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ST. JOHN MACOMB HOSPITAL

BYLAWS, RULES AND REGULATIONS FOR THE MEDICAL STAFF

INTRODUCTION

PREAMBLE

Recognizing that St. John Detroit Macomb Campus doing business as St. John Macomb Hospital is a nonprofit corporation organized under the laws of the State of Michigan;

That its purpose is to serve as a general hospital organization providing patient care, education and research; and

That the medical staff is responsible for the quality of medical care in the hospital and must accept and discharge this responsibility, subject to the ultimate authority of the hospital's governing board, and that the cooperative efforts of the medical staff, the governing board and its designees are necessary to fulfill the hospital's obligations to its patients;

Practitioners in St. John Macomb Hospital hereby organize themselves into a medical staff in conformity with these bylaws.

DEFINITIONS

For the purpose of these bylaws, the term "medical staff" shall be interpreted to include all practitioners who are privileged to attend patients in association hospital.

The term "governing board" refers to the board of trustees, responsible for the conduct of the hospital.

The term "president" refers to the individual appointed by the governing board to act in its behalf in the overall management of the hospital.

The term "chief of staff", as defined in Article IX, refers to the presiding officer of the medical staff who shall have general supervision over all the medical work of the hospital.

The term "hospital" shall be interpreted to apply to St. John Macomb Hospital.

The term "practitioner" means an appropriately licensed medical physician, osteopathic physician, dentist or podiatrist.

ARTICLE I
NAME OF ORGANIZATION

The name of this organization shall be the Medical Staff of St. John Macomb Hospital.

ARTICLE II
PURPOSES

The purposes of this organization are:

1. **To organize and maintain a wide range of quality medical service consistent with community needs;**

2. **To provide to all patients admitted to or treated in any of the facilities, departments, or services of the hospital continuous medical care within the standard of practice;**

3. **To monitor the level of professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital;**

4. **To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill and to establish, maintain or assist with programs of education for members, house staff and paramedical students;**

5. **To initiate and maintain rules and regulations for self-government of the medical staff in accordance with the Michigan Hospital Licensing Act for the purpose of reducing morbidity and mortality and improving the care provided in the hospital for patients.**

6. **To provide a means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the president and the governing board.**

ARTICLE III
MEMBERSHIP

SECTION 1. ***- LIMITATIONS -***

Membership on the medical staff is a privilege which can be maintained only by those practitioners who continuously meet qualifications, standards and requirements set forth in these bylaws, who are practicing in the community at a reasonable distance from the hospital, and who uses the facilities of the hospital or provides some special service necessary for good patient care. There shall be no discrimination on the basis of race, color, age, creed, sex, handicap or national origin or any other illegal basis.

SECTION 2. ***- ETHICS AND ETHICAL RELATIONSHIPS -***

a. The code of ethics as adopted by the American Medical Association, American Osteopathic Association, American Podiatric Association, and American Dental Association, as applicable, shall govern the professional conduct of the members of the medical staff. Specifically, all members of the medical staff shall pledge themselves that they will not receive from nor pay to another practitioner, either directly or indirectly, any part of a fee received for professional services. On the contrary, it shall be agreed that all fees shall be collected and retained by the individual practitioner in accordance with the value of services rendered.

b. Acceptance of membership on the medical staff shall constitute the staff member's agreement that he will abide strictly by the code of ethics noted above, these bylaws and the Corporate Bylaws.

SECTION 3. ***- QUALIFICATIONS -***

Membership to the medical staff is limited to practitioners who:

a. Are licensed to practice in the State of Michigan;

b. Are, where applicable, licensed by the Michigan Board of Pharmacy and the U.S. Department of Justice, Drug Enforcement Administration, for the use of controlled substances;

c. Can document their background, training, experience and demonstrated competence, and their ability to work with others to provide quality patient care.

d. Desire to use the facilities of the hospital, or to offer a needed service, if appointed;

e. Are willing to participate in the work of the medical staff, including committee and teaching assignments;

f. Are willing to be governed by the professional and ethical standards and the bylaws, rules and regulations of the medical staff, and those of the hospital.

g. Board Certification: All new applicants to St. John Macomb Hospital who apply after April 25, 2000 must verify candidacy for board certification at the time of the initial application. The candidacy must be for certification in a specialty recognized by the American Board of Medical Specialties The Bureau of Osteopathic Specialists, The American Dental Association, or the American Board of Podiatric Surgery, and The American Medical Association Council on Medical Education, or the Osteopathic equivalent. The specific board certification requirements that are referred to in this section must reflect the specific practice of the applicant; i.e. gastroenterology boards for a subspecialist practicing in gastroenterology-not internal medicine boards. Where there are two boards required to achieve final certification, each board certification must be considered in sequence. For those specialties that do not allow recent graduates to become candidates until a certain number of years have passed, their candidacy will have to be verified at the time of provisional reappointment. Physicians in any specialty who cannot demonstrate candidacy or the potential for candidacy at the time of application, will not be eligible to become members of the medical staff.

All physician candidates must have achieved board certification in the primary specialty of the applicant's residency program, within five years after initial application to the Medical Staff. In the event a member of the medical staff does not achieve board certification within five years after initial application to the Medical Staff, their membership to the medical staff at (SJMH) shall terminate automatically.

<u>Recertification:</u> Where board certification has been given in time limited fashion, all new applicants to SJMH who apply after April 1, 2004, must re-certify in the specialties in which the member primarily practices, at the time designated by such individual boards. In addition, a prerequisite for reappointment to the medical staff is the timely re-certification in those specialties in which the member primarily practices.

Licensure, professional memberships and hospital privileges elsewhere do not alone qualify the individual for membership.

SECTION 4. *- TERMS AND CONDITIONS OF APPOINTMENT -*

a. **Appointments to the medical staff shall be made by the governing board of the hospital only after reviewing the recommendation of the medical executive committee.**

b. **Practitioners approved for membership shall be appointed in provisional status for an initial period of one year. Subject to evaluation of performance during the initial year, provisional appointees may be: 1) dropped from the medical staff, 2) reappointed in provisional status, or 3) appointed in regular status.**

c. **At the end of the hospital's medical staff year, the governing board of the hospital may reappoint members of the medical staff for a further period of two (2) years, without any changes in status or privileges, provided the medical executive committee has not recommended that any specific appointment not be renewed.**

d. **In no case shall the governing board take action on an application, refuse to renew an appointment, or cancel an appointment previously made without consultation and advice of the medical executive committee.**

e. **Appointment to the medical staff shall confer upon the appointee only such privileges and responsibilities as have been granted by the governing board.**

SECTION 5. - APPLICATION AND PROCEDURE FOR APPOINTMENT -

a. **A practitioner employed by the corporation, whose duties include clinical responsibilities, must be a member of the medical staff. Practitioner's appointment shall be made in accordance with the provisions for application and procedure for appointment as contained in these bylaws and said appointment shall entitle practitioner to all the rights and privileges of every member of the medical staff. Specifically, practitioner shall not have his medical staff privileges reduced, suspended or revoked without right to the appeal and appellate review procedure as contained in Article VII unless otherwise agreed to by the practitioner.**

b. **Each application for appointment to the medical staff shall be in writing on the form prescribed by the hospital, shall be signed by the applicant, and submitted to the corporate office of the hospital for the attention of the office of medical affairs for collection of reference data and transmittal to the credentials and professional standards committee for evaluation.**

c. **The applicant will be required to document: (1) whether applicant's appointment or clinical privileges have been revoked, suspended, reduced, not renewed, challenged, or voluntarily relinquished or reduced pending an investigation at any other health care institution, and the outcome of such proceeding; (2) whether membership in any medical society or licenses of whatever nature have been revoked, suspended, reduced, not renewed, challenged, involuntarily or voluntarily relinquished or reduced pending an investigation, and the outcome of such attempt; (3) report applicant's liability actions including past adverse final judgments or settlements and pending liability claims.**

d. **Each application shall contain the applicant's specific acknowledgment of every medical staff member's obligations to provide continuous care and supervision of his patients on a timely basis, to abide by the medical staff bylaws, rules and regulations and the bylaws of the governing board, to accept committee assignments, and to accept teaching and consultation assignments as appropriate.**

e. **By applying for appointment or reappointment, the applicant authorizes the hospital to seek any information pertinent to the privileges he desires and releases from liability those individuals who obtain or disclose such information in good faith.**

f. **Upon receipt of an application, the credentials and professional standards committee shall investigate the character, professional competence and judgment, his physical condition and mental health, and other qualifications and standings of the applicant. Such investigation shall include examination of past affiliations, education background and clinical capabilities. The credentials and professional standards committee shall consult with the chiefs of appropriate services and divisions regarding their recommendations on each applicant and then, as soon thereafter as possible, it shall report to the medical executive committee recommending that an application shall be accepted, deferred, or rejected.**

g. **With a recommendation of acceptance, the credentials and professional standards committee shall also recommend clinical privileges. In recommending deferral or rejection of any applicant, the committee shall appropriately indicate reasons for such deferral or rejection.**

h. The medical executive committee shall promptly review the report of the credentials and professional standards committee and shall immediately recommend to the governing board that the application be accepted, deferred or rejected, and if accepted, the clinical privileges which should be granted. Recommendation for acceptance shall require approval by a majority of the members present at a meeting of the medical executive committee. If the application is deferred or rejected, appropriate reasons must be stated in the report to the governing board.

I. The formal recommendations of the medical executive committee shall be forwarded through the corporate offices of the hospital for consideration, in turn, by the board's Quality Assurance/risk management/credentialing committee and the governing board.

j. The governing board may either accept the recommendation of the medical executive committee or reject or defer such action. However, in the event of rejection or deferment, it shall refer such application back to the medical executive committee for its further consideration, including in this referral specific information as to the reasons for rejection or deferral.

k. Decision by the governing board authorizes the president to transmit the information to the applicant, and if he is appointed to membership, to secure his written agreement to be governed by these bylaws, rules and regulations and bylaws of the governing board.

l. When a practitioner's application is rejected, he may appeal his case via the procedure outlined in Article VII.

SECTION 6. *- PROCEDURE FOR REAPPOINTMENT -*

a. Reappointment to the medical staff shall be accomplished biennially, without reapplication upon recommendation, in turn, of the chief of service and division, the credentials and professional standards committee, the medical executive committee and by formal action by the governing board.

b. Each recommendation for reappointment of a medical staff member, including any changes in his status or clinical privileges, shall include, but not be limited to, a review of his professional competence and judgment, his physical condition and mental health to the extent they impact his/her ability to perform the privileges sought, his compliance with the standards, participation and other requirements of these bylaws, rules and regulations, and his demonstrated interest in maintaining good relations with patients, public, hospital and fellow practitioners; and payment of medical staff dues.

