

BYLAWS

OF THE

MEDICAL STAFF OF HENRY FORD WYANDOTTE HOSPITAL

**As adopted by the Henry Ford Health System Board
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BYLAWS
OF THE
MEDICAL STAFF OF HENRY FORD WYANDOTTE HOSPITAL

PREAMBLE

The Practitioners practicing at Henry Ford Wyandotte Hospital adopt these Bylaws for the purpose of (1) describing the organizational structure of the Medical Staff and the rules for its self-governance, and (2) carrying out its responsibilities relating to the quality of patient care at the Hospital.

ARTICLE I.

NAME

The name of this organization shall be “The Medical Staff of Henry Ford Wyandotte Hospital.”

ARTICLE II.

DEFINITIONS AND INTERPRETATION

2.1 DEFINITIONS

In these Bylaws, and in the Rules adopted in conformity herewith, the following terms are defined.

Activity Unit means an inpatient admission, or a procedure, consultation or test interpretation performed at the Hospital.

Administration means the executive and administrative organization of the Hospital headed by the CEO.

Allied Health Professional or “AHP” means an individual, other than a licensed allopathic or osteopathic physician, dentist or podiatrist whose patient care activities require that his or her authority to perform specified patient care services be processed through the usual Medical Staff channels. Allied Health Professionals are not Members of the Medical Staff. The Board, acting on the recommendation of the MEC, shall determine from time to time which categories of licensees are eligible for AHP status.

Approved residency means for physicians, a post-graduate specialty training program accredited by the American Medical Association’s Council for Graduate Medical Education or the American Osteopathic Association (including its councils or committees which accredit osteopathic graduate medical education programs); and for podiatrists, a post-graduate training program in podiatry approved by the Council on Podiatric Medical Education.

Board certified means that a physician or dentist is certified by a specialty board organization, recognized as such by the American Board of Medical Specialties, the American Osteopathic Association, or the American Dental Association, or that a podiatrist is certified by the American Board of Podiatric Surgery.

Board eligible means that a physician or dentist is determined by a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the American Dental Association to be eligible to sit for that specialty board's certification examination, or that a podiatrist is determined by the American Board of Podiatric Surgery to be eligible to sit for that Board's certification examination.

Board of Trustees or Board means the governing body of the Hospital, or a body specifically designated by the full Board to act on its behalf (e.g., the executive committee of the Board).

Bylaws means these Bylaws of the Medical Staff of the Hospital.

Chief Executive Officer or CEO means the chief executive officer of the Hospital appointed by the Board and, unless specifically required otherwise, includes his or her designee; a "designee" of the CEO shall be a person the CEO specifically designates to act in his or her place and stead, or a person within the Administration of the Hospital who is designated by means of a policy or organization chart approved by the CEO or Board.

Clinical area means a Hospital department, service, cost center, or unit such as physical therapy, respiratory care, or critical care.

Clinical Director means a physician who is qualified based upon special training and experience to administer the medically-related professional and administrative aspects of a clinical area and who has been appointed by the CEO, in consultation with the MEC, to do so.

Clinical privileges or privileges means the permission granted consistent with these Bylaws to a Member to render specific form(s) of direct patient care at the Hospital.

Contract Practitioner is defined in Section 4.7.1 below.

CVO means the Henry Ford Health System Medical Staff Credentials Verification Office.

Dentist means a person licensed to practice dentistry in the State of Michigan.

Department Chairperson means the Member duly appointed/elected in accordance with these Bylaws to serve as the head of a Medical Staff Department.

Ex officio means service on a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

Hospital means Henry Ford Wyandotte Hospital, including the Henry Ford Health Center - Brownstown.

Hospital-Based means a department, division or clinical area whose Members are Contract Practitioners.

MEC or Executive Committee means the Executive Committee of the Medical Staff.

Medical Staff means the organized medical staff of the Hospital composed of physicians, dentists, and podiatrists who have been granted clinical privileges (other than temporary) to practice in the Hospital.

Medical Staff Policy means a policy of the Medical Staff at large (rather than affecting only selected Department(s)) that is adopted in accordance with Article XV (Authority to Make Rules and Policies).

Medical Staff Year means the 12-month period beginning January 1 and ending December 31.

Member (when capitalized) means a member of the Medical Staff.

Physician means a person licensed to practice allopathic or osteopathic medicine in the State of Michigan.

Podiatrist means a person licensed to practice podiatric medicine and surgery in the State of Michigan.

Practitioner (when capitalized) means a health care professional (i.e., Member and Allied Health Professional) granted Medical Staff membership and clinical privileges or specified service authority in the Hospital.

President of the Medical Staff or President means the elected chief of the Medical Staff.

Rules means the Medical Staff and Departmental rules and regulations and Medical Staff Policies adopted in accordance with Article XV (Authority to Make Rules and Policies).

Special notice means written notice (a) sent by receipted overnight delivery service, (b) sent by certified or registered mail, return receipt requested, or (c) delivered in person by a representative of the Hospital.

Specified service authority means the permission given to an Allied Health Professional to perform specified types of clinical services at the Hospital under the supervision of a Member.

Vice President for Medical Affairs or VPMA means the physician appointed by the Chief Executive Officer, with input from the Medical Executive Committee, to act on behalf of Administration and the Board in coordinating the Hospital's clinical activities with the Medical Staff.

2.2 INTERPRETATION

Terms used in these Bylaws shall be read as a singular or plural, as the context requires. The headings in these Bylaws do not limit or alter the content of these Bylaws.

ARTICLE III.

PURPOSE AND RESPONSIBILITIES OF THE MEDICAL STAFF

3.1 PURPOSE OF THE MEDICAL STAFF

The purposes of the Medical Staff are:

- 3.1.1 to strive to maintain a uniform standard of quality and efficient patient care in the Hospital at a level consistent with community standards;
- 3.1.2 to serve as the primary means for assessing the appropriateness of the professional performance and ethical conduct of the Members and other Practitioners;
- 3.1.3 to be the formal organizational structure through which:
 - 3.1.3.1 the obligations of Medical Staff membership may be fulfilled, and
 - 3.1.3.2 the benefits of membership on the Medical Staff may be obtained by individual physicians, dentists, and podiatrists.

3.2 RESPONSIBILITIES OF THE MEDICAL STAFF

The responsibilities of the Medical Staff are:

- 3.2.1 to strive to achieve quality professional performance of all Practitioners in the Hospital;
- 3.2.2 to provide a continuing medical education program based in part on accumulated knowledge from quality assessment activities;
- 3.2.3 to provide a utilization review program to allocate medical and health services based upon determination of individual medical needs;
- 3.2.4 to structure itself to monitor patient care practices and provide a uniform standard of quality of care by all Practitioners in the Hospital;
- 3.2.5 to conduct reviews and evaluations of the quality of patient care rendered by Practitioners;
- 3.2.6 to recommend to the Board action with respect to Medical Staff appointment and reappointment, Medical Staff category, clinical privileges of Members, and the specified service authority of AHPs;

- 3.2.7 to advise the Board regarding the quality and efficiency of patient care rendered to patients at the Hospital through reports and recommendations;
- 3.2.8 to initiate and conduct corrective action with respect to Practitioners when warranted;
- 3.2.9 to develop, administer and seek compliance with these Bylaws and the Rules;
- 3.2.10 to assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs;
- 3.2.11 to coordinate and participate in medical student and resident education activities at the Hospital;
- 3.2.12 to conduct care and treatment for patients in a manner and an atmosphere free of discrimination because of sex, creed, national origin, race, religion, sexual preference, physical handicap, marital status or source of payment.

ARTICLE IV.

MEDICAL STAFF MEMBERSHIP

4.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of the Hospital shall be extended only to a professionally competent physician, dentist or podiatrist who continuously meets the requirements set forth in these Bylaws, as determined by the MEC and the Board following the processes set forth in these Bylaws. A Member shall exercise only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws, following receipt of a recommendation of the MEC.

4.2 GENERAL CONSIDERATIONS FOR APPOINTMENT

4.2.1 Ability to Accommodate the Applicant

Appointments and privilege delineations shall take into account the present and future needs of the communities within the Hospital's service area, taking into consideration:

- 4.2.1.1 the Hospital's ability to provide adequate facilities and support services for the applicant and his or her patients;
- 4.2.1.2 the need for the professional skills of the applicant in the Hospital's delivery of care to its patients; and
- 4.2.1.3 Hospital contractual obligations.

Denial of appointment or clinical privileges on this basis shall not be considered an expression of any kind on the applicant's qualifications but rather is based on an inability to accommodate the applicant.

4.2.2 Non-Discrimination

Decisions regarding membership on the Medical Staff and clinical privileges shall not be based upon the applicant's race, creed, age, sex, national origin, or any other basis prohibited by law.

4.3 BASIC QUALIFICATIONS FOR MEMBERSHIP ON THE MEDICAL STAFF

Each physician, dentist and podiatrist who applies for membership on the Medical Staff, and each Member, must continuously possess the following qualifications:

4.3.1 Licensure

The practitioner must be currently licensed to practice medicine, dentistry, or podiatry in the State of Michigan. A practitioner who wishes to prescribe controlled substances in the Hospital must possess the required valid state and/or federal license(s) to do so.

4.3.2 Education

The practitioner must provide evidence of satisfactory performance at and completion of appropriate education in his or her profession.

4.3.3 Background, Experience and Competency

The practitioner shall document his or her background, experience, training, judgment and demonstrated competency. A dentist, except one seeking or holding privileges to perform only general practice, shall be at minimum a specialty licensed dentist. Physicians, podiatrists and oral surgeons shall, at minimum, have completed an approved residency program in their specialty.

Board certification is encouraged for physicians, podiatrists and oral surgeons who joined the Medical Staff prior to July 29, 2004, but not required unless certification was required in their Departments prior to July 29, 2004.

Physicians, podiatrists and oral surgeons who join the Medical Staff after July 29, 2004 must at all times:

- a. be board eligible, and obtain board certification within five years of becoming board eligible. Failure to become board certified within five years after becoming eligible will cause the practitioner's Medical Staff membership to terminate automatically, unless the MEC and Board of Trustees determine there is a good cause for an extension of the deadline for certification or that the practitioner has established comparable

education, training and competence through the medical staff credentialing process consistent with this section and a waiver of the requirement has been recommended by the Credentials Committee and the MEC;

or

- b. be board certified and maintain board certification in the specialty(s) corresponding to their current privileges. Members are expected to maintain board certification without interruption, and to continuously work towards completion of board certification requirements, unless the MEC and Board of Trustees determine there is a good cause for an extension of the deadline for re-certification or unless the practitioner has established comparable education, training and competence through the medical staff credentialing process consistent with this section and a waiver of the requirement has been recommended by the Credentials Committee and the MEC and approved by the Board.
- c. Waiver of board certification shall be considered for an applicant for whom the following is documented:

“Citizen of the World”

An individual whose accomplishments and expertise are nationally/internationally recognized and has knowledge, skill or other qualifications that only a few individuals could bring to Henry Ford; or

Familiarity with Competence of Candidate by Direct Observation by current HFW medical staff member(s); or

Equivalent Certification

The candidate is certified by a group that ACGME/AOA considers peer: as example, the Royal Colleges of Physicians and Surgeons of Canada, United Kingdom

Termination of membership due to failure to obtain or maintain board certification is not subject to hearing or appeal.

4.3.4 Ethics

The practitioner shall adhere to the ethics of his or her profession, comply with applicable law, maintain a reputation which enhances and does not detract from the stature of both him or her and the Hospital in the community.

4.3.5 Work Cooperatively With Others

The practitioner shall work cooperatively with other practitioners and supporting staff and conduct himself or herself in a manner consistent with the Medical Staff Code of Conduct.

4.3.6 Capability to Practice

The practitioner's mental and physical health status must be such that he or she is capable of appropriately and safely performing the clinical privileges he or she seeks or holds.

4.3.7 Osteopathic Physicians

Osteopathic physicians shall subscribe to and utilize the distinctive osteopathic approach in the provision of care.

4.3.8 Professional Liability Insurance

Each member shall maintain in force professional liability insurance in not less than the minimum amounts, if any, as from time to time may be jointly determined by the Board of Trustees and the Medical Executive Committee. The MEC, for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary, discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:

- 1) Whether the member has applied for the requisite insurance;
- 2) Whether the member has been refused insurance and, if so, the reasons for such refusal; and
- 3) Whether insurance is reasonably available to the member and, if not, the reasons for its unavailability.

4.4 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

In addition to maintaining the qualifications set out in Section 4.3, each Member shall fulfill the following basic responsibilities:

4.4.1 Recognized Quality of Care

A Member shall provide continuous care for, and supervision of, his or her patients; said care shall be at the level generally accepted as consistent with community standards and available resources.

4.4.2 Compliance With Medical Staff Documents

A Member shall abide by the Medical Staff Bylaws and Rules.

4.4.3 Timely Completion of Records

A Member shall prepare and complete in a timely manner the medical and other records required by Medical Staff Rules for all patients he or she admits or to whom he or she provides care in the Hospital.

4.4.4 Histories and Physicals

As required by the Medicare Conditions of Participation, CFR 482.22(c)(5), a physical examination and medical history must be completed and documented for each patient no more than thirty (30) days before or twenty-four (24) hours after an admission or registration, but before surgery or a procedure requiring anesthesia. If the history and physical were performed before admission or registration, an updated examination of the patient must be completed and documented within twenty-four (24) hours after admission or registration, but before surgery or a procedure requiring anesthesia. The physical examinations and histories and updates thereto described in this Section shall be performed and documented by (a) a physician Member, (b) an oral surgeon, in appropriate cases described in Section 7.1.4, or (c) an Allied Health Professional, provided the Practitioner has been granted privileges or specified service authorization, as applicable, in accordance with these Bylaws, to perform the function. Additional requirements regarding histories and physicals are contained in the Rules.

4.4.5 Required Consultations

Members shall comply with the consultation requirements contained in the Rules.

4.4.6 Office Location

A Member's office shall be located within a reasonable distance of the Hospital as necessary to meet direct patient care needs and to assure continuity of care for patients. Exceptions to this rule may be made by the MEC and the Board, for good cause, when in their judgment there are adequate assurances that the Member's patients will have continuity of care.

4.4.7 Discharge of Medical Staff Responsibilities

A Member shall discharge such Medical Staff and Hospital functions for which he or she is responsible by appointment, election, or assignment, including meaningful service upon Medical Staff, Hospital and interdisciplinary committees when appointed to serve and maintaining the confidentiality of quality and peer review information.

4.4.8 Reporting of Governmental Actions

A Member shall report to the VPMA sanctions, fines, convictions, terminations, suspensions, and other similar adverse action taken by a governmental agency

relating to the Member's professional activities or license within three business days.

4.4.9 Risk Management

A Practitioner shall participate meaningfully in Hospital's programs for risk management and promotion of patient and staff safety and support activities designed to address issues identified by these programs, as reasonably requested by the Hospital.

4.5 PROCEDURE FOR INITIAL APPOINTMENT

4.5.1 Initiation of Process

A physician, dentist or podiatrist desiring to become a Member of the Medical Staff shall request an application form from the CVO. The CVO shall furnish him or her an application and a copy of the Bylaws and Rules of the Medical Staff.

4.5.2 Application Form

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form, and signed by the applicant.

4.5.3 Applicant's Responsibility

The applicant shall have the responsibility of timely producing adequate information for proper evaluation of all his or her qualifications for Medical Staff membership and privileges, as well as resolving any doubts about any qualification. The applicant shall complete the application in a complete and intellectually honest manner. Inaccuracies of any kind in the application or supporting documents, including misleading or incomplete statements, which are attributable to the applicant and are deemed material by the MEC or Board may be grounds for rejection of the application. An application will not be processed if the applicant fails to meet the minimum objective criteria for Medical Staff membership.

4.5.4 Effect of Application

By applying for appointment to the Medical Staff, the applicant confirms his or her agreement to the terms of these Bylaws including Article XIII (Confidentiality, Immunity, and Releases.)

4.5.5 Submission and Verification of the Application

The applicant shall submit his or her completed application to the CVO. The CVO shall then, in a timely fashion, seek to collect or verify the credentialing information submitted, and shall confirm the applicant's identity and query the National Practitioner Data Bank concerning the applicant. In verifying such information, primary data sources will be used whenever feasible. If the applicant completed

residency training within the last five years, one peer recommendation shall be from the director of the applicant's residency program and, if the applicant is currently a member of another hospital medical staff, one peer recommendation shall be from the chair of the medical staff department or chief of the medical staff division to which the applicant is assigned at that hospital. The CVO shall obtain and consider additional information from other sources such as the American Medical Association Physician Masterfile and the American Osteopathic Association Physician Database. The CVO shall notify the applicant of any information needed to complete the application. An application shall not be considered to be complete until all information has been collected and verified. If an application remains incomplete six months after it was received by the CVO, the application will be deemed withdrawn with no evaluation of the applicant made. If an applicant whose incomplete application was deemed withdrawn wishes to pursue Medical Staff membership, he or she must complete a new application and proceed through the normal credentialing process.

