MEDICAL STAFF BYLAWS
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Note: The following Manuals / Policies are associated with these Medical Staff Bylaws. Revisions to these documents are outlined under Article 15.6, Medical Staff Policies,

- Medical Staff Credentialing Manual
- Medical Staff Fair Hearing Plan
- Manual of Professional Staff Required Functions

- Medical Staff Policies include and are not limited to:
  - Code of Conduct
  - Confidentiality
  - Practitioner Health
  - OnCall Responsibilities
  - Election Process

Note: McLaren Macomb was formerly known as Mount Clemens Regional Medical Center prior to Jan 2012

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PREAMBLE

WHEREAS, Mount Clemens Regional Medical Center* is a non-profit corporation organized under the laws of the State of Michigan; AND

WHEREAS, its purpose is to serve as a general hospital, providing patient care, education, and research; with an emphasis upon Osteopathic care

WHEREAS, it is recognized 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 Governing Body, and that the combined efforts of the Medical Staff, Chief Medical Officer, Chief Executive Officer and the Governing Body are necessary to fulfill the Hospital's obligations to its patients;

THEREFORE, the practitioners within this Hospital hereby organize themselves into one Medical Staff in conformity with these Bylaws.

* Mount Clemens Regional Medical Center became known as McLaren Macomb (Jan 2012)
1. ADMINISTRATION means the executive and administrative organization of the Hospital.

2. ALLIED HEALTH PROFESSIONAL means a health care professional whose patient care activities require that his authority to perform specified patient care services be processed through medical staff channels or with involvement of medical staff representatives.

3. ALLOPATHIC member means a physician who is licensed as a Medical Doctor.

4. BOARD or governing body means the Board of Trustees of Mount Clemens Regional Medical Center.

5. BYLAWS means the Mount Clemens Regional Medical Center Medical Staff Bylaws.

6. CHIEF EXECUTIVE OFFICER or "CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

7. CHIEF MEDICAL OFFICER (CMO), also known as Vice President, Medical Affairs shall mean a physician who may be appointed by the CEO to serve at his pleasure in such capacity and who will perform such functions and duties as may be requested by the CEO. The CMO will be an ex-officio member of all standing and special committees of the Medical Staff. In the event such office should at any time be vacant, its functions and duties may be performed by such other physicians and/or administrative personnel as may be designated by the CEO.

8. CHIEF OF STAFF (President) - means a physician elected by the Medical Staff to serve as its chief administrative officer.

9. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted to medical staff members and others to provide patient care and includes access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.

10. DENTIST means an individual who has been awarded the degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.D.M.).

11. DEPARTMENT (without further qualification) means a clinical administrative subdivision of the Medical Staff as described within these Bylaws.

12. EX-OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

13. GOOD STANDING means the staff member has met the attendance requirements during the previous medical staff year, is not in arrears in dues payment, and is not under suspension of his appointment or admitting privileges.

14. GOVERNING BODY refers to the Board of Trustees of Mount Clemens Regional Medical Center.

15. HE, HIS or HIMSELF refers to both he and she, his and her or himself and herself throughout the Medical Staff Bylaws.

16. HOSPITAL means McLaren Macomb formerly known as Mount Clemens Regional Medical Center.

17. VICE PRESIDENT, MEDICAL AFFAIRS or “VPMA” (see Chief Medical Officer (CMO)
18. MEDICAL STAFF or STAFF means the formal organization of all licensed physicians, including Doctor of Osteopathy (D.O.), Doctor of Medicine (M.D.) and Doctor of Podiatric Medicine (DPM), who have met the requirements for Medical Staff membership and have been granted such membership and clinical privileges by the governing body.

19. MEDICAL STAFF YEAR means the period from January 1st through December 31st.

20. MEMBER (capitalized and without qualification) means a member of the Medical Staff.


22. Osteopathic Member means a physician who is licensed as an Osteopathic Physician.

23. PHYSICIAN means an individual who has been awarded the degree of Doctor of Osteopathy (D.O.) or Doctor of Medicine (M.D.)

24. PRACTITIONER means, unless otherwise expressly limited, any appropriately licensed physician, podiatrist, or oral surgeon (dentist) applying for, or exercising, clinical privileges in this hospital.

25. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a staff member or allied health professional, and exercisable subject to the conditions and limitations imposed in these Bylaws and in other Hospital and Medical Staff policies.

26. PRESIDENT (also known as “CHIEF OF STAFF”) means a physician elected by the Medical Staff to serve as its chief administrative officer.

27. PODIATRIST means an individual who has been awarded the degree of Doctor of Podiatric Medicine (D.P.M.), and licensed as a podiatrist.

28. PSYCHOLOGIST means an individual who has been awarded the degree of Doctor of Philosophy (Ph.D.) in Clinical Psychology.

29. STAFF EXECUTIVE COMMITTEE (SEC) means the Executive Committee of the Medical Staff.
ARTICLE I: NAME

The name of this organization shall be the Mount Clemens Regional Medical Center Professional Medical Staff.

ARTICLE II: PURPOSES & RESPONSIBILITIES

2.1 PURPOSES

2.1-1 These Bylaws are adopted in order to provide for the organization of the Medical Staff and to provide a framework for self-governing in order to permit the Medical Staff to perform its responsibilities in matters involving the quality of medical care and to govern the orderly resolution of these purposes. These Bylaws provide the professional structure for Medical Staff operations, organized Medical Staff relations with the Governing Body and relations with applicants to and Members of the Medical Staff.

2.1-2 To provide a mechanism for accountability to the Board, through defined organizational components and positions for the appropriateness of the patient care services, professional and ethical conduct and teaching and research activities of each individual appointed to the Medical Staff.

2.1-3 To promote a high level of professional performance by all Medical Staff members through appropriate delineation of privileges for each, including screening of applicants for Membership and reviewing Privilege requests.

2.1-4 To provide an appropriate Osteopathic educational setting and to maintain the scientific and educational standards for house staff physicians and members of the Medical Staff.

2.1-5 To provide a forum in which issues of concern to the Medical Staff may be discussed with the Hospital Administration and the Board.

2.1-6 To provide quality and continuous care to all patients treated in any of the facilities of Mount Clemens Regional Medical Center and to assist the Hospital in meeting the goals described in its mission statement.

2.2 RESPONSIBILITIES

To effectuate the purposes enumerated above, the responsibilities of the Medical Staff are:

2.2-1 To participate in the hospital’s quality review and utilization management program by conducting all required and necessary activities for assessing, maintaining and improving the quality and efficiency of medical care provided in the hospital:

A. Evaluating practitioner and institutional performance through valid and reliable measurement systems based when appropriate on clinically-sound criteria.

B. Engaging in the ongoing monitoring of critical patient care practices.
C. Evaluating practitioner's credentials for appointment and reappointment to the medical staff and for the delineation of clinical privileges that may be exercised by each individual practitioner in the hospital.

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

2.2-2 To make recommendations to the board concerning appointments and reappointment to the staff, including category and department assignments, clinical privileges and corrective action.

2.2-3 To participate in the development and conduct of, as well as the monitoring of, medical education and training programs.

2.2-4 To develop and maintain Bylaws and related rules and regulations/policies that are consistent with sound professional practices, organizational principles, and external requirements, and to enforce compliance with them.

2.2-5 To participate in the hospital's long-range planning activities, to assist in identifying community health needs and to participate in developing and implementing appropriate institutional policies and programs to meet those needs.

2.2-6 To exercise through its officers, committees and other defined components the authority granted by these Bylaws and related manuals to fulfill these responsibilities in a timely and proper manner and to account thereon to the board.

ARTICLE III: STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the staff of Mount Clemens Regional Medical Center is a privilege which shall be extended only to professionally competent practitioners, who continuously meet the qualifications, standards, and requirements set forth in these Bylaws. Appointment to and membership on the staff shall confer on the staff member only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws, and shall include staff category, and department assignments.

3.2 BASIC QUALIFICATIONS FOR MEMBERSHIP

3.2-1 Basic Qualifications

Only practitioners, (D.O., M.D., D.P.M.) with a current and unrestricted license to practice in the State of Michigan who:

A. Document their experience, background, training, demonstrated ability, current professional competence, judgment and character; and, upon request, their physical and/or mental health status, with sufficient adequacy to demonstrate to the staff and the board that they will provide care to patients in accordance with applicable and prevailing professional standards of practice, in an economically efficient manner, taking into account the patients' needs, the available hospital facilities and resources, and utilization standards in effect at the hospital;
B. Are determined, on the basis of documented references to adhere strictly to the valid and lawful ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of staff responsibilities;

C. Maintain professional liability insurance covering all professional activities at the Hospital in an amount not less than the minimum coverage as determined by the Board, provide the Hospital with a certificate of such insurance at initial appointment and reappointment, and agree to promptly notify the Hospital in writing of any reduction or cancellation of such insurance.

D. Board Certification requirements for Staff membership*

In order to qualify to receive an application for medical staff membership, an applicant must be either board eligible (admission), or certified, or in the last three months of an accredited residency program. Then upon appointment to the staff, the physician must comply with the following:

1. Board Certification must be obtained within requisite number of years as identified by the specialty Board.

2. Subspecialty certification is required for those individuals practicing in subspecialties, (this also extends to “Certificates of Added Qualifications” in those areas where no subspecialty certificate exists),

3. Physicians will be required to maintain certification (recertification) if required by that specialty board,

4. All current members of the Professional Staff (as of 12/1/00) may be grandfathered* which is defined as exempt from fulfilling these new requirements in order to meet continued membership criteria at the time of adoption of this requirement.

*as recognized by the American Osteopathic Association (AOA), American Medical Association (AMA) / American Board of Medical Specialties (ABMS) or American Board of Podiatric Surgery (ABPS)

** board eligible / admissible is defined as being current in pursing Board Certification as defined by the respective specialty board.

3.2-2 Effect of Other Affiliations

No practitioner, is entitled to membership on the staff or to the exercise of particular clinical privileges solely because he is licensed to practice in this or in any other state, or because he is a member of any professional organization, or is certified by any clinical board, or presently or formerly held staff membership or privileges at another health care facility or in another practice setting.