Each applicant for reappointment must state on the required reappointment form (1) whether applicant's appointment or clinical privileges have been revoked, suspended, reduced, not renewed, challenged, or voluntarily relinquished or reduced pending an investigation at any other health care institution, and the outcome of such proceeding; (2) whether membership in any medical society or licenses of whatever nature have been revoked, suspended, reduced, not renewed, challenged, involuntarily or voluntarily relinquished or reduced pending an investigation, and the outcome of such attempt; (3) report applicant's liability actions including past adverse final judgments or settlements and pending liability claims.

c. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented. When a practitioner fails to secure reappointment to the medical staff, or when his clinical privileges are reduced through reappointment, he may appeal his case via the procedure outlined in Article VII.

d. Clinical Privilege Restricted

Medical staff appointees are required to immediately notify the Chief of Staff of any sanction by State or Federal agencies or sanctions reported to the National Practitioner Databank at any other institution or any voluntary changes in licensure at another institution.

ARTICLE IV
CATEGORIES OF THE MEDICAL AND DENTAL STAFF

The Medical and Dental Staff of St. John Macomb Hospital shall be organized within the categories listed below. New appointments may be to the Consulting, Active, Associate, Courtesy, Office Based Affiliate, House Staffs and, except for the Consulting Staffs, will be on a provisional status for at least one year. Appointments and reappointments to the Medical Staff categories will be recommended by the Credentials Committee to the Medical Executive Committee. The privileges of each Staff appointee will be recommended at the time of appointment and reappointment by the chief of the service, by the Credentials Committee and approved by the Medical Executive Committee, the Quality Assurance/ Risk Management/ Credentialing Committee, and the Board of Trustees. All categories are afforded hearing and appeal rights.

SECTION 1. ***- HONORARY STAFF -***

The Honorary Staff shall consist of physicians and dentists who are appointed to Honorary positions on the medical staff. The Honorary Staff shall have no assigned duties, no voting privileges and shall not pay dues. These may be:

1. **Physicians and dentists who have retired from active service with the hospital.**

2. **Other physicians who have made noteworthy contributions to the hospital, or who by reason of outstanding reputation or achievement are considered worthy of appointment to the Honorary Staff.**

3. **The Staff category "Honorary with Distinction" shall include physicians who have made significant contributions to the medical staff at St. John Macomb Hospital; which physician fulfills this category shall be determined by the Medical Executive Committee.**

SECTION 2. ***- CONSULTING STAFF -***

The Consulting Staff shall consist of physicians and dentists in the community who have special skills or academic achievements and have signified willingness to accept such appointments. Appointees to the Consulting Staff are restricted to ten (10) admissions in a calendar year and have no numerical restrictions on consultations. They may neither vote nor hold office nor serve as division chairman or service chief appointment.

SECTION 3. *- ACTIVE STAFF -*

The Active Staff shall consist of physicians and dentists who regularly admit patients to the Hospital and/or who actively participate in and accept responsibility for the functions of the Medical and Dental Staff and educational programs of the Hospital. To be eligible for appointment to the Active Staff the physician or dentist must be certified by the applicable American specialty board. They shall have full voting privileges and may serve as an officer, service chief, or division chairman and may serve on committees, including committee chairmanship. They shall attend at least fifty (50) percent of the Medical Staff meetings and those Service and division meetings required by the service and division to which they are appointed. They shall pay dues.

SECTION 4. *- ASSOCIATE STAFF -*

Appointees of the Associate Staff shall consist of physicians and dentists who intend to regularly admit patients to the Hospital and/or who actively participate in and accept responsibility for the functions of the Medical and Dental Staff and educational programs of the Hospital. Physicians and dentists newly appointed to the Medical Staff, as well as those who have not achieved certification by the applicable American specialty board, will be assigned appointment on the Associate Staff. Appointees of the Associate Staff may serve on committees and vote on committee matters. They are not eligible for appointment or election as an officer of the Staff or as service chief or member-at-large. They shall attend at least fifty (50) percent of the Medical Staff meetings and those meetings as required by the service and division to which they are appointed and may vote at Medical Staff, service, and division meetings. They shall pay dues.

SECTION 5. *- COURTESY STAFF -*

The Courtesy Medical Staff shall consist of physicians and dentists qualified for Staff membership who only occasionally admit patients to the Hospital or who act only occasionally as consultants or who are legitimate associates of active or associate staff who routinely and regularly makes rounds and participate in the care of their patients. Each physician and dentist on the Courtesy Staff is restricted to a total of ten (10) admissions and/or consultations and/or operations in a calendar year. Appointees of the Courtesy Staff wishing to exceed this number should demonstrate a willingness to assume responsibilities of the Associate Staff and should submit a written request for promotion to the President. Appointees of the Courtesy Staff may not vote at meetings of the Medical Staff or at department meetings. They may serve on committees but are not required to do so. When serving on a committee, appointees of the Courtesy Staff may vote on matters coming before that committee. Attendance at meetings is encouraged but not required. They may not be committee or division chairman, nor are they eligible for appointment or election as an officer of the Staff, a service chief or for nomination as an at-large representative of the clinical services. They shall pay dues.

SECTION 6. -*OFFICE BASED AFFILIATE*

The Office Based Affiliate Category shall consist of Practitioners who provide office-based ambulatory care, refer patients to members for hospital admission and management of acute care needs and pay dues. Office-Based members may not exercise privileges, write orders, make progress notes or render direct care.

Office Based Affiliate members may:

- **Visit their patients admitted on the service of active or courtesy members.**
- **Have access to the records of these patients and to obtain copies of such records.**
- **Attend educational programs at the hospital and received continuing medical education credit.**
- **Attend and orally participate, but not vote or hold office on the Medical Staff Service, divisions or committees.**

SECTION 7. *- HOUSE STAFF -*

The House Staff shall consist of graduate physicians in training, i.e. interns and residents, fellows or licensed individual practitioners. Responsibilities of the House Staff shall be determined by the appropriate section chiefs and administration. House Staff may neither vote nor hold office. Privileges of physicians in the House Staff category shall terminate at the end of the approved period of training and/or at the termination of their employment.

SECTION 8. -SUPPORT STAFF PHYSICIANS-

The Support Staff Physicians shall consist of licensed physicians employed by the corporation to provide coverage for in-house emergencies and patient care as directed by the active physician staff and/or section chiefs and administration. The Medical Support Staff Physicians shall not have admitting privileges and shall perform duties as described in the employment agreement. Terms and conditions of employment shall be limited to the written contractual agreement. All Support Staff Physicians will be required to file an application for staff privileges and will be subjected to the credentialing process in the determination of privileges. Such physicians may attend professional staff meeting, however, shall not have voting rights and cannot hold office nor shall they be required to pay medical staff dues.

SECTION 10. *- SPECIFIED PROFESSIONAL STAFF -*

Professional persons other than physicians and dentists trained in scientific disciplines pertinent to health care, (clinical psychology, podiatry, nurse practitioners and physician assistants), who have attained the doctorate or equivalent academic status, practicing their profession within the Hospital having a current, valid state license where appropriate, may be appointed to the Specified Professional Staff. While not Medical and Dental Staff appointees, they may render service to Hospital patients under the following conditions. They shall pay dues.

a. Request for appointment to the Specified Professional Staff will be initiated on recommendation of the chief of the service to which the nominee will be assigned. This recommendation will be accompanied by a written application stating the qualifications of the applicant.

b. With the exception that the application for appointment to the Specified Professional Staff must be sponsored by the chief of the service to which the applicant would be assigned, the procedure for such appointments will otherwise follow the same pattern as outlined for appointees of the Medical and Dental Staff. Whenever applicable, the Staff Bylaws and Rules and Regulations will apply to appointees of the Specified Professional Staff.

c. Appointees of the Specified Professional Staff shall be assigned to appropriate clinical divisions, and privileges and scope of activity will be defined and supervised by the chief of that service. Such appointees may be assigned for service either to outpatient services or to inpatient services.

d. Specified Professional Staff appointees will not admit patients to the Hospital nor write orders for patient care.

e. The services of Specified Professional Staff will be performed at the request of an appointee of the Medical Staff who will be responsible for the patients and his records.

f. Appointees of the Specified Professional Staff shall not have the right to vote or hold office.

g. Doctors of Podiatric Medicine shall be assigned to the Specified Professional Staff subject to the Rules and Regulations of ARTICLE IV of the Bylaws, as stated above. Recommendations for appointments to the Podiatric Staff will be made by the Chief of Orthopedic Services. Appointees of the Podiatric Staff will be assigned to the department of Orthopedic Services and will be supervised by the Chief of the Surgical Services. Doctors of Podiatric medicine shall have the ability to admit patients and write orders for patient

care within their scope of practice.

SECTION 11. ***- ALLIED HEALTH PROFESSIONALS –***

Applicants for this staff category as approved by the Board of Trustees on recommendation from the Medical Executive Committee may appoint members of the medical staff to this category. This would include, nurse anesthetists, physician assistants, nurse practitioners, assistant to the physicians, etc.

A "Dependent AHP" means any AHP who is employed by a member, a practice entity or the hospital; not licensed to practice independent of supervision. The dependent AHP will practice only under the supervision of an active member of the medical staff and entitled to only specified services authority.

An "Independent AHP" means any AHP who is licensed to practice independent of supervision by another health care professional. The independent AHP will be assigned to a Medical Staff Department based on their education and training and is eligible to obtain privileges.

AHP's privileges are determined for each individual by the department with the approval of the Credentials and Professional Standards Committee, Medical Executive Committee and the Board of Trustees. The applicant will be asked to indicate which Service they wish to be assigned to based on their education and training. If the applicant wishes a Service that is not already established, it will be considered individually by the medical Executive Committee.

AHP's shall not be a member, pay dues, admit patients and therefore shall not be eligible to vote or hold office, not shall they be entitled to the procedural rights specified in the Medical Staff Bylaws.

SECTION 12. ***- RESIDENTS IN TRAINING –***

Residents in Training shall consist of medical students and graduate physicians and dentists in training. Residents in training shall not hold membership on the medical staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the Vice President of Medical Affairs, Director of Medical Education, Medical Education Committee, Administration or the Medical Director in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities, including which types of residents may write patient care orders, under what circumstances they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care.