4.5.6 Interviews, Questions and Documentation

At any time in the application review process (or the reappointment review process described in Section 4.6), the applicant may be required, by request of the MEC or Credentials Committee, to:

- 4.5.6.1 appear before the requesting body for an interview where the applicant will be required to answer questions regarding his or her application and related matters; and/or
- 4.5.6.2 prepare and submit, within 30 days after a written request, a signed statement answering questions posed by the requesting body(ies), regarding his or her application and related matters. A written copy of the questions, the applicant's written statement and supporting materials will be kept and made part of the documentation relating to the application.

If either the MEC or Credentials Committee wishes to interview or submit written questions to an applicant pursuant to this section, this should be done with advance notice to the other, to facilitate mutual participation in the process.

4.5.7 Recommendations

Each individual and committee that is responsible for making a recommendation regarding an application shall recommend acceptance or rejection of the application and, if acceptance is recommended, recommend which clinical privileges should be granted. The reason(s) for any adverse recommendation shall be stated. Applications shall be considered in a timely manner and, except for good cause (such as the need to table an application in order to secure additional information), shall be processed within the time periods stated in these Bylaws.

4.5.8 Department Recommendations

Within 30 days after an application is deemed to be complete, the CVO shall transmit the application form and all supporting materials to the chairperson of every department in which the applicant seeks clinical privileges. The chairperson's review may include an interview with the applicant. Each Department Chairperson shall submit his or her recommendation to the Credentials Committee within 30 days after receiving the application.

4.5.9 Credentials Committee Recommendation

The Credentials Committee shall review and evaluate the application and supporting materials, including the chairperson's recommendation, and shall make a written recommendation to the MEC within 60 days after the Credentials Committee receives the completed application. Along with its report, the Credentials Committee shall transmit to the MEC the completed application and all other documentation considered in arriving at its recommendation.

4.5.10 Executive Committee Recommendation

Within 60 days after the MEC receives the report of the Credentials Committee, the MEC shall consider the application and make a written recommendation. A favorable recommendation shall be forwarded to the Board for action. When an MEC recommendation is unfavorable, the CEO will notify the applicant of his or her right to review pursuant to these Bylaws. If the applicant does not submit a timely request for review, the applicant will be deemed to have acquiesced in the adverse recommendation or action, with the following results:

- (a) If the MEC recommended non-appointment, the application will be considered withdrawn and will not be submitted to the Board for action;
- (b) If the MEC recommended less than all of the privileges the applicant requested, assignment to a different department or category than requested, or imposition of special conditions on the applicant, the applicant will be deemed to have requested said changes.

4.5.11 Special Definitions

As used in this Article IV:

- (a) "Favorable" means a recommendation by the MEC or a decision by the Board to grant membership on the Medical Staff, with all privileges requested by the applicant;
- (b) "Unfavorable" means an MEC recommendation or Board decision which is not "favorable," as defined above.

4.5.12 Board Action

At the next regularly scheduled meeting of the Board following receipt of a favorable MEC recommendation regarding an applicant or following waiver or exhaustion of an applicant's procedural rights described in these Bylaws, the Board shall take action on the recommendation. However, in any case where the Board does not agree with the recommendation of the MEC, the application shall be referred to the Joint Conference Committee for review and recommendation before final action by the Board. The CEO shall notify the applicant of the Board's action. If the Board's action is favorable, that action is final. If the Board's action is unfavorable, the decision will not be final until the Member's rights (if any) under these Bylaws are exhausted or waived.

4.6 REAPPOINTMENT

4.6.1 Periodic Review

Each Member may be appointed to the Medical Staff for a term of up to two years. All Members are required to request reappointment prior to expiration of their current term, in order to maintain Medical Staff membership. Requests for reappointment are subject to review as to both continued Medical Staff membership and clinical privileges. The review will evaluate the Member's continued ability to provide quality care within the privileges requested. Reappointment forms must be completed and returned by the date designated by the MEC.

4.6.2 Application

Each application for reappointment to the Medical Staff shall be in writing, submitted on the prescribed form, and signed by the Member. The Member's responsibilities for completing this form shall be the same as those of an initial applicant submitting an application (Section 4.5.3). (See Section 11.5 regarding notice of pending investigation to a Member who opts not to request reappointment or renewal of privilege(s).)

4.6.3 Verification of Information

The CVO shall verify the information in the Reappointment Form and, when legally required, secure a report regarding the Member from the National Practitioner Data Bank and then transmit the Reappointment Form and any pertinent supporting materials to the chairperson of the department to which the Member is assigned and to the Credentials Committee. In verifying such information, primary data sources will be used whenever feasible. The department chairperson's comments regarding reappointment shall be furnished to the Credentials Committee.

4.6.4 Recommendations

Each individual and committee that is responsible for making a recommendation regarding a reappointment application shall recommend acceptance or rejection of

the application and, if acceptance is recommended, recommend which clinical privileges should be granted. The reason(s) for any adverse recommendation shall be stated. Applications for reappointment shall be considered in a timely manner and, except for good cause (such as the need to table an application in order to secure additional information), shall be processed within the time periods stated in these Bylaws.

4.6.5 Credentials Committee and Department Recommendations

In conjunction with the relevant department chairperson, the Credentials Committee shall review the Member's performance (including clinical and technical skills), quality assurance data, and information contained in the reappointment application. Within 60 days of receipt of an application, the Credentials Committee shall submit its recommendation to the MEC.

4.6.6 Executive Committee Recommendation

Within 60 days of the MEC's receipt of the report of the Credentials Committee, the MEC shall complete its review of the Credentials Committee recommendation and all relevant information available to it and forward same to the CEO, along with the MEC's recommendation, for transmittal to the Board. A favorable MEC recommendation, as defined in Section 4.5.11, shall be forwarded to the Board for action. When a MEC recommendation is unfavorable, as defined in section 4.5.11, the CEO shall notify the Member of his or her right to review pursuant to these Bylaws. If the Member does not submit a timely request for review, the Member shall be deemed to have acquiesced in the MEC's recommendation and said recommendation will be forwarded to the Board.

4.6.7 Board Action

At the next regularly scheduled meeting of the Board following receipt of a favorable MEC recommendation or following waiver or exhaustion of a Member's procedural rights described in these Bylaws, the Board shall take action on the recommendation. However, in any case where the Board does not agree with the recommendation of the MEC, the application shall be referred to the Joint Conference Committee for review and recommendation before final action by the Board. The CEO shall notify the Member of the Board's action. If the Board's action is favorable, that action is final. If the Board's action is unfavorable, the decision will not be final until the Member's rights (if any) under these Bylaws are exhausted or waived.

4.7 CONTRACT PRACTITIONERS

4.7.1 Definition

A Contract Practitioner is a physician, dentist or podiatrist who has entered into a contract with the Hospital to provide professional or medical-administrative services, or who is affiliated (e.g., as a partner, member, employee, or

subcontractor) with a professional entity (“Entity”) which has entered into such a contract. Each Contract Practitioner will be assigned to an appropriate Medical Staff category (e.g. Active) and department.

4.7.2 Qualifications, Responsibilities/Limitations

A Contract Practitioner shall meet all the qualifications, fulfill all responsibilities, and will have all of the benefits of Medical Staff membership. However, a Contract Practitioner’s Medical Staff membership and clinical privileges may be limited, and/or may be subject to termination, without a hearing or appellate review, if so provided in a written contract between the Contract Practitioner and the Hospital or the Entity.

4.7.3 Medical Staff Input

Before the Hospital enters into a contract for the services of Contract Practitioners, the MEC shall be advised of the contemplated duties, termination and other significant non-financial provisions of the proposed contract, for review and comment.

4.8 ALLIED HEALTH PROFESSIONALS

4.8.1 Qualifications

Allied Health Professionals must possess a license to practice their profession in Michigan and shall apply for specified service authority on a form prescribed by the CEO and approved by the MEC. Applications for initial and renewed specified service authority will be processed using the procedures set forth in Sections 4.5 and 4.6, and based on the criteria stated in Sections 4.3 and 7.2 (to the extent applicable to the practitioner’s profession). The Board, upon recommendation of the MEC and the CEO, may grant Allied Health Professionals specified service authority. An AHP may provide direct patient care at the Hospital only within the scope of his or her specified service authority.

4.8.2 Assignment, Supervision and Compliance

Although responsible to the Medical Staff and the Board, Allied Health Professionals granted specified service authority are not Members. Each Allied Health Professional shall function at the Hospital under the overall supervision of a designated physician Member, provided a podiatric physician’s assistant may function under the overall supervision of a designated podiatrist Member. An Allied Health Professional’s specified service authority may not exceed the scope of the privileges held by his or her supervising Member. Allied Health Professionals shall comply with these Bylaws and the Rules to the extent relevant in light of their scope of practice, and any Hospital policies intended to govern their activities.

4.8.3 Meeting Attendance

Allied Health Professionals may attend General Staff meetings, at the request of their supervising Member and with the permission of the President. Allied Health Professionals may attend Department and/or Medical Staff committee meetings, at the request of their supervising Member and subject to the approval of the appropriate department chairperson or committee chairperson. If so permitted to attend a meeting, Allied Health Professionals may not vote, nor may they participate unless so requested by the presiding officer of the meeting.

4.8.4 Suspension and Termination

An Allied Health Professional may have his or her specified service authority suspended, revoked, or not renewed in the same manner as a Member, as well as in accordance with the terms of any written contract the Allied Health Professional may have with the Hospital. If (a) the designated supervising Member ceases to be a Member or (b) the supervising arrangement (e.g. collaboration agreement or employment) between the Allied Health Professional and the designated supervising Member terminates, then the Allied Health Professional's specified service authority shall terminate automatically, without hearing or appeal. If the designated supervising Member's privileges are voluntarily or involuntarily reduced, there shall be an automatic corresponding reduction in the Allied Health Professional's specified service authority, without hearing or appeal.

ARTICLE V.

CATEGORIES OF THE MEDICAL STAFF

5.1 MEDICAL STAFF CATEGORIES GENERALLY

Appointments to the Medical Staff shall be in one of the following categories: Active, Courtesy, Affiliate, or Honorary.

5.2 ACTIVE CATEGORY

The Active category shall consist of Members who:

- 5.2.1 have been Members in the Courtesy category for at least 6 months;
- 5.2.2 in a non-Hospital-Based department, (a) performed at least 24 Activity Units during the 6 months preceding their request to transfer to the Active category or (b) if already in the Active category, performed 24 Activity Units per year since their last appointment to the Active category;
- 5.2.3 in a Hospital-Based department, (a) spent the majority of their time practicing at the Hospital during the 6 months preceding a request to transfer to the Active category or (b) if already in the Active category, spent the majority of their time

practicing at the Hospital during the 24 months since their last appointment to the Active category;

5.2.4 hold clinical privileges; and

5.2.5 assume all of the functions and responsibilities of membership on the Active Medical Staff.

Members in the Active category shall be appointed to a specific department, shall be eligible to vote, to hold Medical Staff and department office, and to serve on Medical Staff committees. They shall be required to attend 50% of regular Medical Staff and department meetings, serve on committees and pay dues.

5.3 COURTESY CATEGORY

The Courtesy category shall consist of Members who (a) desire to admit or treat comparatively few patients at the Hospital or are new to the Staff and wish to transfer to the Active category when eligible to do so, and (b) hold clinical privileges. Except as otherwise provided in Section 5.7, they shall not be entitled to vote or hold Medical Staff or department office. They may volunteer to serve on committees. They shall be encouraged to attend general Medical Staff meetings and department meetings. They shall be assigned to a department, and shall be required to pay dues as determined by the MEC. If a Courtesy Member performs more than 24 Activity Units per year, he or she must transfer to the Active category at the time of reappointment, unless the MEC determines that the Member has an unusual sub-specialty that is otherwise unavailable at the Hospital and approves the Member's reappointment to the Courtesy category.

5.4 AFFILIATE CATEGORY

The Affiliate category shall consist of Members who do not hold privileges at the Hospital, but who arrange for their patients to be admitted to the Hospital under the care of another Member. Except as otherwise provided in Section 5.7, they shall not be entitled to vote or hold Medical Staff or department office. They may volunteer to serve on committees. They may attend general Medical Staff meetings and department meetings. They shall be assigned to a department and shall be required to pay dues as determined by the MEC. To assist in treating patients outside the Hospital, they may access Hospital medical records of patients under their care.

5.5 HONORARY CATEGORY

The Honorary category shall consist of Members who are not active in the Hospital, including those honored by emeritus positions. These may be Members who have retired from active hospital practice or who are of outstanding reputation, not necessarily residing in the community. Honorary category Members shall not have clinical privileges, shall not be eligible to vote, hold office or to serve on standing Medical Staff committees, and shall not be required to pay Medical Staff dues or to attend meetings. Honorary Category Members are not required to hold a current license to practice their profession or satisfy other requirements relating to current clinical credentials.

5.6 AFFILIATE OR COURTESY STATUS WITH VOTING RIGHTS

A Member who has served in the Courtesy or Affiliate category without vote for at least 12 months may request at the time of reappointment that the MEC appoint him or her to a Medical Staff committee for the purpose of qualifying for voting rights. If for the next 24 months, the Member (a) serves on the committee to which appointed and attends at least 2/3 of the meetings of that committee and (b) attends at least 50% of general Medical Staff meetings and meetings of the department to which the Member is assigned, the Member may then request voting rights at the time of next reappointment. "Voting rights" consist of the right to vote on Medical Staff and department matters and to be elected to department office. A Member in the Active category, who will transfer to the Courtesy or Affiliate category at reappointment, may request voting rights as part of his or her reappointment application, in which case his or her committee participation and attendance at Medical Staff/department meetings while he or she was in the Active category may be used to qualify for voting rights pursuant to this Section. A Courtesy or Affiliate category Member granted voting rights pursuant to this Section must continue to satisfy the committee participation and meeting attendance standards described in this Section to be reappointed with voting rights.

5.7 CHANGES IN MEDICAL STAFF CATEGORY OR VOTING STATUS

A Member may request (a) transfer to the Active category, (b) appointment to a committee for the purpose of obtaining voting rights pursuant to Section 5.6, or (c) voting rights pursuant to Section 5.6, only as part of his or her application for reappointment. Such changes and appointments, if granted, will be effective only as of the date of reappointment.

5.8 MEMBERS ON LEAVE OF ABSENCE

5.8.1 Any Member may request a leave of absence from the Medical Staff for a period not to exceed 2 years, by written request to the President, stating the reason(s) for the leave. The MEC will recommend to the Board that the request be granted or denied, and the Board will take final action on the request. A requested leave of absence shall be granted, unless the MEC or Board identifies specific good cause for rejecting the request. All records for which the Member is responsible must be timely completed. Members on leave of absence will not be eligible to vote, hold office, or serve on committees, and will not be assessed dues or required to attend meetings. A leave of absence shall not be deemed a surrender of privileges or a resignation from the Medical Staff.

5.8.2 At least 45 days prior to expiration of the leave of absence, or at any earlier time, the Member may request reinstatement of his or her privileges by submitting a written notice to that effect to the President. In addition, the Member shall submit a written summary of his or her relevant activities during the leave. In the event of a leave of absence due to illness, the Member shall submit a letter from his attending physician stating that the Member is able to safely resume his or her professional practice. A request for reinstatement shall be submitted and processed in the manner specified for reappointment to the Medical Staff. Failure, without good

cause, to request reinstatement at least 45 days prior to the expiration date of the leave of absence or to provide a requested summary of activities or other relevant information, shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership. A Member whose request for reinstatement from a leave of absence is denied by the Board, or is the subject of an adverse recommendation by the MEC, shall be entitled to the procedural rights provided in these Bylaws. A Member who is reinstated from a leave of absence subject to requirements that do not affect his or her privileges (such as requiring participation in reorientation activities) is not entitled to the procedural rights provided in these Bylaws.

- 5.8.3 If a Member's term of appointment will expire during a leave of absence, the Member may apply for reappointment during the leave in accordance with Section 4.6. Reappointment of a Member during a leave of absence does not guarantee that the Member's request for reinstatement from leave of absence will be granted. If a Member on leave of absence does not submit a timely application for reappointment, Medical Staff membership will expire; the individual may later apply for Medical Staff membership and will be treated as a new applicant.

ARTICLE VI.

DEPARTMENTS

6.1 ORGANIZATION OF CLINICAL DEPARTMENTS

- 6.1.1 Each department shall be organized and shall have a chairperson who shall be responsible for the overall supervision of the clinical work within the department. In addition, each department shall also have a vice chairperson and secretary.
- 6.1.2 The departments of the Medical Staff, and practice areas they encompass are as follows:
- 6.1.2.1 Department of Anesthesiology;
 - 6.1.2.2 Department of Emergency Medicine;
 - 6.1.2.3 Department of Family Medicine;
 - 6.1.2.4 Department of Medicine, including Internal Medicine, Allergy and Immunology, Cardiology, Dermatology, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Nephrology, and Neurology;
 - 6.1.2.5 Department of Obstetrics and Gynecology;
 - 6.1.2.6 Department of Pathology;
 - 6.1.2.7 Department of Pediatrics;

- 6.1.2.8 Department of Physical Medicine and Rehabilitation;
- 6.1.2.9 Department of Radiology/Medical Imaging;
- 6.1.2.10 Department of Surgery, including General Surgery, Neurosurgery, Ophthalmology, Dentistry, Oral Surgery, Proctology, Otolaryngology, Thoracic Surgery, Urology, Vascular Surgery, and Podiatry;
- 6.1.2.11 Department of Orthopedic Surgery;
- 6.1.2.12 Department of Psychiatry.

