps in information received from the applicant or appointee, verification or references.

(iv) Completion of a usual education/training sequence.

(v) No disciplinary actions or legal sanctions of any kind.

(vi) No malpractice cases initiated, pending or judgments rendered within the past two (2) years.

(vii) Unremarkable medical staff/employment history.

(viii) Request for reasonable privileges based on experience, training, and current competence and in compliance with all other applicable credentialing, privileging and appointment criteria.

(ix) Never sanctioned by a third-party payer (e.g. Medicare, Medicaid, private insurance).

(x) Never convicted of a felony.

(xi) Request is for privileges consistent with applicant's or appointee's specialty, training, experience, and current competency.

(xii) History of an ability to relate to others in a harmonious, collegial manner.

(b) Category II Applications reflect any of the following:

(i) Peer references and/or prior affiliations indicate potential problems (e.g., difficulty with interpersonal relationships, minor patient care issues, etc.)

(ii) Discrepancies between information the applicant or appointee submitted and information received from other sources.

(iii) Privileges requested vary from those traditionally requested by other Practitioners in the same specialty.

(iv) Gaps in time for which the applicant or appointee has not accounted.

(v) Unsatisfactory peer references and/or prior affiliation references.

(vi) Current challenge or a previously successful challenge to licensure or registration, DEA, or a prior criminal conviction.

(vii) Past voluntary or involuntary termination of medical staff appointment, or voluntary or involuntary limitation, reduction, denial or loss of privileges at another health care organization.

(viii) Removal from a provider panel of a managed care entity for reasons of unprofessional conduct or quality of care issues.

(ix) Borgess-Pipp Hospital determines that there has been either an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant.

(x) Substantial number (more than five) of medical licenses across the United States.

(xi) Substantial number of health care organization affiliations in multiple areas during the past five (5) years.

(xii) Otherwise fails to meet criteria which satisfy Borgess-Pipp Hospital that an application should be processed as a Category I.

(c) Processing Category I Applications

(i) The Medical Staff Office receives and processes the completed application in accordance with the Bylaws.

(ii) The appropriate Department Chief reviews the completed and verified application for appointment/reappointment and/or clinical privileges and forwards a report with findings to the Chair of the MEC.

(iii) The Chair of the MEC, and/or one member of the MEC who is experienced with Category I applications, reviews the completed and verified application for appointment/reappointment and/or clinical privileges and forwards a report with findings to the MEC.

(iv) The MEC reviews the completed and verified application appointment/reappointment and/or clinical privileges and all reports, and forwards a report with findings and a recommendation to a subcommittee of the Board of Trustees consisting of not less than two (2) voting members of the Board ("Subcommittee"). If the recommendation of the MEC is adverse or has limitations, the matter shall be referred back for processing as a Category II application.

(v) The Subcommittee reviews Category I applications on behalf of the Board, performs a final review of the completed and verified application for appointment/reappointment and/or privileges and, pursuant to policy adopted by the Board, grants appointment/reappointment and/or clinical privileges to the Medical Staff or AHP applicant. The date of appointment is the date the Subcommittee grants approval of the application and request for clinical privileges. If the Subcommittee's decision differs from the MEC's recommendation, the matter shall be referred back to the MEC for further evaluation or for processing as a Category II application, as applicable. The Subcommittee must maintain separate minutes of all actions taken by it. Actions of the Subcommittee shall be reported to the Board at the Board's next regularly scheduled meeting.

(vi) If at any time during any of the above reviews a negative recommendation is made or the reviewers are otherwise not all in agreement, the application shall be automatically classified as a Category II application and processed accordingly.

6. Resignations and Terminations

(a) Resignation from the Medical Staff - Resignations from the Medical Staff shall be submitted in writing to the Medical Staff Office. Upon receipt of the resignation, notification of the resignation shall be forwarded to the MEC and then to the Board.

(b) Automatic Termination from Medical Staff – In those cases when a Practitioner moves away from the area without submitting a forwarding address or the Practitioner's written intentions with regard to his/her Medical Staff appointment, the Practitioner shall be automatically terminated from the Medical Staff at the end of the Practitioner's current appointment term.

If a forwarding address is known, the Practitioner will be asked his/her intentions with regard to the Medical Staff appointment, and if the Practitioner does not respond within thirty (30) days, the Practitioner's name will be submitted to the appropriate committees for approval of automatic termination. The COO will inform the Practitioner by Special Notice of the approved termination.

(c) No Right to Fair Hearing – Termination under this Section does not give any rise to any rights pursuant to Article IX of these Bylaws.

(d) Impact of Final Adverse Decision/Resignation/Withdrawal. – A Practitioner who has received a final adverse decision regarding, (or who has voluntarily resigned or withdrawn an application for), appointment, reappointment, Medical Staff category, Department assignment, or privileges may not reapply for appointment to the Medical Staff or for privileges for a period of at least one (1) year from the later of (a) the date of the notice of the final adverse decision; or (b) the effective date of the resignation or application withdrawal; or (c) the final court decision, as applicable. Any re-application after the one (1) year period will be processed as an initial application, and the Practitioner must submit such additional information as required by the MEC, or the Board to show that any basis for the earlier adverse action has been resolved.

ARTICLE VII
DELINEATION OF CLINICAL PRIVILEGES

1. Exercise of Privileges. Medical Staff appointment or reappointment shall not confer any privileges or right to practice at Borgess-Pipp Hospital. Each individual who has been granted an appointment to the Medical Staff or who otherwise provides clinical services at Borgess-Pipp Hospital may only exercise the clinical privileges specifically granted by the Board or temporary privileges granted in accordance with Article VII, Section 6. Regardless of the level of privileges granted, each Practitioner must consult with other Practitioners as required by the Medical Staff Rules & Regulations, and other policies of the Medical Staff, Departments, or Borgess-Pipp Hospital. The organized Medical Staff determines, through the privileging process, which practitioners are qualified to serve in the role of primary care clinician.

2. Basis for Privileges Determination. Clinical Privileges recommended to the Board shall be based upon information submitted by the Practitioner in accordance with these Bylaws and the criteria identified in Article V, Section 1. The following factors also may be used in determining privileges: patient needs in the area for the type of privileges requested; the geographic location of the Practitioner; available coverage in the Practitioner's absence; and the adequacy of professional liability insurance. If necessary, review of patient records treated in other hospitals or practice settings may affect privilege determinations. Privilege determinations for current Medical Staff Practitioners seeking reappointment or a change in privileges must include observed clinical performance and documented results of Medical Staff quality assessment and utilization review activities including, but not limited to, appropriateness of admissions and lengths of stay, necessity of procedures, and indication for ancillary services.

3. Consultation and Other Conditions. Special requirements for consultation may be required of Practitioners as a condition to the performance of any or all privileges, in addition to the consultation requirements in the Bylaws or in the Rules & Regulations and policies of the Medical Staff, a Department or Division, or Borgess-Pipp Hospital. Each Practitioner requesting privileges agrees that in dealing with cases outside the scope of his/her training or in an unusual area of practice, he/she will seek appropriate consultation with a Practitioner who has expertise in such cases and, if necessary, refer such case to the Practitioner.

4. Clinical Privileges for Dentists:

   The scope and extent of surgical procedures that a dentist may perform in Borgess-Pipp Hospital shall be delineated and recommended in the same manner as other clinical privileges. A medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the Borgess Medical Staff before dental surgery can be performed, and this designated physician from the Borgess Medical Staff shall be responsible for the daily medical care of the patient throughout the period of hospitalization, including the clinical resume.

On an individual basis, qualified oral surgeons may be granted privileges to admit, perform H&Ps and clinical resumes, and be responsible for the daily medical care of their patients. The dentists shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the hospital and Medical Staff Bylaws.

5. Clinical Privileges for Podiatrists:

The scope and extent of surgical procedures that a podiatrist may perform in this Hospital shall be delineated and recommended to the Board in accordance with the provisions of these Bylaws and such policies as may be adopted by the Board from time to time. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of the Department of Surgery. A medical history and physical examination of the patient shall have taken place and been recorded in the medical record by a physician who holds an appointment to this Hospital before podiatric surgery can be performed and this designated physician of this Hospital Medical Staff shall be responsible for the daily medical care of the patient throughout the period of hospitalization. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination as well as all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his license in compliance with the Medical Staff Bylaws, Rules and Regulations.

6. Temporary Privileges. Temporary privileges may be granted only in the circumstances and under the conditions set forth in this Section. Special requirements of consultation and reporting may be imposed by the Medical Director or Department Chief. Under all circumstances, the Practitioner requesting temporary privileges must agree in writing to abide by the Medical Staff Bylaws, Rules & Regulations, and applicable policies of Borgess-Pipp Hospital.

The COO may, after review and concurrence by the Medical Director, grant temporary privileges on a case by case basis in the following circumstances:

(a) New Applicants: To a new applicant for privileges but only after: recommendation of the applicable Department Chief and the Medical Director, provided the recommendation is prior to the recommendation made by the MEC; receipt of a completed application for privileges; verification of the qualifications required by Article VI of these Bylaws relating to licensure and professional education and training, DEA/controlled substances registration, adequate professional liability insurance; NPDB query; a complete and fully positive written or oral competency reference from a responsible medical staff authority at each of his/her principal hospital affiliations over the past five (5) years where the applicant must have exercised the particular privileges being requested; current clinical competence and ability to perform privileges requested. Along with the

completed application, the record must establish that the applicant has no current or previously successful challenges to licensure or registration; has not been subject to involuntary termination from a medical staff appointment at any other organization; and has not been subject to any involuntary limitation, reduction, denial, or loss of clinical privileges.

Temporary privileges may be granted in this circumstance for one hundred twenty (120) days. Any such renewal shall be made by the COO and may be made only when the information available continues to support a favorable determination regarding the Practitioner's application for privileges. Under no circumstances may temporary privileges be initially granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) To Fulfill an Important Patient Care, Treatment, and Service Need: To a Practitioner to fulfill an important patient care, treatment, and service need after verification of licensure and one verification of competency (which can be accomplished telephonically.) Temporary privileges may be granted in this circumstance not to exceed sixty (60) days.

(c) Locum Tenens: Practitioners seeking temporary privileges as a locum tenens shall submit an application and shall have such application processed in accordance with Article VI of these Bylaws. An approved application for privileges as a locum tenens shall be valid for a period of two (2) years. Temporary privileges may be granted in this circumstance, not to exceed one hundred twenty (120) days. In the event a Practitioner seeks to act in the capacity of a locum tenens more than once during this two (2) year period, the Practitioner will not be required to submit a new application; rather, the Practitioner will only be required to update the information given in the prior approved application and such other information as is deemed necessary by the Medical Director or COO similar to the reappointment process. In this circumstance, temporary privileges must be reinstated, not to exceed one hundred twenty (120) days.

(d) Temporary Privileges under Proctorship: Practitioners seeking to apply for an extension of privileges when they have training but no adequate documentation of experience to apply for independent privileges may apply for temporary privileges under a probationary proctorship period with concurrent case review defined by the appropriate Department Chief or the MEC. Once the proctorship is completed the Practitioner is required to apply for permanent privileges. Temporary Privileges under Proctorship does not constitute grounds for or entitle the Practitioner to request a hearing under Article IX of these Bylaws.

(e) Termination of Temporary Privileges: The COO may revoke a Practitioner's temporary privileges for (i) failure to abide by the Medical Staff Bylaws, Rules & Regulations, or any applicable Hospital or Medical Staff policy; or (ii) upon the discovery of any information or the occurrence of any event of a nature which

raises a question about a Practitioner's professional qualifications or ability to exercise any or all of the privileges granted. The COO may at any other time, revoke any or all of a Practitioner's temporary privileges.

Where the life or well-being of a patient is determined to be endangered, a Practitioner's temporary privileges may be terminated by any person entitled to impose summary suspensions pursuant to the Medical Staff Bylaws.

In the event a Practitioner's temporary privileges are revoked, the Practitioner's patients then in Borgess-Pipp Hospital shall be assigned to another Practitioner by the Department Chief responsible for supervision or the Medical Director. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

A Practitioner shall not be entitled to the procedural rights afforded by Article IX 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.

7. Emergency Privileges. In case of an emergency as defined in this paragraph, any Practitioner on the Medical Staff is authorized and shall be assisted to render medical treatment to attempt to save a patient's life or to save a patient from serious harm, as allowed within the Practitioner's scope of practice, and notwithstanding the Practitioner's Department affiliation, Medical Staff category, or level of privileges. A Practitioner exercising emergency privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care. For purposes of this section, "emergency" is defined as a situation where serious permanent harm is imminent or in which the life of a patient is in immediate danger and delay in administering treatment could increase the danger to the patient.

8. Disaster Privileges. In the event Borgess-Pipp Hospital's emergency management plan is activated, and Borgess-Pipp Hospital is unable to manage immediate patient care needs, the Chief Operating Officer may grant temporary privileges during a disaster or emergency. In order for volunteers to be considered eligible to act as licensed independent practitioners or Allied Health Professionals the individual(s) granting the privileges must first obtain from each volunteer practitioner at a minimum, a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following: a current hospital picture ID card that clearly identifies professional designation; a current license to practice; primary source verification of the license; identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups; identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); identification by current hospital or medical staff member(s) who

possesses personal knowledge regarding volunteer's ability to act as a licensed independent practitioner during a disaster.

Based on its oversight of each volunteer licensed independent practitioner, the Hospital determines within 72 hours of the Practitioner's arrival if granted disaster privileges should continue. Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents himself or herself to the Hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's license cannot be completed within 72 hours of the Practitioner's arrival due to extraordinary circumstances, the Hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the Practitioner's arrival
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
- Evidence of the Hospital's attempt to perform primary source verification as soon as possible

If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the Practitioner's arrival, it is performed as soon as possible.

All Practitioners who receive disaster privileges must at all times at Borgess-Pipp Hospital wear an identification badge, with photograph, from the facility at which they otherwise hold privileges. This badge shall be used to distinguish volunteer practitioners. If the Practitioner does not have such identification, he/she will be issued a badge identifying him/her and designating the Practitioner as a volunteer disaster provider. The individual Practitioner will be supervised by and assigned duties, as needed, under the direction of the Medical Director, or an appropriate member of the medical Staff. Supervision of the practitioners may be accomplished by direct observation or medical record review. These disaster privileges shall cease upon alleviation of the circumstances of disaster as determined by the COO.

A Practitioner shall not be entitled to the procedural rights afforded by Article IX because disaster privileges are refused or because all or any portion of the Practitioner's disaster privileges are terminated, limited, or suspended for any reason at any time.

9. Telemedicine Privileges. Prior to a Practitioner providing telemedicine services (including the rendering of a diagnosis or other provisions of clinical treatment) to patients of Borgess-Pipp Hospital, the Practitioner must be appropriately credentialed and granted appropriate privileges by Borgess-Pipp Hospital. Such Practitioner must be credentialed and privileged in accordance with Article VI of these Bylaws. The MEC shall recommend which clinical services are appropriately delivered through a telemedicine link and are consistent with commonly accepted quality standards.

10. Leave of Absence.

(a) Persons appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Board for a definitely stated period of time not to exceed one (1) year or the final date of the individual's current appointment term, whichever date occurs first.

(b) Requests for leaves of absence shall be made to the chief of the department in which the individual applying for leave has his/her primary clinical privileges, and shall state the beginning and ending dates of the requested leave. The Department Chief shall transmit the request together with his/her recommendation to the Medical Executive Committee for action by the Board.

(c) During the Leave of Absence, the individual is not entitled to exercise any of his/her clinical privileges, has no appointment rights and responsibilities. Prior to a Leave of Absence being granted, the individual shall have made arrangements for the care of his/her patients during the Leave of Absence that is acceptable to the MEC.

(d) At the conclusion of the Leave of Absence, the individual shall submit to the Chief(s) of the Department(s) a written request for reinstatement and such information that is required to update his/her Medical Staff file. In addition, the individual shall also provide such other information that may be requested by the MEC or the Board.

(e) Upon the recommendation of the Department Chief, the MEC shall consider the request for reinstatement and shall make its recommendation, and the same process as is followed for appointments shall apply.

(f) For good cause and upon notice received not less than thirty (30) days prior to expiration of a Leave of Absence, an individual's Leave may be extended by the MEC, with approval of the Board, for an additional period not to exceed the final date of the individual's current appointment term.

(g) If an individual fails to request reinstatement at the termination of the Leave of Absence, the MEC may deem such a lack of request as voluntary resignation of his/her appointment and clinical privileges. Such voluntary resignation shall not give rise to any hearing and appeal rights pursuant to Article IX of these Bylaws.

ARTICLE VIII
CORRECTIVE ACTION

1. Informal Problem Resolution. Informal problem resolution may be initiated to address conflicts and complaints through educational or administrative solutions, prior to and/or in lieu of formal corrective action. Even if an "informal complaint" is made, the situation may warrant investigation or a referral for corrective action, or a request for corrective action may be made at any time during the informal problem resolution process.

   Any Practitioner, AHP, or Borgess-Pipp Hospital personnel may bring a concern regarding the performance or conduct of a Practitioner to the attention of an appropriate party including, but not limited to, an officer of the Medical Staff; the Medical Director, a Department Chief in which the Practitioner holds membership or exercises privileges, a member of any standing committee or subcommittee of the Medical Staff or the COO. This informal complaint process is a recognition that many issues can be resolved by counseling and other informal non-adverse actions. However, this process of bringing forward an informal complaint and any associated investigation review, or informal resolution is not a substitute for a formal request for corrective action when that is warranted. If the problem giving rise to the informal complaint is not resolved or if the problem persists or is deemed to constitute grounds for formal corrective action under Section 2 below, the problem may be referred for corrective action in accordance with the procedures set forth in this Article below. Informal problem resolution may be taken by (i) the Medical Director, (ii) a Department Chief, or (iii) any standing committee of the MEC.

   The informal problem resolution process described in this section is not a procedural right of the Practitioner and need not be conducted according to the procedural rules provided in this Article or Article IX of these Bylaws.

2. Grounds for Formal Corrective Action. Corrective action against a Practitioner with Medical Staff appointment or privileges may be initiated whenever the Practitioner engages in or exhibits actions, statements, demeanor, or conduct within Borgess-Pipp Hospital that is, or is reasonably likely to be:

   (a) Contrary to the Medical Staff Bylaws, Rules & Regulations, Borgess-Pipp Hospital's Compliance Plan, or other applicable Hospital or Medical Staff policies or procedures.

   (b) Detrimental to patient safety or to the quality or efficiency of patient care in Borgess-Pipp Hospital.

   (c) Disruptive to Hospital operations.

   (d) Damaging to the Medical Staff's or Borgess-Pipp Hospital's reputation.

   (e) Below the applicable standard of care.

(f) In violation of any law or regulation relating to federal or state healthcare reimbursement programs.

3. Authorized to Initiate. Any of the following may request that corrective action be taken or initiated: (i) The Medical Director; (ii) A Department Chief in which the Practitioner holds membership or exercises privileges; (iii) Any standing committee or subcommittee of the Medical Staff (iv) The COO; or (vi) The Board of Trustees or the chair thereof.

4. Discretionary Interview Prior to Corrective Action. Prior to initiating or requesting corrective action against a Practitioner, the party considering initiating such action may, but is not obligated to, afford the Practitioner an informal interview at which the circumstances prompting the corrective action can be discussed and the Practitioner permitted to present relevant information on his/her own behalf. The interview provided in this section is not a procedural right of the Practitioner and need not be conducted according to the procedural rules provided in Article IX of these Bylaws. The party initiating the interview shall prepare a dated, written record of the interview indicating the type of problem, what was discussed with the Practitioner, and any proposal as to the type of intervention that will be undertaken to address the problem. If the interview is with a committee, the required writing may be reflected in minutes. This written report shall be forwarded to the MEC and shall be retained in the Practitioner's confidential peer review file.