SECTION 13. - HOSPITALISTS –

A Hospitalist shall consist of physicians qualified for Staff membership who has 100% of their practice based in the hospital. A hospitalist cannot have a medical office or clinic to see patients and they must return the patients back to the primary physicians at the time of discharge. The hospitalist primary specialty shall be Internal Medicine. Hospitalists may not vote at meetings of the Medical Staff or at department meetings. Attendance at meetings is encouraged but not required. They may not be committee or division chairman, nor are they eligible for appointment or election as an officer of the Staff, a service chief or for nomination as an at-large representative of the clinical services. Hospitalists cannot take emergency room on-call assignments. Primary physicians may refer their patients to the Hospitalists on a voluntary basis. They shall pay dues.

ARTICLE V
CLINICAL SERVICES AND DIVISIONS
OF THE MEDICAL AND DENTAL STAFF

- ASSIGNMENTS TO SERVICES AND DIVISIONS -

The appointees of the Staff shall be assigned to the following services and divisions of the Medical and Dental Staff on appointment by the Board of Trustees:

I. <u>SURGICAL SERVICES</u>

- **a. Division of Colon/Rectal Surgery.**
- **b. Division of General Surgery.**
- **c. Division of Neurosurgery.**
- **e. Division of Ophthalmology.**
- **f. Division of Dentistry & Oral/Maxillofacial Surgery.**
- **g. Division of Otolaryngology.**
- **I. Division of Peripheral-Vascular Surgery.**
- **j. Division of Plastic Surgery.**
- **k. Division of Thoracic Surgery.**
- **l. Division of Urology.**

II. <u>MEDICAL SERVICES</u>

- **a. Division of Allergy.**
- **b. Division of Cardiology.**
- **c. Division of Dermatology.**
- **d. Division of Endocrinology.**
- **e. Division of Gastroenterology.**
- **f. Division of Hematology.**
- **g. Division of Infectious Disease.**
- **h. Division of Internal Medicine.**
- **I. Division of Nephrology.**
- **j. Division of Neurology.**
- **k. Division of Oncology.**
- **l. Division of Physical Medicine.**
- **m. Division of Pulmonary Disease.**
- **n. Division of Rheumatology.**

III. <u>OBSTETRICS-GYNECOLOGY SERVICES</u>

- **Division of Pediatrics**

IV. <u>FAMILY PRACTICE SERVICES</u>

V. <u>CLINICAL SUPPORT SERVICES</u>

- **a. Division of Anesthesiology.**
- **b. Division of Emergency Care.**
- **c. Division of Laboratory.**
- **d. Division of Radiology.**
- **e. Division of Radiation Oncology**

VI. <u>PSYCHIATRY SERVICES</u>

VII. <u>ORTHOPEDIC SERVICES</u>

- **a. Division of Hand Surgery**
- **b. Division of General Orthopedic Surgery**
- **c. Division of Podiatry**

The divisions of the Hospital shall be organized by the chief of the service, who shall recommend, as appropriate, the appointment biennially of a head of each division within his service to the Chief of Staff, who shall in turn recommend the appointments to the Board of Trustees. Each service, every two years, shall elect a Vice-chief who shall serve, in all capacities, in the absence of the Chief.

A division, which in order to exist must have the approval of the Medical Executive Committee, must also have at least three (3) members from the given specialty. Matters needing approval within divisions need a two-thirds vote from division members.

ARTICLE VI
STAFF APPOINTMENT

SECTION 1. ***- QUALIFICATIONS FOR STAFF APPOINTMENT -***
All appointees of the Staff shall be graduates of approved medical, osteopathic, or dental schools and currently licensed to practice their profession in the state of Michigan.

SECTION 2. ***- TERMS OF APPOINTMENT -***
Appointment to the Staff shall be made by the Board of Trustees upon recommendation of the Medical Executive Committee and the Quality Assurance/Risk Management/Credentialing Committee and shall be for a period of two (2) calendar years or balance thereof unless the date designated for reappointment is extended or unless appointment is earlier terminated by the Board of Trustees.

Practitioners appointed to the Active, Associate, Courtesy, House Staff or Organizational Staffs shall be appointed in provisional status for an initial period of one (1) year. Subject to evaluation of performance during the initial year, provisional appointees may be: (1) dropped from the Medical Staff, (2) reappointed in provisional status, or (3) appointed in regular status.

SECTION 3. ***- APPOINTMENT ROSTER -***
The Hospital shall maintain appropriate records concerning each Staff appointee, including, without limitation, a record of current licensure, health status, category of Staff membership and delineation of privileges. These records shall be maintained in a confidential manner in the office of Medical Affairs.

SECTION 4. ***- APPLICATION FOR STAFF APPOINTMENT -***
The following procedure shall be employed for the purpose of staff appointment and reappointment:

a. Application for appointment on the Staff shall be made by the prospective applicant in writing pursuant to a prescribed form which shall require application to state, and if required, to document the applicant's:

1. Education, completed residency in an American college of graduate medical education approved program, experience, qualifications and references.

2. Good standing: (1) whether applicant's appointment or clinical privileges have ever been sought to have been revoked, suspended, reduced, not renewed, or voluntarily relinquished or reduced pending an investigation at any other health care institution, and the outcome of such proceeding; (2) whether membership in any medical society or licenses of whatever nature have ever been or sought to have been revoked, suspended, reduced, not renewed, involuntarily or voluntarily relinquished or reduced pending an investigation, and the outcome of such attempt; (3) report involvement in professional liability actions including past adverse final judgments or settlements and pending professional liability claims.

3. The nature of the practice in which the practitioner is engaged or intends to engage, specification of the facilities of the Hospital which are contemplated, a projected basis of intended utilization, and a request for specific clinical privileges.

4. The areas of research and continuing education in which applicant is professionally interested and his indication of willingness to participate

in accordance with the terms of these Bylaws as a student or instructor, where qualified.

5. Applicant's acknowledgment of understanding of the application procedures and Bylaws, Rules and Regulations furnished in connection therewith and pledge to abide by the Principles or Codes of Ethics pertinent to his profession, as well as the Bylaws, Rules and Regulations of the Staff.

6. Executed release of medical information and waiver of any medical or physician-patient privilege authorizing the release of information relating to applicant's physical or mental health, and releasing persons from liability for release of information furnished in connection therewith.

7. Office and home addresses and phone numbers.

8. Except for Honorary Staff, Visiting Staff, and Emeritus Staff, evidence of professional liability insurance coverage with limits of liability as may be required by the Board of Trustees. The Board of Trustees or its representatives shall annually confer with the Medical Executive Committee regarding the required coverage limits.

9. Photocopy of current license and state and federal drug and narcotics licenses.

10. An alternate who is willing and able to provide patient care coverage in the Medical Staff appointee's absence.

b. The application for appointment on the Staff shall be submitted to the President, who shall refer it to the Credentials and Quality Assurance/Risk Management/Credentialing Committees.

Upon receipt of application, the Credentials and Professional Standards Committee shall investigate the character, qualifications, and professional standing of the applicant. After consultation with the appropriate division chairman, the chief of service shall make a written recommendation as to the applicant. The service chief must specifically recommend clinical privileges, if any, to be granted. Completed applications will be acted on within three (3) months.

c. Each appointee of the Medical Staff desiring reappointment shall so indicate on the prescribed form for reappointment and return it to the Medical Affairs office. Failure to return the reappointment form shall constitute voluntary

resignation from the Medical Staff.

Information to be provided with the reappointment form will be used to update and maintain the physician or dentist's medical staff file. The following information shall be included in this regard:

1. Office and home addresses and phone numbers.
2. The name of other Hospitals and health care institutions where the Staff appointee provided clinical services during the past year.
3. Any change in American specialty board certification or fellowship status.
4. (a) Whether applicant's appointment or clinical privileges have ever been sought to have been revoked, suspended, reduced, not renewed, or voluntarily relinquished or reduced pending an investigation at any other health care institution, and the outcome of such proceeding; (b) whether membership in any medical society or licenses of whatever nature have ever been sought to have been revoked, suspended, reduced, not renewed, or voluntarily relinquished or reduced pending an investigation, and the outcome of such attempt; © report involvement in professional liability actions including past adverse final judgments or settlements and pending professional liability claims.
5. Evidence of professional liability insurance coverage with limits of liability as may be required by the Board of Trustees. The Board of Trustees or its representatives shall annually confer with the Medical Executive Committee regarding the required coverage limits (except in the case of Emeritus and Visiting Staff members.
6. Photocopy of current license and state and federal drug and narcotics licenses.
7. An alternate who is willing and able to provide patient care coverage in the Medical Staff appointee's absence.

d. The Credentials and Professional Standards Committee will review the status of each appointee of the Staff at least biennially and recommend reappointment, termination or any change in position. In making each recommendation, the Committee shall consider: (a) reports of the Medical Care and Evaluation Committee and the Utilization Review Committee, (b) professional competence and judgment in the treatment of patients, © ethical standards of conduct, (d) the participation in research and educational functions, (e) adherence to the Medical Staff Bylaws, Rules and Regulations, (f) appointee's overall demonstrated interest in maintaining good relations with patients, public, hospital personnel and fellow practitioners, (g) the utilization of the Hospital's facilities for patients, (h) the written recommendation of the chief of service, (I) attendance at required meetings, (j) information required as part of the reappointment form, (k) and any involvement in a professional liability action resulting in a final judgment against or settlement by the applicant in the past two (2) years. The

committee's recommendation shall be submitted to the Medical Executive Committee.

Periodic redetermination of clinical privileges at the time of reappointment review or otherwise shall be based on direct observation of patient care, review of records of patients treated in these or other hospitals, and the results of quality assurance and peer review, utilization review and other means of quality assurance activities conducted by the Hospital. In addition, privilege redetermination shall be based in part on the Hospital's ability to provide the facilities and services requested by the physician or dentist as well as by the Medical Staff appointee's demonstrated use of privileges granted as evidenced through the level of admissions, consultations or operations experienced in the preceding twelve (12) months.

e. The Medical Executive Committee shall promptly review the report of the Credentials and shall recommend to the governing board that the application be accepted, deferred or rejected, and if accepted, the clinical privileges which should be granted. Recommendations for acceptance shall require approval by a majority of the members present at a meeting of the Medical Executive Committee. If the application is deferred or rejected, appropriate reasons must be stated in the report to the governing board.

f. The Quality Assurance/Risk Management/Credentialing Committee shall review the recommendations of the Medical Executive Committee as to acceptance, deferral, or rejection of any application or reappointment. If the Quality Assurance/Risk Management/Credentialing Committee does not concur in the recommendations as reviewed and submitted to it for approval, the recommendations shall be returned to the Medical Executive Committee for further discussion and resubmission to the Quality Assurance/Risk Management/Credentialing Committee. Such recommendations shall be submitted to the Board of Trustees, who shall make final Staff appointments, defer, or reject the application for Staff appointments, and consider the recommendation for reappointment or termination of any physician or dentist already holding Staff appointment. In no case shall the governing board take action on an application, refuse to renew an appointment, or cancel an appointment previously made without consultation and advice of the Medical Executive Committee.