6.2 ADDITIONAL DEPARTMENTS AND DIVISIONS

Upon recommendation of the MEC, the Board may establish as necessary additional departments, may reclassify an existing department as a division of another department and may eliminate an existing department by combining it with another department or division. Each department shall consist of at least 3 Active Members. Divisions of a department may be created as needed by action of the MEC without amendment of the Bylaws. Divisions may be eliminated by action of the MEC without amendment of the Bylaws in consultation with a majority of division members and the appropriate department chairperson.

6.3 DEPARTMENT CHAIRPERSON

Each department shall have a chairperson, who shall:

- 6.3.1 be board certified;
- 6.3.2 be responsible to the MEC for the functioning of the department;
- 6.3.3 institute and maintain policies as to standards of professional care, subject to MEC approval;
- 6.3.4 be accountable for the quality and efficiency of all professional and administrative activities within the department;
- 6.3.5 be responsible for implementation and maintenance of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the department and the clinical performance of all Practitioners in the department through effective peer review and quality assessment activities performed within the department and in cooperation with other departments and committees, and particularly the Peer Review Committee of the Medical Staff;
- 6.3.6 maintain continuing review of the professional performance of all Practitioners in the department and report regularly thereon to the MEC and, when appropriate, to the Peer Review Committee of the Medical Staff;

- 6.3.7 make recommendation to the Medical Staff through the MEC on the criteria for clinical privileges and specified service authority in the department;
- 6.3.8 be responsible for enforcement of the Medical Staff Bylaws and Rules within the department;
- 6.3.9 be responsible for implementation, within the department, of actions taken by the MEC;
- 6.3.10 transmit to the Credentials Committee, the department recommendations concerning the staff classification, appointment, reappointment, and delineation of clinical privileges and specified service authority for all applicants to, and Practitioners in, the department;
- 6.3.11 be responsible for coordination of orientation, teaching and education programs in the department;
- 6.3.12 participate in every phase of administration of the department through cooperation with the nursing service, Administration and other departments in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques, so as to integrate the department into the primary functions of the Hospital and coordinate interdepartmental and intradepartmental services;
- 6.3.13 assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the MEC, the CEO, or the Board;
- 6.3.14 participate in those activities relating to the accreditation and licensure of the Hospital that are relevant to the department;
- 6.3.15 recommend to Administration off-site sources for needed patient care that is not provided by the department or the Hospital;
- 6.3.16 be a member of the MEC, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding the department in order to provide quality patient care, including recommendations regarding needed space and resources;
- 6.3.17 the Chair may appoint an ad hoc committee for a specific purpose.

6.4 DEPARTMENT VICE CHAIRPERSON

Each department shall have a vice chairperson, who shall:

- 6.4.1 be board certified;
- 6.4.2 assumes all the responsibilities of the Chairperson in his or her absence or a vacancy in the position;

6.4.3 at the discretion of the Chairperson, may be required to serve as the department quality and safety officer.

6.5 DEPARTMENT SECRETARY

Each department shall have a secretary, who shall:

6.5.1 see that minutes of all departmental meetings are promptly created and forwarded to the MEC;

6.5.2 send notices of department meetings to the Members of the department.

6.6 DELEGATION

A department chairperson may delegate specific duties to the department vice chairperson and secretary and to the division chairperson. Such delegation, however, shall not relieve the department chairperson of his or her accountability for the matters delegated and their timely and effective performance.

6.7 QUALIFICATIONS OF DEPARTMENTAL OFFICERS

Departmental officers must be board certified and must be voting Members of the Medical Staff at the time of nomination and election and must remain voting Members during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Nominees for departmental office shall have a record of complying with Medical Staff quality and operational standards including Medical Staff Rules relating to peer review and ethics. Members nominated or elected as a departmental chairperson or vice chairperson are subject to the limitations on dual office stated in Section 8.1.5.

6.8 SELECTION OF DEPARTMENT OFFICERS

6.8.1 Department Nominating Committee

In those years when the terms of departmental officers will expire, the department will elect members of a Nominating Committee in an open session of the department at least 90 days prior to the Annual Medical Staff Meeting as provided for in Section 10.1. The Department Nominating Committee shall be comprised of at least three (3) voting Members of the department. In small departments with fewer than six (6) voting Members, the Nominating Committee may be a committee of the whole department. The members of the Nominating Committee will select its Chair.

6.8.2 Meetings of the Nominating Committee

The Department Nominating Committee shall meet at least 75 days prior to the Annual Meeting and select at least 2 candidates for each office (Chairperson, Vice Chairperson and Secretary). The Department Nominating Committee will notify all voting Members of the positions available within their department to solicit

interest. Department Members may self-nominate and make their interest known to the Chairman of the Department Nominating Committee in writing within the prescribed time period. The Nominating Committee will assure all contenders satisfy the qualifications stated in Section 6.7.

6.8.3 Announcement of Nominations

At least 60 days prior to the Annual Meeting, the Nominating Committee shall announce the names of the candidates by posting a notice in the Hospital.

6.8.4 Election Procedures

6.8.4.1 All elections will be conducted by secret ballot. A ballot will be sent to the office address of each qualified voter on file in the Medical Staff Services Office. Completed ballots will be returned in a sealed envelope and placed into another envelope which is then signed on the outside by the voter. Both envelopes shall be placed in the mailing envelope to the President. Signatures will be verified with the voting Member's signature on file at the Hospital. Ballots will be accepted until 5:00 p.m. five days prior to the designated election date. Ballots will be counted on or before the designated election date by tellers designated by the Nominating Committee.

6.8.4.2 Officers shall be elected by each non-Hospital Based department for a two-year term. In the absence of the department chairperson, the vice-chairperson shall assume all of the functions, duties and responsibilities of the chairperson and shall automatically succeed the chairperson if the latter fails to serve for any reason. In the event of a vacancy in the office of department vice-chairperson, the MEC shall in its discretion, determine whether to fill the vacancy by special election or at the next regular election of department officers.

6.8.4.3 In Hospital-Based departments, the Hospital may, by contract, provide for an alternate mechanism for the selection of department chairpersons and vice-chairpersons. MEC input will be sought and considered before implementation of the alternate mechanism.

6.9 REMOVAL OF DEPARTMENT OFFICERS

6.9.1 Non-Hospital-Based Departments.

An officer of a non-Hospital-Based department may be removed from office for failure to carry out his or her duties as described in Sections 6.3 through 6.5 of these Bylaws. A vote to remove may be initiated by (a) a petition that states the grounds for removal and is signed by 1/3 of the voting Members of the department (in accordance with the petition procedures set forth in Section 8.5.2) or (b) the Executive Committee acting in accordance with these Bylaws. Voting Members of the department shall be notified in writing of the date and time of the removal vote

at least thirty (30) days in advance of the regular or special meeting at which the removal vote will be taken. Removal requires the vote of 2/3 of those voting Members of the department present at a regular or special meeting of the department at which there is a quorum. Officers of non-Hospital-Based departments may be removed from office only in accordance with this Section 6.9.1 or by automatic removal for failure to satisfy the qualifications stated in Section 6.7.

6.9.2 Hospital-Based Departments.

An officer of a Hospital-Based department may be removed by the Board, consistent with the terms of the Hospital-Based contract with the Hospital (if any), after considering any timely input provided by a department or the MEC concerning removal, and shall be removed automatically for failure to satisfy the qualifications stated in Section 6.7.

6.10 RESPONSIBILITIES AND FUNCTIONS OF DEPARTMENTS

6.10.1 Reviews

Each department shall develop quality indicators relevant to the department for use by the Peer Review Committee.

6.10.2 Meetings

Each department shall meet at least quarterly.

6.11 DIVISIONS

6.11.1 Selection and Removal of Division Chairperson

6.11.1.1 Chairpersons of Non-Hospital-Based divisions shall be elected by the voting Members of the division, for a two-year term, in the same manner that department chairpersons are elected; however, all voting Members of the division shall act as the nominating committee. An individual may serve no more than two consecutive terms as a division chairperson.

6.11.1.2 In Hospital-Based divisions, the Hospital may, by contract, provide for an alternate mechanism for the selection of division chairpersons. MEC input will be sought and considered before implementation of the alternate mechanism. The term of office for chairpersons of Hospital-Based divisions shall be consistent with Section 6.12, Clinical Directors.

6.11.1.3 The chairperson of a non-Hospital-Based division may be removed by two-thirds vote of those voting Members in the division present at a meeting of the division at which there is a quorum. Removal of the chairperson of a Hospital-Based division shall be conducted in the same

manner as he or she was selected, or as provided in the Hospital-Based contract with the Hospital (if any).

6.11.2 Duties of Division Chairperson

Division chairpersons shall:

- 6.11.2.1 accept such responsibility as may from time to time be delegated by the chairperson of the department of which the division is a part;
- 6.11.2.2 make recommendations, consistent with those duties outlined in Section 6.3 of these Bylaws, to the department chairperson who in turn shall present such recommendations to the MEC.

6.11.3 Division Meetings

Division meetings shall be conducted in accordance with Sections 10.6 and 10.7. Attendance at division meetings is in addition to, and not in lieu of, other department attendance requirements.

6.12 CLINICAL DIRECTORS

6.12.1 Appointment

Clinical directors may be appointed and reappointed by the CEO in consultation with the MEC for the following: Respiratory Therapy, Physical Medicine and Rehabilitation, Critical Care, and such other clinical areas as may hereafter be established at the Hospital in consultation with the MEC.

6.12.2 Qualifications

Clinical directors must be board certified physicians who are Members in the Active category and qualified on the basis of their experience and training to administer all of the medically-related professional and administrative aspects of their respective clinical area.

6.12.3 Term of Office

The term of office of the clinical directors shall be as provided in their appointment notification or written contract, but no more than 2 years. They may, however, be reappointed as clinical directors.

6.12.4 Duties

Clinical directors shall, within their respective clinical area: serve as liaison to the Medical Staff; direct the implementation of Medical Staff policies; periodically report to the MEC and Administration on the clinical area's status from a medical perspective; assume a leadership role in quality improvement activities; in

consultation with the patients' attending physicians, decide priorities when near or at capacity; when requested, serve as a consultant for patients requiring services; arrange for an alternate to assume their responsibilities when they will be unavailable; and if serving as clinical director by virtue of a contractual or employment arrangement, perform such other duties as may be specified in a written contract or position description.

ARTICLE VII.

CLINICAL PRIVILEGES

7.1 NATURE OF CLINICAL PRIVILEGES

7.1.1 Grants of Clinical Privileges

Privileges are granted to individual Members by the Board upon recommendation of the MEC, in the manner provided in Article IV. A Member may also request an increase in privileges during the term of his or her appointment by submitting a written request; any such request will be processed using substantially the same procedures as for a request for reappointment. In any case where the Board does not accept the recommendations of the MEC, the matter shall be referred to the Joint Conference Committee for review and recommendation before final action by the Board.

7.1.2 Special Requirements

Only Members of the Medical Staff with admitting privileges shall be permitted to admit patients to the Hospital. A Member of the Medical Staff shall be directly responsible for each patient's diagnosis and treatment, subject to the clinical privileges granted him or her and his or her license. Each patient's general medical condition shall be the responsibility of a physician Member. Each patient admitted to the Hospital as an inpatient or for an outpatient procedure shall receive a baseline history and physical examination as described in Section 4.4.4 by an authorized physician Member or Allied Health Professional, except as otherwise provided in Section 7.1.4.

7.1.3 Dentists and Podiatrists

Surgical privileges exercised by dentists and podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. All dental and podiatric patients shall receive the same basic medical appraisal as other surgical patients, except as provided in 7.1.4 below. A physician Member must co-admit inpatients with a podiatrist or dentist Member, except as otherwise provided in Section 7.1.4. A physician Member shall be responsible for the care of any medical problems that may be present at the time of admission or that may arise during the hospitalization of a podiatric/dental/oral surgery patient. Podiatrists and dentists will be responsible for the description of the podiatric or dental diagnosis and

treatment, as applicable, on the patient's chart. They will write orders on the patient's chart in accordance with the Rules of the Medical Staff and Department of Surgery and within the scope of their licensure.

7.1.4 Special Conditions for Privileges as an Oral Surgeon

If an oral surgeon is granted privileges to admit patients and to conduct medical histories and physical examinations of all relevant body systems, he or she may assume full management of basically healthy patients who are without a comorbidity, subject to any Rules (general or department) requiring consultation or concurrent management with a physician.

7.2 CRITERIA FOR CLINICAL PRIVILEGES

Clinical privileges shall be based on licensure, education, training, experience, qualifications and demonstrated competence. The MEC shall recommend to the Board particular clinical privileges for each Member of the Medical Staff (other than Members in the Affiliate or Honorary category).

7.3 TEMPORARY CLINICAL PRIVILEGES

7.3.1 Bases

Temporary clinical privileges are an extraordinary measure utilized to provide skills of a practitioner needed by or at the Hospital on an expedited basis. They shall not be granted solely for the convenience of the practitioner who requests them. A qualified practitioner may be granted temporary clinical privileges (a) to fulfill an important patient care or service need, (b) while the practitioner's initial application for Medical Staff membership is awaiting review and approval, or (c) while a Member's application for an additional privilege, submitted under Section 7.1.1, is awaiting review and approval, as further described in Sections 7.3.2 through 7.3.4. All persons requesting and/or receiving temporary privileges shall be bound by the Bylaws and Rules.

7.3.2 Important Patient Care Needs

The CEO, upon recommendation of the President or the chairperson of the department in which temporary privileges are requested, may grant temporary privileges to meet an important patient care need, provided the Vice President of Medical Affairs must first verify the practitioner's current licensure and competence. If temporary privileges are granted under this Section for the treatment of one or more specified, named, Hospital patient(s), the privileges shall automatically expire when the named hospitalized patient(s) is (are) discharged from the Hospital. If temporary privileges are granted under this Section to afford locum tenens coverage or to meet another important patient care need, the privileges may be granted for a period not to exceed 30 days; extensions beyond the initial 30-day period (but not to exceed two additional 30-day periods) may be granted with the approval of the Board.

7.3.3 Pending Initial Application

Temporary privileges may be granted to an initial applicant by the CEO, with the concurrence of the President and the chairperson of the department in which temporary privileges are requested. Temporary privileges may be granted only if the practitioner has submitted a complete application which satisfies the requirements for temporary privileges stated in these Bylaws and requests temporary privileges. The granting of temporary privileges shall be for a period not to exceed 30 days. Extensions may be granted in special circumstances, with the approval of the Board, to accommodate the needs of Administration, the Medical Staff, or Board, but not to exceed two additional 30-day periods. An applicant's temporary privileges shall terminate automatically if the applicant's application for Medical Staff Membership is withdrawn or denied.

7.3.4 Pending Additional Privilege Application

A specific temporary privilege may be granted to a Member by the CEO, with the concurrence of the President and the chairperson of the department in which the temporary privilege is requested. A temporary privilege may be granted only if the Member has submitted a complete request pursuant to Section 7.1.1 which satisfies the requirements for temporary privileges stated in these Bylaws and the privilege sought is one for which Board-approved criteria exist. The granting of a temporary privilege shall be for a period not to exceed 30 days. Extensions may be granted in special circumstances, with the approval of the Board, to accommodate the needs of Administration, the Medical Staff, or Board, but not to exceed two additional 30-day periods. A Member's temporary privileges shall terminate automatically if the Member's application for additional privileges is withdrawn or denied.

7.3.5 Supervision and Termination

A practitioner who performs services in the Hospital pursuant to temporary privileges, shall be under the supervision of the chairperson of the department in which he or she is applying for privileges or to which he or she is temporarily assigned. The President, the CEO, or the MEC may at any time suspend or revoke temporary privileges. In the event of any such termination, the practitioner's patient(s) then in the Hospital shall be assigned to a Member by the President. The wishes of the patient(s) shall be considered, where feasible, in choosing a substitute.

7.3.6 Due Process

A person is not entitled to the procedural rights afforded by these Bylaws because (a) a request for temporary privileges is refused, (b) the granting of temporary privileges is made subject to conditions (such as proctoring), or (c) all or any portion of temporary privileges are terminated or suspended, unless the action described in this item (c) would be reportable to the National Practitioner Data Bank or the state of Michigan, in which case the suspension or termination shall trigger procedural rights under Article XII.

7.3.7 Emergency/Disaster Privileges

Emergency/disaster privileges may be granted by the President of the Medical Staff or designee or the CEO, in accordance with the Hospital's policy on this subject.

ARTICLE VIII.

OFFICERS OF THE MEDICAL STAFF

8.1 OFFICERS: DEFINITION/QUALIFICATIONS/TERM

8.1.1 Officers of the Medical Staff

Officers of the Medical Staff shall be President, President-Elect, Immediate Past President, Secretary/Treasurer, and Members-at-Large (2).

8.1.2 Qualifications of Officers

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

8.1.3 Qualifications of President and President-Elect

To be eligible for nomination for the office of Medical Staff President and President-Elect, the candidate (a) must be board certified, (b) must be a Member of the Active category for at least 5 years, and (c) shall have served for at least 1 year as a member of a standing committee or as chairperson of a clinical department of the Medical Staff.