5. Initiation, Requests, Notices. All requests for corrective action shall be submitted to the MEC in writing, which writing can be reflected by minutes, and shall be supported by a statement of the specific activities or conduct which constitutes the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the bases for its recommendation in its minutes. The Medical Director shall promptly notify the COO in writing of all such requests.

6. Informal Interview. Upon receipt of a request for corrective action, the MEC or its designee may, at the committee's, or designee's, option, conduct an informal interview with the Practitioner against whom corrective action has been requested. At such interview, the Practitioner will be informed of the general nature of the charges against him/her and will be invited to discuss, explain, or refute them. This interview shall not constitute an "formal investigation" as such is described in Section 7 below or a "hearing" as that term is used in Article IX, will be preliminary in nature, and will not be subject to any of the procedural rules provided in these Bylaws with respect to hearings. A written summary of such interview (which may be reflected in minutes) shall be included with the report from the MEC to the Board and shall be placed in the Practitioner's confidential peer review file.

7. Formal Investigation. Upon receipt of the request for corrective action, and following any informal interview with the affected Practitioner as described in the preceding section or Section 4 above, the MEC, or the Executive Committee of the MEC, shall either act on the request or direct, by written resolution, that a formal investigation concerning the grounds for the corrective action request be undertaken. The MEC, or the Executive

Committee of the MEC, may conduct such investigation itself; assign the task to a Medical Staff officer, Department Chief, or the Medical Director, a standing or ad hoc committee; an individual or group who is not affiliated with Borgess-Pipp Hospital, or any other Medical Staff component; or may refer the matter for investigation and resolution by the Board of Trustees. The MEC, or the Executive Committee of the MEC, may in its sole discretion, accept any investigation conducted prior to the formal request for corrective action in addition to or in lieu of conducting another separate investigation, including any informal review or evaluation conducted pursuant to the informal problem resolution process described in Section 1 above. This investigative process is not a "hearing" as that term is used in Article IX and shall not entitle the Practitioner to the procedural rights provided in said Article IX. The investigative process may include without limitation, a consultation with the Practitioner involved; with the individual or group who made the request; and with other individuals who may have knowledge of or information relevant to the events involved. If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation (which may be reflected in minutes) to the MEC as soon as is practicable after its receipt of the assignment to investigate. The MEC may, at any time in its discretion, and shall at the request of the Board, terminate the investigative process and proceed with action as provided below.

If the investigating group or individual has concerns the Practitioner's conduct giving rise to the request for corrective action was the result of a physical or mental disability, the MEC may require the Practitioner involved to submit to an impartial physical or mental evaluation within a specified time and pursuant to guidelines set forth below. The MEC shall name the practitioner(s) who will conduct the examination. Borgess-Pipp Hospital shall pay for the examination. The MEC may, in its sole discretion, refer the Practitioner to the Michigan Health Professional Recovery Program

8. MEC Action. As soon as practicable after the conclusion of the investigative process, if any, the MEC shall act upon such corrective action request. Its action may include recommending, without limitation, the following:

(a) Rejection of the request for corrective action.

(b) Issuance of a verbal or written warning or a letter of reprimand.

(c) Imposing a probationary period with retrospective review of cases and/or other review of professional behavior but without requirement of prior or concurrent consultation or direct supervision.

(d) Recommending a requirement of prior or concurrent consultation or direct supervision or other form of probation that limits the ability to exercise privileges.

(e) Recommending reduction, suspension, or revocation of all or any part of the Practitioner's privileges.

(f) Recommending suspension or revocation of the Practitioner's Medical Staff appointment.

(g) Taking other action as deemed necessary to the circumstances.

9. Effect of MEC Action.

(a) When the MEC's recommendation is adverse (as defined in Article IX of these Bylaws) to the Practitioner, the COO shall immediately so inform the Practitioner by Special Notice, and the Practitioner shall be entitled, upon timely and proper request, to the procedural rights contained in Article IX.

(b) When the MEC's recommendation is favorable to the Practitioner, the COO shall promptly forward it, together with all supporting documentation, to the Board. Thereafter, the procedure set forth in Article VI, Section 3 (e)(i) is applicable.

(c) If the MEC fails to act in processing and recommending action on a request for corrective action within an appropriate time as determined by the Board, the procedure set forth in Article VI, Section 3 (e)(ii) shall be applicable.

10. Suspension of Privileges Pending Investigation. At any time either before or after a formal request for corrective action, the MEC, or the Executive Committee of the MEC, with the approval of the Chief Operating Officer, may suspend all or any part of the clinical privileges of the Practitioner for the protection of any Hospital patient(s). This suspension shall be deemed to be administrative in nature and shall be accompanied by a formal request for corrective action if one has not previously been issued. It shall remain in effect during the investigation of the request for corrective action only, shall not indicate the validity of the charges, shall not be eligible for appeal and shall not exceed fourteen (14) days. In the event, the MEC, or the Executive Committee of the MEC does not conclude its investigation within fourteen (14) days and determines a longer period of suspension is necessary for the protection of any Hospital patient(s), the MEC, or the Executive Committee of the MEC, may, in its discretion, initiate a summary suspension as set forth in Section 11 below. A suspension pursuant to this section that is lifted within fourteen (14) days of its original imposition shall not be deemed an adverse action for purposes of Article IX.

11. Summary Suspension.

(a) Whenever a Practitioner'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 Borgess-Pipp Hospital; to preserve the continued effective operation of Borgess-Pipp Hospital; or in response to a willful disregard or gross violation of the Bylaws, Rules & Regulations, or applicable Hospital or Medical Staff policy or procedure, any of the following has the authority to suspend summarily the Medical Staff appointment and/or all or any portion of the privileges of such

Practitioner: (i) The applicable Department Chief; (ii) the Medical Director; (iii) the COO, after conferring, when possible, with the Medical Director or the appropriate Department Chief/Director; (iv) the MEC; or (v) the Board of Trustees or its chair.

(b) A summary suspension is effective immediately. The person or group imposing the suspension shall immediately inform the COO of the suspension, and he/she shall promptly give Special Notice thereof to the Practitioner. The applicable Department Chief or Medical Director shall assign a suspended Practitioner's patients then in Borgess-Pipp Hospital to another Practitioner, considering the wishes of the patient, where feasible, in selecting a substitute Practitioner.

(c) As soon as possible, but in no event later than five (5) business days after a summary suspension is imposed under either Section 10 or this Section 11 (unless the Summary Suspension is a continuation of a Suspension of Privileges Pending Investigation under Section 10, where this MEC meeting has already occurred), the MEC, if it did not impose the summary suspension, shall convene to review and consider the need, if any, for a professional review action. Such a meeting of the MEC shall in no way be considered a "hearing" as contemplated in Article IX (even if the Practitioner involved attends the meeting), and no procedural requirements shall apply. The MEC may modify, continue, or terminate the terms of a summary suspension provided that the summary suspension was not imposed by the Board or the COO pursuant to Borgess-Pipp Hospital Bylaws. In the case of a summary suspension imposed by Borgess-Pipp Hospital's Bylaws, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation.

(d) Not later than fourteen (14) days following the original imposition of the summary suspension (which shall include any period of time under suspension pursuant to Section 10 above), the Practitioner shall be advised by Special Notice of the MEC's determination or, in the case of a summary suspension imposed by the Board, of the Board's recommendation as to whether such suspension should be terminated, modified, or sustained, and of the Practitioner's rights, if any, pursuant to Article IX. A summary suspension that is lifted within fourteen (14) days of its original imposition shall not be deemed an adverse action for purposes of Article IX.

12. Automatic Suspension.

(a) Occurrences Affecting Licensure:

(i) Revocation: When a Practitioner's license to practice in the state of Michigan is revoked, his/her Medical Staff appointment and privileges shall be immediately and automatically revoked as of the date of license revocation.

(ii) Restriction: When a Practitioner's license to practice in the state of Michigan is limited or restricted, those privileges which he/she has been granted that are within the scope of the limitation or restriction are similarly automatically limited or restricted as of the date of license limitation or restriction.

(iii) Suspension: When a Practitioner's license to practice in the state of Michigan is suspended, his/her Medical Staff appointment and privileges are automatically suspended effective upon and for the term of the suspension.

(iv) Probation: When a Practitioner is placed on probation by his/her licensing authority, his/her voting and office-holding privileges are automatically suspended effective upon and for at least the term of the licensure probation.

(b) Occurrences Affecting Controlled Substances Regulation:

(i) Revocation: Whenever a Practitioner's DEA or other controlled substances number is revoked, he/she shall be immediately and automatically divested of his/her right to prescribe medications covered by the number.

(ii) Suspension or Restriction: When a Practitioner's DEA or other controlled substances number is suspended or restricted in any manner, his/her right to prescribe medications covered by the number is similarly suspended or restricted during the term of the suspension or restriction.

(c) Medical Records Completion: After written warning (and failure to cure by proscribed date) by the MEC, or its designee (such as Medical Records Department), of delinquency or failure to timely prepare or complete medical records, a Practitioner's privileges (except with respect to his/her patients already in Borgess-Pipp Hospital, his/her patients already reserved for admission or surgery, and emergency situations), his/her privileges (including the right to consult with or assume the care of new patients admitted by another member of the Practitioner's group), and his/her voting prerogatives are automatically suspended. The suspension shall be effective on the date specified in the warning and shall continue until the delinquent records are prepared or completed. Failure to complete the medical records that caused the automatic suspension after six (6) weeks from the imposition of the automatic suspension shall constitute a voluntary relinquishment of clinical privileges and resignation of Medical Staff appointment.

(d) Professional Liability Insurance: Failure to maintain the minimum required type and amount of professional liability insurance with an approved insurance carrier shall result in immediate and automatic suspension of a Practitioner's Medical

Staff appointment and privileges until such time as a certificate of appropriate insurance coverage, with proof of coverage of the uninsured period is furnished. In the event such proof is not provided within ten (10) days of such suspension, the Practitioner shall be deemed to have voluntarily resigned his/her appointment and privileges.

(e) Exclusion From State or Federal Health Care Reimbursement Programs: Upon exclusion, or other prohibition from participation in any state or federal health care reimbursement program, the Practitioner's Medical Staff appointment and privileges shall be immediately and automatically suspended until such time as the exclusion or prohibition is lifted.

(f) Conviction of a Crime: If a Practitioner pleads guilty to or is found guilty of a felony or misdemeanor conviction related to drug offense, physical or sexual abuse or health care the Practitioner's Medical Staff appointment and privileges shall be immediately and automatically suspended. The MEC, or its designee, shall investigate such matters and make a recommendation.

(g) Procedural Rights and Additional Corrective Action: No Practitioner shall be entitled to the procedural rights set forth in Article IX as a result of an automatic suspension or termination. As soon as practicable after the imposition of an automatic suspension, the MEC shall convene to determine if further corrective action is necessary and shall make a recommendation to the Board. Any further action with respect to an automatic suspension must be taken in accordance with Section 3 of this Article.

ARTICLE IX
HEARING AND APPELLATE REVIEW PROCEDURES

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 IX do not apply to AHPs. Procedural rights for AHPs are set forth in Article IV.

   (a) Recommendations or actions:

      (i) Denial of initial appointment or subsequent reappointment to the Medical Staff.

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

      (iii) Denial of requested privileges.

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

      (v) Terms of probation resulting in a limitation on previously exercised privileges.

      (vi) Individual application of, or individual changes 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:

      (i) Recommended by the MEC; or

      (ii) 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.

      (i) An oral or written reprimand or warning.

      (ii) The denial, termination, or suspension of temporary or emergency privileges.

      (iii) 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.

(iv) 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.

(v) 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.

(vi) Termination of or the inability to exercise privileges either in whole or in part because Borgess-Pipp Hospital 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.

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

(viii) Ineligibility for Medical Staff appointment or requested privileges because of lack of facilities, equipment, or because Borgess-Pipp Hospital elected not to perform, or does not provide, the service which the Practitioner intends to provide or the procedure for which privileges are sought.

(ix) Suspension, or revocation of Medical Staff appointment or privileges as provided in Section 12 of Article VIII.

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

(xi) 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.

(xii) 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.

(xiii) The denial, termination, or suspension of appointment to the Professional Practice Review Staff.

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

2. Notice of Adverse Recommendation or Action. 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 COO of such action. The notice shall:

(a) 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.

(b) 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.

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

(d) 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.

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 COO by Special Notice.

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.

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 one (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.

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 COO shall deliver the same to the Medical Director 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 Medical Director 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 COO 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 Medical Director. 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 Medical Director or the chair of the Board, as applicable, pursuant to Subsection (d) and/or (e) of this section. 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.

(e) Appointment of Hearing Committee

(i) By Medical Director: A hearing committee appointed by the Medical Director 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 Medical Director.

(ii) 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.

(iii) 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.

(iv) 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.

7. 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 6 (e)(iv) 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:

(i) Call, examine and cross-examine witnesses.

(ii) Introduce any relevant evidence, including exhibits.

(iii) Question any witness on any matter relevant to the issues that are the subject of the hearing.

(iv) Impeach any witness.

(v) Offer rebuttal of any evidence.

(vi) Have a record made of the hearing in accordance with Section 7(h) of this Article.

(vii) Submit a written statement at the close of the hearing.

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 Borgess-Pipp Hospital, 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 therefrom 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 Medical Director, 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. 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 Operating Officer.

(c) Notice and Effect of Result.

(i) Notice: The Chief Operating Officer shall promptly send a copy of the decision to the Medical Director, to the Board and, by Special Notice to the affected Practitioner.

(ii) Favorable Recommendation: If the MEC's recommendation pursuant to Subsection (b) of this Section is favorable to the Practitioner, the Chief Operating 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 Operating 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.

(iii) 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 (c)(i) of this Section shall inform the affected Practitioner of his/her right to request an appellate review by the Board as provided in Section 10 of this Article.

9. 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 Operating Officer by Special Notice. If the Practitioner wishes an attorney to represent him/her at any appellate review appearance permitted under this Section 9, 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 Operating 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 Operating 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).

10. 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)(ii) and (iii) 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 Operating 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.

(i) 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.

(ii) 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.

(iii) 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.

11. 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 an Ad Hoc committee (composed of at least one Board member, one member of the Medical Staff, and one Hospital administrator) prior to issuing notice of its final decision. This Ad Hoc 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 Operating Officer will promptly send notice of the final decision to the affected Practitioner by Special Notice, and to the Medical Director.

12. Reporting. The Chief Operating 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 Hospital procedures regarding the same.

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 X
ORGANIZATION OF THE MEDICAL STAFF

1. Medical Staff Year. For the purpose of these Bylaws the Medical Staff year commences on the first day of January and ends on the last day of December each year.

2. Officers. The officers of the Medical Staff shall be the chiefs of the various Borgess-Pipp Hospital departments. Officers must be physicians or dentists, members of the Active Staff or Consultative Staff in good standing at the time of nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

3. Election of Officers. The regular election of the officers of the Medical Staff shall be held every two (2) years as set forth in Article XIII, Section 3.

4. Removal of Officers. An officer of the Medical Staff may be removed by a majority vote of the Board, or a two-thirds (2/3) majority vote by secret ballot of the MEC and approval by the Board. The officer subject to the removal action shall be given ten (10) days prior written notice of the meeting of the MEC or Board, as applicable, and shall be given an opportunity to speak on his/her behalf at said meeting prior to a vote being taken.

   (a) Grounds. Permissible grounds for removal of an elected Medical Staff officer include, but are not limited to:

      (i) Failure to perform the duties of the position held in a timely and appropriate manner.

      (ii) Failure to continuously satisfy the qualifications for the position.

      (iii) Except for the provisions of Article VIII, Section 12(c), having an automatic or summary suspension imposed by Article VIII of these Bylaws or any other corrective action undertaken against the officer pursuant to Article VIII, which results in a final decision other than to take no action.

      (iv) Conduct that is damaging to the best interests of the Medical Staff or to their goals, programs, or public image.

      (v) Physical or mental infirmity that renders the officer incapable of fulfilling the duties of the position.

5. Vacancies in Office. If there is a vacancy in any other office, the Medical Executive Committee shall appoint another Active Staff member to serve out the remainder of the unexpired term. Such appointments will be effective when approved by the Board.

6. Medical Director of Borgess-Pipp Hospital. The Medical Director of Borgess-Pipp Hospital shall be a physician appointed to the Active Staff by the Board of Trustees after review and approval of the MEC in the matter of initial appointment and reappointment, and contracted by Borgess-Pipp Hospital to perform the following duties:

(a) General Duties:

(i) He/she shall be an ex officio member of all committees of the Medical Staff. He/she shall be a voting member of the Medical Executive Committee and any committee where official appointment is made by the Chief Operating Officer of Borgess-Pipp Hospital. He/she shall be responsible to Borgess-Pipp Hospital for medical affairs and assist the Medical Executive Committee. He/she shall be concerned with medical-administrative and medical-legal aspects of patient care provided in Borgess-Pipp Hospital and with matters affecting the quality of patient care. He/she shall have no punitive or disciplinary powers insofar as the Medical Staff is concerned. He/she shall, however, be responsible for the proper functioning of Medical Staff affairs. As such, he/she shall report any adverse situations to the Chief of the Department, and Chief Operating Officer of Borgess-Pipp Hospital.

(b) Specific Duties:

(i) Maintain continuity of medical planning for development of Borgess-Pipp Hospital and to assist in determining operational goals to meet current and future patient care needs;

(ii) Assist Department Chiefs in matters pertaining to the Medical Staff and represent their concerns in organizational decision making;

(iii) Work in conjunction with the Medical Staff officers and committees to assure:

(A) compliance with standards of The Joint Commission;

(B) optimum utilization of hospital beds and diagnostic and therapeutic facilities;

(C) performance of initiatives related to quality assessment;

(D) that recommended changes to the Bylaws, Rules and Regulations of the Medical Staff be brought to the attention of the appropriate committees for recommendation to the MEC.

(iv) Act in a coordinating and advisory capacity for all departments and services of the Medical Staff.

(v) Prepare an annual report of Medical Staff goals and objectives for presentation to the MEC.

(vi) Review appropriate hospitalized patient communications and provide guidance on resolving any patient care related issues.

(vii) Assist management in the preparation of the annual operating budget for Borgess-Pipp Hospital, including specific responsibility for developing Medical Staff input on:

(A) new patient care program development including deletion, revision, and expansion;

(B) new medical equipment priorities;

(C) patient care criteria; and

(D) selection of general medical supplies.

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

ARTICLE XI
COMMITTEES OF THE MEDICAL STAFF

1. Medical Executive Committee. The Medical Executive Committee shall consist of the officers of the Medical Staff, and the Department of Medicine may have one (1) member at large. The member at large will be elected when there is a vacancy in this position. In addition, the COO and the Chief Nursing Officer shall be members without vote. The Medical Director shall be the chairman of the MEC.

   (a) Duties. The duties of the MEC shall be:

      (i) To represent and act on behalf of the Medical Staff in all matters, without requirement of subsequent approval by the Medical Staff, subject only to any limitations imposed by these Bylaws;

      (ii) To coordinate the activities and general policies of the various departments;

      (iii) To receive and act upon Department, committee, and assigned activity group reports and recommendations.

      (iv) To implement policies of the Medical Staff including, but not limited to, enforcement of the Medical Staff Bylaws, the Rules & Regulations, Borgess-Pipp Hospital Bylaws, and other applicable Hospital and Medical Staff policies and procedures.