SECTION 5. *- PHYSICIAN EMPLOYEES/PHYSICIAN CONTRACTORS -*

Physicians employed by the Hospital or who have service contracts with the Hospital shall apply for appointment on the Staff in the same manner as prescribed for other appointees and shall be subject to the same provisions as set forth above except that appointment on the Staff shall terminate upon termination of the

employment or contractual relationship. These physicians or dentists shall have the right to appeal their termination of privileges according to Article VII. Furthermore, these appointees may make application for individual appointment.

SECTION 6. ***- CLINICAL PRIVILEGES RESTRICTED -***

Existing Medical Staff appointees and applicants alike are restricted to exercising only those clinical privileges as granted by the Board of Trustees. The assignment of privileges shall be on an independent basis for each Medical Staff appointee and applicant as recommended by the chief of the service and Chief of Staff through the Credentials and Quality Assurance/Risk Management/Credentialing Committees and the Medical Executive Committee and the approval of the Board of Trustees.

The applicant must include in the application for staff appointment a request for the specific clinical privileges desired. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information, including an appraisal by the chief of the service in which such privileges are sought. The applicant shall bear the burden of establishing his qualifications and competency in the clinical privileges requested.

Privileges granted to dentists shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery.

SECTION 7. ***- TEMPORARY PRIVILEGES -***

The President or in his/her absence, the Department Chief after consultation with the Vice President of Medical Affairs of the Hospital, can grant temporary privileges at the written request of the applicant’s Department Chairman. The privileges are granted for a limited time. Prior to granting privileges, the following are required:

A. The Michigan license must primarily be verified.
B. The applicant must have an administrative interview which includes the completion of an application, current competencies are verified and acceptance of the Medical Staff Bylaws, Rules and Regulations.
C. The Department Chairman must review a completed application, curriculum vitae and interview the applicant, then if deemed appropriate, request temporary privileges in writing to the Vice President for Medical Affairs.

Temporary privileges may also be granted for the care and treatment of one specified, named, hospital patient, to a physician or dentist. Temporary privileges granted under this circumstance shall automatically expire when the named hospitalized patient is discharged from the Hospital.

In the exercise of temporary privileges, the physician involved shall be under the supervision of the chief of the service, who shall clearly designate the scope of privileges accorded as to those granted and those not granted. Temporary privileges are not to exceed 120 days and must be renewed or terminated at the expiration of that term.

In any case where temporary privileges are granted or extended, such privileges may be summarily suspended or revoked, in whole or in part, at any time by the Chief of Staff or the Chief of Service upon written notice. Immediately upon the imposition of a summary suspension, or revocation of privileges, the appropriate service chief shall have the authority to provide for alternative medical coverage for the patients of the affected Staff appointee still in the Hospital at the time of the suspension or revocation. Notwithstanding anything to the contrary contained in these Bylaws, the decision of the Chief of Staff and service chief to suspend or revoke any grant of temporary privileges shall be final, and there shall be no right to any hearing or appeal from the decision.

SECTION 8. ***- EMERGENCY PRIVILEGES -***

In the case of emergency, any physician or dentist on the scene and attending the patient to the degree permitted by his license and regardless of service or Medical Staff privileges or lack thereof shall be expected to do all in his power to save the life of the patient, including the duty to call such consultation as may be indicated. For the purpose of this section, an emergency is defined as that condition which places the life of the patient in immediate danger and in which any delay in administering treatment would increase that danger.

SECTION 9. ***- DISASTER PRIVILEGES-***

1. **The President of SJMH or designee or in their absence, the Chief of Staff after consultation with the Vice President of Medical Affairs of the Hospital, can grant disaster privileges when the emergency management plan has been activated and the hospital is unable to handle the immediate patient need.**
2. **The responsible person granting the disaster privileges will immediately identify the number of individuals needed to cope with the disaster.**
3. **The individuals granted the disaster privileges, will be given a temporary ID badge with their picture by the SJMH Security Department**
4. **Individuals maybe granted disaster privileges upon presentation of any of the following**
    a. **a current picture hospital ID card**
    b. **a current license to practice medicine and a valid picture ID issued by a state, federal or regulatory agency**
    c. **identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)**
    d. **identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster**

circumstances (such authority having been granted by a federal, state or municipal entity)

   e. **presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity**

5. **The Medical Affairs office will start the verification process for the individuals granted the disaster privileges immediately or as early as possible.**
6. **The disaster privileges are granted for a limited time until the immediate situation is under control at which time the disaster privileges shall automatically expire**
7. **The following are required for the verification process**
   a. **A current license to practice medicine in the United States must be primary source verified**
   b. **The applicant must have an administrative review which includes the completion of an application, verification of current competencies are verified and acceptance of the Medical Staff Bylaws, Rules and Regulations**
   c. **The Department Chairman must review a completed application, curriculum vitae and interview the applicant, if deemed appropriate, request disaster privileges in writing to the Vice President of Medical Affairs.**

SECTION 10. ***- LEAVE OF ABSENCE -***

Upon written request to the Medical Executive Committee, any appointee of the Medical Staff may be granted medical leave for a maximum of one (1) year, educational leave for the duration of the educational program plus one (1) month, or military leave for the duration of military service including any terminal leave plus one (1) month. During the leave of absence, all privileges, including voting are withheld. Where possible, medical records should be completed before the leave is granted.

SECTION 11. ***- DIVISION OF DENTISTRY -***

a. **The practice of dentistry in its surgical specialty, oral and maxillofacial surgery, is defined as that part of dental practice which deals with the diagnosis, surgical and adjunctive treatment of esthetic and functional deformities, defects, diseases, and injuries of the soft and hard tissues of the oral and maxillofacial regions. An oral and maxillofacial surgeon is a dentist who has taken additional graduate work in his specialty and is either eligible for examination for certification by the American Board of Oral and Maxillofacial Surgery, or is a diplomat of that body.**

b. **Oral and maxillofacial surgeons who qualify as medical staff members may be given privileges to independently admit, discharge, obtain a history, conduct physical examinations, assess the medical risks of a procedure on his own patients and perform oral and maxillofacial surgery.**

c. **Oral and maxillofacial surgeons shall have the responsibility to obtain a consultation from a physician member of the medical staff in the event a medical problem or condition presents which is beyond the scope of an oral and maxillofacial surgeon's training and practice.**

ARTICLE VII
CORRECTIVE ACTION,
HEARING PROCEDURE, APPEAL PROCEDURE,
AND SUMMARY SUSPENSION

SECTION 1. ***- GROUNDS FOR ACTION -***

Whenever, on the basis of information and belief, any officer of the Medical Staff service, division, the President, or the Board of Trustees has cause to question:

a. **The clinical competence of any Medical Staff appointee.**

b. **The care or treatment of a patient or patients or the management of a case by any Medical Staff appointee.**

c. **The known or suspected violation by any Medical Staff appointee of applicable ethical standards or the Bylaws, policies, rules or regulations of the Hospital or its Board or Medical Staff.**

d. **Behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Hospital or disruptive of the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others.**

A written request for an investigation of the matter shall be addressed to the Credentials and Quality Assurance/Risk Management/Credentialing Committees making specific reference to the activity or conduct which gave rise to the request.

SECTION 2. ***- INVESTIGATIVE PROCEDURE -***

The Credentials shall meet as soon after receiving the request practicable and if, in the opinion of the committee:

a. **The Credentials shall investigate the matter, appoint a subcommittee to do so, or if it is deemed necessary, appoint an investigating committee.**

  1. **The Investigating Committee shall consist of three (3) physicians of the medical staff. This committee shall not include partners, associates, competitors, major referral sources, or relatives of the affected individual.**

  2. **The Credentials Committee or its subcommittee or the Investigating Committee, if used, shall have available to them the full resources of the Medical Staff and the Hospital to aid them in their work, as well as the authority to use outside consultants as required.**

3. The individual with respect to whom an investigation has been requested shall have an opportunity to meet with the Credentials Committee or its subcommittee or Investigating Committee before it makes its report. At least five (5) days before this meeting, the individual shall be informed of the specific nature of the evidence supporting the investigation requested and shall be invited to discuss, explain, or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. A summary of such interview shall be made by the subcommittee or Investigating Committee, if used, and included with its report to the Credentials Committee.

4. If a subcommittee or Investigating Committee is used, the Credentials and may accept, modify, or reject the recommendation it receives from that committee. The Credentials Committee will forward its recommendation as to any action to the Medical Executive Committee.

SECTION 3: - *MEDICAL EXECUTIVE COMMITTEE RECOMMENDATIONS OR ACTIONS* -

After consideration of any recommendation by the Credentials Committee, the Medical Executive Committee must either: (1) make a recommendation to suspend, reduce, or revoke the physicians clinical privileges which entitles the physician to a hearing; (2) take action, which according to the Bylaws, does not affect the physician's clinical privileges, such as issuing a warning letter or letter of reprimand or imposing a term of probation, which is effective immediately; or (3) take no action when the evidence supports none.

If a recommendation is made which entitles the physician to a hearing, the recommendation is forwarded to the President, who notifies the physician of the recommendation and of his/her right to a hearing prior to a final decision by the Board of Trustees.

If the Medical Executive Committee determines to take action that does not affect the physician's appointment or clinical privileges and thus does not entitle him/her to a hearing, a report of the action is sent to the President and the Quality Assurance/Risk Management/Credentialing Committee, and the Board of Trustees for informational purposes.

SECTION 4: ***- HEARING PROCEDURE -***

A hearing may be requested by an appointee or applicant in the following cases only when the Medical Executive Committee has recommended:

1. **Denial of initial Medical Staff appointment.**
2. **Denial of requested advancement in Medical Staff category.**
3. **Denial of Medical Staff reappointment.**
4. **Revocation of Medical Staff appointment or privileges.**
5. **Denial of requested initial clinical privileges.**
6. **Denial of requested increased clinical privileges.**
7. **Decrease of clinical privileges.**
8. **Imposition of mandatory concurring consultation requirement.**
9. **Suspension or probation of total clinical privileges.**

SECTION 5: ***- NOTICE OF RECOMMENDATION -***
When a recommendation by the Medical Executive Committee is made which, according to these Bylaws entitles an individual to a hearing prior to final decision by the Board of Trustees on that recommendation, the individual shall promptly be given notice by the President in writing, return receipt requested. This notice shall contain:

a. **A statement of the recommendation made and the specific reasons for it.**

b. **Notice that the individual has the right to request a hearing on the recommendation within thirty (30) days of his/her receipt of the notice.**

c. **A summary of the physician's rights in the hearing as provided for in these Bylaws.**

Such physician shall have thirty (30) days following the date of the receipt of such notice within which to request a hearing. Said request shall be made by written notice to the Chief of Staff. In the event the affected individual does not request a hearing within the time and in the manner herein above set forth, he/she shall be deemed to have waived his/her right to such hearing and to have accepted the action involved, and such action shall thereupon become effective immediately upon final Board action.