3.2-3 Nondiscrimination

Staff membership or particular clinical privileges shall not be denied on the basis of any criterion unrelated to the efficient delivery of patient care in accordance with applicable and prevailing professional standards of practice in the hospital, including, but not limited to age, sex, race, creed, color, national origin, or handicap or other considerations not impacting the applicant’s ability to discharge the privileges for which he/she has applied.
3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Staff shall:

A. Provide his patients with continuous care in accordance with applicable and prevailing professional standards of practice, including calling for, or responding to, consultations when required by patient condition or facility requirement.

B. Abide by the Medical Staff Bylaws and Rules and Regulations, and by all other established standards, policies and rules of the Hospital; including policies regarding the privacy, confidentiality, and security of protected health information.

C. Perform such staff, department (division), committee and hospital functions, including quality improvement, for which he is responsible by appointment, election or otherwise.

D. Prepare and complete in timely fashion the medical and other required records for all patients he admits or in any way provides care to in the hospital.

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

F. Promptly notify the CEO/CMO of the revocation or suspension of his professional license, or the imposition of terms of probation or limitation of practice, by any state, or of his loss of staff membership or loss or restriction of privileges including resignation from staff membership, relinquishment of particular privileges or change status or privileges at any hospital or health care institution, or of the commencement of a formal investigation, or the filing of charges, by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or State of Michigan, or of the filing of a claim against the practitioner alleging professional liability.

G. Report to the CEO / CMO the facts and circumstances of any judgment or settlement rising from professional practice in civil cases; any current formal criminal charges (e.g., indictment), any felony conviction, or any other crime arising out of professional practice.

H. Adhere to the ethics of his profession, consistent with the Hospital mission and philosophy, and maintaining a good personal and professional reputation. This includes, but is not limited to, refraining from fee splitting or other inducement related to patient referral.

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

Failure to satisfy any of these basic responsibilities is grounds, as warranted by the circumstances, for non-reappointment or for such other disciplinary action as deemed appropriate by the final action of the Board pursuant Article VIII of these Bylaws.
3.4 CONDITIONS AND DURATION OF APPOINTMENT

All initial appointments, reappointment or revocation of appointments shall be made by the governing body only after there has been a recommendation from the Medical Staff as provided in these Bylaws. Each member of the Staff shall:

A. Demonstrate interest and ability to work cooperatively with other Practitioners, support staff, Administration and the Governing Body, consistent with Hospital policies and rules regarding communications among persons working in the Hospital.

B. Comply at all times with applicable local, Michigan, and Federal law.

C. Participate in Hospital’s program for risk management and promotion of patient and staff safety and support activities designed to address issues identified by these programs.

3.4-1 Duration of appointments

New members of the staff are subject to an initial provisional period as provided in Section 3.5 below and upon satisfactory conclusion of that period are placed in the appropriate reappointment cycle as determined by the hospital's system of staggered reappointment.

Reappointments to the staff shall be for a period not greater than two (2) years, unless otherwise specified in the notice of reappointment.

3.5 PROVISIONAL PERIOD

3.5-1 Applicability and Duration

All new appointments to the Staff, and all grants of initial or increased clinical privileges to new members or existing members are provisional for a minimum period of twelve (12) months or longer, up to a maximum of twenty-four (24) months. Each department shall, subject to the approval of the Staff Executive Committee and the Board, establish conditions for the provisional period, i.e. focused professional practice evaluation. During this provisional period, a practitioner's performance will be reviewed and evaluated by the Chair of the department with which he has his primary affiliation, and by the Chair of each other department in which he exercises his initial or increased privileges, or by other active staff members specifically delegated these tasks by such Chair. In unusual circumstances, the Board may, after receiving the recommendation, if any, of the Staff Executive Committee, waive this requirement.

3.5-2 Status and Privileges During Provisional Period

During the provisional period, subject to the conditions and limitations which may be imposed, a practitioner must demonstrate all of the qualifications, must fulfill all of the responsibilities of his staff category, may exercise all of the prerogatives and the clinical privileges granted to him. A practitioner's exercise of prerogatives and clinical privileges during the provisional period is subject to any conditions or limitations imposed as part of his appointment to the staff or grant of privileges, or as may be imposed during the term of the provisional period as a result of corrective action taken pursuant to Article VIII these Bylaws.

No member of the Active Staff may vote at general staff / department meetings, or hold staff office, or serve as department/division, or committee chairperson during the initial provisional membership status.
3.6 LEAVE OF ABSENCE

A. An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the CEO/CMO. The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

B. Members of the Medical Staff must report to the CEO/CMO any time they are away from Medical Staff and/or hospital patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently in the hospital. Under such circumstances, the CEO/CMO, in consultation with the President of the Medical Staff, may trigger an automatic leave of absence.

C. The CEO/CMO will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the CEO/CMO will consult with the President of the Medical Staff and the relevant department chief. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

D. During the leave / leave of absence, the individual will not exercise any clinical privileges. In addition, the individual will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

E. Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant Department Chairperson, the chair of the Credentials Committee, the President of the Medical Staff, and the CEO/CMO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the SEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, SEC, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

F. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

G. Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the SEC / Board. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

H. If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will lapse at the end of the appointment period, and the individual will be required to apply for reappointment.

I. Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.
ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES OF THE MEDICAL STAFF

The Medical Staff is divided into two regular categories: “Active” and “Active Affiliate”, and one special category: “Honorary” (all defined terms are defined in this Article IV)

4.2. THE ACTIVE STAFF

4.2.1 Qualifications. Appointees to the Active Staff:

A. Must meet basic qualification as set forth in Article 3.2-1

B. Must be able to respond to call within thirty (30) minutes and be able to provide continuing care to their patients and be available within a reasonable time period when the patient’s condition requires prompt attention.

4.2.2 Responsibilities & Prerogatives. Appointees to this Staff may:

A. Admit or be actively involved in the continuity of patient care according to his privileges.

B. Exercise such privileges as are granted to him by the governing body.

C. Participate in the organizational and administrative affairs of the Medical Staff.

D. Actively participate in recognized committees / functions of the Staff appointment including performance monitoring of Staff members during the Provisional period and in performing other Medical Staff functions as may be required from time to time.

E. Participate in the on-call coverage of emergency services or other specialty coverage programs as determined by the appropriate Department Chair or Staff Executive Committee.

F. Pay all Medical Staff dues and assessments promptly.

G. Fulfill any meeting attendance requirements as established by the Medical Staff, and participate in minimum number of cases as required by respective department.

H. Vote on all matters presented at general and special meetings of the staff, and the department, and committees of which he is a member; AND hold office in the staff organization, and in the department and committees which he is a member subject to the following limitation:

I. No member of the Active Staff may vote at general staff / department meetings, or hold staff office, or serve as department/division, or committee chairperson during his provisional membership status.
4.3 THE ACTIVE AFFILIATE STAFF

4.3.1 Appointees to the Active Affiliate Staff must:

(A). Must meet basic qualifications as set forth in Article 3.2

AND

B. Practice actively at the hospital, but do not want to participate actively in medical staff duties and responsibilities,

OR

C. wish to be affiliated with the Medical Staff, do not actively practice at the hospital, but are actively involved in the continuity of patient care (i.e. via patient care referrals, use of hospital's laboratory and diagnostic facilities;

OR

D. wish to be affiliated with the Medical Staff, do not actively practice at the hospital, nor are involved in the continuity of patient care, and may or may not maintain a primary appointment at another hospital.

(Appointees who do not maintain primary appointment at another hospital shall provide information as may be required in order to perform an appropriate evaluation of qualifications including, but not limited to, information from the individual's office practice, information from healthcare plans/managed care organizations in which the applicant participates, and/or receipt of confidential evaluation forms completed by "referring" / "referred to" physicians.);

OR

E. are members of a professional group, which provides periodic coverage for a practitioner who is an Active member in good standing; and has an Active Staff appointment at another hospital, and can provide evidence of clinical performance at their primary hospital as may be requested in such form at time of each application for reappointment.

4.3.2 Responsibilities & Prerogatives: Appointees to this Staff

A. Can exercise such privileges that may be granted by the Governing Body, OR practitioners without clinical privileges can visit those patients whom they have referred, may review, but shall not wrote in the patient's medical records.

B. are excused from service on medical staff committees; however, may serve and/or Chair a Committee

C. are encouraged, but are not required, to attend medical staff or department meetings;
D. may not vote or hold office at General Staff and Department/Division meetings to which he is assigned.

E. shall cooperate with the performance improvement, performance monitoring, and peer review activities at the hospital, including responding fully and timely to any inquiries regarding the care of patients at the hospital;

F. may be excused from the on call coverage of emergency service for the unassigned patients (unless there is a finding by the Staff Executive Committee that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities; and

G. shall pay all Medical Staff, dues and assessments

4.4. **TELEMEDICINE**

4.4.1 Qualifications

A) The Telemedicine category shall consist of Practitioners who are recognized by the Professional Staff for their ability to provide specialized services for patients of the Hospital through telemetry and other telemedicine technology at the request of a Member of the Professional Staff with privileges to order or perform such services, but do not reside within the community.

B) They shall apply for telemedicine privileges, and participate in an application process which provides sufficient information to reasonably assure his identity, education, training and competence in the field in which he will exercise telemedicine privileges.

C) Be active in his/her particular area of practice, and be a member of the Medical Staff of another health care organization, or undergoes a quality performance review in a manner similar to what is required of a member on the Professional Staff of this Hospital.

4.4.2 Responsibilities & Prerogatives

A member in the Telemedicine category may:

A) Exercise only those privileges as granted by the governing body.

B) May attend meetings of the General Medical Staff, and/or Department to which they are assigned, and educational meeting.

C) May not vote or hold office

D) Shall pay all Medical Staff Dues and Assessments specific to this Category.