      (v) To provide liaison among Medical Staff, the Chief Operating Officer, and the Board of Trustees;

      (vi) To recommend action to the Medical Director or the Chief Operating Officer on matters of a medical administrative and hospital management nature;

      (vii) To take steps to ensure the enforcement of Hospital and Medical Staff rules in the best interest of patient care and of the Hospital on the part of all persons who hold appointment to the Medical Staff;

      (viii) To ensure that the Medical Staff is kept abreast of Borgess-Pipp Hospital's accreditation program and informed of the accreditation status of Borgess-Pipp Hospital.

      (ix) To review information available regarding all applicants for appointment to the Medical Staff and clinical privileges and to make recommendations to the Board of Trustees for Medical Staff, Auxiliary Staff, and Paramedical Staff appointments reappointments, Staff category, and individual delineation of privileges.

(x) To make appropriate effort to ensure professional, ethical conduct, and competent clinical performance by all appointees, including the initiation of and/or participation in Medical Staff corrective action or professional review procedures when warranted and implementation of any actions taken as a result thereof.

(xi) To report at general Medical Staff meetings regarding the proceedings of all meetings and decisions made regarding Medical Staff policy in the interim between Medical Staff meetings.

(xii) To make recommendations to the Board regarding Medical Staff structure; participation of the Medical Staff in performance improvement/quality assessment and utilization review activities; and mechanisms for privileges delineation, credentials review, termination of Medical Staff appointment, and fair hearing procedures.

(xiii) To review reports pertaining to performance initiatives, such as house-wide indicators, departmental performance outcomes, procedure validation, blood utilization, infection control, medical records, pharmacy and therapeutics, risk management, and others as necessary, on a regular basis; and synthesize the information in a manner that results in summary reports to the Medical Staff, hospital management, the Board of Trustees, as well as making recommendations for improvement.

(b) In any instance where a member of the Medical Executive Committee has a conflict of interest in any matter involving another Medical Staff appointee which comes before the Medical Executive Committee, that member shall not participate in the discussion or voting on the matter and shall recuse him/herself from the meeting during that time, although he/she may be asked to answer any questions concerning the matter before leaving the meeting.

(c) The Medical Director shall be available to meet with the Board or its applicable committee on all recommendations that the Medical Executive Committee may make.

(d) The Medical Executive Committee shall meet at least four (4) times per year or more often if necessary to transact pending business. Recommendations of the MEC shall be transmitted to the Board of Trustees with the copy to the Chief Operating Officer.

(e) The delegation of authority to the MEC on behalf of the medical staff may be removed through an amendment to these Bylaws.

(f) Removal of members and officers is delineated in Article X Section 4. Removal of Department Chiefs is delineated in Article XIII, Section 5(b). The removal

shall become effective when it has been approved by the MEC and the Board of Trustees.

2. Peer Review Committee. The Peer Review Committee shall consist of the Secretary of the Medical Staff and nine (9) members from the Medical Staff to be appointed on an alternating schedule by the Medical Director and approved by the MEC. Members will serve a minimum of two (2) years. The Medical Director shall serve as an ex-officio member with vote. The Committee Chair will be selected from the existing Peer Review Committee membership as described in the Peer Review Policy.

   (a) Duties. The duties of the Peer Review Committee shall be:

      (i) To ensure compliance with the Medical Staff Peer Review Policy.

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

      (iii) To assess the performance of all individuals granted privileges.

      (iv) To ensure the utilization of peer review assessments to improve patient care and safety.

      (v) To establish the specific indicators and targets to be used for evaluation and keep the Medical Staff informed of same.

      (vi) 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.

      (vii) To perform specific case reviews brought forth as defined in the Medical Staff Peer Review Policy.

      (viii) To create and maintain the process for practitioner feedback.

      (ix) To make recommendations for individual practitioner performance improvement action plan.

      (x) To oversee the educational process for individual performance improvement.

      (xi) To perform timely follow-up of individual performance improvement.

      (xii) To ensure that pertinent practitioner performance data is forwarded for timely review by the MEC.

(b) The Peer Review Committee shall meet at least ten (10) times per year. Recommendations of the Peer Review Committee are given as set forth in the Medical Staff Peer Review Policy.

3. Other Committees. The MEC may, by resolution, and upon approval of the Board of Trustees, without amendment of these Bylaws, establish additional committees to perform one or more Medical Staff functions. In the same manner, the MEC may by resolution and upon approval by the Board of Trustees, dissolve or rearrange committee structure, duties or composition as needed, to better perform the Medical Staff function. Any function required to be performed by these Bylaws which are not assigned to a standing or special committee shall be performed by the MEC.

4. Special Committees. Special committees shall be created and their members and chairman shall be appointed by the Medical Director of Borgess-Pipp Hospital with the approval of the MEC and/or Board as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the MEC. If there is a conflict between the MEC and the Board of Trustees, a special committee called by the Medical Director of Borgess-Pipp Hospital shall serve as the body for resolution and shall be responsible for identifying the conflict, gathering relevant information, and working with the parties involved to protect the safety and quality of patient care. This committee will consist of three (3) members of the Board of Trustees, two (2) members of the MEC and one (1) ad hoc member of the hospital medical staff.

5. Appointments. The members and chairman of each committee, except as otherwise provided for in these Bylaws, shall be appointed biennially by the Medical Director with approval of the MEC. Such individuals shall serve for a term of two (2) years from the date they are appointed, with no limitation on the number of terms they may serve. All appointed members may be removed and vacancies filled by the Medical Director with approval of the MEC for the duration of the current term. The Chief Operating Officer and the Medical Director, or their respective designees, shall be members, ex officio, without vote, on all committees.

6. Quorum and Attendance Requirements. For the committees in this Article, the presence of fifty (50) percent of the persons eligible to vote shall constitute a quorum for any regular or special meetings and members are expected to attend no fewer than fifty (50) percent of the scheduled meetings. Failure to meet this requirement could result in a request to the appropriate party for a replacement.

7. Reports and Recommendations. Except as otherwise provided for in these Bylaws, each committee shall:

(a) Maintain a permanent record of its findings, proceedings, and actions and shall make a report thereon after each meeting to the MEC;

(b) Report (with or without recommendation) to the appropriate Medical Staff committee for its consideration and appropriate action any questions involving the

clinical competence, patient care and treatment, case management, professional ethics, infraction of hospital or Medical Staff Bylaws, Rules and Regulations or policies, and/or unacceptable conduct on the part of any individual appointed to the Medical Staff or who holds clinical privileges.

ARTICLE XII
MEETINGS OF THE MEDICAL STAFF

1. Medical Staff.

(a) Regular Meetings: The full Medical Staff shall meet at least annually, on a date(s) set at the beginning of the year by the Medical Director, for the purpose of reviewing and evaluating departmental and committee reports and recommendations, and to act on any other matters placed on the agenda by the Medical Director.

(b) Special Meetings: Special meetings of the full Medical Staff may be called at any time by the Board of Trustees, the Chief Operating Officer, the Medical Director, a majority of the Medical Executive Committee, or a petition signed by not less than one-fourth (1/4) of the voting staff. In the event that it is necessary for the full Medical Staff to act on a question without being able to meet, the voting staff may be presented with the question by mail and their votes returned to the Medical Director by mail. Such a vote shall be valid so long as the question is voted on by a majority of the Staff eligible to vote.

(c) Quorum: The presence of five (5) percent of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the full Medical Staff. This quorum must exist for any action to be taken. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

(d) Agenda.

(i) The agenda at any regular full Medical Staff meeting may include, but not be limited to:

- Call to order
- Acceptance of the minutes of the last regular and of all intervening special meetings
- Report from the Medical Director
- Report of the Medical Executive Committee
- Committee reports
- Discussion and recommendations for improvement of the professional work of the hospital
- Old business
- New business
- Adjournment

(ii) The agenda at special meetings shall be:

- Reading of the notice calling the meeting
- Transaction of business for which the meeting was called
- Adjournment

(iii) Written minutes of Medical Staff meetings shall be signed by the Medical Director and permanently filed on a confidential basis in Borgess-Pipp Hospital.

2. Department and Committee Meetings.

(a) Meetings: Departments shall hold meetings as called by the Department Chief for that department and shall meet to review and evaluate the clinical work of Practitioners with Department privileges. Departments may establish their own schedules of meetings in accordance with these Bylaws. Committee members may participate by teleconference provided those members participating by teleconference have received all written materials planned for consideration at the meeting. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding.

(b) Special Meetings: Except for meetings of the full Medical Staff, a special meeting may be called by the committee chair, by the Medical Director, or by one-fourth (1/4) of the members of the committee entitled to vote, or at the request of the Board. Committee members may participate by teleconference provided those members participating by teleconference have received all written materials planned for consideration at the meeting. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding.

(c) Quorum: Except for meetings of the medical staff noted in Article XI, the presence of five (5) percent of the total membership of the committee or department eligible to vote at any regular or special meeting (but in no event less than two members) shall constitute a quorum for all actions. A quorum once having been found, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

(d) Minutes: Minutes of each meeting of each committee and each department shall be prepared and shall include a record of the attendance of members, the recommendations made and the votes taken on each matter. Each committee and each department shall maintain a permanent file of the minutes of each of its meetings.

3. Notice: Written or oral notice stating the place, day, and hour of any committee meeting shall be given to each member not less than twenty-four (24) hours before the time of the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting. In lieu of twenty-four (24) hour notice, a committee or department may

issue a schedule at the beginning of each Medical Staff year providing for each regular committee and/or department meeting.

4. Manner of Action: Unless otherwise stated in these Bylaws, the action of a majority of the members present at a meeting at which a quorum is present shall be the action of the committee or department. Action may be taken without a meeting by unanimous consent in writing signed by each member entitled to vote thereon. Members of a committee may participate and vote by conference call provided he/she is provided with copies of the same documents the members physically present at a meeting have before them. Any individual, who, by virtue of his/her position, attends a meeting in more than one capacity, shall be entitled to only one vote.

5. Rules of Order: All meetings, including those of the committees, shall be held in parliamentary fashion, according to the provisions of these Bylaws and Rules and Regulations, the customary practices of the Medical Staff or the committee, or, when necessary, Robert's Rules of Order, Revised.

ARTICLE XIII
CLINICAL DEPARTMENTS

1. Current Clinical Departments. The following are the current clinical departments. Additional departments or divisions within departments, as required from time to time, may be established by the Board of Trustees after considering recommendations from the MEC.

   (a) Emergency Services;

   (b) Internal Medicine/Family Practice;

   (c) Pathology;

   (d) Radiology;

   (e) Surgery.

2. Functions of Departments.

   (a) Each clinical department shall recommend to the MEC written criteria for the assignment of clinical privileges within the department. Such criteria shall be consistent with and subject to the Bylaws, Rules and Regulations and policies of the Medical Staff and Borgess-Pipp Hospital. These criteria shall be effective when approved by the Board of Trustees. Clinical privileges shall be based upon demonstrated training and experience within the specialty covered by the department.

   (b) Cooperate with the performance improvement, quality assessment, and utilization review activities of the Medical Staff and Borgess-Pipp Hospital in their concurrent, or retrospective review of completed records of discharged patients and others for the purposes of contributing to continuing education and to the process of developing criteria to help assure quality patient care and efficient and effective usage of health care services.

   (c) Receive and relay reports regarding performance improvement/quality assessment issues in the applicable departments for referral to the appropriate committees.

   (d) In discharging these functions, each department shall report to the Medical Director whenever further investigation and appropriate action involving any individual member of the department is indicated.

   (e) The MEC shall serve as the Nominating Committee for Department Chiefs. In consultation with the Medical Director, or his/her designee, the Nominating Committee will select nominees for the chiefs of departments. The department will vote by mailed ballot during a fifteen (15) day period during the month of

December for a Chief of the department from among the nominees selected by the Nominating Committee. The chief is elected to serve for a term of two (2) years. The names of the elected chiefs will be presented to the Board for its approval at the next meeting of the Board following election of the Department Chiefs. In the event that any one of the candidates elected is not acceptable to the Board of Trustees, consultation between the Board of Trustees and the Nominating Committee shall take place to determine the acceptable candidates. In case a vacancy occurs, an appointment to fill the un-expired term shall be made by the MEC, with approval from the Board of Trustees. The new chiefs will assume their duties at the annual meeting of the Medical Staff.

3. Department Chief. Election, Qualifications and Appointment.

(a) The chief of each department shall be an appointee to the Active Staff who has administrative ability for the position and is verified by an appropriate specialty board or demonstrates comparable competence affirmatively established through the credentialing process.

(b) The chief of each department shall be elected by the department as set forth above in Section 2(e).

(c) The Board shall receive notice of each Department Chief elected as approved by the MEC. Election of a chief shall be made for a period of up to two (2) consecutive years. The chief may serve additional terms upon the agreement of the chief, Medical Director, and the MEC.

4. Functions of Department Chiefs. Each Department Chief shall:

(a) Be a member of the MEC, giving guidance on the overall medical policies of Borgess-Pipp Hospital and making specific recommendations and suggestions regarding patient care in the department;

(b) Provide ongoing review of the professional performance of all individuals with clinical privileges in the department, including but not limited to monitoring adherence to Medical Staff, Hospital, and department policies and procedures for obtaining consultation, alternate coverage, unexpected patient care management events, patient safety, and adherence to sound principles of clinical practice generally;

(c) Recommend to the Medical Staff the criteria for privileges that are relevant to the care provided in the department;

(d) Make recommendations to the MEC concerning the appointment and delineation of clinical privileges for all applicants seeking privileges in the department;

(e) Appoint an evaluator for each member of the Associate Staff; such evaluators shall report to him/her regularly on the work being done by the Associate Staff member, and he/she in turn will render such report to the Credentials Committee at no less than six (6) month intervals.

(f) Be responsible for implementation within the department of actions taken by the Board and the MEC.

(g) Collaborate with hospital administrative leaders on administrative activities of the department, and in integration of the department into the primary functions of the organization.

(h) Assist in the coordination and integration of interdepartmental and intradepartmental services.

(i) Assist in the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

(j) Make recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

(k) Assess and make recommendations to the COO any off-site sources for needed patient care, treatment, and services not provided by the department of the organization.

(l) 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.

(m) Determine the qualifications and competence of department personnel who are not Practitioners or AHPs and who provide patient care services in the department.

(n) Continuously assess the quality of care, treatment, and services and work with administrative leaders in effecting improvements. Ensure the appropriate quality control programs are in place within the department.

(o) Make recommendations regarding the space and equipment needed by the department.

5. Department Chief Resignation or Removal from Office.

(a) Resignation: A Department Chief may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be made contingent upon

acceptance, takes effect on the date of receipt or at any later time specified therein.

(b) Removal from Position. Removal of a Department Chief shall follow the same process as set forth in Article X, Section 4 of these Bylaws.

ARTICLE XIV
RULES AND REGULATIONS OF THE MEDICAL STAFF

1. Amendment and Adoption

(a) The Medical Staff, with the approval of the Board, shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles of conduct found in these Bylaws. Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in Borgess-Pipp Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. Rules and Regulations shall have the same force and effect as the Bylaws.

(b) Amendments to, repeals or other additions or changes to the Rules and Regulations, may be approved by vote of the MEC at any regular or special meeting provided that copies of the proposed amendments, additions or changes are posted by mail and made available to all members of the MEC and Medical Staff at least fourteen (14) days before being voted upon, and further provided that all persons holding current membership on the Medical Staff have been informed and that all written comments on the proposed changes by any Medical Staff member must be brought to the attention of the MEC before the change is voted upon. Changes in the Rules and Regulations shall become effective only when approved by the Board of Trustees.

(c) Rules and Regulations may also be amended, repealed, added to or changed by the Medical Staff at regular meetings or special meetings called for that purpose provided that the procedure used in amending the Medical Staff Bylaws is followed and that the members of the MEC have been informed in advance. All such changes shall become effective only when approved by the Board of Trustees.

(d) In the case of a conflict between the Medical Staff and the MEC on issues including, but not limited to, proposals to adopt, change or repeal a rule, regulation, or policy, the MEC shall appoint a Task Force composed of equal representation from the MEC and the medical staff to review the dispute and recommend potential resolution. The MEC will review the Task Force findings before taking final action on the matter, and the MEC's final action shall be submitted to the Board for approval disclosing the dispute, the Task Force's and the MEC's proposed final action. The Board will have the final determination to resolve the matter.

(e) The Medical Staff may vote to commend directly to the Board an amendment to the Bylaws, Rules and Regulations, or Policies that are different from what has been recommended by the MEC. If the Board receives differing recommendations from the MEC and Medical Staff, the Board shall also have the option of appointing a Task Force of the Board to study the basis of the differing

recommendations and to recommend appropriate Board action which recommendation is subject to final action by the Board.

(f) In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the MEC and given the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall remain final. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and the MEC, as defined in subsection (d) above, shall be implemented. If necessary, a revised amendment must be submitted to the governing body for action before it becomes final.

(g) When changes in the departmental Rules and Regulations occur which affect a Medical Staff member's current membership and/or privileges within the department, the Department will have the option of recommending to the MEC grandfathering existing members, in accordance with state and local laws.

ARTICLE XV
ADOPTION AND AMENDMENT of MEDICAL STAFF BYLAWS

1. Medical Staff Authority and Responsibility.

   (a) MEC Action. Except as otherwise provided in these Bylaws, proposed amendments of these Bylaws shall, as a matter of procedure, be referred to the MEC. Any member of the Medical Staff may propose an amendment to the Bylaws by submitting the proposal with a petition of support signed by fifteen (15) percent of the general Medical Staff, to the Medical Director or Chief Medical Officer, who shall submit the proposal to the MEC. The MEC shall present its recommendation of the approval or denial of the proposed amendment at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. All amendments, whether the MEC recommends approval or denial, shall be voted upon, by the Medical Staff at that meeting provided that the amendments shall have been posted by mail to all voting staff members at least fourteen (14) days prior to the meeting. To be adopted, an amendment must receive a majority of the votes cast by the voting members of the Medical Staff who are present at the time of such vote and who do vote. Neither the Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. All amendments to the Bylaws must be approved by the Board before they are deemed final.

   (b) The MEC shall have the power to adopt such amendments to the Bylaws as are, in the committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression ("Technical Amendment"). The Medical Staff shall be notified of all such amendments by mail, and the amendment shall be presented to the Board at its next regular meeting. Such technical amendments shall be effective immediately and shall be permanent unless disapprove by the Medical Staff or the Board of Trustees within sixty (60) days of adoption by the MEC. The action to amend may be taken by a motion acted upon in the same manner as another motion before the MEC After adoption, such amendments shall, as soon as practicable, be posted by mail and sent to the Chief Operating Officer.

2. Board Action.

   (a) When Favorable to Medical Staff Recommendation: Medical Staff recommendations regarding adoption or amendment of Bylaws are effective upon the affirmative vote of a majority of the members of the Board or as otherwise provided in the Board's governing documents.

ARTICLE XVI
PROFESSIONAL PRACTICE REVIEW FUNCTIONS

The Medical Staff is organized in a manner in which professional practice review functions are undertaken for the purpose of reducing morbidity and mortality and improving the care of patients. Such review includes, but is not limited to, the necessity of care, the quality of care, and the extent to which complications and deaths are prevented. All professional practice review functions are performed under the direction and authority of the Board of Trustees. The Board shall receive and act upon the reports and recommendations of all committees and individuals so assigned to provide such information.

The officers and committee chairpersons of the Medical Staff and representatives of administration are assigned and perform professional review practice functions, and have authority to assign professional practice review functions to other medical staff or to hospital employees, and shall coordinate the work of all other individuals and committees assigned such functions. Professional practice review functions shall be performed in the various departments and divisions of the Medical Staff and by any committee of the Medical Staff so designated, including those committees described in the Hearing and Appeal process found in Article IX.