SECTION 6. ***- NOTICE OF HEARING AND STATEMENT OF REASONS -***
The President shall schedule the hearing and give notice in writing, return receipt requested, to the person who requested the hearing of its time, place, and date. The hearing shall begin as soon as practicable, considering the schedules and availability of all concerned, but no later than forty-five (45) days after the notice of

the hearing unless a later date has been specifically agreed to in writing by both parties. This notice shall contain a statement of the reasons for the recommendation as well as a list of patient records and/or information supporting the recommendation. This statement and the patient records and information it contains may be amended or added to at any time, even during the hearing, so long as the additional material is relevant to the continued appointment or clinical privileges of the person requesting the hearing, and that person and his/her counsel have sufficient time to study this additional information and rebut it.

SECTION 7. ***- LIST OF WITNESSES -***
A written list of the names and addresses of the individuals, so far as is then reasonably known, who will offer testimony or evidence in support of the committee at the hearing, shall be given with the notice of the hearing. The individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on his/her behalf within ten (10) days after receiving notice of the hearing. The witness list of either party may, at the discretion of the chairperson of the hearing panel, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

SECTION 8. ***- HEARING PANEL -***
When a hearing is requested, the Chief of Staff shall appoint a hearing panel which shall be composed of five (5) members of the Active medical staff who have not actively participated in the consideration of the matter involved at any previous level. The panel shall not include any individual who is in direct economic competition with the affected person, or any individual who is professionally associated with or related to the affected individual. Such appointment shall include designation of the chairperson. Knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel.

SECTION 9. ***- HEARING PANEL CHAIRPERSON -***
The Hearing Panel chairperson shall act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence AND that decorum is maintained throughout the hearing and that no intimidation is permitted. He/she shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence upon which he/she may be advised by legal counsel to the Hospital. In all instances, he/she shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the hearing panel in formulating its recommendations. It is understood that the chairperson is acting at all times to see that all relevant information is made available to the hearing panel for its deliberation and recommendation to the Board.

SECTION 10. ***- REPRESENTATION -***

The individual requesting the hearing shall be entitled to be represented at the hearing by an attorney to examine witnesses and present his/her case. He/she shall inform the Chief of Staff in writing of the name of that person at least ten (10) days prior to the date of the hearing. The President shall appoint a person, who may be an attorney, to support the recommendations that gave rise to the hearing and to examine and cross-examine witnesses at the hearing.

SECTION 11. ***- ADMISSIBILITY OF EVIDENCE -***

The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the hearing panel chairperson if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a memorandum of points and authorities, and the hearing panel may request such a memorandum to be filed following the close of the hearing. The hearing panel may interrogate witnesses, call additional witnesses, or request documentary evidence if it deems appropriate.

SECTION 12. ***- WRITTEN STATEMENT BY PHYSICIAN -***

At the close of the hearing, the physician shall have the opportunity to submit a written statement.

SECTION 13. ***- PANEL MEMBER ATTENDANCE -***

Recognizing that it may not be possible for all members of the hearing panel to be present continually at all sessions of the panel, since it is necessary to conduct a hearing as soon as reasonable after the event or events that give rise to its necessity, the hearing shall continue even though certain members of the hearing panel are not present at all times. The fact that certain panel members were not physically present at all times during the hearing will not disqualify them or invalidate the hearing. The vote shall be by majority of those appointed to the hearing panel. There shall be at least a majority of the panel members present when the hearing takes place.

SECTION 14. ***- DELIBERATION AND RECOMMENDATION OF HEARING PANEL -***

Within twenty (20) days after final adjournment of the hearing, the hearing panel, outside the presence of any other person, shall conduct deliberation and shall render a recommendation accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made and shall deliver such report to the Chief of Staff.

SECTION 15. ***- DISPOSITION OF HEARING PANEL REPORT -***

Upon its receipt, the Medical Executive Committee shall review the hearing panel's report and submit, along with supporting documentation, its recommendation to the Quality Assurance, Risk Management and Credentialing Committee for further action (After physician has had an opportunity to pursue appellate review rights). The President shall also send a copy of the recommendation, return receipt requested, to the person who requested the hearing. A copy of the report of the hearing panel recommendation to the Board shall be delivered by the President to the Credentials and Quality Assurance/Risk Management and Credentialing Committee and Medical Executive Committee.

SECTION 16. ***- BASIS OF DECISION -***

The decision of the hearing panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

1. **Oral testimony of witnesses.**
2. **Memorandum of points and authorities presented in connection with the hearing.**
3. **Any material contained in Hospital's files regarding the person who requested the hearing so long as this material has been admitted into evidence at the hearing, and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it.**
4. **Any and all applications, reference, and accompanying documents.**
5. **All officially noticed matters.**
6. **Any other evidence that has been admitted.**
7. **Medical charts.**

SECTION 17. ***- RECORD OF HEARING -***

A record of the hearing may be kept by a stenographic reporter. The cost of the reporter will be borne by the party requesting the stenographer. If both do so, the fee will be split. The other party may, at its option and expense, order copies of the transcript from the reports.

SECTION 18. ***- FAILURE TO APPEAR BY PHYSICIAN -***

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

SECTION 19. ***- APPEAL TO THE BOARD OF TRUSTEES -***

PRIOR to the final decision on the hearing panel recommendation by the Board of Trustees, the physician may appeal to the Board of Trustees. The physician will be provided with a copy of the hearing panel report and recommendation by the President in writing. This communication will specify the physician's right to

request an appellate review of the hearing panel's recommendation by a review panel of the Board of Trustees.

Such request must be in writing, directed to the President, no later than twenty (20) days following receipt of the notice of the hearing panel recommendation by the physician.

SECTION 20. *- GROUNDS FOR APPEAL -*
The grounds for appeal from an adverse recommendation shall be that:

a. There was substantial failure on the part of the Credentials and Quality Assurance/Risk Management/Credentialing Committees, Medical Executive Committee, or hearing panel to comply with the Medical Staff Bylaws in the matter which was the subject of the hearing so as to deny due process or a fair hearing.

b. The recommendation made by the Credentials and Quality Assurance/Risk Management/Credentialing Committees, Medical Executive Committee, or hearing panel were made arbitrarily, capriciously, or with prejudice.

c. The adverse recommendations were not supported by the evidence.

SECTION 21. *- APPELLATE REVIEW -*
The Chairman of the Board shall appoint a review panel composed of not less than three (3) Board members, including one physician if possible, not previously involved in the matter which was the subject of the hearing, or in direct economic competition with the physician. The review panel may accept additional or original evidence subject to the same rights of cross-examination or confrontation provided at the hearing. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that he/she was deprived of the opportunity to admit it at the hearing, and then only at the discretion of the review panel. Each party shall have the right to representation by counsel and to present a written statement in support of his/her position on appeal, and in its sole discretion, the review panel may allow each party or its representative to appeal personally and make oral argument. The review panel shall recommend final action to the Board of Trustees. The Board may affirm, modify, or reverse the recommendation of the review panel, or, in its discretion, refer the matter for further review and recommendation.

SECTION 22. *- FAILURE TO APPEAL -*
A physician who fails to appeal within twenty (20) days following receipt of the notice of the hearing panel recommendation shall be deemed to have accepted the action taken and to have waived his/her rights to any further review procedures.

SECTION 23. ***- SUMMARY SUSPENSION -***

a. **The President, the Chief of Staff, the Chief of a Clinical Service, the Vice President of Medical Affairs or the Chairperson of the Board, shall each have the authority to summarily suspend all or any portion of the clinical privileges of a Medical Staff appointee, or other individual, whenever such action is in the best interest of patient care or safety or the continued effective operation of the Hospital, or whenever such individual has violated the Bylaws, Rules and Regulations, and policies of the Hospital or Medical Staff. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.**

b. **Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President, the Vice President of Medical Affairs, and the Chief of Staff, and shall remain in effect unless or until modified by the President or the Board of Trustees.**

SECTION 24. ***- CREDENTIALS AND PROFESSIONAL STANDARDS COMMITTEE PROCEDURE -***

Any person who exercises his/her authority to summarily suspend clinical privileges shall immediately report his/her action to the chairperson of the Credentials and Quality Assurance/Risk Management/ Credentialing Committees to take further action as is required in the manner specified in the article dealing with investigation. The summary suspension shall remain in force after the appropriate committee takes responsibility unless and until modified by that committee or the President, or until the matter that required the suspension is finally resolved. An investigation to determine the need for a professional review action will be initiated concomitant with the suspension and will be conducted in a period not longer than fourteen (14) days. The Credentials Committee shall meet as soon after receiving the information of this action, and within thirty (30) days shall provide a recommendation as to further action based on the investigation.

SECTION 25. ***- CARE OF SUSPENDED PHYSICIAN'S PATIENTS -***

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

SECTION 26. ***- REPORTING OF DISCIPLINARY PROCESS -***

Reports concerning disciplinary actions will be made to appropriate internal and external bodies in accordance with these Bylaws and appropriate federal and state

requirements.

SECTION 27. *- AUTOMATIC LOSS OF PRIVILEGES -*

Some circumstances will be deemed sufficient to warrant the automatic loss of the physician or dentist's privileges, through either suspension or loss of Medical Staff appointment. These conditions are as follows:

a. Failure to complete medical records on a timely basis, with charts in excess of thirty (30) days overdue shall result in an automatic suspension of Medical Staff privileges.

b. Probation or suspension of a Medical Staff appointee's license by the appropriate state licensing agency shall result in the automatic suspension of all Hospital privileges.

c. Failure to complete and return the reappointment questionnaire as specified in Article III, Section 6, shall be deemed to constitute a voluntary resignation from the Medical Staff with loss of privileges.

ARTICLE VIII
STAFF ORGANIZATION

SECTION 1. *- COMPOSITION OF THE MEDICAL EXECUTIVE COMMITTEE -*

The Medical and Dental Staff of St. John Macomb Hospital shall be governed by a Medical Executive Committee composed of the following members:

1. Chief of Staff.
2. Vice-Chief of Staff.
3. Secretary/Treasure .
4. Chief of the Medical Services.
5. Chief of the Surgical Services.
6. Chief of the Obstetrics-Gynecology Services.
7. Chief of the Family Practice Services.
8. Chief of the Clinical Support Services (The other three (3) chairmen shall serve as ex officio without vote.)
9. Chief of Psychiatry Services.
10. Chief of Orthopedic Services
11. Five (5) at-large representatives of the Medical and Dental Staff.
12. President of the Hospital, ex officio, without vote.