4.5 **HONORARY STAFF**

Membership on the Honorary Staff is by invitation and is restricted to two classes of practitioners:

1. Former staff members whom, upon retirement from practice, the Staff Executive Committee recommend to the Board for this status in recognition of long-standing service to the hospital, or other noteworthy contributions to its activities, and

2. Other practitioners with outstanding professional attainments

Appointees to this Staff are not eligible for Privileges or have any of the responsibilities associated with membership on the Medical Staff. They may attend Medical Staff and Department meetings, continuing medical education activities and may be appointed to committees as a consultant or nonvoting member.
ARTICLE V: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

5.1 GENERAL PROCEDURE

The staff through its designated departments, committees and officers shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership status and shall adopt and transmit recommendations thereof to the Board. Neither the staff nor its committees are empowered to make any final decisions respecting appointments or privileges; such decisions are the sole responsibility of the Board.

The specific details and provisions for appointments and reappointments are fully set forth in the Medical Staff Credentialing Manual. The procedures set forth in this section cover both those who are applicants for or hold staff membership, and those who are only applicants for or hold privileges, by virtue of being allied health professionals.

ARTICLE VI: DETERMINATION OF CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Every practitioner or allied health practitioner providing direct clinical services at the hospital by virtue of staff membership or otherwise shall, in connection with such practice and except as provided by temporary privileges or emergency privileges shall be entitled to exercise only those clinical privileges or provide patient care services as are specifically granted pursuant to the provisions of these bylaws and the staff rules and regulations.

The specific details and provisions for determination of clinical privileges are fully set forth in the Medical Staff Credentialing Manual.

6.2 EMERGENCY AND TEMPORARY PRIVILEGES

Emergency Privileges or Temporary Privileges may be granted by the CEO / CMO or Chief of Staff in accordance with and set forth in the Medical Staff Credentialing Manual.

ARTICLE VII: PRACTITIONER RIGHTS

7.1 PRACTITIONER RIGHTS

In the event a Practitioner is unable to resolve a difficult issue through His respective Chair, He may, by means of written notice, request to meet with the Staff Executive Committee.

Each member of the Medical Staff may also request discussion of a documented and unresolved concern by the Staff Executive Committee. This concern may be related to Hospital administrative and/or nursing issues. This request should be in writing to the Chief of Staff with documentation of all steps taken to resolve the issue through the usual channels. In the case of disciplinary action, refer to Article VIII: Corrective Action.
Any Practitioner may raise a challenge to any rule or policy established by the Staff Executive Committee. In the event that a rule, regulation or policy is felt to be inappropriate, any Physician may submit a petition signed by 10% of the members of the Active Staff. When such petition has been received by the Staff Executive Committee, it will either (i) provide the petitioners with information clarifying the intent of such rule, regulation, or policy and/or (ii) schedule a meeting with the petitioners to discuss the issue.

A Medical Staff member may, upon reasonable request, within policies and procedures as approved by the Staff Executive Committee, review His own credentialing files and Medical Staff files other than those materials which the Hospital and/or Medical Staff designate as confidential peer or professional review materials.

ARTICLE VIII: CORRECTIVE ACTION

8.1 CORRECTIVE ACTION

8.1-1 Criteria for Initiation

Whenever the activities or the professional conduct of any staff member are believed to be detrimental to patient safety or inconsistent with the efficient delivery of patient care in accordance with applicable and prevailing professional standards of practice, or are reasonably probable of being disruptive to hospital operation, or are reasonably probable of being in violation of these Bylaws, Staff Rules and Regulations, Departmental Rules or other hospital policies, or the practitioner exhibits signs of physical or mental impairment, corrective action against such staff member may be initiated by any officer of the staff, by the Chairperson (or designee) of any department by the CEO/CMO or by the Board. Initiation of corrective action pursuant to Section 8.1 does not preclude imposition of summary suspension as provided for in Section 8.2, nor does it require the prior imposition of such a suspension.

8.1-2 Request

All requests for corrective action shall be in writing, submitted to the Staff Executive Committee, and supported by reference to the specific conduct or activities which constitute the grounds for the request. The Chief of Staff shall promptly notify the CMO / CEO, in writing, of all requests for corrective action received by the Staff Executive Committee; and shall continue to keep the CMO and CEO fully informed of all action taken in connection therewith.

8.1-3 Interviews

When the Staff Executive Committee or the Board receives or is considering initiating an adverse recommendation concerning a Staff member, the Staff member may, at the discretion of the Staff Executive Committee or Board, be afforded an interview, exclusively with the Medical Staff Officers or respective designee, not including the Chief of Staff.

The interview shall not constitute a hearing, shall be preliminary in nature, and shall not be conducted according to the procedural rules provided with respect to hearing. The staff member shall be informed of the general nature of the circumstances and may present information relevant thereto. A record of such interviews shall be made.
8.1-4 Investigation

After consideration of the request, the Staff Executive Committee shall

A). either reject the request and report the reasons for its decision to the CMO and the CEO, or

B) forward the request either to the Chair of the Department in which the questioned activities or conduct occurred, or

C) forward to an ad hoc committee appointed by the Staff Executive Committee to conduct an investigation.

The Staff Member who is under investigation shall be invited to appear before the ad hoc investigating committee. Any such appearance shall be informal in nature and not constitute a hearing, as described in Article IX. Within fourteen (14) days after the receipt of the request, the Department Chair or the ad hoc investigating committee shall forward a written report of the investigation to the Staff Executive Committee.

8.1-5 Staff Executive Committee Action

As soon as practical after the conclusion of the investigation, the Staff Executive Committee shall take action upon the request. Such action may include, without limitation:

A. Determining no corrective action is required.

B. Deferring action for a reasonable time when circumstances warrant additional time.

C. Issuing a warning, a letter of admonition, or a letter of reprimand. In the event such letters are issued, the Staff Member may make a written response to be placed in His Medical Staff file. This action shall not preclude a Department Chair from issuing informal written or oral warning to the Practitioner outside of the mechanism for corrective action in this Article. (These specific actions do not give rise to hearing rights)

D. Recommending limitation of Medical Staff membership which may include suspension, change of category, probation, or revocation.

E. Recommending limitations of clinical privileges that may include requirements for co-admission, mandatory consultation or proctoring of patient care, reduction, modification, suspension or revocation.

8.1-6 Board

The CMO shall report the determination of the Staff Executive Committee under Article 8.1-5 to the Board.
8.2 SUMMARY SUSPENSION

8.2-1 Criteria and Initiation

Whenever a Staff Member willfully disregards or substantially violates these Bylaws, Rules and Regulations, or other Hospital Policies, or whenever His conduct requires that prompt action be taken to protect the life of any patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Hospital, or whenever the conduct of the Staff Member materially disrupts the operations of any department or unit of the hospital, the Chief of Staff or the CEO / CMO shall have the authority to suspend summarily the staff appointment, or all or any portion of the clinical privileges, of such staff member. Such summary suspension shall become effective immediately upon imposition, and the CMO shall promptly give special notice of the suspension to the Staff member, and notice to the Staff Executive Committee of such action.

8.2-2 Staff Executive Committee Action

As soon as reasonably possible after such summary suspension, a meeting of the Staff Executive Committee shall be convened to review and consider the action taken. The Staff Executive Committee shall recommend to the Board modification, continuation or termination of the terms of the summary suspension.

8.2-3 Procedural Rights

Unless the Staff Executive Committee recommends immediate termination of the suspension and cessation of all further corrective action, the staff member shall be entitled to the procedural rights as provided in Article IX.

If the Staff Executive Committee makes any other recommendation to the Board other than termination of the suspension and cessation of all further corrective action, the suspension shall remain in effect until there is a final determination by Board.

8.3 AUTOMATIC SUSPENSION AND REVOCATION

8.3-1 License

If a staff member’s license to practice his profession in the State of Michigan is revoked or suspended, such staff member shall immediately and automatically be suspended from practicing in the hospital. If a staff member's license to practice his profession in the State of Michigan is restricted or limited, such staff member’s clinical privileges shall be automatically limited or restricted to the same extent and duration as of the date this action becomes effective.

8.3-2 Drug Enforcement Administration (DEA) Number

A staff member whose DEA number is revoked or suspended or voluntarily relinquished shall immediately and automatically be divested of his right to prescribe medications covered by such number. As soon as reasonably possible after such automatic suspension the Staff Executive Committee shall convene to review and consider the facts under which the DEA number was revoked or suspended or relinquished. The Staff Executive Committee may then recommend such further corrective action as is appropriate to the facts disclosed in its investigation.

8.3-3 Exclusion from Participation

If a physician is excluded from participating with any payment program or plan, they must immediately notify the CEO / CMO. Medical Staff privileges related to patients covered by the payer excluding the provider shall be considered immediately suspended. Exclusions from any government payment
program (Medicare, Medicaid, Tricare, and veterans health benefits), shall result in loss of privileges related to the care or referral of patient in all of the government payment programs.

If a previously excluded member is reinstated to the plan and/or government healthcare programs, he shall be eligible to apply for reinstatement to the Medical Staff by providing documentation of such program reinstatement and any other documents required by the Credentials Committee to bring his credentials file current. A practitioner whose reappointment came due for renewal within this time period must fulfill the usual reappointment processing provisions of these Bylaws. (Due to the action taken by the payer, all appeals must be to the payer and in conjunction with their established policies and procedures.)

8.3-4 Failure to Satisfy Special Appearance Requirement

A staff member who fails to satisfy the requirements of Section 13.9-3 shall immediately and automatically be suspended from exercising all or such portion of his clinical privileges in accordance with the provisions of said Section 13.9-3.

8.3-5 Conviction of a Felony

Upon exhaustion of appeals after conviction of a felony related to the practice of a profession of a staff member in any court of the United States, either federal or state, the member's staff appointment is automatically revoked. Revocation pursuant to this section of the bylaws does not preclude the staff member from subsequently applying for staff appointment.

8.3-6 Peer Review Activity

No physician member of the Medical Staff shall volunteer to testify about any peer review activity in which he may have been engaged, nor shall any physician member of the Medical Staff in any other manner breach the confidentiality of any peer review process with which he may have been involved as a reviewing physician. The penalty for violation of this provision of the Bylaws shall be automatic suspension of Medical Staff membership.