8.1.4 Terms of Office

All officers shall serve three-year terms or until a successor assumes office, except the Members-at-Large and as otherwise provided in Section 8.6. The two Members-at-Large shall serve two-year terms which expire in alternate years. An individual may serve as Secretary/Treasurer for no more than two consecutive terms; there is no limit on the number of non-consecutive terms an individual may serve as Secretary/Treasurer. Officers shall ordinarily take office on the first day of the Medical Staff year following their election.

8.1.5 Dual Offices

A Member may not simultaneously hold more than one Medical Staff office (such as both President and Member-at-Large) or serve as both a department chairperson or vice chairperson and a Medical Staff officer.

8.2 NOMINATION OF OFFICERS

The procedure for nomination and election of officers of the Medical Staff shall be as follows:

8.2.1 Nominating Committee

At least 120 days prior to the Annual Medical Staff Meeting as provided for in Section 10.1, the President shall appoint, with the concurrence of the MEC, a Nominating Committee. This committee shall consist of one Active Category Member from each Department.

8.2.2 Meetings of Nominating Committee

The Nominating Committee shall meet at least 75 days prior to the Annual Meeting and select at least 2 candidates for each office in which there will be a vacancy in the upcoming Medical Staff Year that will not be filled by automatic succession. The Nominating Committee may seek constructive input from the CEO. The Nominating Committee shall confirm each nominee's eligibility and willingness to run for office before announcing the nominations.

8.2.3 Announcement of Nominations

At least 60 days prior to the Annual Meeting, the Nominating Committee shall announce the names of the candidates by posting a notice in the Hospital. Additional nominations may be made by written petition, signed by at least 40 voting Members of the Medical Staff, and filed with the Chairperson of the Nominating Committee no later than 14 days following the posting of the candidates by the Committee. The individual(s) who circulate such a petition shall confirm the candidate's eligibility and willingness to run for office before circulating the petition. All candidates for a medical staff office shall, at least 30 days before the election, disclose in writing to the President any personal, professional, or financial affiliations or relationships with the Hospital or any other hospital, including a leadership position on another medical staff, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The President shall cause this information to be promptly posted in the Hospital. The Active Medical Staff, for this purpose, is defined as of the date of the last Board of Trustees meeting preceding the posting of the Committee's nominations. Nominations from the floor will not be accepted, nor will "write-in" candidates.

8.3 ELECTION OF OFFICERS

8.3.1 General Procedures

All elections for officers will be conducted by secret ballot. A ballot will be sent to the office address of each qualified voter on file in the Medical Staff Services Office. Completed ballots will be returned in a sealed envelope and placed into

another envelope which is then signed on the outside by the voter. Both envelopes shall be placed in the mailing envelope to the President. Signatures will be verified with the practitioner's signature on file at the Hospital. Ballots will be accepted until 5:00 p.m. five days prior to the designated election date. Ballots will be counted on or before the designated election date by tellers designated by the Nominating Committee.

8.3.2 Additional Rules

The MEC may establish specific rules or procedures regarding election and removal of Medical Staff and departmental officers that are consistent with these Bylaws.

8.4 DUTIES OF OFFICERS

8.4.1 Duties of the President

The President:

- 8.4.1.1 shall call and preside at all general Staff Meetings;
- 8.4.1.2 shall call and preside at all MEC meetings, attend at least 2/3 of MEC meetings, and vote in case of a tie;
- 8.4.1.3 shall be an ex-officio member, without vote, of all Medical Staff committees of which he or she is not a voting member, except the Nominating Committee, on which he or she may not vote or participate;
- 8.4.1.4 shall attend all regular meetings of the Board and shall report to the Board on matters of concern to the Medical Staff;
- 8.4.1.5 shall be a member of the Joint Conference Committee and Quality & Safety Committee;
- 8.4.1.6 shall be responsible for the functioning of the clinical organization of the Hospital;
- 8.4.1.7 except as otherwise provided in these Bylaws, shall appoint the members of all Medical Staff committees and recommend Practitioners for appointment to Hospital committees subject to the approval of the Medical Executive Committee. The Medical Staff President represents the HFWH organized medical staff at various HFHS committees, as necessary or assigned;
- 8.4.1.8 shall be responsible for the enforcement of the Bylaws and Rules and must implement all disciplinary action against all Practitioners, according to the procedures set forth in these Bylaws;

- 8.4.1.9 shall require that the procedural safeguards called for by these Bylaws are provided in all applicable cases;
- 8.4.1.10 shall be responsible for the educational activities of the Medical Staff;
- 8.4.1.11 shall be responsible, in conjunction with the MEC, for implementation of Medical Staff policies;
- 8.4.1.12 shall act in coordination with the Administration and Board in all matters of mutual concern within the Hospital;
- 8.4.1.13 shall be spokesperson for the Medical Staff in its external professional and public relations;
- 8.4.1.14 shall be the individual responsible for the organization and conduct of the Medical Staff with whom the Board shall periodically directly consult in accordance with applicable Medicare requirements.

8.4.2 Duties of the President-Elect

The President-Elect shall be a member and attend at least 2/3 of the meetings of the MEC, the Joint Conference Committee and the Quality & Safety Committee, and shall serve as Chairperson of the Credentials Committee. He or she shall also perform such other duties as may be assigned. The President-Elect, in the absence of the President, shall assume all duties and shall have the authority of the President. The President-Elect shall automatically succeed the President upon expiration of the President's term or if the President fails to complete his or her term for any reason.

8.4.3 Duties of the Secretary/Treasurer

The Secretary/Treasurer shall be a member and attend at least 2/3 of the meetings of the MEC and shall cause accurate and complete minutes of all Medical Staff and MEC meetings to be kept, shall call Medical Staff meetings on order of the President, attend to all correspondence, cause accurate financial records of the Medical Staff fund to be kept, and perform such other duties as ordinarily pertain to his or her office. In case of the simultaneous absence of the President and President-Elect, the Secretary/Treasurer will assume the duties of the President.

8.4.4 Duties of the Immediate Past President

The Immediate Past President shall be a member of the MEC and serve as advisor to the President and MEC when requested, serve as committee member or chair when appointed, and fulfill such other duties as assigned under the Medical Staff Bylaws and Rules.

8.4.5 Duties of the Members-at-Large

The Members-at-Large are members of the MEC. The Senior Member-at-Large will serve on the Peer Review Committee. The Junior Member-at-Large will serve on the Credentials Committee. Each Member-at-Large shall attend at least 2/3 of the meetings of the MEC and of the committee to which he or she is assigned pursuant to this Section.

8.5 REMOVAL OF OFFICERS

8.5.1 Initiation of a Vote to Remove

Any officer of the Medical Staff may be removed for failure or inability to discharge the duties of the office effectively, or any act or course of conduct which could justify corrective action or non-reappointment. A vote to remove may be initiated by (a) a petition that states the ground(s) for removal and is signed by 25% of the voting Members, as further described in Section 8.5.2, or (b) the Executive Committee acting in accordance with these Bylaws.

8.5.2 Petition to Vote for Removal

8.5.2.1 The Member(s) who wish to circulate a removal petition (“the Petitioner”) shall deliver to the Medical Staff President a written notice of intent to circulate a removal petition (“NOI”). If the President is the subject of the petition, the Immediate Past President shall perform all duties assigned to the President related to the petition for removal and the removal process. The NOI shall include the proposed text of the petition. The President shall confirm that the petition complies with the requirements of these Bylaws.

8.5.2.2 Within two business days after receiving an NOI, the President shall deliver a copy of the NOI and petition to the Medical Staff officer who is the subject of the petition (“Officer”), along with a statement of the date on which the President received the NOI and a summary of the relevant deadlines created under these Bylaws. A copy of this notice shall also be sent to the Petitioner.

8.5.2.3 Upon request of the Petitioner, the President will arrange for the Medical Staff Office to mail a written statement from the Petitioner in support of the petition to the Members eligible to vote on the removal petition (the “Voting Members”), but only if the Petitioner delivers his/her written statement to the President no later than five business days after the NOI was filed with the President. The President will also arrange for the Medical Staff Office to mail to the Voting Members a written statement from the Officer opposing the petition (regardless of whether the Petitioner provides a statement), but only if the Officer delivers his/her statement to the President no later than seven business days after the NOI was filed with the President. This mailing will

include a business reply envelope directed to the Medical Staff Office for purposes of returning a confidential, signed petition.

- 8.5.2.4 The text of the petition and any written statements by the Petitioner and Officer shall be accurate and shall be professional in content and tone.
- 8.5.2.5 Neither the Petitioner, the Officer, nor any other person acting on their behalf, shall initiate contact with a Voting Member regarding the removal issue, other than the written communication allowed under Section 8.5.2.3 and distributed by the Medical Staff Office. However, the Petitioner and Officer may respond to communications to them initiated by Voting Members.
- 8.5.2.6 The petition may be signed during the period that begins on the 10th business day after the NOI was delivered to the President, and ends on the 30th business day after the NOI was delivered to the President. Once a Voting Member signs the petition, he or she must submit the signed petition directly to the Medical Staff Office in the prescribed, confidential, business reply envelope. The returned envelopes will only be opened by Medical Staff Members assigned to validate signatures pursuant to Section 8.5.2.8.
- 8.5.2.7 The removal petition document shall contain an identical statement of the ground(s) for the proposed removal on each page of the petition and shall accommodate only one signature per page. Neither the Petitioner nor the individuals who validate the petition pursuant to Section 8.5.2.8 shall disclose to others the identity of the Voting Members who signed the petition. A Voting Member who signs the petition may not remove his or her name from the petition.
- 8.5.2.8 No later than the 31st business day after the NOI was delivered to the President, the signed petitions shall be mailed to the Medical Staff Office in the prescribed confidential, business reply envelope. The President shall designate two or more Members to validate the signatures. The signature validation shall occur within 72 hours after the President receives the petition.
- 8.5.2.9 If the petition contains the required number of valid Voting Member signatures, a meeting of Voting Members to act on the removal proposal shall be scheduled in accordance with these Bylaws.
- 8.5.2.10 Any allegation that this procedure has been violated shall be made in writing, shall describe in reasonable detail the nature of the alleged violation, and shall be delivered to the President. The President shall determine what steps will be taken to evaluate/validate the allegation and shall provide all relevant evidence to the Medical Executive

Committee which shall make a determination in accordance with the officer removal provisions of these Bylaws.

8.5.3 Removal Vote

Voting Members shall be notified in writing of the date and time of the removal vote at least 30 days (rather than the notice period stated in Section 10.4) in advance of the regular or special meeting at which the removal vote will be taken. Removal requires the vote of 2/3 of those voting Members present at a regular or special Medical Staff meeting at which there is a quorum. Officers may be removed from office only in accordance with this Section 8.5 or by automatic removal for failure to satisfy the qualifications stated in Section 8.1.2.

8.6 VACANCIES IN OFFICE

If there is a vacancy in the office of the President and 50% or more of the President's term remains, the President-Elect will serve out the remainder of his or her predecessor's term in lieu of his or her own 3-year term as President. If there is a vacancy in the office of the President and less than 50% of the President's term remains, the President-Elect will serve out the remainder of his or her predecessor's term, in addition to his or her own 3-year term. A vacancy in the office of Immediate Past President will not be filled. A vacancy in the office of President-Elect will be filled by special election. A vacancy in any other office will be filled by (a) the MEC if less than 50% of the term remains, or (b) a special election if 50% or more of the term remains. When a special election is held to fill a vacancy, the procedures described in Sections 8.2 and 8.3 shall be used, and the election shall be completed within 120 days after the vacancy was created.

ARTICLE IX.

COMMITTEES OF THE MEDICAL STAFF

9.1 COMMITTEES GENERALLY

9.1.1 Description of Types

Committees shall be standing or ad hoc. The President shall appoint all committees and their chairpersons and appoint Members to serve on the Hospital Committees listed in Section 9.1.2 (subject to approval by the MEC) for a three-year term at the outset of the President's term of office, except as otherwise provided in these Bylaws. The President shall conduct an annual review of all medical staff committees and report the results to the MEC. Committee members who are appointed by the President may be removed by the President (subject to MEC approval). The CEO and the President or their designees shall be ex-officio members of all standing committees, unless already specifically delineated by these Bylaws as a member in a different capacity. Members may be reappointed to committees and as committee chair for additional terms without limit.

9.1.2 Standing Committees

The standing committees shall be as follows:

- 9.1.2.1 Executive
- 9.1.2.2 Bylaws
- 9.1.2.3 Budget
- 9.1.2.4 Clinical Ethics (Hospital committee)
- 9.1.2.5 Credentials
- 9.1.2.6 Critical Care Clinical Effectiveness Team (Hospital Committee)
- 9.1.2.7 Infection Control (Hospital committee)
- 9.1.2.8 Joint Conference (Hospital-Medical Staff committee)
- 9.1.2.9 Medical Education Oversight (Hospital committee)
- 9.1.2.10 Operating Room (Hospital committee)
- 9.1.2.11 Peer Review
- 9.1.2.12 Pharmacy & Therapeutics (Hospital committee)
- 9.1.2.13 Practitioner Well Being
- 9.1.2.14 Quality & Safety (Hospital committee)

9.1.3 Committee Restructuring by the MEC

The MEC shall have the authority to revise the duties, functions and composition of all Medical Staff committees, or to eliminate or combine standing committees, with the exception of the MEC, Credentials Committee and Joint Conference Committee, whose existence, functions and composition may only be changed by amendment of these Bylaws. Additionally, for those Medical Staff committees whose duties, functions and composition are not described in these Bylaws, the MEC can establish and amend protocols for their operation.

9.1.4 Reports

Each committee shall maintain a written record of its conclusions, recommendations, and actions taken, and shall report same to the MEC.

9.1.5 Committee Procedures

Sections 10.5 through 10.8 govern attendance requirements, quorum and voting standards, and executive sessions for all Medical Staff committees.

9.2 EXECUTIVE COMMITTEE (MEC)

9.2.1 Composition

9.2.1.1 The voting members of the MEC shall consist of the officers of the Medical Staff, the chairperson of each Medical Staff department, and department representatives elected in accordance with Section 9.2.1.2. The President shall serve as chairperson. If the chairperson of a department is absent due to illness, leave of absence, or is unavoidably prevented from attending an MEC meeting, the vice-chairperson of that department may attend and vote in his or her absence. Each voting member of the MEC shall have one vote. The CEO, Director of Medical Education, Nursing Executive, and Vice President for Medical Affairs shall serve on the MEC on an ex-officio basis (as defined in Section 2.1). The voting members of the MEC may invite additional representative(s) of Administration to attend one or more MEC meetings. At the request of a majority of the voting members of the MEC, the MEC may meet in an executive session, attended only by the voting members of the MEC. Discussion and deliberation, but not voting, may occur during an executive session.

9.2.1.2 In addition to the department chairperson, a department with 31-60 voting Members may elect one additional representative to the MEC. A department with more than 60 voting Members may elect two additional representatives to the MEC. MEC members elected pursuant to this Section shall serve two-year terms and shall be qualified, selected, and subject to consecutive term limits and removal in the same manner as departmental officers (see Sections 6.7 through 6.9). The count of voting Members shall be determined as of the last Board meeting prior to October 1 of the year of the election.

9.2.2 Duties

The duties of the MEC shall be as follows:

9.2.2.1 Advise the CEO and Board on matters pertaining to organization of the Hospital's clinical services, the Medical Staff's structure, the process used to review credentials and delineate privileges, the need for medical equipment and clinical facilities, and other relevant medico-administrative matters.

9.2.2.2 Consider the recommendations of the Credentials Committee and the various department chairs regarding appointments, reappointments to

the Medical Staff, department assignments, clinical privileges, and specified service authority, and make appropriate recommendations to the Board on appointments, privileges, and specified service authority, including corrective action.

- 9.2.2.3 Coordinate the activities of the various departments, Medical Staff, and committees.
- 9.2.2.4 Promote the aims and objectives of the Medical Staff committees and acquaint the Members with the work of these committees.
- 9.2.2.5 Review the activities and findings of all committees and departments of the Medical Staff and act on reports from these bodies.
- 9.2.2.6 Monitor activities relating to the accreditation and licensure of the Hospital, review the Hospital's strategic plan, and make recommendations to the Board through the CEO.
- 9.2.2.7 Review the overall quality and efficiency of patient care in the Hospital and initiate action to remedy unacceptable performance.
- 9.2.2.8 Take steps to maintain professionally ethical conduct and competent clinical performance on the part of Practitioners, including initiating investigations and initiating and pursuing corrective action when warranted.
- 9.2.2.9 Review annually the performance of the Vice President of Medical Affairs and communicate the results of the review to the CEO.
- 9.2.2.10 Establish and periodically revise Medical Staff dues, in each case subject to ratification by the Medical Staff.
- 9.2.2.11 Keep minutes of all such meetings, which shall be forwarded to the CEO and made available to the Board.
- 9.2.2.12 Represent and act on behalf of the Medical Staff between meetings of the Medical Staff, subject to any limitations imposed by these Bylaws. The duties delegated to the MEC pursuant to these Bylaws may only be modified by amending these Bylaws in accordance with Article XVI.

9.2.3 Meetings

The MEC shall meet at least quarterly.