Employees of the hospital shall be assigned to participate in the professional practice review function by collecting and providing data, reports, and knowledge, and by assisting committees and individuals in the performance of their professional practice review functions. All data collected by or for individuals and/or committees assigned a professional practice review function shall be confidential; shall be used only for carrying out the function of professional practice review; and shall be withheld from any individual or entity not assigned to perform or participate in professional review functions. Such records, data, and knowledge shall be entitled, without limitation, to the protection of the applicable state and federal regulations protecting peer review.

Members of the Medical Staff, representatives of administration, and third parties shall be immune, to the fullest extent permitted by law, from liability to an applicant or member of the Medical Staff for damages or other relief for any action taken or statements or recommendations made within the scope of his duties as a member of the Medical Staff or representative of administration by reason of providing information concerning such person who is, or has been, an applicant to or a member of the Medical Staff who did, or does, exercise clinical privileges or provided services at the hospital.

All individuals who participate in professional practice review functions at the hospital shall be eligible for indemnification by the Hospital in accordance with the provision of the Hospital's corporate bylaws.

ARTICLE XVII
EMERGENCY MEDICAL TREATMENT AND LABOR ACT

1. EMTALA. The members of the Medical Staff shall abide by Borgess-Pipp Hospital's Rules and Regulations governing Medical Staff responsibilities consistent with Borgess-Pipp Hospital'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").

   (a) The EMTALA Policy requires, among other things, the following:

      (i) 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;

      (ii) that if it is determined that an emergency medical condition exists, Borgess-Pipp Hospital shall provide further medical examination and stabilizing treatment within its capacity, or an appropriate transfer to another medical facility; and

      (iii) that members of the Medical Staff provide on-call service to the Emergency Department in accordance with protocols approved by the MEC and the COO, or his/her designee. Medical Staff obligations relating to on-call service shall be more specifically delineated in applicable Rules and Regulations.

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

      (i) 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.

(ii) 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 XVIII
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

1. HIPAA. The members of the Medical Staff must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including, but not limited to, the following:

   (a) The Medical Staff of Borgess-Pipp Hospital shall participate in the Borgess Medical Center's Organized Health Care Arrangement ("OHCA"), as that OHCA is more particularly described in Borgess Medical Center's Joint Notice of Privacy Practices with respect to patient information created or received by the Medical Staff as part of its participation in the OHCA.

   (b) Individual members Individual members of the Medical Staff shall participate in Borgess Medical Center's OHCA, as described in Borgess Medical Center's Joint Notice of Privacy Practices, and to abide by the terms of the Joint Notice of Privacy Practices with respect to patient information created or received by the individual member of the Medical Staff as part of his/her participation in the OHCA.

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

   (d) Any individual member of the Borgess-Pipp Hospital Medical Staff who does not agree to participate in Borgess-Pipp Hospital's OHCA and who is a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) shall agree to provide to individuals a copy of the members' Notice of Privacy Practices as required by HIPAA.

GENERAL RULES AND REGULATIONS OF THE MEDICAL STAFF

Part A: General Regulations

The Medical Staff shall adopt such regulations as may be considered necessary for the proper conduct of its work.

Adoption and amendment of regulations may be carried out at any general meeting of the Medical Staff by a majority vote of the Active Members present. Regulations and amendments to regulations so adopted shall become effective and binding upon all members of the Medical Staff when approved by the Governing Body.

The Board shall make available to each member of the Medical Staff printed copies of the regulations and shall deposit one copy in the Medical Staff Office for convenient reference.

Part B: Hospital Admissions

1. No patient shall be admitted to Borgess-Pipp Hospital until after an admitting or provisional diagnosis has been stated, except in an emergency, and until the consent of the admitting office secured. In case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible.

2. The attending physician shall be available to attend the patient at all times or shall arrange for another identified and appropriate member of the Medical Staff to be available when the attending is not. Failure to be available to a patient admitted to the hospital (within a reasonable time after a request by Hospital personnel) will be grounds for revocation of Medical Staff membership and clinical privileges.

Part C: Treatment of Patients

1. A list of stock drugs shall be kept at each nursing station, and as far as possible, the use of proprietary remedies shall be avoided.

2. Except in an emergency, only such orders for treatment will be carried out as are issued by the attending physician, or are issued at his request by consultants. If a different physician takes charge, the case will be considered as having been transferred when a formal note so states on the chart.

3. Diagnostic imaging studies performed in the Borgess-Pipp Hospital's Radiology Department shall be interpreted by members of the Department of Radiology who have been granted privileges to render such interpretation.

4. Conscious sedation and analgesia shall be administered to patients at the Borgess-Pipp Hospital only by physicians who have been granted a specific clinical privilege to do so by the Board of Trustees, and shall occur under the guidelines established, monitored and approved by the Executive Committee.

Part D: Consultations

Consultations are recommended on the following cases:

1. The critically ill and poor risks

2. Obscure diagnoses

3. Poor progress without obvious explanation (or cause)

4. Condition outside the competency of the attending physician and requiring evaluation.

5. A satisfactory consultation includes examination of the patient and the record and a written opinion signed by the consultant which is made part of the record. When the consultation relates to a contemplated operative procedure, the consultation note, except in an emergency, should be recorded prior to the operation.

Part E: Medical Records

SECTION I: CONTENT

1. All entries in the medical record should be written clearly, legibly, and completely.

2. All signatures must be written legibly. If not written legibly, the signature must be accompanied by the name printed in block letters or stamped next to the signature.

3. All significant clinical information pertaining to a patient shall be incorporated into the patient's medical record. The record content shall be sufficiently detailed and organized to enable:

    a) clear identification of the practitioner primarily responsible for the patient's care;

    b) the responsible practitioner to provide effective continuing care to the patient, to determine later what the patient's condition was at a specific time, to review the diagnostic and therapeutic procedures performed, and the patient's response to treatment;

    c) a consultant to render an opinion after an examination of the patient and a review of the medical record;

    d) another practitioner to assume care of the patient at any time;

    e) acquisition of effective, pertinent information required for utilization review and quality assessment;

    f) compliance with federal mandates and The Joint Commission requirements.

4. The medical record shall contain sufficient information to identify the patient, support the diagnosis, justify diagnostic procedures and treatment, and to document the course and results of the patient's treatment and promote continuity of care among health care providers. Each record shall contain information accurately as appropriate to the inpatient status.

a) History and Physical:

i. chief complaint

ii. history of present illness(es)

iii. inventory of systems

iv. past history

v. family history

vi. social history

vii. physical examination by body systems

viii. impressions or conclusions

ix. plan for evaluation and treatment

b) Admission Note

c) Progress Note

i. daily documentation

d) Clinical Resume/Conclusions

i. primary and secondary diagnoses

ii. brief history

iii. pertinent physical and laboratory findings

iv. course of treatment

v. condition at discharge

vi. follow-up care

vii. dietary instructions

viii. activity instructions

ix. discharge medications

5. In addition, the medical record shall contain the following items when applicable:

a) Consultation

b) Terminal Resume in lieu of the Clinical Resume in cases of patients who expire in Borgess-Pipp Hospital

i. complete diagnosis

ii. primary and secondary operations and procedures

iii. brief history

iv. pertinent physical and laboratory findings

v. course of treatment and autopsy finding whenever available

6. Should abnormal results of diagnostic testing or procedures become evident after the patient is discharged, the medical record may be re-opened by the attending physician. The physician may address the abnormal results in either a separate supplementary progress note or the clinical resume; any such entry must clearly indicate the date on which it was written and be authenticated by the attending physician.

SECTION II: HISTORY AND PHYSICAL

Inpatient H&P:

1. The History and Physical must be performed and documented by a member of the Medical Staff, House Staff, Auxiliary Staff or an authorized member of the Paramedical Staff, e.g. e.g., physician assistant or nurse practitioner, within the first twenty-four (24) hours of admission, prior to surgery or procedure that requires sedation, analgesia, or anesthesia. H&P must be signed, dated, and timed.

2. If the History and Physical is dictated, a brief written admission note that includes reason for admission, pertinent exam findings, and assessment and plan, must be included in the record.

3. If a completed History and Physical examination has been performed within the thirty (30) days prior to the day of admission or procedure that requires sedation, analgesia, or anesthesia, an updated note must be documented indicating any changes since the H&P was completed. If there are no changes to the H&P as written, it is acceptable to document a note stating that the H&P has been reviewed, that the patient has been examined, and that there have been no significant interval changes. The updated note

must be documented within twenty-four (24) hours of admission or prior to a procedure that requires sedation, analgesia, or anesthesia and must be authenticated by the attending physician with signature, time, and date.

4. A History and Physical examination performed greater than thirty (30) days prior to the day of admission not to be acceptable.

5. A legible, handwritten History and Physical that is authenticated with signature, time, and date and placed in the Progress Notes section of the record is acceptable.

6. Completion of the History and Physical is the responsibility of the attending physician. In the case in which an authorized member of the Paramedical Staff, e.g., physician assistant or nurse practitioner, has dictated, the report is to include a brief, pertinent comment and authenticated with signature, time and date by the attending physician, after which the History and Physical will be considered complete.

7. Authentication of a History and Physical examination must be completed prior to any invasive procedure performed while the patient is hospitalized, unless the delay would constitute a hazard to the patient.

8. The H&P for an inpatient shall include at least the following:

    a. chief complaint;

    b. history of present illness(es);

    c. current medications and dosages;

    d. inventory of systems;

    e. past history;

    f. family history;

    g. social history;

    h. allergies;

    i. physical examination by body systems;

    j. impressions or conclusions; and

    k. plan for evaluation and treatment

9. The Medical Staff will monitor the quality of medical histories and physical examinations.

Outpatient H&P:

1. A History and Physical must be performed and documented prior to any outpatient procedure that requires sedation, analgesia, or anesthesia. The designated short form H&P may be used in these areas.

    a. The H&P for an outpatient procedure must include documentation of at least the following: (i) a pre-procedure diagnosis; (ii) indications/symptoms for the procedure; (iii) current medications and dosages; (iv) allergies including medication reactions; (v) existing co-morbid conditions; (vi) mental status assessment; (vii) examination of the patient specific to the procedure performed; and (viii) heart and lung assessment.

2. A History and Physical may be completed by a member of the Medical Staff, or an authorized member of the Paramedical Staff, e.g. physician assistant, nurse practitioner.

3. Completion of the History and Physical is the responsibility of the attending physician. In a case in which an authorized member of the Paramedical Staff, e.g., physician assistant or nurse practitioner, or House Staff, has dictated, the report is to be authenticated with signature, time and date by the attending physician, after which the History and Physical will be considered complete.

4. If a completed History and Physical examination has been performed within the thirty (30) days prior to the day of the procedure, an updated note that includes any changes since the H&P was completed must be documented and authenticated prior to any procedure that requires sedation, analgesia, or anesthesia. If there are no changes to the H&P as written, it is acceptable to document a note stating that the H&P has been reviewed, that the patient has been examined, including documentation of heart and lung assessment, and that there have been no significant interval changes.

5. A History and Physical examination performed greater than thirty (30) days prior to the day of the procedure is not to be used.

6. Patients being admitted by an oral surgeon will need a complete dental examination. Along with this documentation, the patient will need to have a complete History and Physical by a Medical Staff physician, unless the oral surgeon has received an extension of privileges to perform History and Physicals for patients without medical problems. The pre-anesthesia note may be used in lieu of a surgeon's update.

7. Patients being admitted by a podiatrist will need a complete podiatric examination. Along with this documentation, the patient will need to have a complete History and Physical examination provided by a Medical Staff physician. The pre-anesthesia note may be used in lieu of a surgeon's update.

8. Authentication of a History and Physical examination must be completed prior to any invasive procedure.

9. The Medical Staff will monitor the quality of medical histories and physical examinations.

SECTION III: PROGRESS NOTE

1. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems will be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. An attending physician shall see the patient at least daily and document same. Failure to comply may be grounds for loss (revocation) of Medical Staff membership.

2. Progress notes written by ancillary area personnel, e.g., dietary, physical therapy, pharmacy, etc. are to be signed by the responsible employee.

SECTION IV: CONSENT

1. The medical record shall contain evidence of informed consent for procedures and treatments, according to the policy on informed consent.

SECTION V: PATIENT CARE ORDERS

1. All orders must be in writing and dated, timed, and signed (authenticated) by the earlier of (a) the date of the ordering practitioner's next visit; or (b) within forty-eight (48) hours.

2. All medication orders must include the drug name, dose, route, frequency, and time to be administered. All prn orders must include indication or symptom. Standard medication times are listed in BPH Policy 4252.

3. Only abbreviations approved by Borgess-Pipp Hospital may be used. When unacceptable abbreviations are used, the nurse or pharmacist will verify and correct the order before it is filled by pharmacy.

4. The first page of admission orders must include diagnosis and allergies. A yellow copy of admission orders with this information must go to pharmacy for every patient.

5. Verbal Orders and Telephone Orders may be given by a physician, nurse practitioner or physician assistant, to the registered nurse, except as stated in Number 8 below. For all Verbal and Telephone Orders taken, there must be a read-back of the complete order by the person receiving the order.

6. Verbal Orders may be used only under emergency circumstances, during the performance of a procedure, or in the Emergency Department. In those cases, the practitioner will be responsible to sign, date and time the Verbal Order by the earlier of (a) the date of the ordering practitioner's next visit; or (b) within forty-eight (48) hours.

7. All orders, either written, taken by telephone, or rewritten for pharmacy, must be signed (authenticated), dated, and timed by the earlier of (a) the date of the ordering practitioner's next visit; or (b) within forty-eight (48) hours.

8. Telephone Orders may be accepted and written only by registered nurses, pharmacists, respiratory therapists, dieticians, Referral Center Emergency Medical Technicians (EMT) Communication Specialists, licensed physical therapists and registered occupational therapists in accordance with the following limits:.

    a) A registered respiratory therapist or respiratory therapist who is registry eligible may obtain and write orders for the purpose of respiratory therapy intervention only.

    b) A registered dietician may obtain and write orders for nutrition consults, diet order changes, tube feedings and hyperalimentation orders, nutritional assessment monitoring parameters, and vitamin and mineral supplementation.

    c) A pharmacist may accept and document orders for pharmaceuticals and other products dispensed through the pharmacy.

    d) A Referral Center EMT Communication Specialist may accept and document orders for Emergency Department services.

    e) A physical therapist may accept and document orders for physical therapy services only.

    f) An occupational therapist may accept and document orders for occupational therapy services only.

9. The ordering physician, physician assistant or nurse practitioner must authenticate (signature), date and time all Verbal and Telephone Orders by the earlier of (a) the date of the ordering practitioner's next visit; or (b) within forty-eight (48) hours.

10. Pharmacists, under an authority of a physician, may write orders related to medication management in accordance with dosing and medication management protocols approved by the Medical Staff. These orders do not require co-signature by a physician.

11. A nurse practitioner or physician assistant may write orders under the supervision of his/her supervising physician. The order must include both the name of the nurse practitioner or physician assistant and the name of the supervising physician.

    a) When delegating the authority to prescribe Schedule III to Schedule V controlled substances, the supervising physician is required to:

        i. Establish written authorization containing the signature of both parties.

        ii. Record limitations or expectations to the delegation.

iii. Document the effective date of the delegation.

iv. Record amendments.

v. Review and update the authorization annually.

vi. Note that a listing of scheduled medications is available in BPH policy 4254, Pyxis Medstation.

b) Schedule II controlled substances can be delegated only if both the delegating physician and the nurse practitioner or physician assistant are practicing within the Borgess-Pipp Hospital. In this instance, a prescription cannot be issued for more than a seven (7) day period to a patient who is being discharged.

c) Only physicians can prescribe Schedule I controlled substances.

12. A physician shall not prescribe or delegate the prescription of a drug or device individually, in combination, or in succession for a woman known to be pregnant, with the intention of causing miscarriage or fetal death.

13. All orders written by medical students (identified with M.S. after their signature) and physician assistant students must be cosigned by the attending physician, physician assistant or house officer. This authentication must be completed prior to implementing the orders.

14. A physician, nurse practitioner or physician assistant must give a telephone or written order to implement preprinted orders.

15. All medication orders must be reviewed and rewritten when a patient is transferred to a different level of care. This may be accomplished in one of two ways:

a) The physician may write a completely new set of medication orders; or

b) The physician may use the Post-op/Transfer Medication Reconciliation Record as an order form in the following manner.

i. Check either "Continue" or "Discontinue" located to the right of each current medical order. If modifying a current order check "Discontinue" and use a separate physician order form to write a new order. Cross through any medication to be discontinued, initial and write "D/C" in the space where the medication is listed.

ii. Sign and date the Post-op/Transfer Medication Reconciliation Record at the bottom of each page. This authentication verifies that the physician has reviewed all medications and is ordering all medications as listed to be continued. Any new medication (s) or other orders are to be written on the standard order sheet.

16. Patients transferring from the Emergency Department to a care unit must have orders written prior to transfer.

17. Orders such as “meds per home”, “resume previous orders”, “resume pre-op orders” are not acceptable. It is the attending physician’s responsibility to assure that accurate, complete, and timely orders are available for patient care.

18. Abbreviations must not be used when writing medication names. The medication name must be written out in full.

19. Orders written for recurring, long-term medications or procedures given or performed during repeated outpatient visits (e.g. antibiotics, plasmaphoresis, wound care), not specifically prescribed as to time or number of doses must automatically be stopped after six (6) months.

SECTION VI: CONSULTATION

1. Providing consultations shall be the responsibility of members of the Medical Staff (e.g. physicians, dentists, podiatrists), or Auxiliary Staff (e.g., psychologists).

2. 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.

3. 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. In a case in which an authorized member of the Paramedical Staff has performed the review, a brief, pertinent, authenticated note by the Licensed Independent Practitioner will document the consultant’s review and involvement in the consultation.

4. Consultations by ancillary personnel, e.g., dietary, physical therapy, pharmacy, are to be signed by the responsible employee.

SECTION VII: CONCLUSIONS AT TERMINATION OF HOSPITALIZATION

1. All relevant diagnoses established by the time of discharge will be recorded on the face sheet using acceptable disease and operative terminology.

2. A clinical resume shall be dictated for all hospitalizations over forty-eight (48) hours within fourteen (14) days of discharge and shall concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and the treatment rendered, the condition of the patient on discharge, and any specific instructions given to

the patient and/or family. This includes documentation of instructions given which relate to physical activity, medication, diet, and follow-up care.

a) If possible, the condition of the patient discharged should be stated in terms that permit a specific measurable comparison with the condition on admission.

b) When pre-printed instructions are given to the patient or family, the record should so indicate and a sample of the instruction sheet shall be placed on the record.

c) The attending physician at the time of discharge is responsible for the clinical resume.

d) The clinical resume may be prepared by a physician, or an authorized member of the Paramedical Staff, i.e., physician assistant or nurse practitioner. It will be considered complete when authenticated with signature and date by the attending physician.

3. A final progress note may be substituted for the resume in the case of patients with problems that require less than a forty-eight (48) hour period of hospitalization, with the exception of death. The final progress note will include the discharge diagnosis, condition of the patient at discharge, and the discharge plan, including medications prescribed, and any other instructions given to the patient and/or family.

4. In the event of death, a signed terminal summary is required. It shall include the time and cause of death and the events leading to death, the complete diagnoses, primary and secondary operations and/or procedures, a brief history of pertinent physical and laboratory findings, course of treatment, and autopsy report when available.

5. Every member of the Medical Staff shall be encouraged to secure autopsies when appropriate.

6. No autopsy shall be performed without the written consent of the next-of-kin or other legally responsible person. All autopsies shall be performed by the hospital pathologist or by a physician to whom this duty is delegated.

7. The Health Information Services Department shall add any reports that are delayed until after the patient's discharge to the appropriate record.