8.3-7 Medical Records

An automatic suspension of clinical privileges shall be imposed for failure to complete medical records within thirty (30) days after patient discharge, and shall remain in effect until the incomplete medical records are completed. (See Medical Record Completion Guidelines: Suspension Process)

8.3-8 Procedural Rights

A Staff Member under automatic suspension by operation of Section 8.3-6 shall be entitled to the procedural rights provided in Article IX.

A Staff Member whose appointment or privileges has been automatically suspended or revoked by operation of Section 8.3-1, 8.3-2, 8.3-3, 8.3-4, 8.3-5 and 8.3-6 may request a hearing by a committee to present evidence to establish that the automatic suspension or revocation was invoked in error. The hearing and any subsequent proceedings shall be conducted in accordance with the provisions of the Article IX. The invoking of an automatic suspension does not preclude initiation of corrective action pursuant to Section 8.1.
8.4 CONTINUITY OF PATIENT CARE

Upon the imposition of summary suspension or the occurrence of an automatic suspension, the Chief of Staff or the Chair of the Department of which the suspended staff member is assigned, shall provide for alternative coverage for the patients of the suspended staff member’s patients in the hospital. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner. The suspended staff member shall confer with the substitute practitioner to the extent necessary to safeguard the patient.

ARTICLE IX: HEARING AND APPELLATE REVIEW

All hearings and appellate reviews shall be in accordance with the procedure safeguards set forth in the Medical Staff Fair Hearing Plan.

ARTICLE X: OFFICERS OF THE STAFF AND DEPARTMENTS

10.1 OFFICERS OF THE STAFF

10.1-1 Identification: The Officers of the Medical Staff shall be:

1. President (Chief of Staff)
2. Vice-President
3. Secretary/Treasurer
4. Immediate Past President

10.1-2 Qualifications

Officers must be members of the Active Staff in good standing at the time of nomination and election and must remain members in good standing throughout the terms of office. They shall be willing and able to faithfully discharge the functions of his office; and shall be certified by a specialty board recognized by either the AOA or ABMS. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.1-3 Nominations

The Nominating Committee shall consist of four (4) members of the Medical Staff: three (3) Past Presidents of the Medical Staff, with the Immediate Past President serving as Chair. Recommendations of the Nominating Committee will be presented at the annual meeting.

10.1-4 Elections

Officers shall be elected at the annual meeting of the staff, voting can be by secret ballot. Proxy voting shall not be permitted. A nominee shall be elected upon receiving a majority of the votes cast. Appointment will begin on January 1st with approval granted by the Board of Trustees.

The current President (Chief of Staff) shall automatically succeed to the position of Immediate Past Chief of Staff.

Election process / procedure is outlined in a separate Policy of the Medical Staff.
10.1-5  Term of Elected Office

The term of office shall be for two (2) years and shall begin on January 1st of the year following the annual meeting of the staff.

10.1-6  Removal of Officers

An officer shall be removed from office if a majority of the Active Staff vote in favor of removal, and provided that the Staff Executive Committee and Board concur. Action directed toward removing an officer from office may be initiated by submission to the Staff Executive Committee of a petition seeking removal of an officer signed by members of the Active Staff with voting rights.

10.1-7  Vacancies in Staff Office

Vacancies within the Medical Staff Officer positions, other than the President, will be appointed by the Chief of Staff in consultation with the Medical Staff Officers. Such appointments to the “office” is limited to the remaining term of that “office.” If there is a vacancy in the office of the President, the Vice-President shall become President and serve out the remaining term.

10.1-8  Duties of Elected Officers

The Medical Staff Officers, individually or as a group, shall be responsible for reporting the activities of the Staff Executive Committee (SEC) to the General Staff.

A.  President (Chief of Staff). The President shall serve as the chief administrative officer and principal elected official of the Medical Staff. As such, he shall:

1. Act in coordination with the CMO and the Chief Executive Officer in all matters of mutual concern within the hospital;

2. Be accountable to the Board, in conjunction with the Staff Executive Committee, for the quality and efficiency of clinical services and performance within the hospital and for the effectiveness of the quality/utilization management program;

3. Develop and implement, in cooperation with the department and committee chairmen, methods for credentials review and for delineation of privileges, continuing education programs, utilization review, concurrent monitoring of practice and quality assessment;

4. Appoint the staff representatives to all standing and special committees of the Medical Staff unless otherwise expressly provided by these bylaws or hospital bylaws, policies or procedures;

5. Communicate and represent the opinions, policies, concerns, needs and grievances of the staff to the Board and the Chief Executive Officer; and shall be responsible for reporting the activities of the Staff Executive committee to the Board of Trustees and vice-versa. The President may designate another Medical Staff Officer to report to the Board in his/her absence.

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

7. Call, preside at, and be responsible for the agenda of all general meetings of the staff;
8. Serve as Chair of the Staff Executive Committee and as an ex-officio member of all other staff committees;

9. Serve as a spokesperson of the staff in its external professional and public relations in conjunction with the CMO.

B. Vice-President. The Vice-President shall be a member of the Staff Executive Committee. His duties shall be to:

1. In the temporary absence of the President, he shall assume all the duties and have the authority of the President.

2. He shall also assume the duties of the Chairperson of the Annual Resident Graduation / Medical Staff Honors Banquet

3. He shall perform such additional duties as may be assigned to him by the President, the Staff Executive Committee or the Board.

C. Secretary-Treasurer: The Secretary-Treasurer shall be a member of the Staff Executive Committee. His duties shall be to:

1. Give proper notice of all staff meetings on order of the appropriate authority;

2. Be responsible for accurate and complete minutes for all meetings;

3. Supervise the collection and accounting for any funds that may be collected in the form of staff dues, assessments, or applications fees, and maintain proper records of such funds;

4. Perform such other duties as ordinarily pertain to his office.

D. Past President: He shall be a member of the Staff Executive Committee by virtue of this position.

10.2 DEPARTMENT OFFICERS:

10.2-1 Department Chair

A. Qualifications: Each Chair shall be and remain a (physician) member in good standing of the Active Staff, shall have demonstrated ability in at least one of the clinical areas covered by the department, be certified by an appropriate specialty Board (AOA or ABMS), and shall be willing and able to faithfully discharge the functions of his office.

A. Appointment: At least thirty (30) days prior to the end of the medical staff year, the Active members of each department shall nominate a member of the department who meets the qualifications of Section 10.2-1(A) to serve as department Chair, and transmit its nomination to the Staff Executive Committee and onto the Board for final approval.

C. Term of office: A department Chair shall serve a term of one (1) medical staff year. A department Chair shall be eligible to succeed himself.
D. Removal of a Department Chair from office may be initiated by a two-thirds majority vote of all Active Staff members of the department, but no such removal shall be effective until it has been approved by the Staff Executive Committee and the Board.

E. Vacancy: Upon a vacancy in the office of Department Chair, the Vice-Chair shall become department Chair until a successor is appointed.

F. Duties: Each Chair shall:

1. Account to the Medical Staff Executive Committee (SEC) all clinically related activities of the department, as well as administratively related activities of the department, unless otherwise provided by the hospital

2. Act as presiding officer at all Departmental meetings, and implement actions taken by the SEC

3. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges

4. Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department

5. Recommending clinical privileges for each member of the department

6. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization

7. Integration of the department or service into the primary functions of the organization

8. Coordination and integration of interdepartmental and intradepartmental services

9. Development and implementation of policies and procedures that guide and support the provision of care, treatment and services

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

11. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and services

12. Continuous assessment and improvement of the quality of care, treatment and services

13. Maintenance of quality control programs, as appropriate

14. Orientation and continuing education of all persons in the department or service

15. Recommending space and other resources needed by the department or service
10.2-2 Vice-Chair

A. Each Vice-Chair shall have the qualifications set for in Section 10.2-1(A) for department Chair and shall be appointed in the same manner as defined in 10.2-1(B).

B. Term of office: A Vice-Chair shall serve a term of one (1) medical staff year.

C. Vacancy: Upon a vacancy in the office of Vice-Chair, the Chair shall appoint a member of the department to fill the vacancy.

D. Duties: The Vice-Chair shall:

1. In the absence of the Chair, carry out the duties of the Chair;
2. Perform such duties as may be assigned to him by the Chair.

10.2-3 Chief of Clinical Division

A. Qualifications: Each Chief of a Division shall be and remain a member in good standing of the Active Staff and a member of that service which he is to head, shall be qualified by training, experience, interest and demonstrated current ability in the clinical area covered by the service, and shall be willing and able to discharge the administrative responsibilities of his office;

B. Selection: The Chief of the Division shall be elected by a majority vote of the Division members or appointed by the Department Chair. This selection shall be submitted to the Staff Executive Committee for their consideration and subsequently referred to the Board for final approval.

C. Term of Office: Each Chief shall serve a term, commencing on his appointment for a period of one year.

D. Removal of a Chief during his term of office may be initiated by a two-thirds (2/3) majority vote of all Active Staff members of that Division, but no such removal shall be made effective unless and until it has been approved by the Staff Executive Committee, after recommendation from the department and referred to the Board for final approval.

E. Duties: Each Chief of Division shall:

1. Account to his department Chair for the effective operation of his service and for his service’s discharge of all tasks delegated to it;
2. Develop and implement, in cooperation with his Department Chair, programs to carry out the quality/utilization management functions assigned to his service;
3. Perform such other duties commensurate with his office as may from time to time be reasonably requested of him by his Department Chair.
ARTICLE XI: STAFF DEPARTMENTS (& DIVISIONS)

11.1 ORGANIZATION OF STAFF DEPARTMENTS

Each department shall be organized as a separate part of the Medical Staff and shall have a Chair and a Vice-Chair who are selected and have the authority, duties, and responsibilities as specified in Article X.