9.3 AD HOC COMMITTEES

Ad Hoc committees of the Medical Staff may be established to perform, during a finite period of time, one or more of the Medical Staff functions or objectives required by these

Bylaws and may be composed of Members of any Medical Staff category (other than Honorary) and may include, where appropriate, Allied Health Professionals, and representation from Administration, including Nursing, Medical Records, Pharmacy, Social Services, and such other Hospital departments as are appropriate to the function(s) to be discharged. Unless otherwise specifically provided by the MEC, committee members and the chairperson shall be appointed by the President, with Administration appointees being subject to the approval of the CEO. The committee chairperson may appoint, with the concurrence of the President, a vice-chairperson and secretary. An ad hoc committee shall have those functions determined by the MEC and shall report to the MEC.

9.4 BYLAWS COMMITTEE

9.4.1 Composition

The composition of the Bylaws Committee shall be broadly representative of the Medical Staff, including representation from the non-Hospital-Based clinical departments.

9.4.2 Duties

The Committee shall review the Bylaws and Rules of the Medical Staff annually, and recommend appropriate changes to the Medical Staff through the MEC. The Committee shall review and make a recommendation to the MEC with respect to each proposed amendment to the Bylaws or Rules.

9.4.3 Meetings

The Bylaws Committee shall meet as needed.

9.5 BUDGET COMMITTEE

9.5.1 Composition

The composition of the Budget Committee shall be limited to Members, at least three of whom shall be Active Staff Members, and shall be chaired by the Secretary/Treasurer.

9.5.2 Duties

The duties of the Budget Committee shall be as follows:

9.5.2.1 Prepare an annual Medical Staff Budget for the approval of the MEC and Medical Staff, in which any stipends for elected Medical Staff leaders shall be determined;

9.5.2.2 Make recommendations to the MEC with respect to dues and assessments to be levied;

- 9.5.2.3 Oversee the selection and performance of a qualified professional accountant to maintain financial records, make reports and comply with regulation and standards;
- 9.5.2.4 Recommend to the MEC a suitable financial institution in which Medical Staff funds will be kept, accessible solely by current Medical Staff leaders determined by the MEC;
- 9.5.2.5 Oversee payments of invoices either consistent with the approved budget, or if not budgeted, as authorized by the MEC up to \$20,000, or as approved by vote of the Medical Staff;
- 9.5.2.6 Fulfill such appropriate requests as may be made by the Medical Staff or MEC.

9.5.3 Meetings

The Budget Committee shall meet as needed.

9.6 CLINICAL ETHICS COMMITTEE

9.6.1 Composition

The Clinical Ethics Committee shall consist of adequate representatives of the Medical Staff, along with nurse(s), social worker(s), and a chaplain. The Committee may include representatives of Administration, other health care disciplines, and the community.

9.6.2 Duties

The Committee shall serve as an educational, advisory and consultative body to members of the Medical Staff, Hospital clinical staff, and patients and their families on clinical ethical issues, as more fully described in the Hospital's Clinical Ethics Committee Policy.

9.6.3 Meetings

The Clinical Ethics Committee shall meet at least bi-monthly.

9.7 CREDENTIALS COMMITTEE

9.7.1 Composition

The Credentials Committee shall consist of Members of the Active Staff from a broad range of departments, but shall not include department/division chairpersons. The President-Elect of the Medical Staff shall serve as Chairperson of the Committee. The Junior Member-at-Large shall serve as a member.

9.7.2 Duties

The duties shall be as follows:

9.7.2.1 Review and evaluate the qualifications of each applicant for initial appointment, reappointment, modification of appointment, and for clinical privileges.

9.7.2.2 Review and evaluate the qualifications of each Allied Health Professional applying to perform specified services.

Submit reports, in accordance with Article IV, regarding the qualifications of each applicant for Medical Staff membership, clinical privileges or specified services authority. Such reports shall include recommendations with respect to appointment, Medical Staff category, department affiliation, clinical privileges or specified services authority, and any special conditions attached thereto.

9.7.3 Meetings

The Credentials Committee shall meet at least quarterly.

9.8 CRITICAL CARE CLINICAL EFFECTIVENESS TEAM

9.8.1 Composition

The Critical Care Clinical Effectiveness Team shall consist of adequate representatives of the Medical Staff.

9.8.2 Duties

The duties shall be as follows:

9.8.2.1 Develop and implement a planned and systematic process for monitoring and evaluating the quality and appropriateness of patient care and for resolving and/or improving identified problems in all special care units (e.g., cardiac care unit). Subcommittees of the Critical Care Clinical Effectiveness Team may be established to assist or perform these functions as deemed necessary by the Team's chairperson.

9.8.2.2 Monitor and evaluate all major clinical functions performed in each special care unit, based upon objective criteria reflecting current knowledge and clinical experience.

9.8.2.3 Routinely collect information about important aspects of care provided in each special care unit.

- 9.8.2.4 Make periodic reports to the Quality & Safety Committee, MEC, Administration as appropriate or other Hospital or Medical Staff committees as necessary regarding important aspects of special care units and recommendations for improvement in care in those units.

9.8.3 Meetings

The Critical Care Clinical Effectiveness Team shall meet as needed.

9.9 INFECTION CONTROL COMMITTEE

9.9.1 Composition

The Infection Control Committee shall consist of adequate representatives of the Medical Staff, the Hospital epidemiologist, and representatives of Pathology, Nursing and Administration. The Committee's chairperson shall be a physician who is board-certified in infectious disease.

9.9.2 Duties

The duties shall be as follows:

- 9.9.2.1 Coordinate and assess the Hospital's Infection Control Program for the purpose of reducing the risk of health care associated infections and communicable disease transmission, and creating a safe and healthy patient care and work environment at the Hospital.
- 9.9.2.2 Establish guidelines for the type of surveillance and reporting of selected types of infections.
- 9.9.2.3 Review the infection and surveillance data and recommend methods for the prevention and control of infections in the Hospital.
- 9.9.2.4 Discuss the results of personnel or environmental culturing requested by the Committee, or federal, state, or local agencies, and determine necessary actions to be taken.
- 9.9.2.5 Conduct a continuous review of antibiotic usage in the Hospital. This will include (1) development of criteria for the prophylactic and therapeutic usage of antibiotics, (2) clinical review and statistical analysis of antibiotic usage based on susceptibility/resistance trends and pharmacy records, (3) investigate deviations from accepted criteria of antibiotic usage and report where appropriate to the MEC and (4) maintain written reports of findings and actions taken.
- 9.9.2.6 Institute appropriate investigation and control measures when there is a reasonable possibility that an infection potential may constitute a danger to any patient or Hospital personnel.

9.9.2.7 Implement effective infection control corrective actions plans as needed.

9.9.2.8 Report to the MEC and the Quality & Safety Committee, and identify to the Quality & Safety Committee any infection control problems that should be addressed in Hospital-wide performance improvement or training programs.

9.9.3 Meetings

The Infection Control Committee shall meet at least quarterly.

9.10 JOINT CONFERENCE COMMITTEE

9.10.1 Composition

The Joint Conference Committee shall consist of two non-Practitioner members of the Board, the President and the President-Elect. The CEO shall be an ex-officio member, without vote. The positions of chairperson and vice-chairperson of the Committee shall be held by and rotate between members in opposite categories (when a Board representative is chairperson, a Medical Staff representative shall be vice-chairperson and vice versa). At the request of a majority of the voting members of the Joint Conference Committee, the Committee shall meet in an executive session, attended only by the voting members of the Committee.

9.10.2 Duties

The duties shall be as follows:

9.10.2.1 Serve as a forum for the discussion of significant matters of Hospital policy and practice, especially those pertaining to efficient and effective patient care and provide medico-administrative liaison among the Board, the Medical Staff and Administration.

9.10.2.2 Review and resolve clinical and administrative problems.

9.10.2.3 Dispute management.

9.10.3 Meetings

The Joint Conference Committee shall meet as needed.

9.11 MEDICAL EDUCATION OVERSIGHT COMMITTEE

9.11.1 Composition

The Medical Education Oversight Committee shall consist of the Director of Medical Education/Designated Institutional Official, the Assistant Director of Medical Education/Designated Institutional Official, the Program Director of the

internship program and each residency program in the Hospital, two at-large Members of the Medical Staff, and appropriate representatives of Administration, clinical departments and educational affiliates.

9.11.2 Duties

The Committee shall perform all functions required of it by the organizations that accredit the medical education programs conducted at the Hospital.

9.11.3 Meetings

The Medical Education Oversight Committee shall meet at least as frequently as required to comply with the requirements of applicable training program accrediting organizations.

9.12 OPERATING ROOM COMMITTEE

9.12.1 Composition

The Operating Room Committee shall consist of adequate representatives of the Medical Staff, plus representatives of the Nursing Department and Administration.

9.12.2 Duties

The duties shall be as follows:

9.12.2.1 Review effectiveness and efficiency of surgical scheduling and utilization of surgical suites.

9.12.2.2 Evaluate and recommend to Administration necessary and appropriate equipment.

9.12.2.3 Recommend policies, guidelines and procedures for surgery and post-anesthesia care unit.

9.12.3 Meetings

The Operating Room Committee shall meet periodically.

9.13 PEER REVIEW COMMITTEE

9.13.1 Composition

The Peer Review Committee shall consist of Active category Staff Members in at least the following specialties:

(a) Anesthesiology

(b) Cardiology

- (c) Emergency medicine
- (d) Family Medicine
- (e) General surgery
- (f) Internal medicine
- (g) Ob/gyn
- (h) Psychiatry
- (i) Radiology.

The VPMA shall be an ex-officio Committee member. No more than three (3) voting Committee members may simultaneously be voting members of the MEC.

The Chair of the PRC will be an Active member of the Medical Staff appointed by the Medical Staff President with the approval of the Medical Executive Committee for a term of one (1) year. To be eligible for appointment as Chair, the member must have served on the Committee as a current member for at least one (1) year. Chairs may serve an unlimited number of consecutive terms as long as they are eligible to be a committee member.

Committee members will be expected to attend at least two-thirds of the committee meetings over a twelve-month period to maintain membership. Committee members will be expected to participate in appropriate educational programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing the Committee's responsibilities.

9.13.2 Duties

The duties shall be as follows:

- (a) Improve patient outcomes by pursuing and maintaining excellence in Medical Staff performance.
- (b) Create a culture with a positive approach to peer review by recognizing Member excellence as well as identifying improvement opportunities.
- (c) Promote efficient use of Medical Staff and Quality Staff resources.
- (d) Provide accurate and timely performance data for Medical Staff feedback, Ongoing and Focused Professional Practice Evaluation and reappointment.
- (e) Support Medical Staff educational goals to improve patient care.

- (f) Provide a link with the Hospital performance improvement structure to assure responsiveness to system improvement opportunities identified by the Medical Staff.
- (g) Supervise and conduct surgical case professional review.
- (h) Conduct blood usage review and make appropriate reports to Medical Staff departments of the review activities including conclusions, recommendations and actions taken.
- (i) Implement the Peer Review Policy in a manner consistent with these Bylaws, and recommend Policy amendments as necessary to the MEC.
- (j) Report to the MEC at least two (2) times per year.

9.13.3 Meetings

The Peer Review Committee shall meet at least ten (10) times per year.

9.14 PHARMACY AND THERAPEUTICS COMMITTEE

9.14.1 Composition

The Pharmacy and Therapeutics Committee shall consist of adequate representatives of the Medical Staff and one each from the Pharmaceutical Service, the Nursing Service and Administration. A Hospital Pharmacist shall be a member of and act as secretary for the committee.

9.14.2 Duties

The duties shall be as follows:

- 9.14.2.1 Routinely collect and review data on drug usage to identify opportunities to improve use and resolve problems in use.
- 9.14.2.2 Review and evaluate the clinical (prophylactic, empiric and therapeutic) use of drugs in the Hospital on a continuing basis. Specific emphasis shall be placed on usage of drugs known or suspected of causing adverse reactions or interactions; use for patients at high risk for drug reactions; and very frequently prescribed drugs.
- 9.14.2.3 Develop policies relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials including policies that minimize drug errors, evaluate clinical data regarding new drugs requested for use in the Hospital, prepare and update a drug formulary, and recommend drugs which should be stocked on nursing units.

9.14.2.4 Evaluate and approve experimental or investigatory drug protocols after the investigational use of the drug has been approved by the Institutional Review Board.

9.14.2.5 Provide liaison between the Medical Staff and the CEO, the Chief Pharmacist, the Director of Nursing and other Hospital departments which are relevant to the dispensing of pharmaceuticals.

9.14.3 Meetings

The Pharmacy and Therapeutics Committee shall meet at least quarterly.

9.15 PRACTITIONER WELL BEING COMMITTEE

9.15.1 Composition

The Practitioner Well Being Committee shall consist of adequate representatives of the Medical Staff.

9.15.2 Duties

The Practitioner Well Being Committee shall evaluate and, if appropriate, act upon reports of suspected impairment of a Medical Staff Member, behavioral referrals from Hospital and Medical Staff authorities, and provide non-punitive support for rehabilitation, while protecting patients and others in the Hospital, and fulfill other duties as further described in these Bylaws and the Medical Staff's Policy for Physician Healthcare Assistance. The duties of the Practitioner Well-Being Committee are professional practice review functions; therefore, like other committees described in section 14.1.1, its members and Chair are eligible for indemnification under these Bylaws.

9.15.3 Meetings

The Practitioner Well Being Committee shall meet as needed.

9.16 QUALITY & SAFETY COMMITTEE

9.16.1 Composition

The Quality & Safety Committee is a Hospital-wide committee that includes the following Medical Staff representatives: the President, President-Elect, Vice President of Medical Affairs, and at least 3 Members appointed by the President who shall be broadly representative of the Medical Staff. The Committee shall also include the CEO, Administrator of Clinical Performance Support, Chief Nursing Officer, and members of the Board Quality Committee. The Committee shall be co-chaired by the CEO and a physician Committee member designated by the President.

9.16.2 Duties

The duties shall include the following:

- 9.16.2.1 Develop and prioritize Hospital-wide performance improvement initiatives and oversee Hospital-wide performance improvement and patient safety activities.
- 9.16.2.2 Oversee, direct and coordinate the performance improvement and patient safety review and improvement process within the Hospital.
- 9.16.2.3 Authorize creation, modification and discontinuation of performance teams and define and revise, as necessary, their responsibilities, which may include measuring and evaluating compliance with clinical pathways and recommending measures to improve level of compliance.
- 9.16.2.4 Receive and analyze regular reports from all performance teams and quality-related committees.
- 9.16.2.5 Report regularly on its activities to the MEC and to the Board Quality Committee.
- 9.16.2.6 Promote Practitioner education regarding quality improvement concepts and techniques.
- 9.16.2.7 Promote confidentiality of quality assessment and improvement activities.
- 9.16.2.8 Annually evaluate the Hospital's Plan for Improving Organizational Performance and Patient Safety and recommend priorities for the next year.

9.16.3 Meetings

The Safety & Quality Committee shall meet at least quarterly.

ARTICLE X.

MEETINGS

10.1 ANNUAL MEETING

There shall be an annual meeting of the Medical Staff held in December. Notice of such meeting shall be sent to each Member at least 30 days prior to the meeting. At this meeting, officers shall make such reports as may be requested by the President. Results of elections held for officers for the ensuing year shall be announced.

10.2 REGULAR STAFF MEETINGS

Medical Staff meetings will be held in March, June, and September.

10.3 DEPARTMENT MEETINGS

Each Department shall meet at least quarterly to review and analyze the clinical work of the Department.

10.4 SPECIAL MEETINGS

A special meeting of the Medical Staff may be called at any time by the President, the CEO, or the MEC. A special meeting of the Medical Staff shall be called on petition of 25% of the voting Members of the Medical Staff. At any special meeting, no business shall be transacted except that stated in the notice calling such meetings. Notice of any such meeting shall be delivered by mail, telephone, email, or in person at least 72 hours prior to the time set for the meeting.

10.5 ATTENDANCE AT MEETINGS

Members in the Active category are required to attend 50% of regular Medical Staff meetings and regular meetings of their respective Department and/or Division and 2/3 of meetings of assigned Committees. Members of the Affiliate or Courtesy category with voting rights are subject to the meeting attendance standards stated in Section 5.6. No one may sign-in for another Member. Absence from more than the prescribed number of general Medical Staff, department, division or committee meetings may result in disciplinary action.

10.6 QUORUM

10.6.1 Medical Staff and Department/Division Meetings

The presence in person of 30% of the Members eligible to vote shall constitute a quorum at all Medical Staff and Department/Division meetings.

10.6.2 Committee Meetings

The presence in person of 30% of the voting membership shall constitute a quorum at Medical Staff committee meetings. A member may attend a committee meeting by phone or other means of remote communication by which all participants in the meeting may communicate with one another.

10.7 VOTING

Only Members in the Active category shall be eligible to vote at department, division and general Medical Staff meetings, except as otherwise provided by these Bylaws. Unless otherwise expressly provided in these Bylaws, every question shall be decided by vote of a majority of those voting Members who are present at the meeting.

10.8 EXECUTIVE SESSION

At the call of the individual chairing the meeting, attendance at a meeting of the Medical Staff or a department or committee of the Medical Staff may be restricted to Members, a recording secretary and other individuals designated by the Chair.