SECTION VIII: DOCUMENTATION

1. The quality of the medical record depends in part on the timeliness, meaningfulness, authentication, and legibility of the informational content.

2. Entries in medical records are made only by individuals given this right as specified in Hospital and Medical Staff Policies.

3. All entries in the record shall be authenticated with signature, time, and date.

SECTION IX: ATTENDING PHYSICIAN

1. As general policy, the attending physician accepts responsibility for the care of the patient and shall be held responsible for the preparation of a complete medical record for each patient.

SECTION X: ABBREVIATIONS

1. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. Each abbreviation and symbol has only one meaning. An official record of approved abbreviations is on the file in the Health Information Services Department.

SECTION XI: AVAILABILITY

1. All medical records are the property of Borgess-Pipp Hospital and shall not be removed from Borgess-Pipp Hospital without permission. The medical record of a patient may be removed from Borgess-Pipp Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Unauthorized removal of charts from Borgess-Pipp Hospital is grounds for suspension or other appropriate discipline of the practitioner. No information from the medical record will be given to insurance companies, lawyers, or other legal authorities without written permission of the patient, proper court order, or other legal authority). Whenever information from the patient's medical record is released to an attorney or other legal authority the physician will be given notification.

2. A member of the Medical Staff or other health care professional who is treating an individual who is or was a patient at the hospital may have access to that patient's entire clinical chart, for treatment purposes. Members of the Medical Staff may also have access to the clinical charts of current or former patients in order to comply with chart completion requirements. A member of the Medical Staff who serves on a quality assurance, utilization review, or similar committee may have access to the entire clinical chart of any patient who has been selected for review by such committee, provided that the physician has first signed a business associate contract with the Hospital that satisfies the conditions of HIPAA's Privacy Rule. Researchers may have access to the clinical charts of current or former Hospital patients with written patient authorization that satisfies the conditions of HIPAA's Privacy Rule, or with a waiver of such authorization issued by the hospital's Institutional Review Board or Privacy Board in accordance with HIPAA's Privacy Rule. Current or former members of the Medical Staff may not otherwise have access to Hospital clinical charts without prior approval of the Medical Director.

SECTION XII: COMPLETENESS

1. An inpatient or outpatient medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Record committee.

2. If the medical record is not complete at the time of discharge, the following action will be taken by Borgess-Pipp Hospital:

   a) If the record is incomplete for seven (7) days, the physician or dentist will be notified in writing.

   b) The responsible Practitioner having one (1) or more records delinquent in excess of thirty (30) days automatically will relinquish Hospital clinical privileges to admit or attend new inpatients, perform surgeries and procedures, and accept transfers and consultations. The practitioner may continue to attend patients who are in the hospital at the time the automatic relinquishment of privileges occurs. Privilege relinquishment shall continue until all delinquent records have been completed. The Practitioner so affected by this rule will be notified by mail at least forty-eight (48) hours prior to its occurrence.

   c) All Practitioners with Borgess-Pipp Hospital clinical privileges shall be subject to the above rules.

   d) Loss of certain Hospital clinical privileges as outlined above is not considered suspension from the Hospital Medical Staff, nor is it disciplinary action related to professional practice.

DEPARTMENTAL RULES AND REGULATIONS
OF THE MEDICAL STAFF

PART A: Rules and Regulations in the Department of Emergency Medicine

SECTION I: PURPOSE

To provide high quality care to those patients presenting themselves to the Emergency Trauma Center; to establish standards of care and continuing education for physicians, allied personnel and the public; and to promote the concept of integrated community medicine and preventative care.

SECTION II: MEMBERSHIP

Membership in the Department of Emergency Medicine will be granted to physicians who qualify for Medical Staff membership and who are eligible to be certified or are certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine.

SECTION III: MEMBERSHIP MAINTENANCE

Membership in the Department of Emergency Medicine may be requested at two (2) year intervals through the reappointment process.

SECTION IV: PRIVILEGES

A. Privileges shall be granted based on education, training, and experience, as well as demonstrated competence.

Category I

Physicians who have a full-time practice or the primary portion of practice devoted to Emergency Medicine, with certification in Emergency Medicine or successful completion of an approved residency in Emergency Medicine and certification within five (5) years of Medical Staff membership.

Category II

Physicians who have a full-time practice or devote the primary portion of their practice to Emergency Medicine who have successfully completed an approved residency in a specialty other than Emergency Medicine and certification in that specialty within five (5) years of Medical Staff membership.

Category III

Physicians with privileges in another department who have a part-time practice in Emergency Medicine and who require consultation with a physician with Category I

privileges, when applicable, in connection with any complex procedure relating to Emergency Medicine.

B. Physicians who have been granted privileges in another department shall have those same privileges and only those privileges while in the Emergency Department. However, physicians who have been granted privileges to perform procedures may not perform those procedures in the Emergency Department unless granted the privilege to do so, even though they may do so in other areas of the hospital.

PART B: Rules and Regulations in the Department of Medicine

SECTION I: PURPOSE

Physicians who are members of the Department of Medicine will provide diagnostic and therapeutic services related but not confined to the traditional areas of family practice, internal medicine, or psychiatry, and, with appropriate training, the sub-specialties within the purview of internal medicine.

SECTION II: MEMBERSHIP

Membership in the Department of Medicine will be granted to physicians who qualify for Medical Staff membership and who are eligible for certification or are certified by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, the American Board of Family Practice, the American Osteopathic Board of Family Practice, or the American Board of Neurology and Psychiatry or the American Osteopathic Board of Neurology or Psychiatry.

SECTION III: MEMBERSHIP MAINTENANCE

Membership in the Department of Medicine may be requested at three (3) year intervals through the reappointment process.

SECTION IV: PRIVILEGES

Privileges shall be granted based on education, training, experience, and demonstrated competence.

DIVISION OF GENERAL MEDICINE

Category I: Board Eligible or Certified General Internists and Board Eligible or Certified Family Practitioners

1. Electrocardiogram Interpretation
2. Lumbar Puncture
3. Joint, Tendon, and Bursa Aspiration or Injection
4. Abdominal Paracentesis
5. Arterial puncture for blood gases

6. Endotracheal tube placement
7. Central Venous Line Placement
8. Naso-gastric Tube Placement
9. Naso-gastric Feeding Tube Placement
10. Indirect Laryngoscopy
11. Anoscopy
12. Skin Biopsy
13. Thoracentesis
14 Holter Monitor Interpretation
15. Bone Marrow Aspiration and Biopsy
16. Interpretation of Bedside Spirometry
17. 60 cm Flexible Sigmoidoscopy

Category II: Board Eligible or Certified Specialists within the Department of Medicine

1. Allergy, Asthma, and Immunology

    a. Epicutaneous, Intradermal, and Subcutaneous Skin Testing
    b. Desensitization to medications, Biological Agents, and Inhaled Allergens
    c. Interpretation of Bedside Spirometry

2. Cardiology

    a. Right Heart Catheterization
    b. Echocardiography
    c. Graded Exercise (Stress) Test
    d. Pulmonary Artery Catheter Insertion
    e. Intra-Aortic Balloon Pump Insertion
    f. Elective Electrical Cardioversion
    g. Insertion of Temporary Coronary Pacemakers
    h. Electrocardiogram Interpretation
    i. Holter Monitor Interpretation
    j. Place Arterial Lines
    k. Central Venous Line Placement

3. Dermatology

    a. Skin Biopsy
    b. Cutaneous Cryosurgery

4. Hematology

    a. Chemotherapy for Neoplastic Diseases

5. Critical Care Medicine

a. Arterial Line Placement
b. Pulmonary Artery Catheter Placement
c. Ventilator Management
d. Therapeutic Fiberoptic Bronchoscopy
e. Chest Tube Placement

6. Nephrology

a. Hemodialysis
b. Hemofiltration
c. Plasma Exchange
d. Insertion of Central Venous Line for Hemodialysis
e. Percutaneous Renal Biopsy
f. Peritoneal Dialysis
g. Acute Peritoneal Catheter Insertion

7. Neurology

a. Lumbar Puncture

8. Oncology

a. Chemotherapy for Neoplastic Diseases

9. Pulmonary Medicine

a. Interpretation of Pulmonary Function Tests
b. Ventilator Management
c. Arterial Line Placement
d. Pulmonary Artery Catheter Placement
e. Fiberoptic Bronchoscopy
f. Bronchoalveolar Lavage
g. Chest Tube Insertion
h. Plural Biopsy
i. Pleurodesis
j. Transbronchial Lung Biopsy

10. Rheumatology:

a. Percutaneous Synovial Biopsy

DIVISION OF PSYCHIATRY

Category I: Privileges

Medical and psychiatric evaluation of patients; performing treatment modalities, including Individual Psychotherapy, Group Psychotherapy, Family and Couples Psychotherapy, and Psychopharmacotherapy.

OTHER PROFESSIONAL STAFF

Membership in the Department of Medicine may be extended to Auxiliary Staff, i.e., psychologists, and Paramedical Staff, i.e. physician assistants, nurse practitioners. Membership requirements, initial appointment, and reappointment process will adhere to that which is described in Article IV of the Medical Staff Bylaws.

A psychologist may be granted consultation privileges, which shall be exercised only at the request of a physician on the Medical Staff of Borgess-Pipp Hospital.

Delineation of clinical privileges for Paramedical Staff will be based upon education, training, experience and demonstrated competence and will be within the scope of licensure to practice in the State of Michigan.

PART C: RULES AND REGULATIONS IN THE DEPARTMENT OF PATHOLOGY

SECTION 1: PURPOSE

Physicians who are members of the Department of Pathology will provide quality anatomic pathology services and strive to ensure prompt, efficient, and accurate clinical laboratory services for all patients.

SECTION II: MEMBERSHIP

Membership in the Department of Pathology will be granted to physicians who qualify for Medical Staff membership and who are eligible for certification or are certified by the American Board of Pathology or the American Board of Osteopathic Pathology.

SECTION III: MEMBERSHIP MAINTENANCE

Membership in the Department of Pathology may be requested at three (3) year intervals through the reappointment process.

SECTION IV: PRIVILEGES

Privileges shall be granted based on education, training, and experience, as well as demonstrated competence.

Anatomic Pathology includes Autopsy Pathology, Surgical Pathology, and Cytology.

Clinical Pathology includes Chemistry, Urinalysis, Serology, Microbiology, Coagulation, Hematology, Blood Bank, and Radioisotopes.

PART D: Rules and Regulations in the Department of Radiology

SECTION I: PURPOSE

To provide an environment in which physicians may perform and/or interpret diagnostic imaging studies; perform certain therapeutic procedures in which imaging plays an important role in localization and guidance.

SECTION II: MEMBERSHIP

Membership in the Department of Radiology will be granted to physicians who qualify for Medical Staff membership and who are eligible to be certified or who are certified by the American Board of Radiology or the American Osteopathic Board of Radiology.

SECTION III: MEMBERSHIP MAINTENANCE

Membership in the Department of Radiology may be requested at three (3) year intervals through the reappointment process.

SECTION IV: PRIVILEGES

Privileges shall be granted based on education, training, and experience, as well as demonstrated competence.

Category I - Diagnostic Radiology Privileges

1. General Diagnostic Radiology. Physicians who are qualified for certification or who are certified in Radiology or Diagnostic Radiology by the American Board of Radiology or the American Osteopathic Board of Radiology who interpret all examinations and perform procedures considered to have low risk, including all areas tested by the Boards listed above.

2. Interventional Radiology. Physicians who are qualified for certification or who are certified in Radiology or Diagnostic Radiology by the American Board of Radiology or the American Osteopathic Board of Radiology who perform procedures with potential significant complications that require use of various imaging modalities, and who have documentation of at least six (6) months training appropriate to the privileges requested.

3. Arteriography. Physicians who are qualified for certification or who are certified in Radiology or Diagnostic Radiology by the American Board of Radiology or the American Osteopathic Board of Radiology who perform and interpret various arteriographic procedures and who have documentation of adequate experience in performing and interpreting angiographic procedures in all areas of the body, including aorta, cerebral, renal, iliac, and extremity vessels.

PART E : Rules and Regulations in the Department of Surgery

SECTION I: PURPOSE

Practitioners who are members of the Department of Surgery will provide diagnostic and therapeutic services related to Surgery, Podiatry and Dentistry, and the subspecialties within the purview of Surgery, Gynecology, and Dentistry.

SECTION II: MEMBERSHIP

Membership in the Department of Surgery will be granted to physicians who qualify for Medical Staff membership and who are eligible for certification or are certified by the American Board of Surgery or the American Osteopathic Board of Surgery, the American Board of Obstetrics/Gynecology or the American Osteopathic Board Obstetrics/Gynecology, and to podiatrists and dentists who qualify for Medical Staff membership and who possess the credentials stated in these Rules.

SECTION III: MEMBERSHIP MAINTENANCE

Membership in the Department of Surgery may be requested at two (2) year intervals through the reappointment process.

SECTION IV: PRIVILEGES

Privileges shall be granted based on education, training, experience, and demonstrated competence.

Category I: Board Eligible or Certified Surgeons within the Department of Surgery

1. Cardiothoracic Surgery. Cardiothoracic Surgery shall consist of surgery of the thorax and its contents, including the surgical treatment of congenital anomalies, malfunctions, disease and injuries of the thoracic cage, the tracheobronchial system and lungs, esophagus and other mediastinal contacts, diaphragm, all endoscopic procedures involving esophagus and tracheobronchial trees, in all age groups.

   Cardiothoracic Surgery shall also consist of surgery of the heart and great vessel, including congenital and acquired, closed or open heart procedures, implantation of mechanical devices to support the circulation, placement of pacemaker, pericardiotomy or pericardiectomy, in all age groups.

2. Colon and Rectal Surgery. Colon and Rectal Surgery shall consist of surgery of the middle and lower alimentary tract particularly, but limited to surgery on hemorrhoids, fissures, diverticulosis, cancer, and a multitude of benign and malignant disorders which affect the colon directly or indirectly.

3. General Surgery. General Surgery shall consist of surgery of the head and neck, breast, skin, soft tissues, alimentary tract, abdomen, vascular system, endocrine system, the comprehensive management of trauma and emergency surgery, surgical critical care, endoscopy and endoscopic surgery.

4. Hand Surgery. Hand Surgery shall consist of re-vascularization, nerve repair, tendon repair and bone modification of the hand. May also involve complex graft procedures and re-implantation of amputated digits.

5. Neurosurgery. Neurosurgery shall consist of all the peripheral and central nervous system and major vessels to or in the brain and spinal area.

6. Ophthalmologic Surgery. Ophthalmologic Surgery shall consist of all medical, laser, and surgical care of the eye and its appendages.

7. Orthopedic Surgery. Orthopedic Surgery shall consist of investigation, preservation, and restoration of the form and function of the extremities, the spine, and associated musculoskeletal structures by medical, surgical, and physical means.

    a. Division: Podiatry

        Podiatric Surgery shall consist of surgery of the forefoot, including phalanges, and the rearfoot, of the soft tissue, osseous tissue, and deep soft tissue, and reconstructive surgery on the tendinous and osseous tissue of the ankle.

8. Otorhinolaryngologic Surgery. Otorhinolaryngologic Surgery shall consist of surgery of the head and neck, excluding primary surgery of the eye and brain.

9. Plastic Surgery. Plastic Surgery shall consist of the repair, reconstruction, or replacement of physical defects of form and function involving the skin, musculoskeletal system, cranio-maxillofacial structures, hand, extremities, breast, trunk, and external genitalia, using aesthetic surgical principles not only to improve undesirable qualities of normal structures, but in all reconstructive procedures as well.

10. Trauma and Critical Care Surgery. Trauma and Critical Care Surgery shall consist of surgical care to the critically injured patient and shall be concerned with the trauma system's phases, including pre-hospital, acute care within the hospital, and rehabilitation.

11. Urologic Surgery. Urologic surgery shall consist of all surgery of the genitourinary system and tract.

12. Peripheral Vascular Surgery. Peripheral Vascular Surgery shall consist of surgery of all peripheral vessels, either venous or arterial, involving the extra cranial cerebrovascular circulation, the circulation of the upper and lower extremities, surgical treatment of aneurysmal or occlusive lesions of the thoracic and abdominal aorta and its visceral branches, compressive disorders of the thoracic outlet, surgical treatment of portal

hypertension, complications of venous thrombo-embolic disease, varicose veins, and surgical treatment of lymphedema.

Peripheral Vascular Surgery shall also include renal-vascular hypertension, visceral ischemic syndromes, and vascular access for hemodialysis.

13. Gynecology. Gynecologic surgery privileges (extended to those who have successfully completed an OB/GYN residency program and who are eligible for certification or are certified by the American Board of Obstetrics/Gynecology or the American Osteopathic Board of Obstetrics/Gynecology) shall include but not be confined to the following procedures:

Appendectomy, Cystourethroscopy, Gynecologic Endoscopy including, Laparoscopy and Hysteroscopy, Medical/Surgical treatment of PID or Pelvic Abscess, Surgical procedures of the Ovary including Oophorectomy, Oophoropexy, and Ovarian Cystectomy, Surgical procedures of the Uterus including, Hysterectomy, Myomectomy, and Endometrial Ablation, Surgical procedures of the Cervix including, Conization, Loop Excision, and Trachelectomy, Surgical procedures of the Fallopian Tube including Salpingectomy, Salpingoplasty, and Salpingotomy, Surgical procedures for Benign or Malignant conditions of the Vulva, Vagina, Cervix, Uterus, and Ovaries, Retroperitoneal Lymph Node Resection, Tubal Microsurgery including Tubal Re-Anastomosis, Reconstructive surgery of the female genitourinary tract including Cystocele, Rectocele, Enterocele, Fistula, Paravaginal repair, Sacrospinous Ligament, Vaginal Suspension, Abdominal Sacrocolpopexy, and Bladder Neck Suspension, Medical/Surgical treatment of Ectopic Gestation, Herniorrhaphy.

14. Dentistry.

Category I: General Dentistry

With successful completion of National Board examination and Northeast Regional Dental Boards, the following core privileges are available:

Cavity Preparation and Restoration, Prophylaxis and Deep Scaling and Root Planing, Gingival Surgery, including Periodontal Flap with Scaling and Root Planing; Gingivectomy, Root Canal Therapy, Root Resection and Apical Surgery, Treatment of Fractured Teeth, Treatment of Simple Alveolus Fractures, Extractions, including Simple Extractions, Simple Impaction, and Residual Root Tip Removal, Prosthetics, including: Restorations with Crown and Bridge; Construction of Partial and Complete Dentine; Prosthetic with Implants (additional training needed); Alveoloplasty; Occlusal Adjustment; Treatment of Minor TMJ Disorders; Closure of Minor Lacerations of Oral Cavity; Treatment of Oral Infections; Consultation; Operating Room Privileges; Simple Biopsy.

Category II: General Hospital Privileges

With Category I eligibility and certification of successful completion of a post-graduate general dentistry residency program, the following Core II privileges are available: Category I privileges, Consultation/treatment of medically compromised patents, Operating room privileges for medically compromised patients.

Category III A and Category III B Privileges

With Category I eligibility and successful completion of an accredited training program in Oral/Maxillofacial surgery, the Michigan Specialty board in Oral/Maxillofacial Surgery, and board certified or eligible for board certification by the American Board of Oral and Maxillofacial surgery, the following privileges are available to qualified applicants:

Category III A Core Privileges

Surgical Removal of Teeth, Closure of Lacerations of Mouth and Jaws, Open/closed Reduction of Fractures of Mandible and Maxilla, Treatment of acute/chronic Infection of the Oral Cavity and Surrounding Structures, Excision of Benign hard/soft Tissue Lesion of Mouth and jaws, Pre-prosthetic surgeries, Foreign Body Removal of Dentogenic Origin from Maxillary Sinus, Closure of Oral-Antral Fistula, Calculi Removal from Salivary Glands.