11.2 DEPARTMENTS

11.2-1 Current Departments
A. Department of Anesthesiology
   includes specialty of pain management
B. Department of Emergency Medicine
C. Department of Family Practice
   includes specialty of Neuromuscular Medicine (OMM)
D. Department of Medicine
   (includes specialties of ...........
   Allergy/Immunology  Cardiology *
   Dermatology       Endocrinology
   Gastroenterology  General Internal Medicine
   Geriatrics        Hematology/Oncology
   Infectious Disease Nephrology
   Neurology         Psychiatry; Clinical Psychology
   Pulmonary Disease Physical Medicine & Rehabilitation
   Rheumatology

   *Division
E. Department of Obstetrics & Gynecologic Surgery
   includes specialties of .......
   Reproductive Endocrinology Maternal & Fetal Medicine
   Gynecologic Oncology
F. Department of Orthopedic Surgery
   includes specialties of .......
   Orthopedic Surgery    Hand    Foot & Ankle
   Orthopedic Oncology   Ortho.Spine Ortho.Trauma Sports Medicine
G. Department of Ophthalmology, Otorhinolaryngology, and Oro-Facial Plastic Surgery (EENT & PS)
   includes specialties of .......
   Ophthalmology
   Otorhinolaryngology & Oro-Facial Plastic Surgery
   Oral & Maxillofacial Surgery
   General Dentistry
H. Department of Pathology & Laboratory Medicine
I. Department of Pediatrics
   includes specialties of ……..
   Neonatology
   Peds. Allergy / Immunology
   Peds. Neurology
   Peds. Oncology – Hematology

J. Department of Radiology
   includes specialties of………..
   Nuclear Medicine
   Radiation Oncology

K. Department of Surgery
   includes specialties of …………….
   Cardiovascular-Thoracic Surgery
   General Surgery
   Plastic Surgery
   Trauma Surgery
   Vascular Surgery

Specialties / subspecialties are not limited and may be added or revised in concert with specialties/subspecialties as recognized by the AOA (American Osteopathic Association), ABMS (American Board of Medical Specialties, or ABPS (American Board of Podiatric Surgery).

11.2-2 Future Departments (and Divisions)

When deemed appropriate, the Staff Executive Committee and the Board, by their joint, action, may create a new, eliminate, subdivide, further subdivide or combine departments and divisions.

11.3 ASSIGNMENT TO DEPARTMENTS

Each member of the staff shall be assigned membership in at least one department, but may be granted clinical privileges in another department or division. The exercise of privileges within each department/division shall be subject to the rules and regulations therein and to the authority of that department Chair. A staff member with privileges in more than one department shall vote and attend meetings in the department in which he holds primary privileges.

11.4 FUNCTIONS OF DEPARTMENTS

The primary responsibility delegated to each department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in that department. To carry out this responsibility, each department shall:

A. Participate in the quality/utilization management program for the purpose of reviewing and evaluating the quality of care within the department. Each department shall review all clinical work performed under its jurisdiction;

B. Establish guidelines for the granting of clinical privileges within the department and submit recommendations regarding the specific privileges each staff member or applicant may exercise;

C. Conduct or participate in continuing education programs;
D. Monitor, on a continuing and concurrent basis, adherence to:

1. Staff and hospital policies and procedures,
2. Requirements for alternate coverage and for consultations,
3. Sound principles of clinical practice, and
4. Hospital-wide safety programs.

E. Coordinate the patient care provided by the department members with nursing and other professional patient care services and with administrative support services;

F. Submit written reports to the Staff Executive Committee on a regular basis following departmental meetings containing:
   1. Findings of the department's review and evaluation activities, actions taken thereon and results of such action,
   2. Recommendations for maintaining and improving the quality of care provided in the department and the hospital, and
   3. Such other matters as may be requested from time to time by the Staff Executive Committee

G. Meet at least Quarterly for the purpose of receiving, reviewing and considering findings of the quality/utilization management program and the results of the department's review, evaluation and education activities and of performing, or receiving reports on, other department and staff functions; and,

H. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it.

11.5 DIVISIONS

A Division is recognized as a separate part within a department, and subordinate to that department, comprised of a sufficient number of physicians practicing in a particular specialty wherein it is more effective and efficient for them to perform the review and monitoring functions as required of that specialty within the Department.

Such "Division" may be created or dissolved, as recommended by a Department Chair, subject to the approval of the Staff Executive Committee and Board of Trustees.

11.6 FUNCTIONS OF DIVISIONS

Each Division shall meet Quarterly and perform the functions assigned to it by the Department Chair. Such functions may include, without limitation, conducting quality/utilization management activities, continuing education programs, and credentials review and privileges delineation. Each Division shall transmit regular reports to the Department Chair on the conduct of its assigned functions, as well as the Staff Executive Committee.

11.7 ATTENDANCE AT DIVISION MEETINGS

Upon the approval of the Department Chair, attendance at a division meeting may be considered as attendance at a department meeting for the purpose of satisfying any attendance requirements that may be imposed upon any member of the staff.
ARTICLE XII: COMMITTEES

12.1 DESIGNATION, STRUCTURE AND FUNCTION

There shall be such standing and special committees of the staff as may from time to time be necessary and desirable to perform the functions of the staff required by these bylaws or necessarily incidental thereto. All staff members to serve on committees and committee chairmen shall be appointed by the President of the Staff except as otherwise provided in these Bylaws. All hospital personnel, other than staff members, to serve on committees shall be appointed by the Chief Executive Officer (CEO). The CMO is ex-officio on all committees. Committee appointments are for the Medical Staff year.

All committees shall:

1. Maintain a record of attendance at their meetings;
2. Maintain a record of their activities;
3. Submit timely reports of their activities and copies of the minutes of their meetings to the Staff Executive Committee.

The Standing Committees of the Medical Staff are set forth below and also recognized in the Manual of Professional Staff Required Functions:

12.2 BOARD INDEMNIFICATION

All Medical Staff appointees who act on behalf of the hospital in professional activities pursuant to these Bylaws are indemnified to the fullest extent permitted by law.

12.3 STAFF EXECUTIVE COMMITTEE

A. Membership

The Executive Committee shall be the top echelon of control of the Medical Staff, responsible to the Board of Trustees, through the Chief Executive Officer (CEO) and shall be staffed as follows:

1) The STAFF EXECUTIVE COMMITTEE (SEC) will be comprised of the following specific representation:
   - Surgery (2)
   - Medicine (4)
   - Ancillary (1)

   Members at Large (5)
   - Immediate Past Chief of Staff (1)

Definitions:
- Ancillary = Emergency Medicine, Pathology and Radiology
- Surgery includes ALL Departments/Divisions of Surgery, including OBGYN, & Anesthesiology
- Medicine includes all Departments / Divisions of Medicine, Family Medicine, Pediatrics
- Members “at large” can be elected from among any of the Active (voting) members of the Medical Staff regardless of Department assignment.

2. The CEO (Chief Executive Officer) and CMO (Chief Medical Officer) shall be members, ex-officio, of this committee

Election process / procedure is outlined in a separate Policy of the Medical Staff

B. Term of appointment: two years with effective date of appointment to be consistent with the calendar year effective January 1st
C. **Removal of a SEC Member:** An elected member of the SEC shall be removed from office if a majority of the Active Staff vote in favor of removal, and provided that the SEC and Board of Trustees concur. Action directed toward removing a member of the SEC may be initiated by submission to the SEC of a petition seeking removal signed by members of the Active Staff with voting rights.

D. **Vacancy on the SEC:** Vacancy within the Medical Staff Executive Committee will be filled at the discretion of the Chief of Staff, in consultation with the Medical Staff Officers, and will be reflective of the represented position, i.e. specialty or member-at-large representative. The appointment is limited to the remaining term of the vacated position.

E. **Meetings:** This committee shall meet at least once a month. Special meetings may be called by the President at the request of three committee members.

F. **Functions**

1. Receive and act upon reports and recommendations from the departments, committees and officers of the staff concerning the findings of the quality/utilization management program and other quality maintenance activities, and the discharge of their delegated administrative responsibilities;

2. Coordinate the activities of, and policies adopted by the staff, departments and committees;

3. Recommend to the Board all matters relating to appointment, reappointment, staff category, department (and division) assignments, clinical privileges and corrective action,

4. Account to the Board and to the staff for the overall quality and efficiency of care rendered to patients in the hospital;

5. Initiate and pursue corrective action, when warranted, in accordance with these bylaws;

6. To investigate any breach of ethics that is reported to it;

7. Make recommendations on medico-administrative and hospital management matters to the Board through the President (Chief) of Staff;

8. Inform the staff of the accreditation program and the accreditation status of the hospital;

9. Represent and act on behalf of the staff, subject to such limitations as may be imposed by these bylaws.

### 12.4 CREDENTIALS COMMITTEE

A. **Membership & Meetings**

The Chief of Staff shall appoint the members of the Credentials Committee from the Active Medical Staff. They shall be considered on the basis of their maturity, objectivity and experience on other committees. Selection will ensure representation of clinical and hospital-based specialties as well as the Medical Staff at large.

The Credentials Committee shall meet at least annually, but more often if necessary. They shall receive written applications at least every two years from all providers requiring credentialing, inclusive of medical staff members and all other credentialed staff.
B. Functions:
1. Review the credentials of all applicants for medical staff appointment, reappointment, and clinical privileges (including expansion and/or limitation of privileges), investigate and interview such applicants as may be necessary, and to make a written report of its findings and recommendations.
2. Review the credentials of all applicants who request to practice at the hospital as an allied health professional, make investigations of and interview such applicants as may be necessary, and make a written report of its findings and recommendations.
3. Review, as questions arise, all information available regarding the clinical competence and behavior of persons currently appointed to the medical staff and of those practicing as allied health professionals, and, as a result of such review, make a written report of its findings and recommendations to the Staff Executive Committee.
4. Review, consider, and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the hospital, and determine minimum continuing education requirements for appointees to the staff.