10.9 ELECTRONIC MEANS

10.9.1 Meetings

The medical staff, and any medical staff committee or service line, can notify its members of meetings and hold meetings or any other functions, including elections and adoption of recommendations, bylaws, rules and regulations, policies, by email, telephone or internet conference, or other electronic means. The chair of the meeting, or a majority of those entitled to vote in the meeting, shall determine whether to hold the meeting solely by electronic means, or by meeting in person, or by a combination of in-person meeting and individual participation by telephone or other electronic means. The action of meetings held electronically has the same weight as meetings held in person. Quorum, voting eligibility and majority requirements, and parliamentary standards are the same for electronic and in-person meetings.

10.9.2 Hearings and Appeals

At the call of the presiding officer, presence and notice requirements at hearings, appeals, and related meetings can be fulfilled electronically. Hearings and appeals can be held in part or entirely electronically over a secure means of communication, so long as all participants can be heard and can hear the proceedings.

10.9.3 Support

The Hospital shall support electronic meetings by and communication among medical staff leadership and members, who are obligated to supply and update the necessary contact information.

ARTICLE XI.

CORRECTIVE ACTION AND CODE OF CONDUCT

11.1 CODE OF CONDUCT

11.1.1 Definitions Applicable to Section 11.1

11.1.1.1 “Appropriate behavior” means any reasonable conduct to advocate for patients, to recommend improvements in patient care, to participate in the operations, leadership or activities of the organized medical staff, or to engage in professional practice including practice that may be in competition with the hospital. Appropriate behavior is not subject to discipline under the Medical Staff Bylaws.

- 11.1.1.2 “Disruptive behavior” means any abusive conduct including sexual or other forms of harassment, or other forms of verbal or non-verbal conduct that harms or intimidates others and is disruptive to hospital operations.
- 11.1.1.3 “Harassment” means conduct toward others based on their race, religion, gender, sexual orientation, nationality or ethnicity, which has the purpose of direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating, or otherwise hostile work environment.
- 11.1.1.4 “Inappropriate behavior” means conduct that is unwarranted and is reasonably interpreted to be demeaning or offensive. Persistent, repeated inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.”
- 11.1.1.5 “Medical staff member” means physicians and others granted membership on the Medical Staff, Allied Health Professionals, and, for purposes of this Code, includes individuals with temporary clinical privileges.
- 11.1.1.6 “Sexual harassment” means unwelcome sexual advances, requests for sexual favors, or verbal or physical activity through which submission to sexual advances is made an explicit or implicit condition of employment or future employment-related decisions; unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person’s work performance or which creates an offensive intimidating or otherwise hostile work environment.

11.1.2 “Appropriate Behavior”

Medical staff members cannot be subject to discipline for appropriate behavior. Examples of appropriate behavior include, but are not limited to, the following:

- A. Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care and safety;
- B. Encouraging clear communication;
- C. Expressions of concern about a patient’s care and safety;
- D. Expressions of dissatisfaction with policies through appropriate grievance channels or other civil non-personal means of communication;
- E. Use of cooperative approach to problem resolution;

- F. Constructive criticism conveyed in a respectful and professional manner, without blame or shame for adverse outcomes;
- G. Professional comments to any professional, managerial, supervisory, or administrative staff, or members of the Board of Trustees about patient care or safety provided by others;
- H. Membership on other medical staffs; and
- I. Seeking legal advice or the initiation of legal action for cause.

11.1.3 “Inappropriate Behavior”

Inappropriate behavior by medical staff members is discouraged. Persistent inappropriate behavior can become a form of harassment and thereby become disruptive, and subject to treatment as “disruptive behavior.” Examples of inappropriate behavior include, but are not limited to, the following:

- A. Belittling, berating statements or intentionally condescending language;
- B. Name calling, use of profanity or disrespectful language;
- C. Inappropriate comments written in the medical record;
- D. Blatant failure to respond to patient care needs or staff requests pertaining to patient care;
- E. Deliberate lack of cooperation without good cause;
- F. Deliberate refusal to return phone calls, pages, or other messages concerning patient care or safety;
- G. Intentionally degrading or demeaning comments regarding patients and their families, nurses, physicians, hospital personnel and/or the hospital.

11.1.4 “Disruptive Behavior”

Disruptive behavior by medical staff members is prohibited. Examples of disruptive behavior include, but are not limited to, the following:

- A. Physically threatening language directed at anyone in the hospital including, but not limited to physicians, nurses, other medical staff members, or any hospital employee, administrator or member of the Board of Trustees;
- B. Physical contact with another individual that is threatening or intimidating;
- C. Throwing instruments, charts or other things;
- D. Threats of violence or retribution;

- E. Sexual harassment; and,
- F. Other forms of harassment including, but not limited to, persistent inappropriate behavior and repeated threats of litigation.

11.1.5 “Interventions”

Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on and rehabilitating the offending medical staff member, and protecting patient care and safety. The medical staff supports tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the appropriate department or division chairperson. Further interventions can include an apology directly addressing the problem, a letter of admonition, a final written warning, or correction action pursuant the medical staff bylaws, if the behavior is or becomes disruptive. The use of summary suspension should be considered only where the physician’s disruptive behavior presents an imminent danger to the health of any individual. At any time rehabilitation may be recommended. If there is reason to believe inappropriate or disruptive behavior is due to illness or impairment, the matter may be evaluated and managed confidentially according to the established procedure of the medical staff’s Practitioner Well-Being Committee.

11.1.6 Procedure

Complaints about a member of the medical staff regarding allegedly inappropriate or disruptive behavior should be in writing, signed and directed to the Senior Vice President for Medical Affairs, and include to the extent feasible:

- A. the date(s), time(s) and location of the inappropriate or disruptive behavior;
- B. a factual description of the inappropriate or disruptive behavior;
- C. the circumstances which precipitated the incident;
- D. the name and medical record number of any patient or patient’s family member who was involved in or witnessed the incident;
- E. the names of other witnesses to the incident;
- F. the consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or hospital personnel or operations; and
- G. any action taken to intervene in, or remedy, the incident, including the names of those intervening.

The Senior Vice President for Medical Affairs; the respective Department Chairman, or Vice Chairman; the Chairman or Vice Chairman of the Practitioner Well-Being Committee will review and investigate all complaints of alleged

Inappropriate Behavior and alleged Disruptive Behavior. When a matter of Inappropriate Behavior can be resolved through intervention by the Department Chairman and the Chief Medical Officer, the matter will be handled through collegial intervention.

All matters of confirmed Disruptive Behavior will be referred to the Medical Staff President.

The complainant will be provided a written acknowledgement of the complaint.

The medical staff member subject of the complaint shall be provided a copy of this Code of Conduct and a copy of the complaint within 30 days from receipt of the complaint by the Chief Medical Officer. The medical staff member will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of this Code of Conduct and may result in corrective action against the medical staff member. The Senior Vice President for Medical Affairs, the respective department or division chairman or vice chairman, and the Chairman or Vice Chairman of the Practitioner Well-Being Committee will determine the authenticity and severity of the complaint. They shall dismiss any unfounded complaint and may dismiss any complaint if it is not possible to confirm its authenticity or severity, and will notify both the complainant and the subject of the complaint of the decision reached.

If the Senior Vice President for Medical Affairs, the respective department or division chairperson and the Chairman of the Practitioner Well-Being Committee determine the complaint is well founded, the complainant and the subject of the complaint will be informed of the decision within 14 days of the decision, and the complaint will be address as follows:

- A. If this is the first incident of inappropriate behavior, the department or division chairperson shall discuss the matter with the offending medical staff member, and emphasize that the behavior is inappropriate and must cease. The offending medical staff member may be asked to apologize to the complainant. The approach during this initial intervention should be collegial and helpful.
- B. Further isolated incidents that do not constitute persistent, repeated inappropriate behavior will be handled by providing the offending medical staff member with notification of each incident, and a reminder of the expectation the individual comply with this Code of Conduct.
- C. If, in spite of this admonition and intervention, inappropriate behavior recurs, the Senior Vice President for Medical Affairs and the respective Department or Division Chairman shall meet with and advise the offending member such behavior must immediately cease or corrective action will be initiated. A “final warning” shall be sent to the offending medical staff member in writing via certified mail following this meeting.

- D. If after the “final warning” the inappropriate behavior recurs, request for corrective action shall be immediately initiated pursuant to the Medical Staff Bylaws.
- E. If a single incident of disruptive behavior or repeated incidents of inappropriate behavior constitute an imminent danger to the health of an individual or individuals, the offending medical staff member may be summarily suspended as provided in the medical staff bylaws. The medical staff member shall have all of the due process rights set forth in the medical staff bylaws.
- F. If the Senior Vice President for Medical Affairs, the respective Department or Division Chairman, and the Chairman or Vice Chairman of the Practitioner Well-Being Committee determined the offending medical staff member has demonstrated persistent, repeated inappropriate behavior, constituting harassment (a form of disruptive behavior) and has violated a “final warning,” or has engaged in disruptive behavior on the first offense, the matter will be referred to the Medical Staff President/Medical Executive Committee requesting Routine Corrective Action pursuant to the Medical Staff Bylaws.

11.1.7 Inappropriate or Disruptive Behavior Against a Medical Staff Member

Inappropriate or disruptive behavior which is directed against the organized medical staff or directed against a staff member by a hospital employee, administrator, board member, contractor, or other member of the hospital community shall be reported by the medical staff member to the Hospital pursuant to hospital policy LD#30 entitled “Code of Conduct to Prevent Disruptive Behaviors.”

11.1.8 Abuse of Process

Threats or actions directed against the complainant by the subject of the complaint will not be tolerated under any circumstance. Retaliation or attempted retaliation by medical staff members against complainants will give rise to corrective action pursuant to the medical staff bylaws. Individuals who falsely submit a complaint shall be subject to corrective action under the medical staff bylaws or hospital employment policies, whichever applies to the individual.

11.2 ROUTINE CORRECTIVE ACTION

11.2.1 Criteria for Initiation

Any officer of the Medical Staff, department chairperson, the CEO, the VPMA, or the Board may request corrective action with respect to a Practitioner for, but not limited to, any of the following grounds:

- 11.2.1.1 Personal activities or professional conduct which are or are likely to be:

- (a) detrimental to patient safety; or
 - (b) detrimental to delivery of patient care.
- 11.2.1.2 Unethical professional practice in or outside of the Hospital.
 - 11.2.1.3 Formal institution of felony charges, e.g., an indictment, or conviction of, or plea of guilty or nolo contendere to, any felony.
 - 11.2.1.4 Conviction of any crime involving medical practice or Hospital activities.
 - 11.2.1.5 A finding by any professional licensing board that a Practitioner violated licensing statutes or administrative rules, regardless of whether a court has stayed the action.
 - 11.2.1.6 A finding by any local, state or national professional organization that a Practitioner committed unethical act(s).
 - 11.2.1.7 Acts indicating the Practitioner is totally or partially incapacitated or incompetent (including due to mental or physical condition).
 - 11.2.1.8 Failure to continuously meet and/or discharge the responsibilities of Medical Staff membership.
 - 11.2.1.9 Unauthorized disclosure of confidential Hospital or Medical Staff information relating to patient care or professional review involving either the Hospital or Medical Staff.
 - 11.2.1.10 Repeated disregard of utilization review findings and requirements.
 - 11.2.1.11 Violation of these Bylaws or the Rules (including falsification of application or credential documents).
 - 11.2.1.12 Failure to comply with a course of therapy, alternative action program, or practice quality improvement protocol as recommended by the Practitioner Well Being Committee or required by the MEC or Board.

11.2.2 Requests and Notices

All requests for corrective action made under Section 11.2.1 shall be in writing, submitted to the MEC, and supported by reference to the specific activities or conduct which constitute the grounds for the request. Unless corrective action is requested by the CEO, the CEO shall be notified in writing of all requests for corrective action received by the MEC and shall, in any event, be kept fully informed of all action taken in conjunction therewith.

11.2.3 When Investigation Is Deemed Necessary or Appropriate

The MEC may designate a person or an ad hoc committee to investigate the grounds for the request for corrective action, if deemed necessary or appropriate. The designated person or committee shall promptly investigate the matter (which may include an interview with the affected Practitioner) and, within 30 days after receipt of the designation, shall forward a written report of the investigation to the MEC. If the affected Practitioner is interviewed, the interview shall be informal; such an interview does not constitute a hearing and therefore none of the procedural rules relating to hearings shall apply.

11.2.4 Interview of Practitioner by MEC

At any point after a corrective action request is received, the MEC may, upon request, have the opportunity to interview the affected Practitioner. As noted in Section 11.1.3, any such interview does not constitute a hearing.

11.2.5 MEC Action

Within 45 days after receipt of the corrective action request or, if an investigation was performed, within 45 days after receipt of the investigative report, the MEC shall take action upon the corrective action request. Action taken by the MEC may include, without limitation:

- 11.2.5.1 reject the request for corrective action;
- 11.2.5.2 issue a written warning, letter of admonition, or letter of reprimand;
- 11.2.5.3 impose individual requirements of proctoring or consultation (with consent of the consultant or proctor not being required before patient care may be provided), additional training, retraining or continuing education;
- 11.2.5.4 require a health assessment by a health professional or at a facility selected by the Executive Committee and under such conditions (including reports to the Committee or its designee) as the Committee may establish, and/or require the affected Practitioner to undergo appropriate treatment.
- 11.2.5.5 recommend reduction, suspension or revocation of privileges;
- 11.2.5.6 recommend reduction of Medical Staff category;
- 11.2.5.7 recommend suspension or revocation of Medical Staff membership;
- 11.2.5.8 recommend any other form of discipline that materially limits the Practitioner's right to provide direct patient care as previously authorized (such as requiring proctoring or consultation, with consent

of the proctor or consultant being required before patient care may be provided).

If the request for corrective action is directed against a member of the MEC, that member shall not participate in the discussion or action taken in regard to such request.

11.2.6 Report to the Board

All MEC actions regarding a corrective action request shall be reported promptly to the Board. Potential responses by the Board include:

11.2.6.1 A decision by the MEC to reject a request for corrective action or to take an action specified in Section 11.2.5.2 through 11.2.5.4 shall not be final until approved by the Board (either by specific Board action or implied approval as provided in this Section). Silence or non-action by the Board for 60 days after receipt of notice of the MEC's action on a request for corrective action shall constitute the Board's implied approval of same. The affected Practitioner shall be notified of the MEC's decision, as approved by the Board. If the Board does not agree with the MEC's response to the corrective action request, the Board may (after consideration of the matter by the Joint Conference Committee) take any action specified in 11.2.5, subject to applicable hearing and appeal rights, if any.

11.2.6.2 If the MEC recommends any of the actions specified in Sections 11.2.5.5 through 11.2.5.8, the Board will not act on the recommendation until the affected Practitioner has either waived or completed a hearing.

11.2.7 Procedural Rights

Any recommendation by the MEC or action by the Board listed in Sections 11.2.5.5 through 11.2.5.8 shall entitle the affected Practitioner to hearing and appeal rights to the extent provided in these Bylaws.

11.3 SUMMARY ACTION

11.3.1 Summary Suspension or Conditions

A combination of any two of the following: (a) President, (b) President-Elect, (c) chairperson of the department to which the subject Practitioner is assigned, or (d) VPMA, shall have the authority to summarily suspend, or place conditions upon the exercise of, all or any portion of the clinical privileges of a Practitioner based on a good faith belief that the Practitioner's conduct requires that immediate action be taken to protect the life of any patient, employee, or other person present in the Hospital or to reduce the substantial likelihood of immediate injury or damage to the physical or mental health or safety of any patient, employee or other person present in the Hospital. The person imposing the summary suspension shall

immediately put in writing the reason(s) for and the circumstances surrounding the suspension. The summary suspension shall become effective immediately upon imposition and, as soon as possible, the CEO shall give the suspended Practitioner Special Notice of the suspension and shall notify the Board and MEC of the suspension.

11.3.2 MEC Review

The President and/or the CEO shall call an emergency meeting of the MEC within two (2) business days after the suspension takes effect to review the suspension. The CEO will endeavor to give notice of the MEC meeting to the affected Practitioner by the most expeditious means possible. The affected Practitioner may request or be requested by the MEC to appear before the MEC and discuss the situation before the MEC votes. Such an interview does not constitute a hearing. The meeting may be delayed at the request of the affected Practitioner. If the affected Practitioner is also a MEC member, he or she may not be present during deliberations and may not vote.

11.3.3 MEC Action

The MEC may recommend modification, continuation or termination of the terms of the summary suspension and shall recommend the future status of the Practitioner's Medical Staff membership/privileges (e.g. reinstate after suspension of a specified duration, or terminate Medical Staff membership/privileges).

11.3.3.1 Favorable MEC Recommendation. If the MEC, acting pursuant to this Section 11.3.3, recommends termination of the suspension and a disposition of the matter which does not trigger hearing/appeal rights, such recommendation shall be transmitted immediately, together with all supporting documentation, to the Board. The terms of the summary suspension as originally imposed shall remain in effect pending a final decision of the Board, provided, however, that unless the Board makes a final decision to the contrary within fifteen (15) days after the MEC's recommendation is transmitted to it, the action of the MEC to terminate the suspension shall become effective.

11.3.3.2 Unfavorable MEC Action. If the MEC, acting pursuant to this Section 11.3.3, recommends a continuation of the suspension and/or a disposition of the matter that triggers hearing/appeal rights, the Practitioner shall be entitled to the procedural rights provided in these Bylaws. The terms of the suspension shall remain in effect pending a final decision by the Board.