SECTION 2. *- DUTIES -*

The duties of the Medical Executive Committee shall be to coordinate the activities and general policies of the various Services, to act for the Staff as a whole and to receive and act upon reports of all standing and special committees. The Medical Executive Committee shall meet regularly and maintain a permanent record of its

proceedings and actions.

SECTION 3. ***- OFFICERS -***
The officers of the Staff elected by the entire Medical and Dental Staff shall be the Chief of Staff, the Vice-Chief of Staff and the Secretary/Treasurer. The election of officers of the Staff is official only after ratification by the Board of Trustees of St. John Macomb Hospital.

SECTION 4. ***- NOMINATIONS -***
The Nominating Committee shall consist of the Medical Executive Committee.

The Nominating Committee shall convene and submit at least two (2) names for the offices of Chief of Staff, Vice-Chief of Staff, and Secretary/Treasurer and at least eight (8) names for five (5) at-large members of the Medical Executive Committee. The nominees must be members of the Active staff. The Chairman of the Nominating Committee shall receive nominees from the Service Chiefs. The Service Chiefs shall obtain the nominees from the floor of the service meeting.

The names of such nominees shall be reported to the Medical Staff at least thirty (30) days prior to the Annual Meeting. Additional names can be added to the ballot by submitting a separate petition to the Secretary/Treasurer of the Staff over the signature of at least twenty (20) of the voting members of the Medical Staff at least fifteen (15) days prior to the Annual Meeting.

SECTION 5. ***- ELECTIONS -***
Elections shall occur at the Annual Meeting of the Medical Staff every other year. Only Staff members accorded the prerogative to vote under Article IV shall be eligible to vote. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the position receives a majority vote on the first ballot, a run-off election shall be held promptly between the two (2) candidates receiving the highest number of votes.

SECTION 6. ***- RATIFICATION -***
Officials duly elected shall take office on the first day of the month following the Board of Trustees meeting at which the elections were ratified.

SECTION 7. ***- TERMS OF OFFICE -***
All officers and at-large members of the Medical Executive Committee (elected officials) shall serve a term of two (2) years. All elected officials shall be eligible to succeed themselves without restriction as to the number of terms. The provisions of any contractual agreement between the Hospital and a Staff officer shall take precedence, in case of conflict between it and these provisions.

SECTION 8. *- VACANCIES -*

Vacancies in offices other than that of the Chief of Staff or service chiefs shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the Chief of Staff, the Vice-Chief shall serve out the remaining term. If there is a vacancy in the office of a service chief, that appointment shall be made as described in Section 11.

SECTION 9. *- REMOVAL OF OFFICERS -*

Failure of an officer to maintain active status results in automatic removal from office.

In addition, the Board of Trustees acting on its own recommendation or the Medical Staff, by a two-thirds majority vote may remove any Medical Staff officer for failure to fulfill his responsibilities, malfeasance in office, physical or mental infirmity to a degree that renders him incapable of fulfilling the duties of his office, or conduct detrimental to the interests of the Hospital and/or Medical Staff.

At no time shall the removal of an officer be effective unless ratified by the Board of Trustees.

If an officer is removed or rejected, written reason shall be given to him, and a hearing for reconsideration will be granted before the Professional Liaison Committee provided it is requested in writing within fourteen (14) days from the date of notice. Its recommendation will be forwarded to the Board.

SECTION 10. *- DUTIES OF ELECTED OFFICERS -*

a. <u>Chief of Staff</u>

The Chief of Staff shall be the chairman of the Medical Executive Committee; (1) shall call and preside at all of its meetings and the annual meeting of the entire Staff; (2) shall make appointment to Standing Staff Committees; (3) shall be a member ex-officio of all committees; and (3) shall have general supervision of all of the professional work of the Hospital while reporting to and working under the direction of the President of St. John Macomb Hospital in accordance with the authority conferred upon him by the Board of Trustees.

b. <u>Vice-Chief of Staff</u>

The Vice-Chief of Staff shall serve as a member of the Medical Executive Committee and shall serve as chairman of the Credentials and Professional Standards Committee.

In the absence of the Chief of Staff, the Vice-Chief shall assume all of

his duties and have all of his authority. He shall be expected to perform such duties as may be assigned to him.

c. Secretary/Treasurer

The Secretary/Treasurer shall keep accurate and complete minutes of all Medical Staff and Medical Executive Committee meetings, shall attend to all other correspondence, and shall perform other duties as pertain to his office.

SECTION 11. *- ORGANIZATION OF SERVICES AND DIVISIONS -*

A chief of each service shall be recommended by a search committee composed of three (3) members of the department concerned, elected by secret ballot by the members of the department; the President or a member of the medical staff appointed by the President; and three (3) members of the Board of Trustees or their designates. Recommendation of the search committee shall be provide to the Board of Trustees for approval or recommitment.

The performance of the chiefs of departments shall be reviewed by a review committee every two (2) years, formed in the same manner as the search committee described above and recommendations shall be made to the Board of Trustees as to their reappointment.

The chief of each service shall forward to the Chief of Staff a recommendation for Chief of Division, who shall be appointed to the Chief of Staff every two (2) years and approved by the Medical Executive Committee and the Board of Trustees. A Vice-Chief shall attend and vote on the Medical Executive Committee and act for the chief of the service in his/her absence.

SECTION 12. *-QUALIFICATIONS AND SELECTION OF CHIEF OF SERVICE-*

Each chief shall be a member of active staff and shall be qualified by training, experience, leadership skills and demonstrated ability for the position. The chief of each service shall plan, design, direct and coordinate services to meet the needs of patients and other users of the hospital and focus on continuously improving performance to meeting these needs.

SECTION 13 *-FUNCTIONS OF CHIEF OF SERVICE-*

The chief of service shall coordinate activities within his service. He shall represent the service on the Medical Executive Committee. The Chief of Service shall have supervision over the clinical work falling within his service and shall be responsible for the assignment of members of the service to their respective divisions and for the establishment of the proper organization of each division. The chief shall be responsible for continued surveillance of the professional performance of all individuals who have delineated clinical privileges within the service. The chief shall recommend the criteria for overall clinical privileges within the service as well as

recommend clinical privileges for each member of the service. The chief shall also be responsible for the assignment of the necessary appointees of the service to the emergency service of the Hospital.

Appointing or removal of chairman and members of the department of quality assurance committee are recommended by the Chief of the Service Division in consultation with the Chief of Staff and approved by the Medical Executive Committee

ARTICLE IX
STAFF MEETINGS

SECTION 1. ***- REGULAR MEETINGS -***
The Medical and Dental Staff shall meet in April and October. The April meeting shall constitute the Annual Meeting.

SECTION 2. ***- SPECIAL MEETINGS -***
Shall be called by the Chief of Staff:

a. At any time upon his own initiative.
b. At any time upon such written request of the Medical Executive Committee or Board of Trustees;
c. Within fourteen (14) days of written request signed by thirty (30) voting appointees of the Staff stating the reason and purpose for such meeting.

At any special meeting, no business shall be transacted except that stated in the notice calling the meeting. Notice by mail, at least five (5) days before the time of the meeting, shall be deemed sufficient.

SECTION 3. ***- QUORUM -***
The quorum for official conduct of the several types of meetings above shall be as follows:

Regular semi-annual meetings - 25% of the active medical staff.
Special meetings of the membership - 25% of the active medical staff.
Medical executive committee- 40%
Subcommittees - 40%

SECTION 4. ***- ATTENDANCE -***
Each appointee of the Staff, except Honorary, Consulting, Courtesy, and House Staff, shall be required to attend at least one (1) of the two (2) regular Staff meetings.

Appointees of the Consulting and Courtesy Staffs shall not be required to attend meetings, but are encouraged to attend and participate.

SECTION 5. ***- AGENDA -***

a. **The agenda format for the regular Staff Meetings will be as follows:**

1. **Call to order by the Chief of Staff.**
2. **Reading and approval of the minutes of the last regular and all special meetings held since the last regular meeting.**
3. **Communications and announcements.**
4. **Unfinished business.**
5. **Report of the President.**
6. **Report of the Chief of Staff.**
7. **Report of Vice President of Medical Affairs**
8. **Reports by the service chiefs and committee chairmen, when indicated;**
9. **New business.**
10. **Adjournment.**

b. **Special meetings: The agenda format for special meetings will be as follows and will be posted five (5) days before the meeting:**

1. **Reading of the notice calling for the meeting.**
2. **Transaction of the business for which the meeting was called.**
3. **Adjournment.**

SECTION 6. ***- SERVICE AND DIVISION MEETINGS -***

Each clinical service of the Staff (Medicine, Surgery, Obstetrics-Gynecology, Psychiatry and Family Practice) shall be required to hold quarterly meetings for the purpose of reviewing the medical or dental work done by appointees in that service. More frequent meetings may be held as determined by the service chief and division chairman. These service meetings should provide for clinical case reviews. Surgical case review shall be conducted for each case, whether or not a tissue or non-tissue specimen was removed. However, when a surgical case review consistently supports the justification and quality of individual surgical procedures or the surgical procedures performed by individual practitioners, the review of an adequate sample of cases is acceptable. Clinical service appointees at the Active and Associate Staff levels are required to attend at least fifty (50) percent of the regularly scheduled service and divisional meetings unless a request for excused absence has been submitted in writing and been accepted by the chief of the service. Additional meeting attendance requirements may be determined by the service chief.

a. **Appointees of the Consulting, Courtesy, and Visiting categories of the Staff shall not be required to attend meetings, but are encouraged to attend and**

participate.

b. Appointees of Anesthesiology, Emergency Care, Laboratory, and Radiology Services and Radiation Oncology have the option of fulfilling service and division meeting requirements through either attendance at meetings of the clinical services or divisions or by holding their own meetings. It will normally be expected that members of the Emergency Care Services have their own service meetings due to medical record review requirements. The chiefs of the remaining services in this group shall advise the Chief of Staff of the decision regarding the fulfillment of meeting attendance requirements.

c. Appointees of the Associate and Active Staff who do not attend the required number of meetings during the preceding twelve (12) months are subject to demotion or loss of Medical Staff appointment at the time of the yearly Staff reappointment. They may apply for promotion to the previous level of appointment after a three (3) month waiting period and upon achieving a satisfactory record of required meeting attendance.

d. An appointee of any category of the Staff who has attended a case that is to be represented for discussion at any meeting shall be notified and shall be requested to be present. Further, it shall be the responsibility of the Chief of the Clinical Service whose Staff member is having a case presented to assure that the physician or dentist is notified.