12.5 MEDICAL EDUCATION COMMITTEE

A. Membership & Meetings

The Chief of Staff shall appoint the members of this Committee; such membership shall consist of the Active Medical Staff who are the Residency Training Program Directors or their designee. The Director of Medical Education (DME) and CEO / CMO shall be ex-officio members.

The Medical Education Committee shall meet on a regular basis.

B. Functions

1. This committee shall act in an advisory capacity to the DME to oversee the selection, supervision, and evaluation of the teaching programs for medical students, interns, and residents.
2. It shall assist the Administration in matters of governance and discipline of interns, residents, fellows and teaching faculty; and act as mediator among departments/divisions in any controversial matter related to medical education.
3. It shall provide oversight and direction to the medical library.
4. It shall direct and coordinate the development of and evaluate the effectiveness of continuing medical education (CME) programs for the Medical Staff that:
   a. are responsive to the needs identified in quality review, risk management, and utilization findings and by Medical Staff members;
   b. are designed to inform the Medical Staff of developments in diagnostic and therapeutic aspects of care pertinent to medical practice, and
   c. assist the Medical Staff in aspects of basic medical education.

12.6 OSTEOPATHIC PRINCIPLES & METHODS COMMITTEE

A. Membership & Meetings

The Chief of Staff shall appoint the members of this committee. Membership shall consist of at least three osteopathic physicians; if possible, one osteopathic physician from each of the organized departments should serve on the committee.
This committee shall meet quarterly.

B. Functions

1. Recommendations to improve utilization of osteopathic principles and practice, record osteopathic findings, describe osteopathic manipulative treatment and to apply such modalities as part of the comprehensive care received by patients;

2. Establishing and recording retrospective and current audits of patient charts relating the application of osteopathic principles and practice to patient diagnosis and treatment;

3. Informing osteopathic physician of the evaluations of patient charts done by the committee to improve utilization of osteopathic principles and practices.

12.7 QUALITY ASSESSMENT / IMPROVEMENT COMMITTEE

A. Membership & Meetings

The Chief of Staff shall appoint the membership of this Committee;

Membership will include a physician Chairman, representation from quality management, Medical Staff, and the Chief Medical Officer. The Director of Medical Education shall be ex-officio.

The committee shall meet on a regular basis.

B. Functions

This review committee is responsible for oversight of the hospital-wide QA/I Plan specific to medical staff activities. Functions include, at least appropriateness of the selected service/activity and the management of same in the following processes:

1) Medication therapy – including antibiotics and nonantibiotics for all service types of patients, i.e. in, out, ambulatory and emergency care.;

2) Infection control – including community acquired and healthcare acquired infections in patients and healthcare workers;

3) Surgical / invasive and manipulative procedures including tissue and nontissue producing cases, with and without anesthesia and/or moderate sedation;

4) Blood (including component) produce usage (including for all service types of patients);

5) Data management (accuracy, currency, transferability) – with emphasis on medical record pertinence and timeliness;

6) Discharge planning & utilization review,

7) Utilization management;

8) Complaints regarding medical staff related issues;

9) Restraint / seclusion usage; and

10) Mortality review
12.8 UTILIZATION REVIEW COMMITTEE

A. Membership and Meetings.

The Chief of Staff shall appoint the membership of this Committee; membership must be comprised of at least three (3) or more physicians. The UR Physician Advisor(s) will be included in this membership. The following will support the committee in an advisory (ex-officio) capacity: Administrative Representative, Director, Health Information Management, Manager; UR Department, Manager, Case Manager; Director of Quality Systems

The committee shall meet at least quarterly.

B. Functions

1. This review committee is responsible for oversight of the Utilization Review (UR) Plan which provides for review of services furnished by the facility and by members of the Medical Staff.

2. UR activities are kept as peer review; and UR activities are kept confidential.

12.9 SPECIAL COMMITTEES

Special committees may be appointed from time to time as may be required to carry out properly the duties of the medical staff. Such committees shall confine their work to the purpose for which they were appointed and shall report to the Staff Executive Committee or to the full Medical Staff if so directed. They shall not have the power of action unless such is specifically granted by the motion creating such a committee.

12.10 OTHER COMMITTEES

All other committees of the Medical Staff are set forth in the Manual of Professional Staff Required Functions.

ARTICLE XIII: MEETINGS

The Medical Staff is organized in a manner to provide ongoing review of the professional practices of the Hospital, for the purpose of striving to reduce morbidity and mortality and to improve the care of patients. Since review includes but is not limited to the quality and necessity of care provided, and the preventability of complications and death; to the extent that any committee of the Medical Staff performs such functions, such review is hereby designated as professional practice review functions.

13.1 PARTICIPATION BY CEO

The CEO of Mount Clemens Regional Medical Center and any representative assigned by the CEO may attend any meeting of the Medical Staff in a non-voting capacity.
13.2 EXECUTIVE SESSION

Executive Session may be requested by any Active member of the respective General Staff, Department (Division) or Committee. (Thus “Executive Session” requires a request* to close the meeting to all but voting members unless exception is made by the Chair of the respective assembly, OR if “Executive Session” is predetermined by the Chair via published agenda or as soon as the meeting is Called to Order.)

*this request can be in the form of a motion, wherein the Chair should attempt to gain general consent. Otherwise, the Chair should ascertain if there is a second to the motion and continue process in accordance with Roberts Rules of Order

13.3 COMMITTEE AND DEPARTMENT MEETINGS

13.3-1 Professional Practice / Peer Review Functions

The Medical Staff is organized in a manner to provide ongoing review of the professional practices of the Hospital, for the purpose of striving to reduce morbidity and mortality and to improve the care of patients. Since review includes but is not limited to the quality and necessity of care provided, and the preventability of complications and death; to the extent that any committee of the Medical Staff performs such functions, such review is hereby designated as professional practice review functions.

Peer review functions are performed by the various Departments / Divisions of the Medical Staff, by the officers and committees, and from time to time by each Department / Division as a committee of the whole reviewing his/her professional practice. The Officers of the Medical Staff and Administration are assigned and performed professional practice review functions and coordinate the work of all individuals and committees assigned such functions.

13.3-2 Regular Meetings

Committees, Departments (and Divisions) may, by resolution, provide for the time for holding regular meetings and no notice other than such resolution shall then be required. The frequency of such meetings shall be as required by these bylaws.

13.3-3 Special Meetings

A special meeting of any committee, department (or division) may be called by, or upon request of, the Chair (or Chief) thereof, the Chief of Staff; or shall be called by the Chair or Chief within five (5) days after receipt of a written request of at least three (3) of the group's then current members. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.4 NOTICE OF MEETINGS

Written or printed notice stating the place, day and hour of any general staff meeting, of any special meeting, or of any regular committee, department or division meeting not held pursuant to resolution shall be delivered either personally or by mail and/or by electronic communication (i.e. fax) to each person entitled to be present thereat not less than five (5) days before the date of such meeting. Notice of department, division and committee meetings may be given orally. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail addressed to the member at his address as it appears on the records of the hospital with postage thereon prepaid. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.
13.5 QUORUM

13.5-1 General Staff Meetings

A. Quorum for transaction of business will be defined as those Active members present and voting.
B. Quorum for revision of Bylaws will be defined as those Active members present and voting.

13.5-2 Department (Division) and Committee Meetings

Quorum will be defined as those present and voting providing there are at least three voting members. (Members specifically described as ex-officio shall not be counted in determining the presence of a quorum.)

13.6 MANNER OF ACTION

Except as otherwise specified in these bylaws, the action of a majority of the members present and voting shall be the action of that group.

There will be no proxy voting accepted at any regular or special meeting of the general staff, department (division) or committee.

Voting may be in the form of a Ballot. This can be requested by the Chair or any member of the respective general staff, department (division) or committee.

Action may be taken without a meeting by a department (division) or committee by a communication setting forth the action so taken signed by each member entitled to vote thereat and this action will be ratified at the next regular meeting of this group.

13.7 PROCEDURAL RULES

The latest edition of Roberts Rules of Order shall be used to guide the parliamentary procedures of all meetings held pursuant to these Bylaws, except where specifically prohibited in these Bylaws.

13.8 MINUTES

Minutes of each regular or special meeting shall include a record of attendance and the outcome of the vote taken on each matter. Copies of such minutes shall be submitted by the presiding officer and forwarded to the Staff Executive Committee. A permanent file of the minutes of each meeting shall be maintained in the Office of Medical Affairs or designated area.

13.9 ATTENDANCE

13.9-1 Regular Attendance

Each member of the Active Medical Staff shall be required to attend each year:

A. At least fifty percent (50%) of all staff meetings duly convened pursuant to these bylaws; and
B. At least fifty percent (50%) of all meetings of each department (division) of which he is a member.
C. Failure to meet the attendance requirements of Section 13.9 may be grounds for removal from such department (division) or committee.
13.9-3  Special Appearances

Whenever apparent or suspected deviation from standard clinical practice in involved, special notice shall be given to the staff member and shall include a statement of the issue involved and that the staff member's appearance is expected. Failure of a staff member to appear at any meeting with respect to which he was given such special notice shall, unless excused by the Staff Executive Committee upon a showing of good cause, may result in an automatic suspension of all or such portion of the staff member's clinical privileges as the Staff Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved by subsequent action of the Staff Executive Committee or the Board or through corrective action if necessary.

13.10  GENERAL STAFF MEETINGS

13.2-1  Regular Meetings

The staff shall hold quarterly staff meetings in March, June, September and December of each year. The December meeting constitutes the annual meeting at which the election of officers shall be conducted.

13.2-2  Special Meetings

Special meetings of the staff may be called at any time by the Chief of Staff, the Staff Executive Committee, or shall be called by the Chief of Staff within five (5) days after receipt of a written request of at least five (5) members of the Active Staff, and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

13.2-3  Order of Business and Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff. The agenda shall include at least:

A. Review and approval of the minutes of the last regular and of all special meetings held since the last regular meeting;

B. Old Business;

C. Administrative reports from the Chief Executive Officer, Chief Medical Officer, Director of Medical Education, Departments/Divisions, Committees;

D. Reports by responsible officers, committees and departments on the overall results of quality/utilization management program and other quality maintenance activities of the Staff, and on the fulfillment of the other required staff functions;

E. New Business, Announcements, Communications, Elections when appropriate;

F. Adjourn
ARTICLE XIV: CONFIDENTIALITY, IMMUNITY AND RELEASE

14.1 SPECIAL DEFINITIONS

For the purposes of this Article, the following definitions shall apply:

A. INFORMATION means records of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 14.5-2.

B. MALICE means the dissemination of a known falsehood, or of information with a reckless disregard for whether it is true or false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the fact.