11.3.4 Responsibilities

The appropriate department chairperson shall arrange for coverage of the suspended Practitioner's patients in the Hospital at the time of suspension, until the

patients are discharged from the Hospital. The coverage shall be arranged in conjunction with the wishes of the respective patients.

11.4 AUTOMATIC ACTION

11.4.1 Circumstances

Automatic action shall be summarily imposed for any reasons enumerated in this Section 11.4. Automatic Action is not based on the Hospital's evaluation or determination of the affected Practitioner's competence and, therefore, to the greatest extent legally possible, not reportable as disciplinary action or a professional review action in accordance with State and Federal reporting requirements. The imposition of Automatic Action does not preclude the MEC and/or Board from taking corrective action or other forms of disciplinary action with respect to the behavior in question. There shall be no right of hearing or appeal from an administrative action imposed pursuant to this Section 11.4.

If (a) a Practitioner's membership and/or privileges are suspended pursuant to Section 11.4.2 or 11.4.6, and (b) the suspension has not yet converted to a termination of membership, and (c) the circumstances that caused the suspension cease to exist, the Practitioner's membership and/or privileges shall be restored upon the Practitioner's request accompanied by a written explanation of the circumstances that caused the suspension, unless the MEC determines the basis for suspension warrants review and potential initiation of corrective action, which review must be completed within thirty (30) days after the MEC's determination to review.

11.4.2 Professional License

A Practitioner whose license to practice his or her profession in the State of Michigan is terminated, suspended or lapses, shall immediately and automatically be suspended from practicing in the Hospital. If a Practitioner's health profession license in the State of Michigan is terminated or suspended or lapses for more than one-hundred- twenty (120) consecutive days, the individual's Medical Staff membership, if applicable, and clinical privileges at the Hospital shall terminate automatically.

11.4.3 DEA Registration or State Board of Pharmacy License

A Practitioner whose DEA registration or Michigan State Board of Pharmacy License is terminated or suspended or lapses shall immediately and automatically be divested of the right to prescribe medications covered by such registration or licensure; there shall be no right of hearing or appeal from such a suspension. As soon as possible after such automatic suspension, the Department Chair shall review the facts under which the DEA registration or Michigan license was terminated, suspended or lapsed and may, if appropriate, request corrective action or recommend to the MEC such other action as is appropriate to the facts disclosed in his or her investigation.

11.4.4 Medical Records

A Practitioner who fails to complete medical records or medical record entries for which he or she is responsible within the time limit stated in the Rules shall be subject to suspension of all clinical privileges until the delinquent charts are completed.

11.4.5 Professional Financial Responsibility

In the event a Member fails to meet applicable professional financial responsibility requirements (e.g. Medical Staff dues or special assessments) required by these Bylaws, all clinical privileges of the Member may be withheld until the requirement is met or his or her Medical Staff appointment terminates. While privileges are withheld, the Member may not see, treat, consult with respect to, or admit a patient at the Hospital.

11.4.6 Federal Program Exclusion

Exclusion of a Practitioner from a federal health care program shall cause an automatic suspension of the Practitioner's Medical Staff membership and clinical privileges which shall be reviewed by the MEC at its next regularly scheduled meeting. The suspension shall remain in effect during the period of exclusion unless the MEC recommends that the suspension be terminated and the Board adopts the recommendation. If a Practitioner remains excluded from a federal health care program for more than ninety (90) days, the individual's Medical Staff membership, if applicable, and clinical privileges at the Hospital shall terminate automatically.

11.5 MEMBER-INITIATED TERMINATION OF MEMBERSHIP OR PRIVILEGES WHILE UNDER INVESTIGATION

A Member may initiate termination of his or her Medical Staff membership or individual privilege(s) either by resigning membership or privilege(s), by opting not to request reappointment to the Medical Staff, or by opting not to request renewal of specific privilege(s). A resignation of membership or privilege(s) shall be submitted in writing to the Medical Staff Office and becomes effective when received by the Board. If a Member (a) submits a written resignation of membership or privileges or does not apply for reappointment of Medical Staff membership or renewal of one or more privileges, and (b) is under investigation at the time, such that the Hospital would be required to report the termination of membership or privilege(s) to the National Practitioner Data Bank ("NPDB"), the Medical Staff Office shall notify the Member in writing of the existence of, and grounds for, the investigation and the Hospital's NPDB reporting obligation; the notice shall provide the Member with an opportunity to retract his or her resignation before the request is transmitted to the Board or to request reappointment or renewal of existing privilege(s), as applicable, and the notice shall state a reasonable deadline for the Member to take such action.

ARTICLE XII.

REVIEW, HEARINGS AND APPELLATE PROCEDURES

12.1 DEFINITIONS

The following definitions shall be used in this Article XII, in addition to the definitions stated in Article II:

12.1.1 The term “Appellant” means a Practitioner or an individual who is applying for Medical Staff membership, clinical privileges or specified service authority at the Hospital, who has requested a hearing and/or appellate review pursuant to the Medical Staff Bylaws.

12.1.2 The term “Parties” means the Appellant and the other party to the hearing or appeal under this Article (i.e. the MEC or Board of Trustees, as applicable).

12.1.3 All references in this Article to clinical privileges shall apply equally to specified service authority, unless the context clearly indicates the contrary.

12.2 RIGHT TO A HEARING

12.2.1 Adverse Recommendation or Action

A practitioner shall be entitled to a formal hearing when the MEC has made a recommendation, or the Board of Trustees has taken an action (that was not preceded by an adverse recommendation by the MEC, and which remained adverse after the Joint Conference Committee considered the matter pursuant to Section 4.5.12 or 4.6.7 of the Medical Staff Bylaws), if the recommendation or action covers any matter set forth in Section 12.2.2 below.

12.2.2 Appealable Matters

A recommendation or action shall entitle an affected practitioner to a formal hearing only if one of the following matters is involved:

12.2.2.1 denial of Medical Staff membership;

12.2.2.2 denial of Medical Staff reappointment;

12.2.2.3 denial of requested initial or renewed clinical privileges;

12.2.2.4 denial of requested increased clinical privileges;

12.2.2.5 suspension or revocation of Medical Staff membership;

12.2.2.6 reduction, suspension or revocation of clinical privileges;

12.2.2.7 denial of a request for reinstatement from a leave of absence;

- 12.2.2.8 termination or suspension of temporary privileges that is reportable to the National Practitioner Data Bank or the State of Michigan; or
- 12.2.2.9 other material limitation of the right to provide direct patient care as previously authorized (such as requiring proctoring or consultation, with consent of the proctor or consultant being required before patient care may be provided).

12.2.3 Non-Appealable Matters

A practitioner will not be entitled to a hearing as a result of a recommendation or action that is not listed in Section 12.2.2, including the following matters:

- 12.2.3.1 summary action when rescinded within 14 days;
- 12.2.3.2 non-reappointment for failure to file a timely application for appointment;
- 12.2.3.3 a reduction of privileges which applies equally and generally to all of a class of Practitioners of like or similar training, experience, and Medical Staff membership duration;
- 12.2.3.4 denial of Medical Staff membership or requested privilege(s) based on the practitioner's failure to satisfy written qualifications for membership or the privilege(s) which apply equally and generally to all practitioners;
- 12.2.3.5 voluntary resignation of clinical privilege(s) or Medical Staff membership, including voluntary resignation pursuant to Section 5.8.2 of the Bylaws (due to failure to make a timely request for reinstatement from a leave of absence);
- 12.2.3.6 issuance of a warning, a letter of admonition or a letter of reprimand;
- 12.2.3.7 imposition of a consultation or proctoring requirement, if the consent of the consultant/proctor is not required before patient care may be provided;
- 12.2.3.8 imposition of automatic suspension or termination pursuant to Section 11.4 of the Bylaws;
- 12.2.3.9 denial of a request for, or (except as otherwise provided in Section 12.2.2.8) suspension or termination of, temporary privileges;
- 12.2.3.10 denial of a request for a leave of absence;
- 12.2.3.11 imposition of a requirement for retraining, additional training or continuing education, which does not affect current privileges;

12.2.3.12 requiring a health assessment, report and/or treatment, as described in Section 11.2.5.4 of these Bylaws.

12.3 INITIATION OF HEARING

12.3.1 Notice of Adverse Recommendation or Action

An individual who is entitled to a hearing because of an adverse recommendation or action shall promptly be given Special Notice of the recommendation or action and the reason(s) therefor by the President. The Special Notice shall also advise the individual of his or her right to a hearing and a summary of his or her hearing rights.

12.3.2 Request for Hearing

An individual who has received a Special Notice pursuant to Section 12.3.1 shall have thirty (30) days following the date of his or her receipt of the Special Notice within which to submit a written request for a hearing. The written request shall be delivered to the Vice President of Medical Affairs via Special Notice. A Practitioner who is subject to a summary suspension may request an early hearing as described in Section 12.4.1.

12.3.3 Hearing Waived if Not Requested

An individual who fails to request a hearing within the time and in the manner provided in this Article waives his or her right to a hearing and appellate review and accepts the action or recommendation. The adverse action or recommendation shall become effective immediately upon final Board approval.

12.4 PRE-HEARING PROCEDURE

12.4.1 Scheduling Hearing

The Vice President of Medical Affairs shall schedule the hearing. The hearing date shall ordinarily be not less than thirty (30) days nor more than sixty (60) days after the date the Vice President of Medical Affairs receives the Appellant's hearing request. The hearing shall be held as soon as the arrangements may reasonably be made if the Appellant is subject to a summary suspension and requested an early hearing pursuant to Section 12.3.2.

12.4.2 Notice of Hearing

The Vice President of Medical Affairs shall give the Appellant Special Notice of the hearing at least thirty (30) days before the hearing date unless otherwise agreed by the Parties. The Special Notice shall include:

12.4.2.1 the time, date and place of the hearing; and

12.4.2.2 a list of the witnesses, if any, expected to testify at the hearing on behalf of the Hospital. The Hospital shall supplement the list with a written list of the names and addresses of additional witnesses as they are determined.

12.4.3 Appellant's Witness List

Not less than 14 days before the hearing, the Appellant shall furnish to the Vice President of Medical Affairs a written list of the names and addresses of the individuals, as far as is then reasonably known, who may testify on behalf of the Appellant at the hearing. The Appellant shall supplement the list with a written list of the names and addresses of additional witnesses as they are determined.

12.4.4 Witness Cut-Off

Any witness who was not identified in writing to the other party at least seven (7) days before the start of the hearing may testify only if the presiding officer determines there was good cause for not furnishing earlier notice.

12.4.5 Hearing Panel Appointment

12.4.5.1 When a hearing is triggered by an adverse recommendation by the MEC, the Medical Staff President and the Vice President of Medical Affairs, acting on behalf of the Hospital, will jointly appoint a Hearing Panel which shall be composed of not less than three (3) Active Members.

12.4.5.2 When a hearing is triggered by Board action, the Chairperson of the Board and the Medical Staff President will jointly appoint a Hearing Panel which shall be composed of five people, three of whom shall be Active Members and, unless the Chairperson of the Board and President of the Medical Staff agree otherwise, two of whom shall be Board members.

12.4.5.3 Individuals who have actively participated in the consideration of the matter involved at any previous level, who are in direct economic competition with the Appellant, or who are professional or business associates of the Appellant shall not be appointed to the Hearing Panel. Mere knowledge of the matter involved shall not preclude an individual from serving as a member of the Hearing Panel. The individual(s) who appoint the Hearing Panel shall (a) make a good faith effort to select Panel members whose training and/or experience qualify them to evaluate the subject matter at issue, (b) determine the size of a Panel appointed pursuant to Section 12.4.5.1, and (c) designate one of the Panel members as chairperson. The chairperson of the Panel shall be entitled to vote.

12.4.6 Pre-Hearing Conference

Prior to or at the beginning of any hearing the presiding officer may, in his or her discretion, require the representatives of the Parties to participate in a conference to consider:

- 12.4.6.1 framing and simplification of issues to be presented at the hearing;
- 12.4.6.2 admission of facts or documents which will avoid unnecessary hearing testimony and proof;
- 12.4.6.3 limitation of the number of witnesses to be called by the Parties in order to reduce repetitive or irrelevant testimony;
- 12.4.6.4 such other matters as the presiding officer determines may aid in the expeditious disposition of the matters before the Hearing Panel.

The presiding officer may submit a summary of the decisions reached at the conference to the Hearing Panel and such summary may be used to control the subsequent course of the hearing.

12.5 HEARING PROCEDURE

12.5.1 Personal Presence Required

The personal presence of the Appellant at the hearing shall be required. An Appellant who, without good cause, fails to appear and proceed at such hearing waives his or her right to a hearing and appellate review and accepts the recommendation or action. The adverse recommendation or action shall become effective upon final action by the Board.

12.5.2 Hearing Officer

The individuals designated in Section 12.4.5 to appoint the Hearing Panel may appoint a Hearing Officer to preside at the hearing. The Hearing Officer may not be legal counsel to the Board, the Medical Staff or the Appellant and shall not act as a prosecuting officer, or as an advocate for the Board, the MEC or the Appellant. The Hearing Officer may participate in the private deliberations of the Hearing Panel, be a legal advisor to it, and assist in drafting the Hearing Panel's report, but shall not be entitled to vote.

12.5.3 Presiding Officer

The presiding officer at the hearing shall be the Hearing Officer or, if none has been appointed, the chairperson of the Hearing Panel. The presiding officer shall insure that all participants in the hearing have a reasonable opportunity to be heard and to present all permitted evidence, maintain decorum throughout the hearing, determine the order of procedure during the hearing, determine what evidence is

admissible, rule on any issues that arise, set deadlines for the submission of briefs or other documentation, and ensure that all parties present their positions without delay. The presiding officer may limit the number of witnesses and/or duration of testimony, especially character witnesses or evidence that is repetitive.

12.5.4 Representation

The Appellant may be represented at the hearing by a practitioner licensed to practice in the State of Michigan, an attorney or other person of the Appellant's choice. If the Appellant elects to be represented at the hearing, he or she shall notify the Vice President of Medical Affairs of this election in his or her initial request for a hearing. The Appellant will then notify the Vice President of Medical Affairs of the representative's name, address and telephone number promptly after determining who the representative will be. The other party (the MEC or Board) shall appoint a representative to present its case.

12.5.5 Rights of Parties

During the hearing, each of the Parties shall have the right to:

- 12.5.5.1 call and examine witnesses, however, neither party has the authority to compel witnesses to appear;
- 12.5.5.2 introduce written evidence;
- 12.5.5.3 cross-examine any witness on any relevant matter;
- 12.5.5.4 impeach any witness; and
- 12.5.5.5 rebut any evidence.

An Appellant who does not testify in his or her own behalf may be called and examined as if under cross-examination.

12.5.6 Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a court reporter or by an electronic recording of the proceedings. The cost of a court reporter, if used, shall be borne by the Hospital. The Appellant has a right to obtain a copy of the hearing transcript upon payment of the reasonable cost of preparing the transcript.

12.5.7 Procedure and Evidence

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Upon the request of either of the Parties, the presiding officer shall order that oral

evidence be taken only on oath or affirmation administered by any person designated by the presiding officer and entitled to notarize documents in the State of Michigan. Members of the Hearing Panel may question witnesses. Each of the Parties shall be entitled to submit a memorandum concerning any issue of law or fact at the close of the hearing, which shall become part of the hearing record. The Hearing Panel may require such memoranda to be filed within a specified time after the close of the hearing and may limit the length thereof.

12.5.8 Postponement

Requests for postponement of a hearing may be granted by the Hearing Panel, in its discretion, but only upon a showing of good cause and only if the request is made as soon as is reasonably practical.

12.5.9 Recess

The presiding officer may recess the hearing and reconvene the same at the convenience of the participants without Special Notice.

12.5.10 Burden of Proof

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its position. The Appellant shall thereafter be responsible for supporting a challenge to the adverse recommendation or action by evidence that (a) the grounds for the adverse recommendation or action lacked any substantial factual basis or (b) the conclusions drawn from the evidence were arbitrary or capricious.

12.5.11 Basis of Decision

The decision of the Hearing Panel shall be based on the record, which shall consist of the following:

12.5.11.1 testimony of witnesses;

12.5.11.2 materials introduced as evidence at the hearing; and

12.5.11.3 memoranda presented during or after the hearing.

12.6 POST-HEARING PROCEDURE

12.6.1 Adjournment

Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Panel shall thereafter, at a time convenient to itself, outside of the presence of the Parties, conduct its deliberations. Action of the Hearing Panel shall be by majority vote.

12.6.2 Hearing Panel Recommendation

Within twenty (20) days after (a) the final adjournment of the hearing or (b) the deadline for submission of final memoranda by the Parties (whichever is later), the Hearing Panel shall reach a decision and submit a written report that contains a concise statement of its recommendation(s) and the reason(s) for its recommendation(s), to the Vice President of Medical Affairs. The VPMA shall deliver a copy of the Panel's recommendation and report to the Medical Executive Committee and a copy to the Appellant via Special Notice.