Minutes of the service and divisional meetings shall be recorded and submitted to the Chief of Staff and the Medical Affairs office.

ARTICLE X
COMMITTEES

To further implement policies and procedures governing the Staff and the monitoring of its activities, the Chief of Staff shall, with the approval of the Medical Executive Committee, appoint members and chairmen as follows:

SECTION 1. *- CREDENTIALS AND PROFESSIONAL STANDARDS COMMITTEE* -Which shall consist of the Vice-Chief of Staff as chairman, the chiefs or vice-chiefs of each service, Secretary/Treasurer and the five (5) at large representatives from the Medical and Dental staff on the Medical Executive Committee. The Chief of Staff shall also sit ex-officio on the committee. The committee shall meet as specified in Article VI, Section 4.D.

As so constituted, the Credentials and Professional Standards Committee shall:

a. **Review the credentials of all applicants and make recommendations for appointment and delineation of clinical privileges.**

b. **Report to the Medical Executive Committee on each applicant for Medical Staff appointment or clinical privileges, including specific consideration of the recommendations from the services in which such applicant requests privileges.**

c. **Review periodically all information available regarding the competence of Staff appointees and, as a result of such reviews, make recommendations for the granting of privileges, reappointments and the assignment of practitioners to the various services.**

d. **Investigate any reported breach of ethics.**

e. **Review reports that are referred from the Medical Executive Committee, Medical Records, Medical Care and Evaluation, and Utilization Review Committees, and the Chief of Staff.**

f. **Review and/or investigate and adopt recommendations in response to official requests for corrective action.**

SECTION 2. ***- MEDICAL CARE AND EVALUATION COMMITTEE -***
Which shall consist of the Chiefs or the Vice-Chiefs of all the Services and the Chiefs of the Divisions of Laboratory, Radiology, Anesthesiology, Emergency Care, Psychiatry, Cardiology, Cardiovascular Surgery, Orthopedic Surgery, Gastroenterology or their designee. The Chairman shall be appointed from its members by the Chief of Staff. The Committee shall hold at least ten (10) monthly meetings per year to evaluate the quality of care, utilization of resources, patient satisfaction, and outcomes of all patients at the Hospital and shall report monthly and forward any recommendations to the Medical Executive Committee. The Committee shall receive reports of the Transfusion, Infection Control, Pharmacy and Therapeutics, Cancer, Medical Record Committee, Critical Care Committee plus other Committees concerned with patient care. The Chief of the Medicine, Surgery, Obstetrics-Gynecology, and Family Practice, shall appoint quality assurance and/or peer review committees within their services which shall meet as often as needed and report to the Service Chief and the Medical Care and Evaluation Committee. These committees will be responsible for monitoring quality indicators, utilization of resources, patient satisfaction, and outcomes, as specified by the Medical Care and Evaluation Committee to ensure the proper, necessary, and efficient use of the Hospital services and facilities. These committees shall review procedures of the tissues and fluids removed by all services, included, but not limited to, surgery. This process should provide adequate review to determine the effect of any

recommended action. Surgical procedures in which no tissue was removed shall also be reviewed.

Each Committee shall maintain a record of its peer review activities and provide a written report to the Service or Division Chief, as necessary, of its findings in this regard, when chronic noncompliance with the Utilization or Quality Plan indicates corrective action as specified in Article VII. In addition, it shall forward an annual report of peer review findings to the Credentials and Professional Standards Committee for consideration as part of reappointment review.

The Hospital's Utilization and Quality Plan shall be reviewed at least annually and presented to the Medical Executive Committee and Board of Trustees for approval.

Minutes of each meeting should be permanently maintained in a confidential manner in the Medical Affairs Office but may be reviewed by the Medical Executive Committee in considering reappointment to the Medical Staff and delineation of privileges.

SECTION 3. ***- BLOOD TRANSFUSION COMMITTEE -***

Which shall consist of the Director of the Blood Bank and the Chiefs of the Services of Medicine, Surgery, and Obstetrics-Gynecology. Such committee shall assure itself of the adequacy, quality, and safety of the supply of blood and blood components used in the Hospital. It shall review the records of transfusion and make recommendations to the Medical Executive Committee concerning policy governing utilization. The committee shall require the preparation of records of blood used which are adequate to identify and indicate transfusion reactions, transmission of diseases, and general use of blood and blood products. The committee shall meet at least quarterly and shall report to the Medical Care and Evaluation Committee.

SECTION 4. ***- PHARMACY AND THERAPEUTICS COMMITTEE -***

Which shall consist of at least three (3) representatives of the Medical Staff as appointed by the Chief of Staff and one (1) each from the Pharmaceutical Service, the Nursing Service and Hospital Administration as appointed by the President. Such committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimal clinical results and a minimal potential for hazard. The committee shall develop a formulary of all policies concerning drugs within the Hospital, including, but not limited to, the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, drug reactions, and the clinical use and review of antibiotics. It shall meet at least quarterly and report to the Medical Care and Evaluation Committee.

SECTION 5. ***- CANCER COMMITTEE -***

Which shall consist of representatives from the Clinical Services of Medicine, Surgery, Obstetrics-Gynecology, Family Practice, and Divisions of Laboratory, Radiology, Oncology and the Cancer Liaison Physician. In addition, ancillary representatives from Administration, Nursing, Social Services, Pharmacy, Rehabilitation, Quality Assurance, Clinical Dietary and Respiratory, as well as the Cancer Registrar will be ex-officio members without vote. The purpose of this committee is to stimulate lifetime follow-up multidisciplinary consultation and maintenance of a tumor education program compatible with the requirements of the American College of Surgeons for designation as a cancer Hospital. It shall meet every other month and report to the Medical Care and Evaluation Committee.

SECTION 6. ***- CARDIAC AND INTENSIVE CARE COMMITTEE -***

Shall consist of members of the Active and Associate Medical Staff as appointed by the Chief of Staff. Ex-officio (without vote) members shall include appropriate representation from nursing and administration. The committee shall meet at least six (6) times per year and submit a written report to the Medical Care and Evaluation Committee. The committee shall:

a. Recommend policies, procedures, equipment and safety measures relative to the admission and care of patients in cardiac and intensive care units.

b. Evaluate the clinical care provided in the cardiac and intensive care units including review and analysis of monthly admissions and statistics.

SECTION 7. ***- MEDICAL RECORDS COMMITTEE -***

Which consists of not less than three (3) members appointed by the Chief of Staff from the active Staff whose duties will be to appraise medical records to assure their maintenance at the required standard and their adequacy as a legal document. It shall meet at least quarterly and shall report to the Medical Care and Evaluation Committee. Representatives from nursing and Medical Records shall be appointed by the President and serve as ex-officio members without vote.

SECTION 8. ***- BYLAWS COMMITTEE -***

Shall be composed of the Vice-Chief of Staff as chairman; the chiefs or vice-chiefs of Services, the four members at large representatives of the Medical and Dental Staff on the Medical Executive Committee, and at least one (1) representative from Administration who shall serve ex-officio, without vote. The committee shall meet at least annually to review the Bylaws, Rules and Regulations of the Medical Staff and to make recommendations for revision or amendment to the Medical Executive Committee. The Medical Executive Committee may also, prior to the consideration of any proposal, refer proposed amendments or revisions of the Bylaws, Rules and Regulations to the Bylaws Committee for review. The committee shall submit a written report of its recommendations to the Medical Executive Committee at least annually.

SECTION 9. *- RADIATION SAFETY COMMITTEE -*
Shall be chaired by the Chairman of the Division of Radiology and shall consist of members so selected as to conform with the requirements of licensure of the standards of the Nuclear Regulatory Commission. The duties of the Radiation and Safety Committee shall be to supervise and control use of radioactive materials in the Hospital in accordance with good medical practice and the standards of the Nuclear Regulatory Commission, with particular emphasis on the safety of all concerned. The committee shall meet at least once a quarter and submit a written report to the Medical Executive Committee.

SECTION 10 - JOINT MEDICAL ENDOSCOPY/SURGICAL OPERATIONS COMMITTEE-
The Joint Medical Endoscopy/Surgical Operations Committee shall consist of representatives from Pulmonary, Thoracic Surgery, General Surgery, Ob/Gyn, Gastroenterology, and Anesthesiology as appointed by the Chief of Staff. Ex-Officio (without vote) members shall include appropriate representation from nursing and administration. The purpose of this committee is to recommend policies, procedures equipment and safety measures relative to the care and treatment of patients undergoing endoscopy and to evaluate the clinical care. It shall meet at least nine (9) time per year and report to the Medical Care and Evaluation Committee.

SECTION 11. *- SPECIAL COMMITTEES -*
Other special and standing committees may be appointed by the Chief of Staff from time to time as may be required to carry out properly the duties of the Staff and the requirements of these Bylaws, Rules and Regulations. They shall not have authority to establish medical policy except as such authority is extended by recommendation of the Medical Executive Committee with the approval of the Board of Trustees.

SECTION 12. *- EX-OFFICIO COMMITTEE MEMBERS -*
The Chief of Staff shall be ex-officio member, with vote of all standing committees of the Medical Staff. The Vice President of Medical Affairs shall be an ex-officio member, without vote of all standing committees of the Medical Staff.

SECTION 13. *– INFECTION CONTROL COMMITTEE –*
The Infection Control Committee shall be a standing committee consisting of members of the Medical Staff including representation from infectious diseases and pathology. The duties of the Infection Control Committee will be to maintain surveillance of Hospital infection potentials, identify and analyze the incidence and cause of significant infections, develop and implement preventative and corrective actions to minimize infection hazards. The Committee shall meet regularly as determined by Medical Executive Committee and maintain records of its activities and submit a written report.

ARTICLE XI
AMENDMENTS

These Bylaws and Rules and Regulations adopted pursuant thereto may be amended only in accordance with the following procedures:

a. Recommendation for amendment shall be initiated by or through:
   1. The Bylaws Committee.
   2. The Medical Executive Committee.
   3. The Quality Assurance/Risk Management/Credentialing Committee
   4. The Board of Trustees.

Amendments shall be initiated by mailing a copy of the proposed change to members of the Medical Executive Committee at least seventy-two (72) hours in advance of any regularly scheduled meeting, or any special meeting called for the purpose of considering the proposed amendment.

b. If approved by the Medical Executive Committee, such proposed amendment shall then be presented at the next regular or special Staff meeting for approval by majority vote of those present.
c. Amendments to these Bylaws, Rules and Regulations after approval by the Medical Executive Committee and the medical staff shall then be presented to the Quality Assurance/Risk Management/Credentialing Committee and the Board of Trustees and shall be effective when approved by the Board of Trustees. The Medical Staff or the Board of Trustees can not unilaterally amend the Bylaws.
d. To the extent consistent with the Michigan Hospital Licensing Act, the medical staff bylaws and amendments, when approved are equally binding on the medical staff and the Board of Trustees.