C. PRACTITIONER means a physician, podiatrist or Allied Health Professional

D. REPRESENTATIVE means the Board and any member of committee thereof; the Chief of Staff, the staff organization and any member, officer, department, service or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

E. THIRD PARTIES means both individuals and organizations providing information to any representative.

14.2 AUTHORIZATION AND CONDITIONS

By applying for, or exercising, clinical privileges within this hospital, a practitioner:

A. Authorizes representative of the hospital and the staff to solicit, provide and act upon information bearing on his professional ability and other qualifications;

B. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article; and

C. Acknowledges that the provisions of this Article are express conditions to this application for, or acceptance of, staff membership, or his exercise of clinical privileges at this hospital.

14.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, shall to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative or the practitioner, or used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general hospital records.
14.4 IMMUNITY FROM LIABILITY

14.4-1 For Action Taken

No representative of the hospital or staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his duties as a representative, if such representative acts in good faith and without malice. Regardless of any provisions of state law to the contrary, truth shall be an absolute defense for a representative in all circumstances.

14.4-2 For Providing Information

No representative of the hospital or staff and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this hospital or staff or to any other hospital, organization of health professionals, or other health-related or educational institution or organization concerning a practitioner who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges at this hospital, provided that such representative or third party acts in good faith and without malice.

14.5 ACTIVITIES AND INFORMATION COVERED

14.5-1 Activities

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other educational or health-related institution's or organization's activities concerning, but not limited to:

A. Applications for appointment and clinical privileges,
B. Periodic reappraisals for reappointment and clinical privileges,
C. Corrective action,
D. Hearings and appellate reviews,
E. Quality assessment activities,
F. Utilization reviews, and
G. Other hospital, department, division, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

14.5-2 Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in the Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, professional ethics, ability to work cooperatively with others, economic efficiency or any other matter that might directly or indirectly affect patient care of the efficient functioning of an institution or organization.

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1 see Medical Staff Policy: Confidentiality of Medical Staff Records; and/or Medical Staff Member Access to Credentials & Quality Files)
14.5-3 Conflict of Interest Disclosure

If any Staff member has, or reasonably could be perceived as having a conflict of interest or a bias, in the matter under review, the individual with such conflict shall not participate in the discussion or voting on the matter, and shall be excused from the meeting during this time. However, the individual may be asked, and may answer, any questions concerning the matter before leaving.

The fact that a Department Chief or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness.

If any such member of the body reviewing the matter feels they cannot participate in the review objectively and without bias, they shall so refrain and may be excused from participation. This shall not be interpreted as a finding of actual conflict.

The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the President of the Medical Staff or applicable Committee Chair or Department Chair by any other member with such knowledge of it.

14.6 RELEASES

Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercises of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of Michigan.

14.7 CUMULATIVE EFFECT

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

ARTICLE XV: GENERAL PROVISIONS

15.1 STAFF RULES AND REGULATIONS

Subject to approval by the Board, the staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of staff organizational activities as well as embody the level of practice that is to be required of each staff member of allied health professional in the hospital. Such rules and regulations shall be a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board. Such Rules and Regulations shall not be inconsistent with these Bylaws, and are compliant with law and regulation.

(See Medical Staff Standing Rules)
15.1.1 Urgent Amendment to Rules and Regulations.

In cases of a documented need for an urgent amendment to Rules and Regulations necessary to comply with law or regulation, the Medical Staff Executive Committee may provisionally adopt, and the Board may provisionally approve an urgent revision without prior notification of the Medical Staff. In such cases, the Medical Staff shall be notified by the Chief of Staff (or designee) prior to the next regular meeting of the General Staff. The Medical Staff has the opportunity for retrospective review and comment on the provisional amendment. If there is no conflict between the organized Medical Staff and the Medical Staff Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized Medical Staff and the Medical Staff Executive Committee is implemented as outlined in Section 15.7, “Conflict Resolution.” If necessary, a revised amendment is then submitted to the Board for action.

15.2 History and Physical Requirements.

The requirements for completing and documenting medical histories and physical examinations exist in the Rules and Regulations of these Bylaws, and may only be performed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with State law and Hospital policy.

15.3 DEPARTMENT (and DIVISION) RULES AND REGULATIONS

Subject to the approval of the Staff Executive Committee and the Board, each department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these bylaws, the general rules and regulations or policies of the Medical Staff, or other policies of the hospital. A permanent file of current department (and division) rules and regulations shall be maintained in the Office of Medical Affairs.

15.4 DESIGNEES TO PERFORM FUNCTIONS OF THE PRESIDENT (CHIEF OF STAFF)

Any responsibility assigned, or authority granted, to the President may be fulfilled or exercised by another administrative official of the hospital, designated by the President or the Board to perform such function, except as otherwise provided by the Board or in the Hospital Bylaws.

In the event that the President (Chief of Staff), is unavailable or unable to perform the responsibilities, then the following Medical Staff Officers will be contacted in specific order: Vice President, Secretary/Treasurer, Immediate Past Chief of Staff.

15.5 GOOD STANDING

The prerogatives and rights provided by these Bylaws to staff members to vote at staff meetings, to be nominated for and to hold staff office or serve as a member of the Staff Executive Committee, and to serve as a department (or division) officer or committee Chair, shall be limited to ACTIVE Staff members in good standing.

15.6 CONSTRUCTION OF TERMS AND HEADINGS

Words used in these Bylaws and related manuals read as the masculine gender will apply to both the masculine or feminine gender. The captions or heading in these Bylaws or related manuals are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws and related manuals.
15.7. **MEDICAL STAFF POLICIES**

Medical Staff Policies which are developed for proper conduct of the Medical Staff and may be necessary to implement more specifically the general principles found within these Bylaws, as well as embody the level of practice that is required of each Staff Member or Allied Health Professional in the Hospital shall be approved by the Medical Staff Executive Committee; such policies shall become effective when approved by the Board of Trustees.

Policies of the Medical Staff shall be supportive of and congruent with the Bylaws, Rules & Regulations of the Medical Staff or Hospital. Such policies will require triennial review (every three years).

15.8. **CONFLICT RESOLUTION**

Whenever the Board’s proposed final decision will be contrary to the last recommendation of the Medical Staff Executive Committee, the Board shall submit the matter to the Joint Conference Committee (JCC) for further review and recommendation.

If there is conflict between the organized Medical Staff, and the Medical Staff Executive Committee, this matter will be referred to the Joint Conference Committee.

The Joint Conference Committee may invite an affected applicant or Staff Member to appear before, or participate in the Joint Conference Committee proceedings, and may also invite other individuals to appear before or participate in the JCC proceedings.

This appearance or participation shall be under such conditions as may be established by the JCC.

**ARTICLE XVI: ADOPTION AND AMENDMENT OF BYLAWS**

16.1 **STAFF RESPONSIBILITY AND AUTHORITY**

The Medical Staff shall have the responsibility and authority to formulate and submit recommendations to the Board regarding the Medical Staff Bylaws, and amendments thereto. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. Adoption or amendment of Medical Staff Bylaws cannot be delegated.

All amendments or revisions shall be effective when approved by the Board.

Medical Staff Bylaws require triennial review (every three years) by a committee serving in this function as appointed by the Chief of Staff.

16.2 **METHODOLOGY**

Medical Staff Bylaws may be adopted, amended or repealed by the following combined action:

16.2-1 Staff

Proposed amendment revisions will be presented at a regularly scheduled business meeting of the General Staff, with subsequent mailing to the Active Medical Staff to include a mail ballot and return within thirty (30) days to the Office of Medical Affairs.

A majority of those mail ballots returned will determine action taken and will be so reported to the Staff Executive Committee.
16.2-2 Board

These Bylaws will become effective when approved by the Board of Trustees.

16.3 ADOPTION

The Medical Staff Bylaws with the appended rules and regulations, shall be adopted at any regular meeting of the Active Medical Staff, shall replace any previous bylaws, rules and regulations and shall become effective when approved by the governing body of the hospital.

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Newly Revised Bylaws
(replaced the original documents recommended by General Staff June 1989, and approved by the Board of Trustees July 18, 1989)

Recommended: General Staff: 10/17/09; 12/2011; 03/2013; 07/2015; 01/2016; 03/2016

APPROVED: Board of Trustees 11/24/09; Jan, 2012; May 2013; July 2015; January 2016; March 2016
MEDICAL STAFF BYLAWS:

MEDICAL STAFF STANDING RULES

Standing rules may be adopted, amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such Rules and Regulations shall not be inconsistent with these bylaws.

STANDING RULES:

1. Smoking is strictly and positively forbidden.

2. No physician will be permitted to practice in the hospital under the influence of alcohol.

3. No surgical operation may be delayed to permit a tardy referring physician to arrive, as schedules in the surgery suite must be maintained. The surgeon and his assistants must be ready to scrub 15 minutes prior to the time the operation is scheduled to begin. Likewise, the anesthesiologist must be in the department ready to begin.

4. Any physician who attempts any procedure, which is obviously beyond his capability, will be held to a strict accounting by the department chairman and/or the Staff Executive Committee. The chairman of the department shall have the right to render or to order assistance in such cases, even though such assistance is unwelcomed by the physician in question.

Hazardous surgical cases require a physician first assistant to be scrubbed. Hazardous procedures are defined as: elective major operative procedures.