12.6.3 Action on the Panel's Recommendation

Within thirty (30) days after receiving the Hearing Panel's recommendation and report, the MEC shall consider the Hearing Panel's recommendation. If the hearing was triggered by an adverse MEC recommendation, the MEC shall reconsider its initial recommendation and shall affirm, modify or reverse its initial recommendation. If the Hearing was triggered by an adverse Board action, the MEC shall make a recommendation regarding resolution of the matter. In all cases, the MEC shall transmit its recommendation to the Vice President of Medical Affairs.

12.6.4 Procedures When Hearing Was Initiated by MEC Action

12.6.4.1 Within seven (7) days after the MEC makes its post-hearing recommendation, the Vice President of Medical Affairs shall forward the recommendation, together with all supporting documentation and the Hearing Panel's recommendation and report, to the Board of Trustees for its decision.

12.6.4.2 At its next regularly scheduled meeting, but not later than thirty (30) days after receipt of the MEC's recommendation and the Hearing Committee's recommendation and report, the Board of Trustees shall make its post-hearing decision on the matter.

12.6.5 -Hearing Action

12.6.5.1 The Board shall consider the recommendations of the MEC and the Hearing Panel.

12.6.5.2 When the Board of Trustees' post-hearing decision is favorable to the Appellant, the Board of Trustees' decision is final and the matter is closed. The Chief Executive Officer shall notify the Appellant and the MEC of the favorable decision by Special Notice.

12.6.5.3 When the Board of Trustees' post-hearing decision is unfavorable to the Appellant, the Chief Executive Officer shall, within seven (7) days after the Board of Trustees acts, notify the Appellant and the MEC by Special

Notice of the adverse decision and the Appellant's right to request an Appellate Review.

- 12.6.5.4 For purposes of this Section 12.6.5, a recommendation or action is "unfavorable" if it entails any of the appealable matters listed in Section 12.2.2, and is "favorable" if it does not entail any of the appealable matters listed in Section 12.2.2.

12.7 APPELLATE REVIEW

12.7.1 Request for Appellate Review

An Appellant who has received a Special Notice of an action by the Board after a hearing, which is adverse to the Appellant in any of the respects listed in Section 12.2.2, shall have ten (10) days following receipt of the Special Notice in which to deliver a written request for appellate review. The request shall be delivered to the CEO via Special Notice and shall include a brief statement of the grounds for the appeal. If the Appellant wishes to make an oral statement to the Appellate Review Panel, the Appellant's request for appellate review must include a request to make an oral statement.

12.7.2 Failure to Request Appellate Review

If the Appellant does not deliver a request for appellate review in the time and manner required by Section 12.7.1, the Appellant waives his or her right to any appellate review and the Board's post-hearing adverse decision shall be immediately effective.

12.7.3 Grounds for Appellate Review

The grounds for appellate review from an adverse recommendation or action shall be limited to:

- 12.7.3.1 substantial failure of the MEC, Hearing Panel or Board to comply with these Bylaws in connection with the hearing, so as to deny a fair hearing;
or
- 12.7.3.2 action taken arbitrarily, capriciously or lacking any substantial factual basis.

12.7.4 Scheduling and Notice of Appellate Review

Whenever an appeal is requested as set forth in Section 12.7.1, the CEO shall schedule and arrange for an appellate review. The date of appellate review shall be not less than fifteen (15) days from the date of receipt of the request for appellate review. However, when appellate review is requested by an Appellant who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made (provided the Parties agree to a modification

of the usual notice period provided in this Section). The CEO shall give the Appellant and the President of the Medical Staff Special Notice of the date of the appellate review at least fifteen (15) days in advance, unless otherwise agreed by the Parties. The President of the Medical Staff will communicate the content of the Special Notice to the MEC.

12.7.5 Nature of Appellate Review

The Chairperson of the Board shall appoint a review panel composed of not less than three (3) Board members and shall designate a chairperson. A person shall not be precluded from serving as a member of the Review Panel by virtue of having knowledge of the matter and/or having participated in prior action with respect to the matter, provided the same person may not serve on both the Hearing Panel and Review Panel. Proceedings on the appeal shall be based on the record upon which the recommendation/action being appealed was based. The Appellant may submit a written statement regarding those factual and procedural matters with which the Appellant disagrees and the reasons for such disagreement. The MEC may submit a written statement of the MEC's position on the matter under Appellate Review. Such written statements shall be submitted to the CEO via Special Notice. The Review Panel may limit the length of written statements. The MEC and Appellant or their respective representative shall be permitted to state their positions regarding the adverse decision and the Appellant shall answer questions by members of the Review Panel. The Board of Trustees shall also be represented by one of its members, or by an attorney if the Board so desires, to present its position and answer questions by any member of the Review Panel. New or additional matters not raised during the original hearing or in the Hearing Panel's report may be introduced at the Appellate Review only if the evidence is relevant and could not have been presented at the hearing. The Appellate Review Panel shall, in its sole discretion, determine whether such new matters will be accepted. Within twenty (20) days after conclusion of the appellate review, the Review Panel shall submit its recommendation, including a statement of the reasons therefor, to the Board.

12.7.6 Final Decision of the Board

Within forty-five (45) days after receipt of the Review Panel's recommendation, the Board of Trustees shall consider the Panel's recommendation and make its final decision in the matter and shall send notice of its final decision to the Appellant by Special Notice and to the MEC. The final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review.

12.8 GENERAL PROVISIONS

12.8.1 Right to One Hearing and Appeal Only

No individual shall be entitled to more than one hearing and appellate review on any matter which may be the subject of a hearing/appeal, without regard to whether such subject is the result of a recommendation or an action of the MEC or the Board,

or a combination of recommendations or actions of such bodies. If more than one hearing and/or appeal with respect to the same Appellant are proceeding simultaneously (e.g., summary suspension and non-reappointment), the Board may order the proceedings consolidated into a single hearing or appeal. In this respect, the Board shall have the authority to suspend or modify time limits and take whatever action is reasonably necessary to accommodate the consolidation.

12.8.2 Waiver

If, at any time after receipt of Special Notice of an adverse recommendation, action or result, an individual fails to make a required request or appearance or otherwise fails to comply with this Article or to proceed with the matter, the individual shall be deemed to have consented to such adverse recommendation, action or result and waives all rights to which he or she might otherwise have been entitled with respect to the matter involved.

12.9 TERMINATION OF CONTRACT

A Practitioner's contract with the Hospital or with his or her employer may provide that the Practitioner's Medical Staff membership and/or clinical privileges will terminate automatically (i.e. without a hearing or appeal) upon termination or expiration of (a) the Practitioner's contract with his or her employer or the Hospital or (b) his or her employer's contract with the Hospital, without regard to the Practitioner's professional competence. A Practitioner whose Medical Staff membership and/or clinical privileges are terminated solely by reason of contract expiration or termination shall be entitled upon request to a written statement to that effect, a copy of which shall be maintained on file by Administration.

ARTICLE XIII.

CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 SPECIAL DEFINITIONS

The following special definitions apply in this Article:

13.1.1 "Facility" means a health care facility or organization and includes the Hospital, other hospitals, clinics, universities, health maintenance organizations, prudent purchaser organizations and independent practice associations.

13.1.2 "Hospital practitioner" means a physician, dentist, podiatrist, or allied health professional who has applied for or has been granted Medical Staff membership, Allied Health Professional affiliation, clinical privileges and/or specified service authority at the Hospital.

13.1.3 "Professional review" means the review of the health, clinical ability, ethics, and education of a Hospital practitioner and includes, but is not limited to: morbidity

and mortality review; utilization review; patient care and audits; performance reviews in an academic or practice setting; insurance underwriting reviews; credential investigations; appraisals for medical staff or allied health professional appointment or reappointment; review of applications for employment at a facility (as defined); or initiation of corrective action proceedings or appellate reviews in the course of a facility's medical staff or allied health professional staff affairs.

13.1.4 "Professional review information" means records, data, and knowledge developed or collected in connection with professional reviews, and includes, but is not limited to, applications, reports, minutes, transcripts, recommendations, and summaries respecting professional review.

13.1.5 "Professional review action" means an action taken in the process of a professional review or on account of professional review information. Professional review actions include but are not limited to: appointment, non-appointment, reappointment and non-reappointment of medical staff or allied health staff of a facility; corrective action proceedings, hearings or appeals in a facility; preparation of reports regarding conduct of a Hospital practitioner's activities in a facility; and a recommendation or imposition of discipline or restrictions upon the professional activities of a Hospital practitioner.

13.1.6 "Representative" means a person, committee, medical staff organization, board, facility or entity which is authorized to: conduct professional review; undertake professional review actions; or collect, prepare, hold or disclose professional review information concerning a practitioner or applicant.

13.2 AUTHORIZATIONS AND CONDITIONS

By applying for clinical privileges or specified service authority at the Hospital, each Hospital practitioner:

13.2.1 Authorizes representatives of the Medical Staff and the Hospital to solicit, receive, provide to other representatives, and act upon professional review information and other information bearing on the practitioner's character, conduct, ethics, physical and mental health, competence and other qualifications (collectively, "Qualifications"), and authorizes all individuals and organizations to provide such information to representatives of the Medical Staff and Hospital.

13.2.2 Consents to representatives of the Medical Staff and Hospital inspecting all records and documents relevant to an evaluation of the Practitioner's Qualifications.

13.2.3 Agrees to be bound by the provisions of this Article and to waive and release all legal claims against any representative and facility for any professional review action taken, and for the disclosure of professional review information, in good faith, with respect to the Hospital practitioner. There shall be a presumption of good faith, and truth shall be an absolute defense, in any legal proceeding charging a representative or facility with liability for professional review actions taken or for professional review information disclosed.

13.2.4 Acknowledges that the provisions of this Article are express conditions to his or her application for, or acceptance of, Medical Staff membership, Allied Health Professional affiliation, clinical privileges and/or specified service authority at the Hospital.

13.2.5 Acknowledges and agrees that in the event that his or her ability to practice at any other facility is voluntarily or involuntarily limited, denied, suspended, or terminated, he or she shall promptly provide the Hospital with notice of, and all documents or professional review information related to, such action.

13.2.6 Agrees to maintain the confidentiality of all Hospital professional practice review information.

13.3 CONFIDENTIALITY OF PROFESSIONAL REVIEW INFORMATION

Professional review information regarding a Hospital practitioner held by the Hospital shall be confidential to the fullest extent permitted by law. Professional review information regarding a Hospital practitioner shall not be disclosed to anyone other than a representative or facility which is conducting professional review involving the Hospital practitioner or as required by law. Professional review information concerning a Hospital practitioner shall not be a part of a patient's medical record or the Hospital's general business records. Prior to reporting any adverse action to the National Practitioner Data Bank, the affected Hospital practitioner, if a Member, shall be provided with a copy of the report form and be permitted to point out any errors or inaccuracies to the Hospital prior to the submission of the report. The Board, the MEC, the President, a department chairperson, and the CEO shall each have the authority to enforce this Section.

13.4 CUMULATIVE EFFECT

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE XIV.

ASSIGNMENT OF PROFESSIONAL PRACTICE REVIEW FUNCTIONS

14.1 REVIEW FUNCTIONS OF MEDICAL STAFF AND ADMINISTRATION

14.1.1 The Medical Staff is organized in a manner to provide ongoing review of the professional practices of the Hospital, for the purposes of striving to reduce morbidity and mortality and to improve the care of patients. To the extent any committee of the Medical Staff performs such functions, that committee is hereby designated as a committee assigned professional practice review functions. The committees so designated include, but are not limited to, the investigative, hearing and appeal bodies described in these Bylaws and the following committees, which are further described in these Bylaws: Executive, Clinical Ethics, Credentials,

Critical Care Effectiveness, Emergency Room, Infection Control, Joint Conference, Medical Record, Operating Room, Peer Review, Pharmacy & Therapeutics, Practitioner Well Being, and Quality & Safety.

- 14.1.2 Professional practice review functions are also performed in the various clinical departments and divisions of the Medical Staff, the clinical programs of the Hospital, by the Medical Staff Officers, clinical directors, and Administration, and by the participants in the proceedings that are described in Article XI and Article XII, all of which are assigned professional practice review functions.
- 14.1.3 Employees of the Hospital are assigned and perform professional practice review functions by providing information, records, data and knowledge to, and otherwise assisting, individuals and committees in the performance of their professional practice review functions.
- 14.1.4 Members of the medical staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and medical staff, such as participation in any of the professional practice review functions described in this Section 14.1. Subject to applicable law, the Hospital shall indemnify against actual and necessary expenses, costs, and liabilities incurred by medical staff members in connection with the defense of any pending or threatened action, suit or proceeding to which he is made a party by reason of his having acted in an official capacity, in good faith on behalf of the Hospital or Medical Staff. However, no Member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of fiduciary duty, self-dealing or bad faith.

14.2 CONFIDENTIALITY OF INFORMATION

All records, data, and knowledge collected by or for individuals and committees assigned professional practice review functions shall be confidential, shall be used only for carrying out of such functions, and shall be made available only to other persons and entities that have been assigned such functions for the Hospital. Such records, data and knowledge shall be entitled to the protection of Sections 20175 and 21515 of the Michigan Public Health Code, Act 270 of the Public Acts of 1967 and Section 1143(a) of the Michigan Mental Health Code, as amended.

ARTICLE XV.

AUTHORITY TO MAKE RULES

15.1 MEDICAL STAFF RULES

- 15.1.1 MEC – Initiated Rules. The Medical Executive Committee may vote to adopt, amend, or repeal Medical Staff Rules provided same are consistent with these Bylaws and are announced and made available to the Medical Staff for comment

before the MEC votes on the them. Such Rules, and changes thereto adopted by the MEC are effective upon approval by the Board.

15.1.2 Medical Staff – Initiated Rules. The Medical Staff, by means of a petition signed by at least 15 voting Members and delivered to the Medical Staff President, may propose in writing adoption, amendment or repeal of Medical Staff Rules, provided the proposal is consistent with these Bylaws. The MEC shall review the proposal and submit it to a vote of the Medical Staff in the manner described in Section 16.3. The voting procedures set out in Section 16.3 shall be used for the Medical Staff vote on the proposal. Such Rules, and changes thereto adopted by the Medical Staff are effective upon approval by the Board.

15.1.3 No Unilateral Action. Neither the Medical Executive Committee, Medical Staff, nor Board may unilaterally adopt, amend or repeal a Medical Staff Rule.

15.2 DEPARTMENT RULES

A Department may adopt Departmental rules which are consistent with these Bylaws and the Medical Staff rules, only with the affirmative approval of the MEC.

ARTICLE XVI.

AMENDMENT OF THE BYLAWS

16.1 PROPOSED AMENDMENTS

Amendments, additions and repeals of the Bylaws may be proposed by the MEC, the Bylaws Committee, any voting Member of the Medical Staff, the CEO or the Board.

16.2 PERIODIC REVIEW

The Bylaws and Rules of the Medical Staff shall be reviewed by the Bylaws Committee annually for the purpose of considering any changes made necessary or appropriate by internal or external conditions affecting the Hospital and the proper functioning of the Medical Staff. If the Bylaws Committee determines, upon review, that no amendments, additions or repeal of the Bylaws or Rules are necessary, it shall report same to the MEC which, if in agreement, shall forward the report and its concurrence to the Board.

16.3 AMENDMENT PROCESS

Any proposed amendment, addition or repeal of the Bylaws provided for in this Article will be submitted in writing to the President of the Medical Staff, who in turn will submit the proposal to the Bylaws Committee for a recommendation. The Bylaws Committee will send its recommendation to the MEC for review. The MEC will then submit the proposed amendment to the Medical Staff membership for review, at least two weeks before the Medical Staff will vote on the proposed amendment. Absent unusual circumstances, the proposed amendment will be presented to the Medical Staff no later than ninety (90) days after the Medical Staff President received the proposal. The adoption of such proposals

shall require a vote of 2/3 of those Members who are eligible to vote and are present at a meeting at which there is a quorum. If the MEC determines that a Bylaw proposal will be voted on by mail ballot, rather than at a meeting, the adoption of the proposal requires a vote of 2/3 of those Members who are eligible to vote and who submit a timely mail ballot, provided at least 30% of Members who are eligible to vote submit a timely ballot. The proposal, if adopted, shall take effect when approved by the Board. Except in unusual circumstances, the Board will act upon a Bylaw proposal approved by the Medical Staff within ninety (90) days after the Board receives the proposal. Neither the Board nor the Medical Staff may unilaterally amend, add to, or repeal these Bylaws.

ARTICLE XVII.

RULES OF ORDER

The provisions of the current edition of The Standard Code of Parliamentary Procedure (formerly the Sturgis Standard Code of Parliamentary Procedure), shall apply to the conduct of all Medical Staff meetings and procedures, to the extent not inconsistent with these Bylaws.

ARTICLE XVIII.

NATURE OF BYLAWS

These Bylaws and the Rules are documents setting forth policy for Practitioners. The Bylaws, the Rules and any documents promulgated thereunder (e.g., applications or policies) do not constitute a contract or an agreement upon which any individual or group may claim contract rights.

ARTICLE XIX.

ADOPTION

The foregoing Bylaws of the Medical Staff were ADOPTED and RECOMMENDED for Board approval by the Members in the Active category of the Hospital on Friday, October 16, 2020.

The foregoing Bylaws of the Medical Staff were APPROVED by the Henry Ford Health System Board on Friday, December 18, 2020.