ARTICLE XII
CONSTRUCTION

For purposes of construction, wherever in these Bylaws words, including pronouns, are used in the masculine, they shall be read and construed in the feminine or neuter wherever they would so apply, and wherever in these Bylaws words, including pronouns, are used in the singular or plural they shall be read and construed in the plural or singular, respectively, wherever they would so apply.

ARTICLE XIII
ANNUAL REVIEW OF BYLAWS

To insure that these Bylaws remain current and properly reflect developments in administration and procedure, they shall be reviewed annually by the Bylaws Committee with the approval of the Medical Executive Committee. The committee shall submit annually a written report to the Medical Executive Committee at the November meeting.

RULES AND REGULATIONS

SECTION 1. ***- ADMISSIONS -***

a. **No patient shall be admitted to the Hospital until after a provisional diagnosis has been stated. Physicians and dentists admitting private patients shall disclose such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever. The chief admitting clerk will admit patients on the basis of the following order of priority: (1) emergency, (2) urgent, and (3) elective. The definition of each category shall be recommended by the Utilization Review Committee and established by the Medical Executive Committee.**

b. **A "staff patient" shall be defined as anyone seeking services who states he has no physician or dentist of his own. Such patient needing admission to the Hospital when seen in the emergency rooms shall be assigned to the appropriate Staff on a rotation schedule which is approved by the chief of service.**

c. **For purposes of acceptance and execution by Hospital personnel, all orders for treatment upon admission shall be in writing. An order shall be considered to be in writing if dictated to a registered nurse, respiratory therapist, pharmacist, or registered dietician physical therapist, speech therapist and occupational therapist within their scope of practice and signed by the active physician or dentist. Orders may be dictated by telephone only to a registered nurse, pharmacist or respiratory therapist, physical therapist, speech therapist and occupational therapist and must be signed by the person to whom dictated with the name of the physician or dentist and confirmed by the written countersignature of the ordering or covering or active physician or dentists. All verbal orders should be signed by the ordering physician at the time of his/her next visit. Under certain circumstances in which the physician through no fault on his/her own does not have access to the chart he/she may sign the verbal order at the next available opportunity. Automatic formulary substitutions, physician or dentist directed pharmacy dosing service and its necessary associated component laboratory tests need not be signed by the ordering or active physician or**

dentist.

SECTION 2. ***- DISCHARGE -***

The Hospital discharge hour is designated as 11:00 a.m. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

SECTION 3. ***- MEDICAL RECORDS -***

a. Entries into the medical record by the active physician or dentist involved in the care of a patient shall be legible, pertinent and current. Documentation in each medical record shall include identification data, admitting notes, history and physical examination, statement of the conclusions or impressions drawn from the admission history and physical examination, statement of the course of action planned for the patient while in the Hospital, daily clinical observations, including results of therapy reports and results of procedures and tests, diagnostic and therapeutic orders, and clinical resume at discharge from the Hospital. History and Physicals are to be completed within 24 hours of admission. If an Assistant to the Physician assists the active physician with the history and physical examination, the active physician must review and authenticate the findings by signing off on the history and physical within 48 hours of admission of the patient.

b. An admission note must be written within twenty-four (24) hours after the patient has been admitted and shall:

1. **Document the need for admission.**
2. **List the chief complaint of the patient.**
3. **Include a description of the patient's condition.**
4. **State the provisional diagnosis and treatment plan.**
5. **Have a plan of the post-Hospital care and follow-up, if known at the time of admission. If the post-Hospital care is not decided until later, it can be written as a progress note.**

a. Active Physicians or his/her designee is required to see the patient every day and write in the progress notes.

d. All records are the property of the Hospital and shall not be removed or copied without authorization by the President, or his designee. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee.

In case of readmission of a patient, all previous records, or microfilm

condensation thereof, shall be available for the use of the active physician or dentist, irrespective of whether he be attended by the same physician or dentist.

e. Except as provided below, all of the patient's medical records, including progress notes, final diagnosis, and clinical resume shall be completed at the time of discharge. The clinical resume shall include information relative to the condition of the patient at the time of the discharge and pertinent instructions given to the patient and/or family, particularly in regard to physical activity limitations, diet, medications, and medical follow-up.

Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the record room.

At the time of discharge, the practitioner shall see that the record is complete, state his final diagnosis, and sign the record in order to expedite processing by the medical record staff. Whenever a medical record is incomplete for fourteen (14) working days after referral to the practitioner, it shall be considered delinquent. The existence of one or more delinquent records will result in the temporary cessation of all Hospital privileges, except continuation or treatment of patients then under the practitioner's care, until these records are completed. Any such action shall be preceded by: (a) due allowance for illness and absence from the city, (b) written notice, and © a forty-eight (48) hour grace period. Physicians and dentists who continue on the no admit list for thirty (30) or more consecutive days shall be suspended from the Medical Staff after ten (10) days notice in writing except in unusual circumstances such as prolonged illness. Such practitioner may apply for reinstatement after delinquent work is completed, but request must be approved by the Credentials and Professional Standards, Medical Executive, Quality Assurance/Risk Management/Credentialing, and Board of Trustees.

f. An accepted nomenclature approved by the Medical Executive Committee and the Board of Trustees shall be used for all diagnoses and procedures. Free access to all medical records of all patients shall be afforded to appointees of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Executive Committee before records can be studied. Subject to the discretion of the Chief of Staff or Hospital President, former appointees of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

SECTION 4. ***- OPERATIONS -***

a. A surgical operation may be performed only with the written consent of the patient or his legal representative, except in emergencies. The physician is responsible for obtaining and documenting consent.

b. Every case going to surgery shall be accompanied by the patient's chart, except for outpatient minor surgical cases to be done under local anesthesia, and must include: (1) complete laboratory work-up, (2) history and physical, (3) a preoperative diagnosis and explanation of proposed surgery, (4) consultations as required including all cases for primary caesarean section and operations which may interrupt a known, suspected or possible pregnancy, (5) and written consents for surgery as required . Outpatient minor surgical cases done under local anesthesia require use of a short form history and physical which must be accompanied by written consent for surgery as required.

c. Surgeons must be in the operating room and ready to commence operation at the time scheduled, and in no case will the operation room be held longer than fifteen 15 minutes after the time scheduled.

d. The description of all operations performed must be fully transcribed in writing or by dictation immediately following performance of surgery by the active surgeon. Any operative dictation not completed immediately after surgery will be considered delinquent. Any such delinquency will result in temporary suspension of Hospital privileges under the same rule as delinquent medical records. All specimens removed at operation shall be sent to the Hospital pathologist who shall make such examinations as he may consider necessary to arrive at a pathological diagnosis.

SECTION 5. ***- CONSULTATIONS -***

a. It shall be the responsibility of the active physician to contact the consultant in all cases of urgent consultation and/or referral. Nurses shall be responsible for transmitting requests of active physicians for consultations or referrals when a written order has been made. The active physician shall complete and sign the consultation form at his earliest convenience, and shall advise the patient to anticipate the consultant's visit and his subsequent fee for service.

b. Whereas judgment as to the nature of an illness and questions concerning prognosis rest with the practitioner responsible for the care of the patient, it is the belief of the Medical Staff that the good conduct of medical practice at the Hospital requires the proper and timely use of consultation with persons qualified to give opinions in the field in which the advice is sought.

Medical situations calling for required consultation when the quality of care is questionable will be recommended by the service chief with the concurrence of the Medical Executive Committee.
Proper consultation includes examination of the patient, review of the record, and written opinion signed by the consultant and made a part of the record. When operative procedures are involved, the consultant note, except in emergency, shall be recorded prior to operation.

c. When there is a seriously ill patient and it appears there is a question of inadequate or improper treatment, the chief of service, or Vice-Chief in his absence, shall be notified, and he shall make an informal investigation. If he concurs, he shall request the active physician and/or dentist to obtain consultation or implement suitable treatment. If consultation is not obtained within the time designated by the chief of service, the Chief of Service shall call suitable consultations. Whenever the chief of service confirms repeated instances of inadequate or improper care, his official actions shall include reporting the cases in question to an appropriate review committee. Further, such matters should be referred to the Chief of Staff only where the normal procedure does not accomplish the desired results.

d. All urgent consultations should be answered within 24 hours of request.

SECTION 6. *- AUTOPSIES -*
Every appointee of the Staff shall use best efforts to secure permission for autopsies in all deaths that meet the criteria adopted by the medical staff. All autopsies shall be performed by the Hospital pathologist or by a physician to whom the duty may be delegated, but no autopsy shall be performed without written consent of the responsible party.

SECTION 7. *- ABSENCES -*
Each appointee of the Staff intending to be absent from the area shall name an appointee of the Staff who may be called to attend that Staff appointee's patients in the Hospital. In cases of failure to name such an associate, the chief of the department concerned shall have the authority to call any appointee of the Staff should it be considered necessary. All Staff appointees must maintain a telephone number with the Hospital for emergency calls on a twenty-four (24) hour basis. The physician must notify the Hospital or the answering service of the appointee of the Staff who may be called to attend his patients in the Hospital in his absence.

SECTION 8. *- STAFF DISASTER ASSIGNMENTS -*
A written plan for the care of mass casualties coordinated with the Emergency Services of the Hospital, as currently formulated, adopted or hereafter modified,

shall be maintained at all times. All appointees of the Active Staff, Associate Staff, and House Staff must fulfill Staff disaster assignments. Failure to fulfill this assignment will be reported to the Medical Executive Committee and may be grounds for declining reappointment to the staff.

SECTION 9. ***- HOSPITAL FORMULARY -***

The Hospital Formulary shall be that as adopted by the Medical Executive Committee and the Board of Trustees and shall be made available to each appointee of the Staff.

As far as possible, only drugs in the Hospital Formulary shall be prescribed. When other drugs are ordered for private patients by the active practitioner, they will be secured and a special charge made to the patient.

SECTION 10. ***- MEDICAL STAFF DUES -***

Before the end of each calendar year, the Medical Executive Committee shall establish the annual dues, and notification of these dues will be sent to the Staff in April. Any member delinquent six (6) months after notification will be dropped from the Medical Staff unless excused by the Medical Executive Committee. The Honorary, Emeritus, Visiting, Consulting, and House Staff categories of the Medical Staff shall not be required to pay annual dues.