Category III B Core Privileges

History and Physical, Management of Surgical and/or Medical Infections of Oral and peri-oral Structures, Root tip Recovery from Accessory Facial Sinuses, Treatment of Medical/Surgical Temporomandibular Joint Diseases, Arthroscopic Procedure of TMJ, Open/Closed fractures of Zygoma and Zygomatic Arch, Repair of Peri-oral and Facial lacerations associated with Facial Trauma, Cheiloplasty, Removal of Benign Neoplasm of Oral/Peri-oral regions and associated reconstruction, Removal of malignant Neoplasm of Oral/Peri-oral regions and associated Reconstruction, Biopsy of Oral/Peri-oral Neoplasms, Surgical correction of Dental/Skeletal deformities of Maxilla/Mandible, Grafting of Skin, Mucosal and Bone to Mouth and Jaws with appropriate Surgical Assistance, Placement of Implants/Implant materials for Reconstruction, Partial Glossectomy or Glossopathy, Frenectomies, Exostosis Removal, Sialographic Procedures, Sialolithotomy Procedures, Intra-Oral Salivary Resection.

SECTION V: OTHER PROFESSIONAL STAFF

Membership in the Department of Surgery may be extended to Paramedical Staff, i.e., surgical assistant, scrub nurse, physician assistant, etc. Membership requirements, initial appointment, and reappointment process will adhere to that which is described in Article IV of the Medical Staff Bylaws.

Delineation of clinical privileges for Paramedical Staff will be based upon education, training, experience, and demonstrated competence and will be within the scope of licensure to practice in the State of Michigan.

MEDICAL STAFF POLICIES AND PROCEDURES

ABSENT PHYSICIAN POLICY

If any individual in the Hospital has reason to believe that the safety of a patient is jeopardized because the primary physician caring for that patient cannot be located, following the Medical Staff or Patient Care Services Policy Guidelines, he must notify one of the following individuals (in descending order of attempted communication) whose responsibility it will be to find and designate another physician immediately to care for the patient, until either (a) the patient's safety is no longer in danger; or (b) the primary physician is located.

The Department Chief; or
The Medical Director.

Approved: Borgess-Pipp Hospital Medical Executive Committee, 9/2004; 5/5/2010; 6/1/16

Approved: Medical Staff – 4/22/2010; 6/15/16
Board of Trustees –5/25/2010; 7/19/16

Revised: 5/2010

ACUTE OCCUPATIONAL EXPOSURE TO BLOOD OR BODY FLUID POLICY

POLICY

Response to Medical Staff acute occupational exposure to blood and body fluid occurring in the Hospital will be timely and with support of Hospital resources.

DEFINITION

An occupational exposure occurs when skin, eye, mouth, and other mucous membrane non-intact skin have contact with patient blood, body fluid, or other potentially infectious materials during patient care.

PROCEDURE

1. If the source patient is a known HIV positive, report immediately to the Emergency Department for emergent evaluation and treatment.
2. If the source patient HIV status is unknown, initiate patient source testing. Orders are pre-printed and available in all patient care areas. The patient's blood sample is obtained and sent to the Lab with instructions that it is blood work due to a Medical Staff exposure and it requires rapid testing. Results are to be called back to the physician ordering the testing. Rapid test results will be either "reactive" or "non-reactive."
3. If the source patient test results are "reactive" the exposed individual should report immediately to the Emergency Department for emergency evaluation and treatment. Follow-up by a personal physician is recommended.
4. If the acute exposure occurs during an operative procedure, the exposed Medical Staff may request that the routine first dose medication be sent to the operating suite directly from the Pharmacy. The Pharmacy shall be given the following information: Date, time, and name of exposed individual.
5. If the source patient is a known negative or "non-reactive" for the HIV virus, the exposed Medical Staff individual should seek evaluation from a personal physician within four (4) days.
6. If the source patient is unknown, the exposed individual should report to the Emergency Department of exposure evaluation. Follow-up with a personal physician is recommended.
7. All Medical Staff acute exposures are to be documented through the use of the Hospital incident reporting system.
8. All Medical Staff acute exposures are to be reported to the Infection Control Department at 226 8135. Provide the name of the patient, the name of the exposed Medical Staff member, location of the incident, and whether or not the exposed individual has had Hepatitis B vaccine.

Approved: Medical Staff Executive Committee, 12/1998; 6/15/16

Approved: Borgess-Pipp Hospital Medical Executive Committee, 9/2004; 6/1/16

CENTRAL VASCULAR ACCESS DEVICE POLICY

POLICY

The Medical Staff of Borgess-Pipp Hospital recognizes the need to ensure the safety of patients undergoing insertion of Central Vascular Access Devices (C-VADs). C-VADs have been associated with risk of infection, which increases morbidity, mortality, hospital length of stay and costs. Education of health care workers decreases health care associated infections. Therefore a mandatory educational module will be provided to aid physicians in achieving maximum infection control practices during insertion of vascular access devices and raise the status of this procedure to that of an extension of privileges.

DEFINITIONS

1. A Central Vascular Access Device is a "Central Line" that terminates at or close to the heart or in one of the great vessels.

2. Neither the location of the insertion nor the type of device may be used to determine if a line qualifies as a "Central Line."

3. Central Vascular Access Devices are defined as

    a. Central Venous Catheters – single lumen or multi lumen
    b. Pulmonary Artery Catheters
    c. Hemodialysis Catheters
    d. Plasmapharesis Catheters
    e. Peripherally Inserted Central Catheter (PICC)

PROCEDURE

1. Risk factors have been identified for central line related blood stream infections. These include:

    a. Infections elsewhere - remote
    b. Colonization of the catheter with organisms
    c. Catheters left in place for longer than 72 hours
    d. Inexperience of personnel inserting the Central Vascular Access Device
    e. The use of stopcocks

2. There are evidence-based steps to preventing central line related blood stream infections. These include:

    a. Cleaning hands with either waterless alcohol based hand sanitizer or washing hands with soap and water
    b. Use of a 2% Chlorhexidine-based product for skin preparation
    c. Use of maximal barrier precautions, including

(1) For the Provider – Cap, Face Mask, Sterile Gown and Sterile Gloves
(2) For the Patient – large sterile drape covering the patient's head and body

d. Selecting the best insertion site which means avoiding femoral lines as the primary option

e. Removing the catheter as soon as possible

3. The Medical Staff Executive Committee has approved the Borgess Medical Center Patient Care Policy, Central Vascular Access Device Insertion. Insertion of a Central Vascular Access Device must comply with this policy.

4. Audits of compliance will be performed periodically and reviewed by the Medical Director and the Chief of the Departments. Physician representatives from the Departments of Surgery, Medicine, Radiology, and Emergency Medicine may also participate in the review.

5. The Medical Staff Executive Committee must recommend changes in the policy governing insertion of a Central Vascular Access Device.

6. Physicians who fail repeatedly to comply with the requirements outlined in the Hospital patient care policy will be deemed to voluntarily relinquish the privilege.

Approved: Borgess-Pipp Hospital Medical Staff Executive Committee, August 3, 2005; 6/1/16

Approved Board of Trustees – 7/19/16

CONCURRENT PATIENT CARE QUALITY CONCERNS

POLICY

A Medical Staff quality concern will be addressed as soon as it arises, in order to maintain patient care and safety, without involving documentation of such concerns in the medical record.

DEFINITION

A Medical Staff quality concern is an issue with the potential to interfere with a favorable clinical outcome.

PROCEDURE

1. A quality patient concern regarding a Medical Staff member can be raised by Medical Staff, Nursing Staff, and through the quality improvement process.

    A. A collegial resolution between physicians is desired. Direct communication is encouraged. If initially unsuccessful, the concerned party is encouraged to involve associates of the involved physician.

    B. A member of the Nursing Staff may address a concern to the appropriate Medical Staff member or to an associate of the involved physician, or the Department Chief.

    C. Quality concerns arising through the activities of the quality improvement process will be directed to the appropriate Department Chief.

2. If a collegial approach to the concern is not effective, the concerned party will file a written report in the Medical Staff Office. Medical Staff leadership, Department Chief, and/or the Chief Medical Officer will become involved.

3. Medical Staff leadership will determine if the quality concern is valid.

    A. If the decision reached indicates an invalid concern, the process will be terminated.

    B. If the decision reached indicates a valid concern, the involved physician will be asked to respond to the written complaint and make an adjustment to the case.

4. In the event the involved physician refuses to make an appropriate adjustment in the case, summary suspension and transfer of patient may ensue.

Approved: Medical Staff Executive Committee, 3/1994; 6/15/16
Approved: Borgess-Pipp Hospital Medical Executive Committee, 9/2004; 6/1/16

DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY

POLICY

The Medical Staff recognizes the importance of maintaining good communication with patients and providing information to foster good decision-making. The communication of unanticipated outcomes shall be part of the communication process, therefore, any unanticipated outcome, either positive or negative, shall be reported promptly to the patient and/or the patient's family.

DEFINITIONS

Unanticipated Outcome: An outcome that differs significantly from the expected treatment or procedure outcome.

Adverse Event: An unexpected occurrence involving death, serious physical injury (loss of limb or function), serious psychological injury, or the risk of any of the above (includes any process variation for which reoccurrence would carry a significant chance of serious outcome).

PROCEDURE

1. In the event of an unanticipated outcome, prompt disclosure about the event shall be made according to the following guidelines.

    A. If the result of a treatment or procedure differs significantly from what was anticipated, the responsible licensed independent practitioner or designee shall explain the outcome clearly to the patient.

    B. Should the patient be incapable of understanding the explanation, the practitioner shall provide the outcome explanation to the patient's guardian, durable power of attorney for healthcare or appropriate family members.

    C. The outcome explanation should not include any admission or denial of liability. At no time shall information be communicated to the patient or patient's family concerning the cause of the adverse event until the matter has undergone a thorough investigation and review coordinated by the Department of Legal Affairs and Risk Management.

    D. Disclosure of an adverse event should include the following:

        1) A statement of facts that are known following the event. This should include the patient's current condition.
        2) Information about any action taken to reverse or ameliorate the unanticipated result.
        3) An explanation of the short-term and long-term effects on the patient's health and future care and a discussion of any plans for continued treatment.

4) A statement that there will be an evaluation of how the treatment or procedure is performed to see if any changes are advisable.

5) An offer to assist the family or patient with a referral to another practitioner, if a change in practitioners is requested.

E. The disclosure should be made with compassionate concern and should include a statement that everyone involved is truly sad that this unanticipated result occurred and that all available resources, other practitioners, social services staff, etc., will be committed to assisting the patient and family.

2. The outcome of the patient's treatment or procedure, the services that were made available to the patient and family, and any referrals made at the request of the patient or family.

A. The date, time, and identity of all persons present in the discussion should be recorded.

B. An Incident Report should be completed following an adverse event, with an additional verbal report made to Legal Affairs and Risk Management as soon as possible.

1) Any delay that may occur in the disclosure of the event to the patient or family should also be documented, along with the reason for the deferral and the plan for disclosure.

2) An accusation of liability or threat to sue made by the patient or family should be recorded on the Incident Report and not in the patient's medical record. A verbal report of those threats should also be provided to Legal Affairs and Risk Management.

3) The results of any investigation or analysis of the event shall not be documented or placed in the patient's medical record.

3. Legal Affairs and Risk Management should be consulted before any further disclosure of the circumstances of the event is made to the patient or family.

4. At no time shall information regarding adverse outcomes be communicated to the public or representatives of the media without explicit advance approval from the Department of Marketing and Public Relations.

REFERENCE

Joint Commission Standards in Support of Patient Safety and Medical Care Error Reduction (R.I. 1.2.2)

RELATED POLICIES

Incident Reporting
Release of Patient Information to the Media

Approved: General Medical Staff, 7/2003; 6/15/16
Approved: Borgess-Pipp Hospital Medical Executive Committee, 9/2004; 6/1/16

DISRUPTIVE CONDUCT (BEHAVIOR) POLICY

POLICY

It is expected that all individuals within Borgess-Pipp Hospital will be treated courteously, respectfully, and with dignity. All employees, physicians, and allied health practitioners are expected to conduct themselves in a professional and cooperative manner. Therefore, conduct that is so disruptive to the operation of the Hospital that the value of the clinical work is outweighed by the negative impact of certain behaviors will not be tolerated. Note, however, a practitioner's behavior that is unusual, unorthodox, or different is not sufficient to justify disciplinary action.

DEFINITION

Disruptive Conduct is conduct that a reasonable person would find offensive to others or that is disruptive to the workplace or to safe patient care. Disruptive Conduct includes any action that negatively impacts the capacity of the health care team to function according to acceptable and customary standards of cohesion, respect, effective communication, relationship centered care, quality and safety.

Disruptive Conduct may be written, verbal, or behavioral and may include, but is not limited to:

- Disrespectful conduct
- Contact that is inappropriate, unnecessary and unwanted
- Use or abuse of instruments or other objects as a means of intimidation or as a display of anger
- Use of profane or vulgar language, sexual comments or images
- Racial or ethnic slurs
- Gender-specific demeaning comments
- Any comment that would offend a reasonable person under the same similar circumstances on the basis of the age, race, color, marital status, gender, sexual orientation, religion, national origin, ancestry, or physical or mental handicap
- Publicly airing criticisms in a manner that is unprofessional in content or language that is loud, intrusive, or occurs in an inappropriate setting
- Behavior that a reasonable person would regard as:
    - Threatening

- Retaliatory
- Abusive
- Passively or aggressively hostile, negligent, or intimidating
- Detrimental to the normal conduct of business of delivery of care
- Intended to undermine the confidence of staff, patients, or families to an unreasonable degree

PROCEDURE

1. Documentation of disruptive conduct is critical since it is ordinarily not one incident that justifies disciplinary action, but rather a series of similar incidents. Any provider, employee or visitor who observes behavior by a practitioner that disrupts the smooth operation of the Hospital or jeopardizes patient care may report the incident. That report shall include:

   a. date and time of the questionable behavior;
   b. name of the patient, if the behavior affected or involved a patient or his/her family, or the name of the employee or colleague;
   c. circumstances which precipitated the situation;
   d. a description of the questionable behavior limited to factual, objective language;
   e. consequences, if any, of the disruptive behavior as it relates to patient care, safety or Hospital operations; and
   f. a record of any action taken to remedy the situation including date, time, place, action and name(s) of those intervening.

2. The report shall be submitted to the Chief of the Department and the Medical Director who will initiate an informal investigation as he/she deems appropriate. It will be then forwarded to the Chief Operating Officer if deemed necessary.

3. If the single incident warrants a discussion with the offending practitioner, the Chief of the Department, and/or Medical Director shall initiate that and shall emphasize to the individual that such conduct is inappropriate. The practitioner shall be given a copy of this policy and procedure.

4. Following the second event, f it appears to the Chief of the Department or the Medical Director that a pattern of disruptive behavior is developing, the matter will be informally discussed with the practitioner.

   - The initial approach should be collegial and designed to be helpful to the practitioner assisting them in identifying means of structuring professional and working relationships and resolving problems without disruptive behavior.

- It should be emphasized that if the behavior continues, more formal action will be taken in order to have the behavior stopped.

- A follow-up letter to the practitioner shall reiterate that they are required to behave professionally and cooperatively at all times. This letter will be placed in the practitioner's quality file.

5. All meetings with the practitioner will be documented and placed in their quality file.

6. After a third event, the Medical Director, shall meet with and advise the practitioner that such conduct is intolerable and must stop. This meeting is not a discussion, but rather constitutes the practitioner's final warning. This warning will be given with the understanding that if disruptive behavior continues formal disciplinary action will ensue. The meeting shall be followed with a letter reiterating the warning. That letter becomes a part of the practitioner's quality file and will be forwarded to the COO.

7. A single additional incident shall result in the initiation of formal disciplinary action pursuant to the Medical Staff Bylaws. Appropriate disciplinary action may be up to and including summary suspension. The Medical Executive Committee shall be fully apprised of the previous warnings issued to the practitioner so it is willing to take whatever action is necessary to terminate the unacceptable conduct.

8. This process may be altered depending on the level of egregiousness of the incident.

9. In some cases, a practitioner's impairment may manifest itself as disruptive conduct. If at any time the Chief of the Department, Chief of Staff, Chief Medical Officer, Chief Quality Officer or any Medical Staff member reasonably believes that an offending practitioner's conduct may be due to possible impairment, any review and/or investigation of the practitioner's behavior shall also be handled in accordance with the Medical Staff Impairment Policy.

Approved: BPH Medical Staff – 5/12/2010; 6/1/16
Board of Trustees – 1990; 5/22/2010; 7/15/16
MEC - 1990, 9/2004, 5/12/2010; 6/15/16

Revised 5/2010

DOCUMENTING CURRENT COMPETENCY POLICY

POLICY

Physicians who obtain and maintain Medical Staff membership and clinical privileges at Borgess-Pipp Hospital must document clinical competence, first of all, as a provisional staff member and again at the time of reappointment. A physician who does not have clinical activity within the hospital environment sufficient to determine current competency in the care of patients will be evaluated by means applicable to the physician's practice. This may include, but not be limited to, review of office files, evaluation by physicians who share patients with the involved physician, evaluations from hospitals at which the individual has privileges, or another means that may provide the needed information.

PROCEDURE

1. Medical Staff Office will determine that a physician does not have sufficient Hospital activity to render a meaningful evaluation of current competency.

2. The Medical Staff Office will advise the individual physician that it will be necessary to obtain information from outside the Hospital in order to determine current competency. The individual will be asked to provide the names of three physicians with whom they share patients and from whom an evaluation of current competency can be obtained.

3. In addition, information will be obtained from hospitals if Medical Staff appointment and privileges are held at other institutions and office records will be requested if deemed appropriate to the circumstances.

4. The Department Chief will review the information obtained and provide comments to the Credentials Committee.

6. The Credentials Committee shall evaluate the information received and determine the action to be recommended to the Board of Trustees.

Approved: Medical Staff Executive Committee, 2000; 6/15/16
Approved: Borgess-Pipp Hospital Medical Executive Committee, 9/2004; 6/1/16

ELECTRONIC COMMUNICATION POLICY

Borgess-Pipp Hospital provides electronic communication tools to improve productivity and enable efficient, high quality work. This document identifies guidelines for use of Borgess-Pipp Hospital electronic communication tools.

POLICY

Borgess-Pipp Hospital restricts the use of its electronic communication tools to business related purposes only, such as patient care, research, and other legitimate business purposes of Borgess, shall monitor all access to its resources electronic systems. Medical Staff members are expected to follow the Borgess Health policy on confidentiality, abide by Medical Staff ethical and legal responsibilities, and access information only necessary to their responsibilities to Borgess. Medical Staff members are prohibited from accessing patient information, unless required for legitimate business purposes consistent with the requirements of HIPAA and state law with respect to patient information. Medical Staff members are prohibited from accessing mental health patient information unless the Medical Staff member is providing mental health services to the patient or unless there is a compelling need to access such information based upon a substantial probability of harm to the patient or other individuals.

DEFINITION

Electronic communication tools include all aspects of voice, video, and data communications, such as voice mail, e-mail, fax, Internet, electronic health record and so forth.

PROCEDURE

The following procedure shall apply if any individual is found to misuse or abuse electronic communication tools:

1. A written report shall be filed with the Medical Director. The report shall include a factual description of the incident or statement.

2. The involved Medical Staff appointee shall be required to meet with the Medical Director. The Medical Staff appointee shall be advised of the concern and be provided an opportunity to respond.