5. Medical records are important from standpoint of the patient's welfare, professional welfare and in the case of court action. Records must be kept honestly, fearlessly, properly and completely. The “Medical Records Completion Guidelines”, as an appendix to these Standing Rules, identify basic requirements for medical records, i.e. H&Ps, Consultations, Operative Reports, Progress notes, time frames for completion of medical records, suspension process, etc. (Reference: Medical Records Completion Guidelines.)

6. All operations / procedures performed shall be fully described by the attending surgeon. All tissues removed at operation necessary to establish a diagnosis shall be sent to the pathologist who shall make such examinations as he may consider necessary to arrive at a diagnosis. The tissue specimens are to be accompanied by written requisition with appropriate information pertinent to the case.

7. Any attempt on the part of any physician or hospital employee to falsify a record or mislead witnesses shall be reported to the Staff Executive Committee by anyone who is aware of such attempt. Any
failure to report such offense will be considered evidence of complicity and will subject such person to
deserved correction.

8. In all deaths, the official death certificate must state the cause of death truthfully and without
equivocation or qualification.

9. A doctor of osteopathy or medicine must be on duty or on call at all times. All patients admitted must
be attended by members of the Active or Active Affiliate Medical Staff.

Only a physician (DO/MD) who has been granted staff privileges is responsible for each patient’s
medical plan of care.

10. Laboratory facilities shall be provided by the hospital to insure as complete a service as possible.
Examinations, which cannot be done in the hospital, shall be referred to an outside approved
laboratory.

11. It shall be understood that Group Practices (whose coverage may share or rotate during absences,
i.e. weekends, vacations, illness, etc.) that the physician may write on the chart without a specific
order by the attending physician granting such permission to write on the chart.

12. All records are the property of the hospital and shall not be taken away without permission. In case
of readmission of a patient, all previous records shall be available for the use of the attending
physician. This shall apply whether the patient is free or paid and whether he is attended by the
same physician or another.

13. When an entire surgical team is non-physician (i.e. DDS, DPM), a physician must be immediately
available to the procedure.

14. All laboratory reports of diagnostic studies performed which are pertinent to the diagnosis and
treatment of the patient shall be made a part of the permanent hospital record in the form of the
original report.

15. All physicians’ orders shall be dated, timed and signed. Verbal orders must be countersigned by the
physician responsible for those orders within 48 hours. Facsimile (rubber stamp) authentication is
prohibited for drug orders.
(see Administrative Policy - “Verbal Orders – Telephone Orders”.)

15. Automatic Stop Orders: All drugs will be automatically stopped as follows:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ketorolac (Toradol) injection</td>
<td>48 hours</td>
</tr>
<tr>
<td>Parenteral chemotherapeutic agents</td>
<td>Number of doses of duration of treatment must be specified.</td>
</tr>
<tr>
<td>Nesiritide (Natrecor)</td>
<td>48 hours</td>
</tr>
<tr>
<td>Neuromuscular Blocking agents</td>
<td>48 hours</td>
</tr>
<tr>
<td>Warfarin (Coumadin)</td>
<td>Single-dose orders only</td>
</tr>
<tr>
<td>Heparin, intravenous</td>
<td>4 days</td>
</tr>
<tr>
<td>All other medications</td>
<td>duration of hospital stay</td>
</tr>
</tbody>
</table>

Postoperative prophylactic antibiotics will be limited to not more than 48 hours following
cardiothoracic surgery, or not more than 24 hours following all other surgeries.

( note: Physicians who wish to have antibiotics continued past this time must have an indication
listed on the medication order.)
17. Consultation Policy (see policy) - Specific mandatory consultations may also be identified within individual Departmental Rules and Regulations.

18. An emergency is defined as a threat to life or limb requiring immediate intervention. An urgent case must be completed within the time frame as determined by the admitting surgeon.

19. Only physician members of the Medical Staff shall be credentialed as qualified medical personnel to, in accord with the definitions and requirements of Federal and State laws and regulations: (reference: Federal Emergency Medical Treatment and Active Labor Act, EMTALA)

   1) supervise the delivery of emergency services by the hospital,
   2) conduct all required medical screening examinations of individuals who come to the Hospital and its Emergency Department as those matters are defined by those laws and regulations; and
   3) authorize, certify and document appropriate transfers of such individuals.

20. HIPAA: All members of the Medical Staff and Allied Health Professional Staff shall maintain the confidentiality, privacy, security and availability of all protected health information in records maintained by the hospital or by business associates of the Hospital, in accordance with any and all health information privacy policies adopted by the Hospital to comply with current federal, state and local laws and regulations, including but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Protected health information shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with such health information privacy policies of the Hospital and HIPAA.

21. The hospital and the staff shall conform to the Minimum Standards of the Committee on Hospitals of the American Osteopathic Association for the teaching of interns and residents.

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STANDING RULES

APPROVED:


Board of Trustees---- July 18, 1989; rev. 6/19/90; 3/16/93; 3/17/98; 11/00; 9/01; 6/03; 6/04; 9/04; 3/2005; 6/05; 01/2007; 06/2007; 09/2008; 07/2008; 01/2011; 09/2012


note: revisions specific to spelling, technical or legal modifications in concert with accreditation compliance may be implemented and updated immediately with appropriate communication to the Medical Staff of compliance updates.
CONSULTATION POLICY

Only one Active/Active - Affiliate Staff member may be designated as the admitting (attending) physician responsible for patient care until the patient is transferred or discharged. The attending physician is responsible for requesting a consultation, and there should be documentation of the indication for the consult.

The following categories are recommended:

A. **Consultation Only** which leaves the management to the attending physician and prohibits consultants from writing orders on the chart,

B. **Consultation and Participation** of a specific entity or procedure in which the consultant may write orders to manage the special entity or procedure but overall responsibility remains with the attending physician,

C. **Management is transferred** to another named physician in which case patient care responsibilities in the hospital are transferred to the named physician, and the admitting physician may no longer write orders.

If the attending physician and the consultant disagree on management of a patient, a second consultation shall be ordered.

**MANDATORY CONSULTATIONS:**
Except in emergencies, consultations are required on critically ill patients, patients who are poor surgical risks, and those whose diagnoses are difficult or obscure.

Admission to the ICU requires consultation with Critical Care Services, AND consultation WITH transfer of management to either i.e. general internal medicine, cardiology, endovascular neurology, general surgery or CVT service

Specific mandatory consultations may be identified by the specific specialty services.

**TIME FRAME:** Consultations shall be performed in a timely fashion (24 hours).

**NOTIFICATION** of Consultation –
1. Physician to write an order for Consultation w/ specifics (as noted above),
2. Health Unit Coordinator shall:
   A. Enter the order into the patient care system computer,
   B. Contact the physician via his/her “beeper,” and
   C. Contact the physician via his office, or answering service.  
     (Notice of consultation may not be left on an answering machine; contact must be made with an individual accepting messages for that practitioner.)
3. If Consultant is unavailable, or unable to be reached, the Attending Physician will be notified.
Verbal Orders / Telephone Orders

Reference: Administrative Policy re Verbal/Telephone Orders: PCS 03-316

1. Purpose

1.1. To facilitate patient care in emergency situations with the use of verbal and telephone orders:

1.2. To facilitate timely patient care when the practitioner is not readily available to enter an electronic order or write an order; and

1.3. To provide for timely verbal or telephone authentication of orders.

2. Scope

2.1. Physician, Podiatrist, Dentist, Advanced Practice Nurses, Nursing Staff, Allied Health Professionals or Qualified employees.

3. Definitions

3.1. Telephone order: Requests for patient services from a healthcare practitioner, within the practitioner’s scope of practice, given audibly over the telephone or other telecommunication device, to another healthcare practitioner whose scope of practice includes authorization to receive and document such orders.

3.1.1. A telephone order is a type of verbal order and refers to those situations in which the ordering practitioner is not physically present when providing the patient care orders.

3.2. Verbal Order: Requests for patient services from a healthcare provider, within the practitioner's scope of practice, directly spoken to another healthcare practitioner whose scope of practice includes authorization to receive and document such orders.

4. Policy

4.1. Verbal orders / Telephone Orders may be taken from the following healthcare practitioners duly licensed and/or registered in the State of Michigan, and credentialed at McLaren Macomb: Physicians (D.O., M.D), Podiatrists (D.P.M.), Dentists (DMD, DDS), and Allied Health Professionals.

4.1.1. Qualified employees or Allied Heath Professionals able to receive Verbal orders / Telephone orders include but are not limited to: Licensed professionals (i.e. RN, RPh, PT, NP, CRNA., PA, Clinical Psychologist), Certified or Registered healthcare providers (RT, OT, ST, RD).

4.2. When accepting a verbal or telephone order, the receiving provider will enter the order directly into the Electronic Health Record (EHR) as it is being given in order to obtain clinical decisions for alerts provided during order entry.

4.3. Practitioners authorized to issue verbal or telephone orders shall check their EHR inbox daily for verbal and telephone orders requiring authentication.
4.4. Verbal and telephone orders should be limited to situations where the prescriber is not available to enter the order directly into the Electronic Health Record:

4.4.1. Prescriber is in a location outside the hospital where computer access is unavailable

4.4.2. Prescriber is scrubbed or otherwise unable to enter orders electronically

4.4.3. Pharmacy initiated medication changes.

4.5. Verbal Orders / Telephone Orders

4.5.1. To ensure safety, verbal and telephone orders require “read-back” verification to the ordering clinician of the complete order by the person receiving the order.

4.5.1.1. The receiving health care provider will enter the order in the medical record or clinical information system, and then read back the transcribed order to the ordering practitioner.

4.5.1.2. The ordering clinician must verbally confirm that the repeated order is correct.

4.5.1.3. The individual accepting the order must include the abbreviation “RAV” (Read-Back and Verified) to indicate the order was repeated and verified during downtime procedures or in locations where CPOE is not available.

4.5.2. McLaren Macomb staff shall not accept verbal or telephone orders for chemotherapy.

4.5.3. Verbal / telephone orders must be countersigned, dated and timed by the physician responsible for those orders within 48 hours.

4.5.4. Facsimile (rubber stamp) authentication is prohibited for drug orders.