3. If the Medical Staff leadership determines that they lack reasonable cause to believe that the report of conduct or behavior occurred, no further action shall be taken and the matter shall be closed.

4. If it is determined that the reported acts did occur, the Medical Staff appointee may be given an opportunity to voluntarily cease the conduct that gave rise to the complaint. Access to electronic communications resources may be restricted as deemed appropriate by the Medical Director. If the incident was sufficiently severe, formal disciplinary action may be instituted.

5. If the individual has agreed to stop such conduct, the meeting shall be followed up with a formal letter of reprimand and warning, a copy of which shall be placed in his/her confidential peer review file.

6. If the Medical Staff appointee refuses to agree to stop the conduct, giving rise to the complaint, a formal disciplinary action will be instituted and the Medical Staff appointee shall be advised that he/she will not be permitted to access electronic hospital equipment of any kind.

7. The matter shall be reported to the Medical Staff Credentials Committee and the Operating Committee, along with a brief explanation of the circumstances and applicable policy or regulations.

8. Any further reports of misuse may result in disciplinary action in accordance with Medical Staff Bylaws, Rules, and Regulations.

9. Misuse of electronic equipment by Medical Students and House Officers will result in discontinuation of access pending investigation by the Dean of MSU-KCMS, with restitution of access predicated upon the recommendation of the Dean and the Chief Medical Officer.

Approved, Medical Staff Executive Committee, Board of Trustees, 5/2003; 7/19/16
Approved: Borgess-Pipp Hospital Medical Executive Committee, 9/2004; 6/1/16

EMERGENCY TRAUMA CENTER EMTALA ON-CALL POLICY

POLICY

The Medical Staff will provide on-call coverage schedules listing on-call physicians by name for all medical services provided at Borgess-Pipp Hospital.

DEFINITION

An on-call roster is a list that identifies one individual who is responsible for taking cases on a specific day if requested by the attending physician. The roster will be due in the Medical Staff Office no later than five (5) working days prior to the following month.

PROCEDURE

1. Call rosters apply to Hospital and emergency services provided and shall be developed and maintained in a manner that best meets the needs of Borgess-Pipp Hospital patients.

2. The individual on-call physician shall be required to accept the patient. Unless the on-call physician cannot reasonably treat the patient due to circumstances beyond his or her control. In the event of a difference of opinion, the discretion of the Emergency Department physician shall prevail with regard to the patient's need for specialty care and whether such care should be provided in person or can be achieved through telephone consultation or outpatient evaluation. Refusal to take the patient or come to the Hospital to provide treatment in person when requested to do so will not be acceptable and will be referred to the Medical Staff Office and possibly the Borgess Health Alliance Corporate Responsibility Officer.

3. The following Medical Staff Departments and Divisions will be included:

    (j) Department of Medicine

    (k) Department of Radiology

    (l) Department of Surgery

4. Department Chiefs will provide the on-call rosters for the above services. This will include the rotation schedule using names of those individuals who are on the roster.

5. Medical Staff members who are on Consultative or Honorary Staff will be exempt from the roster. All Active and Associate Staff members will be expected to participate in their Department or Division on-call roster.

6. The recommended referral pathway for patients in the Emergency Department will be:

    (a) Patient preference within the requested specialty

(b) Emergency Department physician preference

(c) Attending physician preference

(d) If coverage has yet to be provided after applying a, b, and c above, the individual on the on-call roster will be called.

7. The on-call physician shall respond to the initial call 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 or active labor will be reported to the Borgess Health Corporate Responsibility Officer and the Medical Staff Office.

8. In the event a particular specialty or on-call physician is unavailable due to circumstances beyond his or her control or due to simultaneous call at another facility, the attending physician shall arrange for further examination and stabilizing treatment within the capabilities of Borgess-Pipp Hospital or, if necessary, follow appropriate transfer procedures and continue to provide examination and stabilizing treatment as necessary and within the capabilities of Borgess-Pipp Hospital throughout the transfer process.

9. A physician who is on call for the Hospital; that is, responsible for the examination, treatment, or transfer of an emergency patient and who negligently violates the law may be subject to governmental fines of up to Fifty Thousand Dollars ($50,000) per violation, reviewed by the Department Chief and/or Medical Staff Credentials Committee as determined by the Medical Staff Office in consultation with the Borgess Health Alliance Corporate Responsibility Officer and may be subject to corrective action under the Medical Staff Bylaws. If the violation is gross or repeated, the physician may be excluded from participation in Medicare and Medicaid program. Exclusion from participation in the federal Medicare/Medicaid program is cause for immediate and automatic relinquishment of Medical Staff appointment and clinical privileges, as stated in the Medical Staff Bylaws.

10. Call rosters will be published fifteen (15) days prior to the effective date. In the event that it is necessary to change the published monthly call schedule, the assigned physician will be responsible to notify the Medical Staff Office and the Emergency Department and to provide all pertinent information regarding the change.

Approved: Borgess-Pipp Hospital Medical Executive Committee, 1/2005; 6/1/16

FITNESS FOR DUTY POLICY

POLICY

Members of the Medical Staff who are disabled and incapable of properly caring for patients or performing the duties of his/her position because of physical, emotional, or other disability, or under the influence of drugs and/or alcohol, shall be prevented from doing so.

Maintaining patient safety is Borgess-Pipp Hospital's first priority. In case of doubt about fitness, the responsible Medical Staff leadership physician will be guided by this priority, while attempting to make the best decision based on the immediately available information.

DEFINITION

Being unfit for duty means that a member of the Medical Staff is observed by health care personnel or other Hospital representatives to be attending patients while in an apparent disabled state because of physical, emotional, or other disability, or appearing to be under the influence of drugs and/or alcohol.

PROCEDURE

The following procedure shall apply in those situations in which a member of the Medical Staff is observed attending patients while apparently unfit for duty.

1. When it appears that a member of the Medical Staff of Borgess-Pipp Hospital is unfit for duty as defined above, the person who observes the situation will immediately report it to the patient care supervisors and/or administrative personnel in charge who will take appropriate action to insure patient safety. The patient care supervisor or administrator in charge should immediately contact the responsible Medical Staff physician, as set forth in Section 2 below.

2. The sequential order for determining and contacting the responsible Medical Staff leadership physician responsible is as follows:

    (a) Chief of Department

    (b) Medical Director

3. It is anticipated that the first responsible physician successfully contacted will:

    (a) Respond immediately and conduct an investigation

    (b) Take proper steps to safeguard the care of patients

    (c) File a written report with the Medical Director regarding the circumstances and the actions taken to assure appropriate follow-up

4. The responsible Medical Staff leadership physician (s) or Chief Medical Officer have the right to immediately test members of the Medical Staff for drugs, alcohol, and other prescribed or illegal substances if the requestor believes a member of the Medical Staff may be unfit for duty or has used unauthorized, illegal, or controlled substances. Refusal to comply with immediate testing is grounds for summary suspension in accordance with procedures outlined in Borgess-Pipp Hospital Medical Staff Bylaws (Article VIII, Section 1).

5. If a physician or other licensed health care professional has reasonable cause to believe that another licensed professional is practicing while impaired; the situation must be reported to the Michigan Department of Consumer and Industry Services consistent with state law.

6. All written or oral communications made pursuant to this policy and procedure is confidential, professional practice review materials and is protected from disclosure by Michigan law. This information may not be discussed except as permitted by this policy and the medical Staff Bylaws and may be used only for professional practice review purposes.

REFERENCE MCLA 333.16221 – Health Professional Reporting Requirements

Approved, Medical Staff Executive Committee, Board of Trustees, 4/2003; 7/19/16
Approved: Borgess-Pipp Hospital Medical Executive Committee, 9/2004; 6/1/16

GRADUATE MEDICAL EDUCATION POLICY

POLICY

The professional graduate medical education program at Borgess-Pipp Hospital is provided in partnership with Michigan State University-Kalamazoo Center for Medical Studies (MSU-KCMS). MSU-KCMS provides a structured process for meeting the educational needs of the participants within limits of safe and effective care of patients.

PROCEDURE

1. MSU-KCMS will provide appropriate physician supervision for all participants in the professional medical education program (Residents).

2. Supervision of Residents will be provided in a way that allows for progressively increasing responsibility for patient care.

3. Physician Resident supervisors will be members of the Borgess-Pipp Hospital Medical Staff. They shall have responsibility for supervision of residents within the extent of privileges granted to them.

4. MSU-KCMS has defined the roles and responsibilities of both the supervising physicians and the Residents. They shall be carried forth in the care provided to patients at Borgess-Pipp Hospital.

5. The Resident's scope of practice is included in Medical Staff General Rules and Regulations, along with the expectations outlined for the Medical Staff.

6. Communication between the Borgess-Pipp Hospital and its Medical Staff and the MSU-KCMS Chief Operating Officer and Program Directors addresses the professional graduate medical education program's ongoing business of providing safe, quality patient care, treatment, and services by its faculty and Residents.

    (a) The Medical Staff supports the professional graduate medical education program and demonstrates compliance with residency review board requirements.

Approved: Borgess-Pipp Hospital Medical Executive Committee, 9/2004; 6/1/16

IMMUNE POLICY

POLICY

The Medical Staff will demonstrate their immunity to Rubella and to M. Tuberculosis.

PROCEDURE

1. Rubella

    (a) All new members of the Medical Staff and the Allied Health Professional Staff will need proof of a positive Rubella titer as part of their credentialing application. The burden of providing proof rests with the applicant.

    (b) Practitioners with a negative Rubella Titer will be required to have an immunization for Rubella and provide proof of its application and subsequent immunity.

    (c) Practitioners will not be required to receive vaccine despite negative titer under the following circumstances.

        1) Pregnancy

        2) Allergy to components of the vaccine

        3) Immune deficiency disease or disease affecting bone marrow or the lymphatic system

        4) Altered immune status due to medication

        5) Contrary to religious beliefs

        6) Discretionary consideration of the Medical Staff Operating Committee

    (d) Failure to comply with these guidelines in a timely fashion, as determined by the Medical Staff Operating Committee, will result in withdrawal of application for Medical Staff membership.

2. M. Tuberculosis Surveillance

    (a) Medical Staff shall include all providers who are credentialed and privileged at Borgess-Pipp Hospital, including Medical Staff and Allied Health Professional Staff.

    (b) TB testing is required at the time of initial appointment to the Medical Staff. If testing was accomplished within the prior twelve (12) months, a record of that testing is acceptable.

1) Two-step testing should be performed on all new Medical Staff who have a negative TB test initially, specifically if the applicant has never been tested or has not had a skin test for at least ten (10) years.

2) Persons with a known positive TB test, including prior BCG immunization, may document negative TB status by chest x-ray obtained within the past twelve (12) months. The x-ray report will be filed in the Medical Staff Office.

3) Repeat skin testing will be done on a yearly basis on all Medical Staff who have a negative TB test status.

4) Persons with a known positive PPD status or prior BCG immunization will be required to file a simple symptom survey on a yearly basis in lieu of skin testing.

5) Medical Staff who convert from a negative TB test status to a positive TB test status within the past twelve (12) months must immediately, upon awareness of test conversion, report this change to the Medical Staff Office. The provider will be seen by their private physician or at the Health Department for an evaluation of their health status. If the provider reports symptoms they will not be allowed patient contact until chest x-ray confirmation of no active disease. A copy of the evaluation outcome report will be filed in the Medical Staff Office.

6) Skin testing may be performed either at the Borgess-Pipp Hospital Laboratory Employee Health or outside of the Hospital. If performed outside, the results must be verified by a physician or by an accredited laboratory.

Approved: BPH Medical Staff – 4/2003; 5/12/2010; 6/1/16
Board of Trustees – 1990; 5/22/2010; 7/19/16
MEC - 9/2004, 5/12/2010; 6/15/16

Revised 5/2010

IMPAIRMENT POLICY

POLICY

Medical Staff practitioners who are or may be impaired can be identified, assessed, and treated, on a voluntary basis, and without the initiation of formal corrective action. The overriding goal in managing the process should be to assist the impaired physician in overcoming the problem and to help the individual to become an active member of the Medical Staff once again.

Confidentiality is a key factor in reaching this goal, since rehabilitation is more likely to occur if the information about the problem is kept confidential.

(When considering issues related to a physician's illness and disability, it is important to keep in mind reporting statutes and the application of the Americans with Disabilities Act. Federal reporting requirements are defined in The Health Care Quality Improvement Act (HCQIA) of 1986. This requires that when a professional review action adversely affects the clinical privileges of a physician for longer than thirty (30) days, or a physician surrenders his or her privileges while under investigation, the health care entity that took professional review action must report to the state licensing board; the licensing board forwards the report to the National Practitioner Data Bank.

However, it is noteworthy that the HCQIA also allows that when a physician voluntarily seeks assistance from the medical staff of a hospital, the hospital is not required to file a report with the National Practitioner Data Bank.

In the State of Michigan, legislation effective April 1, 1994 encourages chemically dependent or mentally ill individuals to seek confidential treatment rather than being sanctioned. The laws created a Health Recovery Committee in the Michigan Department of Commerce and the Health Professional Recovery Program, both of which will assist the impaired physician if the individual is willing to adhere to the criteria developed by the Committee.)

DEFINITION

An impaired physician is one who is unable to practice medicine with reasonable skill and safety because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or the excessive use or abuse of drugs, including alcohol.

PROCEDURE

1. Any individual working in the Hospital who has a reasonable cause to believe that a practitioner appointed to the Medical Staff is or may be impaired may submit an oral, or preferably, a written report to the Chief Operating Officer, the Department Chief, and/or the Medical Director. The report shall include a description of the incident(s) that led to the belief that the practitioner is or may be impaired. The report must be factual. The individual making the report does not need to have proof of the impairment, but must state the facts leading to the suspicions. A practitioner may initiate the process described

in this policy by self-reporting to the Chief Operating Officer, the Department Chief or the medical Director, or self-referring to the Michigan Health Professional Recovery Program.

2. If, after discussing the incident(s) with the individual who filed the report, the Chief Operating Officer, Department Chief, or the Medical Director believes there is enough information to warrant a review or a formal investigation, the Chief Operating Officer shall direct that an investigation be instituted and a report thereof be rendered by:

   (a) the Department Chief, and/or Medical Director;

   (b) a standing committee of the Medical Staff;

   (c) an outside consultant; or

   (d) another individual or individuals appropriate under the circumstances.

   If, after discussing the incident(s) with the individual who filed the report, the Chief Operating Officer, the Department Chief or the Medical Director believe there is enough information to warrant a review or formal investigation it shall be reported to the MEC.

3. If, after the investigation, it is found that sufficient evidence exists that the practitioner is impaired, the Chief Operating Officer shall meet personally with the practitioner or designate another appropriate individual to do so. The practitioner should be told that the results of an investigation indicate that the practitioner suffers from an impairment that affects his or her practice. The practitioner should not be told who filed the report, and does not need to be told the specific incidents contained in the report.

4. Depending upon the severity of the problem, and the nature of the impairment, the Hospital has the following options:

   (a) require the practitioner to undertake a rehabilitation program as a condition of continued appointment and clinical privileges;

   (b) impose appropriate restrictions on the practitioner's practice;

   (c) immediately suspend the practitioner's clinical privileges in the Hospital until rehabilitation has been accomplished if the practitioner does not agree to discontinue practice voluntarily.

5. If the matter cannot be handled internally, or if it jeopardizes the safety of the practitioner or others, the Hospital shall seek the advice of Hospital counsel to determine whether any conduct must be reported to law enforcement authorities or other governmental agencies and what further steps must be taken.

6. The original report and a description of the actions taken by the Chief Operating Officer, Department Chief, and/or Medical Director should be included in the practitioner's peer review file. If the investigation reveals that there is no merit to the report, the report should be destroyed. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the practitioner's personnel file and the practitioner's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem.

7. The Chief Operating Officer, Department Chief, and/or Medical Director shall inform the individual who filed the report that follow-up action was taken.

8. Throughout this process, all parties should avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy.

9. In the event of any apparent or actual conflict between this policy and the Medical Staff Bylaws. Rules and Regulations, or other policies of the Hospital or its Medical Staff, including the due process sections of those bylaws and policies, the provisions of this policy shall control.

10. Rehabilitation

    (a) Hospital and Medical Staff leadership should assist the practitioner in locating a suitable rehabilitation program. A practitioner shall not be reinstated until it is established, to the Hospital's satisfaction, that the practitioner has successfully completed a program in which the Hospital has confidence.

11. Reinstatement

    (a) Upon receiving sufficient proof that a practitioner who has been found to be suffering impairment has successfully completed a rehabilitation program, the Hospital, at its discretion, may consider that practitioner for reinstatement to the Medical Staff.

        (i) In considering an impaired practitioner for reinstatement, the Hospital and its Medical Staff leadership must consider patient care interests paramount.

        (ii) The Hospital must first obtain a letter from the physician director of the rehabilitation program where the practitioner was treated. The practitioner must authorize the release of this information. That letter shall state:

            a. whether the practitioner is participating in the program;

            b. whether the practitioner is in compliance with all of the terms of the program;

c. whether the practitioner attends AA meetings regularly (if appropriate);

d. to what extent the practitioner's behavior and conduct are monitored;

e. whether, in the opinion of those doctors, the practitioner is rehabilitated;

f. whether an after-care program has been recommended to the practitioner and, if so, a description of the after-care program; and whether, in his or her opinion, the practitioner is capable of resuming medical practice and providing continuous, competent care to patients.

(iii) The practitioner must inform the Hospital of the name and address of his or her primary care physician, and must authorize that physician to provide the Hospital with information regarding his or her condition and treatment. The Hospital has the right to require an opinion from other physician consultants of its choice.

(iv) From the primary care physician the Hospital needs to know the precise nature of the practitioner's condition, and the course of treatment as well as the answers to the questions posed above in #3, items (e) and (g).

(b) Assuming all of the information received indicates that the practitioner is rehabilitated and capable of resuming care of patients, the Hospital must take the following additional precautions when restoring clinical privileges:

(i) the practitioner must identify two (2) physicians who are willing to assume responsibility for the care of his or her patients in the event of his or her inability or unavailability;

(ii) the practitioner shall be required to obtain periodic reports for the Hospital from his or her primary physician -- for a period of time specified by the Chief Operating Officer, the Department Chief, and/or the Medical Director -- stating that the practitioner is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the Hospital is not impaired.

(c) The practitioner's exercise of clinical privileges in the Hospital shall be monitored by the department chairperson or by a physician appointed by the department chairperson. The nature of that monitoring shall be determined by the Credentials Committee after its review of all of the circumstances.

(d) The practitioner must agree to submit to an alcohol or drug screening test (if appropriate to the impairment) at the request of a member of Hospital management, a physician, or a nurse who suspects that the practitioner may be under the influence of drugs or alcohol.

(e) All requests for the information concerning the impaired practitioner shall be forwarded to the Chief Operating Officer for response.

12. Practitioner impairment may manifest itself as disruptive conduct. If the practitioner's behavior meets the definition of "Disruptive Conduct" (as defined in the Medical Staff Disruptive Conduct (Behavior) Policy), the practitioner's conduct also may be reported and reviewed in accordance with the Medical Staff Disruptive Conduct (Behavior) Policy.

Related Policy: Disruptive Conduct (Behavior) Policy

Approved: Medical Staff Executive Committee, Board of Trustees, 1990; 7/19/16
Approved: Borgess-Pipp Hospital Medical Executive Committee, 9/2004; 6/1/16

MEDICAL STAFF PEER REVIEW POLICY

I. PURPOSE

To ensure that Borgess-Pipp Hospital, through the activities of the Medical Staff, assesses the performance of individuals who are granted clinical privileges and uses the results of such assessments to improve patient care and safety.

II. GOALS

1. Improve the quality of care provided by individual physicians

2. Monitor the performance of practitioners who have privileges

3. Identify opportunities for performance improvement

4. Monitor significant trends by analyzing aggregate data

5. Assure that the process for peer review is clearly defined, fair, defensible, timely, and useful

III. OVERSIGHT AND REPORTING

Direct oversight of the peer review process is delegated by the Medical Staff Medical Executive Committee ("MEC") to the Peer Review Committee ("PRC"). The responsibilities of the PRC related to peer review are described in the Peer Review Charter. The PRC shall also report to the MEC at least quarterly, and the MEC will present a summary to the Board of Trustees at least quarterly.

IV. PEER REVIEW PROCESS

1. "Peer Review" involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner's professional performance and conduct. These activities serve as the foundation for objective, evidence-based decisions regarding a practitioner's clinical privileges, appointment to membership on the medical staff, and recommendations to grant or deny initial and renewed clinical privileges. Integrating these concepts into the peer review process provides for a more comprehensive evaluation of a practitioner's professional practice. A practitioner's professional practice may be evaluated using the following processes:

    a. General Competencies - developed by the accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative and include the following:

        i. Patient care
        ii. Medical / Clinical knowledge
        iii. Practice-based learning and improvement

iv. Interpersonal and communication skills
v. Professionalism
vi. Systems-based practice

b. Focused Professional Practice Evaluation – This concept focuses the evaluation on a specific aspect of a practitioner's performance and is used in the following three circumstances:

i. when a practitioner has the credentials to suggest competence, but they are new to the medical staff and additional information or a period of evaluation is needed to confirm competence in the organization's setting.

ii. when a practitioner currently on the medical staff has requested a privilege they were not previously privileged for.

iii. when questions arise regarding a currently privileged practitioner's ability to provide safe, high quality patient care.

c. Ongoing Professional Practice Evaluation – This is a process in which an ongoing evaluation is conducted of a practitioner's professional performance. The criteria used in the ongoing professional practice evaluation may include the following:

i. review of operative and other clinical procedure(s) performed and their outcomes
ii. pattern of blood and pharmaceutical usage
iii. requests for tests and procedures
iv. length of stay patterns
v. morbidity and mortality data
vi. practitioner's use of consultants
vii. operative infection rates
viii. data from national data bases
ix. compliance with Medical Staff Bylaws, Rules and Regulations
x. patient and staff complaints
xi. other relevant criteria as determined by the Medical Staff.

The Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation are more fully discussed below in Section V.

2. Peer review shall be conducted by a peer who is practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a cases-by-case basis. For example, for quality issues related to general medical care, any physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, however, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty.

3. Peer review bodies shall include the PRC and other individuals or committees conducting or reviewing peer review information.

   a. For purposes of cases reviewed by the PRC, the initial review shall be performed by the Medical Director, Chair of the PRC, or any member of the PRC to determine the degree of subject matter expertise required in order to be considered a peer. In order to minimize individual or specialty bias, the PRC shall be composed of the Secretary of the Medical Staff and nine physicians from different specialties or departments appointed by the Medical Director. The Chair of the Peer Review Committee will be selected from the existing PRC membership as described in the Peer Review Policy. The PRC may request additional clinical expertise from any specialist on the Medical Staff as it deems appropriate.

   b. Other individuals or bodies conducting peer review shall determine the peer required to conduct a review, as appropriate.

4. Peer review performance indicators that shall be used as measurement tools in evaluating a practitioner's performance include, but are not limited to, the following:

   a. Case Review Indicators – performance brought into question by a specific event and brought to the PRC or other individual or committee via adverse event review, root cause analyses, incident reporting mechanism, patient/family complaint, mortality review, or direct referral from any source to the Medical Staff Office.

   B. Rule Indicators – performance measured against a general rule, standard or recognized professional guideline, or accepted practice.

   c. Rate Indicators – performance measured through aggregated statistical data with target ranges established for each indicator.

5. Conflict of Interest - A member of the Medical Staff asked to perform peer review may have a conflict of interest if he/she might not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the physician involved as a direct competitor or partner. It is the individual reviewer's obligation to disclose the potential conflict. The PRC, or other peer review committee or body, has the responsibility to determine whether the conflict would prevent the individual from participating and the extent of that participation. Individuals determined to have a conflict may not be present during committee discussion or decision, other than to provide requested information.

V. PROCEDURAL DETAIL

1. Focused Professional Practice Evaluation

   a. New Practitioners.

i. A period of focused review shall be implemented on all new practitioners with clinical privileges.

ii. The review process is overseen by the involved Department Chief(s), or his/her designee, who will designate the appropriate evaluator. This review process shall include the development of criteria that determines the type of monitoring to be conducted.

iii. The review may include chart review, monitoring clinical practice patterns, proctoring, external peer review, direct observation, and discussion with other individuals involved in the care of each patient.

iv. Rule and rate indicators may be utilized in the evaluation process.

v. The focused evaluation process shall last for a period of not less than three (3) months or completion of the predetermined number of procedures, whichever is greater. At the conclusion of the evaluation process a formal report will be sent to the Department Chief and copied to the Credentials Committee.

vi. At the discretion of the Department Chief, the focused evaluation period may be extended until the practitioner has satisfactorily demonstrated privilege-specific competency.

vii. The results of each new practitioner's professional practice evaluation shall be reported to the Credentials Committee.

viii. If the Department Chief, the PRC, or the Medical Director, determine that an individual performance improvement plan is indicated, the Department Chief, along with the Medical Director, shall develop the action plan and present to the practitioner, provided such action plan does not limit or restrict the practitioner's clinical privileges. The action plan and results of the action plan shall be reported to the PRC.

ix. In developing an action plan, if there are concerns that the action plan could involve a limitation or restriction of clinical privileges or medical staff membership, the matter will be referred to the MEC for its consideration.

x. Subsequent to the FPPE, periodic evaluations will continue thru the provisional period of staff membership.

b. Currently Privileged Practitioners requesting new privileges.

i. A period of focused review shall be implemented on all practitioners seeking any new clinical privileges.

ii. The review process is overseen by the involved Department Chief(s), or his/her designee, who will designate the appropriate evaluator. This review process shall include the development of criteria that determines the type of monitoring to be conducted.

iii. The review may include chart review, monitoring clinical practice patterns, proctoring, external peer review, direct observation, and discussion with other individuals involved in the care of each patient.

iv. Rule and rate indicators may be utilized in the evaluation process.

v. The focused evaluation process for the new privilege shall last for a period of not less than three (3) months, or the completion of the predetermined number of procedures, whichever is greater. At the conclusion of the evaluation process a formal report will be sent to the Department Chief and copied to the Medical Executive Committee.

vi. At the discretion of the Department Chief and/or the Medical Executive Committee, the focused evaluation period may be extended until the practitioner has satisfactorily demonstrated privilege-specific competency.

c. Currently Privileged Practitioners when concerns are identified through OPPE, peer review or other means.

i. The PRC shall conduct a focused professional practice evaluation when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. Focused professional practice evaluation can be triggered by a single incident or by evidence of a clinical practice trend.

ii. The review may include chart review, monitoring clinical practice patterns, proctoring, external peer review, direct observation, and discussion with other individuals involved in the care of each patient. This review process shall include the development of criteria that determines the type of monitoring to be conducted.

iii. Case review, rule, and rate indicators may be utilized in the evaluation process.

iv. The PRC, along with the Chief of the Department in which the practitioner has privileges shall work together to create and implement an improvement action plan if the results of the focused practice evaluation indicate a need for individual performance improvement, provided such action plan does not limit or restrict the practitioner's clinical privileges.

v. The PRC Chair and/or the Department Chief(s) and/or the Medical Director shall meet with the involved practitioner to present the action plan.

vi. The PRC, or its appointed designee for this purpose, shall conduct ongoing monitoring of the action plan.

vii. The action plan and results of action plan shall be reported to the PRC.

viii. If the PRC Chair or the Department Chief has concerns that the improvement plan may be more complex than usual, or that recommendations may result in adverse action (i.e., restriction of privileges or membership), the matter will be referred to the MEC for its consideration.

2. Ongoing Professional Practice Evaluation

a. Ongoing professional practice evaluations shall be completed on all credentialed practitioners less than every twelve (12) months.

b. The criteria used in OPPE are defined in Section IV. C. of this policy.

c. Department specific indicators may also be identified and approved by the medical staff of the department.

d. The preparation of the OPPE is done under the supervision of the Medical Director. The Department Chief is responsible for reviewing the report.

e. The report is shared with the practitioner and any concerns discussed with the Department Chief and /or Medical Director.

f. Concerns identified will promptly (no more than 30 days) be brought to the Peer Review Committee for consideration of a focused professional practice evaluation.

g. The results of the OPPE will be sent to the MEC within 30 days of its completion and considered by the Medical Executive Committee at the time of reappointment.

3. The PRC shall make the determination on the need for external peer review. No practitioner can require the Hospital to obtain external peer review if it is not deemed appropriate by the PRC. External peer review will take place under the following circumstances if deemed appropriate by the MEC.

a. Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or Medical Staff committees and conclusions from this review will directly affect a practitioner's membership or privileges.

b. Lack of internal expertise – when no one on the Medical Staff has adequate expertise in the specialty under review or when the only practitioners on the Medical Staff with that expertise are determined to have a conflict of interest with the practitioner under review as described above. External peer review will take place if this potential for conflict of interest cannot be resolved appropriately by the MEC or the Board of Trustees.

c. New technology – when a Medical Staff member requests permission to use new technology or perform a procedure new to the Hospital and the Medical Staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved. At the discretion of the MEC, peer review under this circumstance may be conducted by retrospective chart review or direct observation by a physician outside the Medical Staff.

d. Litigation – when dealing with the potential of a lawsuit.

e. Any other circumstance(s) that the MEC or the Board deems appropriate for external review.

4. All peer review information is privileged and confidential in accordance with Medical Staff and Hospital Bylaws, State laws, and Federal laws and regulations pertaining to confidentiality and non-discoverability.

5. All practitioners will receive provider-specific feedback on a routine basis.

6. Any peer review conducted by an individual or peer review body other than the PRC, shall report its findings to the PRC within thirty (30) days of completing the review.

7. Provider-specific peer review results will be considered in the credentialing and privileging process, ongoing provider-specific practice evaluation, and, as appropriate, in performance improvement activities.

8. The Medical Staff Office will maintain provider-specific peer review and other quality information concerning a practitioner in a secure, locked file. Provider-specific information includes information related to:

a. performance data for all dimensions of performance measured for that individual physician

b. the individual physician's role in sentinel events, significant incidents, or near misses

c. correspondence to the physician regarding commendations, comments regarding practice performance or corrective action.

9. Peer review information is available only to authorized individuals who have a legitimate need to know or view the information based upon his/her responsibilities as a Medical Staff leader, hospital employee, hospital legal counsel or Board member. However, he/she shall have access to the information only to the extent necessary to carry out his/her assigned hospital responsibilities. Only the following individuals shall have that access to provider-specific peer review information:

    a. Board of Trustees

    b. Medical Staff Officers

    c. Medical Staff Department Chiefs (for members of their Department only)

    d. Members of the Medical Executive Committee

    e. Hospital Risk Manager

    f. Medical Staff Office staff to the extent that access to this information is necessary for the re-credentialing process or formal corrective action

    g. Individuals with legitimate purpose for access as determined by the Medical Director

    h. The Hospital COO, or designee, for purposes of summary, when information is needed to take immediate formal corrective action

    i. The Hospital legal counsel

10. No copies of peer review documents will be created and/or distributed unless authorized by the Medical Director.

11. A physician may review his/her own peer review file in the Medical Staff Office in connection with a professional practice matter related to the requesting physician, but may not make copies of information contained in his/her peer review file, except in preparation for a Medical Staff hearing or appellate review only after the physician has requested such hearing or appellate review pursuant to Article IX of the Medical Staff Bylaws. Any request for copies pursuant to this paragraph shall be limited to the subject of the hearing or appellate review.

VI. PARTICIPANTS IN THE REVIEW PROCESS

The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities. The PRC should consider and record the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual, if that individual responds within the appropriate time frame.

In the event of a conflict of interest or circumstances that would suggest a biased review, the PRC or the MEC will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

VII. STATUTORY AUTHORITY

The above policy is based upon the statutory authority of the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101 *et seq.*, and Michigan Public Health Code 333.20175 and 333.21515.

Approved: BPH Medical Staff –5/12/2010; 6/1/16
Board of Trustees –9/27/2007; 5/22/2010; 7/1/9/16
MEC - 9/2004; 9/27/2007; 5/12/2010; 6/15/16

Revised 5/2010

SEDATION AND ANALGESIA POLICY

POLICY

The Medical Staff of Borgess-Pipp Hospital recognize the need to ensure the safety of patients undergoing Moderate or Deep conscious sedation throughout the Hospital. Applicable standards of The Joint Commission will be met.

DEFINITIONS

The Medical Staff recognizes the four levels of sedation defined by the American Society of Anesthesiologists (ASA) and The Joint Commission.

1. Minimal Sedation (Anxiolysis): A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

2. Moderate Sedation/Analgesia (Conscious Sedation): A drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. A patent airway is maintained and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3. Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully to repeated or painful stimulation. The ability to independently maintain a patent airway and ventilatory function may be impaired. Airway management intervention may be required. Cardiovascular function is usually maintained.

4. Anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimuli. It must be provided by a member of the Anesthesiology Department and at a site in which general anesthesia is within their scope of service.

PROCEDURE

1. Conscious sedation is a continuum; the exact level of sedation can be difficult to predict. Therefore, non-anesthesiologists who have privileges for the administration of Moderate Sedation/Analgesia, i.e., conscious sedation, must have the skills to rescue patients who enter a state of Deep Sedation/Analgesia.

2. General Anesthesia will be administered by Certified Registered Nurse Anesthetist (CRNA) who is supervised by a surgeon.

3. Planned Deep Sedation and Analgesia will be administered by qualified physicians who have received appropriate privileges to rescue patients from General Anesthesia and who

must be competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation. Such physicians should be experienced in endotracheal intubation, have performed intubations on a regular basis, and hold current membership in the Departments of Surgery or Emergency Medicine.

4. Moderate (conscious) Sedation will be provided entirely by a member of the Medical Staff who has been privileged to do so. The individual requesting this privilege will be required to study the current Patient Care Policy and Procedure Sedation and Analgesia and any other applicable Hospital policies deemed appropriate by the Department of Surgery and Emergency Medicine. The individual will demonstrate competence bypassing at the 80% level a written examination that it based upon these educational materials.

5. The Hospital patient care policy, Sedation and Analgesia, has been approved by the Medical Staff Executive Committee. This policy identifies required pre-assessment examination, training of team members, supervision of patients receiving or recovering from sedation and analgesia, equipment that must be available at the site of administration, monitoring protocols, documentation standards, and discharge protocols. Moderate Sedation/Analgesia provided entirely by a member of the Medical Staff must comply with this policy.

6. Audits of compliance will be performed periodically and reviewed by the Chief Nurse Officer and the Chief of the Department of Surgery and Emergency Medicine. Physician representatives from areas utilizing Moderate Sedation & Analgesia, such as GI Lab, Radiology Special Procedures, Emergency and Trauma Department, Orthopedics, and Surgery, may also participate in the review.

7. Respective Chiefs of the Departments of Emergency medicine and Surgery will monitor competency-based training/education and adherence to airway management intubation guidelines on the part of such physicians providing Deep Sedation. A quality-monitoring tool will be utilized for cases involving planned deep sedation performed by physicians who have membership In the Department of Emergency Medicine and Surgery. Such data will be reported every six (6) months to the Medical Director. Upon review, the Chief shall forward the report to the Medical Executive Committee for further review and acceptance of the Executive Committee.

8. The Medical Staff Executive Committee must approve recommended changes in the policy governing sedation.

9. Physicians who repeatedly fail to comply with the requirements outlined in the Hospital patient care policy, Care of the Patient Receiving Sedation and Analgesia, will be deemed to voluntarily relinquish the Moderate Sedation/Analgesia privilege.

Approved: Medical Staff Executive Committee, 2/ 2001; 6/15/16
Approved: Board of Trustees, 3/2001; 7/1/9/16
Revised: Borgess-Pipp Hospital Medical Staff Executive Committee, 8/2004
Approved: Borgess-Pipp Hospital Medical Staff Executive Committee, 1/2005; 6/1/16

SEXUAL HARASSMENT POLICY

POLICY

The Medical Staff supports Borgess-Pipp Hospital's policy that sexual harassment, intimidation, or exploitation of any employee will not be tolerated, in accordance with Title VII of the Civil Rights Act of 1964. Furthermore, the Medical Staff supports the Hospital in its efforts to ensure that employees, patients, and members of the Medical Staff have recourse should acts of sexual harassment occur and has adopted a procedure to address any such complaints issued in regard to a Medical Staff appointee.

DEFINITION

Sexual harassment includes unwelcome sexual advances, requests for sexual attention as a condition of employment or professional relationship, or other verbal or physical conduct of a sexual nature, where there is an attempt to make submission to such conduct a term or condition of an individual's employment or professional relationship.

Sexual harassment also includes the submission to or rejection of such conduct used as a basis for employment-related decisions and situations in which such conduct has the purpose or effect of substantially interfering with an individual's work performance or of creating an intimidating, hostile, or offensive work environment.

PROCEDURE

The following procedure shall apply if any individual is the object or observer of a Medical Staff appointee engaging in conduct or behavior that constitutes sexual harassment.

1. A written report shall be filed with the employee's supervisor, or in the case of a Medical Staff member, with the Department Chief and/or Medical Director, who shall forward it to the Chief Operating Officer. The report shall include a factual description of the incident or statement and shall be signed by the person making the complaint.

2. If, after a discussion with the individual who filed the report, it is found to constitute a credible report of conduct that constitutes sexual harassment, the Chief Operating Officer shall share the complaint(s) with the chief of the department and/or the Medical Director.

3. The Medical Staff appointee involved shall be required to meet with Hospital and Medical Staff leadership -- the Chief Operating Officer, Department Chief, and/or the Medical Director. The Medical Staff appointee shall be advised of the complaint(s) and be given an opportunity to respond. If, at the conclusion of that discussion, Hospital and Medical Staff leadership are convinced that the reported acts did occur, the Medical Staff appointee shall be advised that such conduct is intolerable and in violation of federal law.

4. If at any time the Medical Staff Leadership and the Chief Operating Officer believe they lack reasonable cause to believe that the reported conduct or behavior occurred and

constitutes sexual harassment, no further action shall be taken and the matter shall be deemed closed, unless a request for corrective action is or has been submitted or another complaint is subsequently submitted.

5. If it is determined that the reported acts did occur, the Medical Staff appointee should, if appropriate, be given an opportunity to voluntarily cease the conduct that gave rise to the complaint, and to apologize to the individual(s) involved.

6. If the Medical Staff appointee refuses to agree to stop the conduct immediately, a formal warning will be issued and the Medical Staff appointee shall be advised that he or she will not be permitted to associate with Hospital employees until that agreement is obtained. Thus, the practitioner shall not be permitted to enter the Hospital. That is not a suspension of clinical privileges, even though the effect is the same. The Hospital, however, has no choice but to protect employees from harassing conduct.

7. If the individual has agreed to stop such conduct, the meeting shall be followed up with a formal letter of reprimand and warning which will be placed in his or her confidential peer review file.

8. The matter shall be reported to the Credentials Committee and the Operating Committee of the Medical Staff along with a brief explanation of the circumstances and the applicable law.

9. Any further reports of harassment, after the Medical Staff appointee has agreed to stop the harassing conduct, shall result in exclusion of the individual from the workplace and institution of formal disciplinary action in accordance with the Medical Staff Bylaws.