

BYLAWS OF
THE MEDICAL STAFF
OF MARQUETTE GENERAL HEALTH SYSTEM
DEFINITIONS AND INTERPRETATION

Special Definitions:

Administration means the executive and administrative organization of the Hospital and System.

Allied Health Professional or AHP means a health care professional who is duly licensed (e.g., a psychologist, physician assistant or nurse affiliate) or, in the case of a profession not subject to licensure, duly trained in accordance with policies and regulations approved by the Board; it does not include certified registered nurse anesthetists, nurses, physical therapists, social workers and professionals who are Hospital employees in fields traditionally credentialed through Hospital employment mechanisms. An **Independent AHP** means an AHP who has a license and has been given Service Authority by the System, which permits the AHP to practice without supervision of a Practitioner as more fully described in these Bylaws or the Policy Manual. A **Dependent AHP** means an AHP granted Service Authority who is not an Independent AHP.

Attending Physician means Admitting Physician or physician so designated by order in the medical record.

Board Certified means that a Practitioner, if a physician, is certified as a specialist by a specialty board organization, recognized as such by the American Council for Graduate Medical Education or the American Osteopathic Association or the equivalent Canadian accrediting organization; if an Oral Surgeon, is specialty certified as such by the Michigan Board of Dentistry and American Board of Maxillo-Facial Surgery; and if a Podiatrist, is certified by the American Board of Podiatric Surgery.

If a physician is certified by a specialty board organization of another country, the appropriate medical staff department and Credentials Committee will carefully review and determine the equivalency and adequacy of training and certification for purposes including qualification for departmental membership.

Board Eligible means a Practitioner has met the educational, post-graduate training and skill qualifications to be eligible to sit for the board certification examination of a specialty board recognized by the Council for Graduate Medical Education, the American Osteopathic Association or the American Podiatric Medical Association, but:

- (a) Has not had the opportunity to meet minimum experience following post-graduate training required by a certifying specialty board before taking the board certification examination; or

- (b) Has not taken or has unsuccessfully taken the board certification examination on one (1) or more prior occasions and remains eligible to take further examinations.
- (c) Meets other criterion as established by the MSEC or Board.

Board of Trustees or Board means the governing body of the Hospital and System.

Bylaws mean the Bylaws of the Marquette General Health System Medical Staff.

Chief Executive Officer or CEO means the executive appointed by the Board to act on its behalf in the overall management of the System. Any duty of the CEO may be performed by a person or persons designated by the CEO, directly or by means of an organizational chart which the CEO approves.

Chief Medical Officer or CMO means the physician employed by the system to serve defined administrative duties including, but not limited to, key interfaces between administration and medical staff.

Chief of Staff or COS means the Member duly appointed in accordance with these Bylaws to serve as the head of the Medical Staff.

Contract Area means a System or Medical Staff Department, a Medical Staff Division or a hospital facility or an operational unit in or for which all Member services are performed pursuant to one or more written contracts.

Contract Member means a Member who is in the System in whole or part subject to a written contract between the Hospital and the Member or the Hospital and/or the Member's employer.

Data Bank means the National Practitioner Data Bank operated under the auspices of the federal government.

Department, without further modification, means a clinical administrative subdivision of the Medical Staff as described in Article IX.

Dentist means a duly licensed dentist who has completed training.

Division means a recognized specialty or specific practice area within a Department.

Hospital means Marquette General Health System, as a corporate entity, or the licensed hospital facility it operates in Marquette, Michigan, depending upon the context.

Licensed Psychologist means a fully-licensed clinical or counseling psychologist who has completed his/her training.

Medical Staff means the governing organization of Members who participate in the System.

Medico-Administrative Officer means a physician or dentist, employed by or otherwise

serving the Hospital on a full or part-time Hospital-compensated basis, whose duties include responsibilities, some purely administrative in nature, some purely clinical in nature, and some both administrative and clinical in nature. Clinical responsibilities are defined as those involving professional capability as a physician or dentist such as requiring the exercise of clinical judgment with respect to patient care.

Member, capitalized and without modification, means a member of the Medical Staff.

MSEC means the Executive Committee of the Medical Staff.

Oral Surgeon means a dentist, practicing as an oral and maxillofacial surgeon, who has been issued health profession specialty certification in that field by the Michigan Board of Dentistry.

Patient Encounter means a patient admission or a consultation, a study, or services on the premises of the Hospital.

Physician means a duly licensed allopathic or osteopathic physician who has completed training.

Policy Manual means the Medical Staff Policy Manual containing the specifics governing the activities of Members and Allied Health Professionals and may include a Credentialing and Appointment Policy, a Confidentiality Policy, a Committee Protocol and Appendices to the Bylaws.

Practitioner means a person who is a physician, dentist, or podiatrist as defined herein.

Privileges, capitalized and except as otherwise modified, mean the permission granted by the Board to a Member to render specific diagnostic, therapeutic, medical, dental, surgical, counseling, or nursing specialty services.

Resident means a person who has graduated from an accredited medical (allopathic or osteopathic) or dental school and is in training as a physician or dentist.

Rules, capitalized and without further modification, mean the rules of the Medical Staff.

Service Authority means the permission granted to an Allied Health Professional to perform services in the Hospital or System.

Service Line means a multi-disciplinary and practice area marketing and operations task force designated to develop and coordinate a line of medical services within the System.

Service Line Director means the Member responsible, selected by the System, to serve as director of a particular service line.

Special Notice means written notice addressed to the office or home of a Member, given by certified mail return receipt requested, registered mail or hand delivery.

System means the Hospital and other licensed health facilities operated by the Hospital. It does not include offices or clinics operated by Members or the Hospital which are not licensed

facilities, nor does it include separately licensed hospitals which are affiliated with the Hospital.

Telemedicine: The use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services. (American Telemedicine Association). Originating Site means the site where the patient is located at the time the service is provided. Distant Site means the site where the practitioner providing the professional service is located.

Interpretational Guidelines: Terms used in the Bylaws shall be read in the singular or plural, as the context requires. When one gender is used in these Bylaws, the term shall represent the masculine, feminine, or neuter gender. The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provisions of the Bylaws.

Amendments: *Definition of Board Certified on Page 1 was amended by the Board of Trustees 11/19/07.*

ARTICLE I

NAME

The name of this organization shall be the Medical Staff of Marquette General Health System.

ARTICLE II

PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The Medical Staff of Marquette General Health System is organized for the purposes of: promoting education of Members and others on the System staff; monitoring and improving the quality and efficiency of patient care by Members in the System; providing a mechanism by which Members may meaningfully participate in policy-making and planning within the System; conducting reviews and making recommendations to the Board of Trustees on appointment and reappointment to the Medical Staff and granting of Privileges within the System; and initiating discipline with regard to Members. In carrying out these purposes, the Medical Staff shall act under the overall responsibility of the Board.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff are:

- 2.2-1 To account to the Board for the appropriateness and quality of patient care rendered by all Members through programs for credentialing, continuing education, utilization review, and monitoring of patient care practices.
- 2.2-2 To make recommendations to the Board on appointments, reappointments, staff category, departmental and division assignments, privileges and, when warranted, corrective action pursuant to the Bylaws and Rules.
- 2.2-3 To develop, administer and seek compliance with the Bylaws and Rules and, when warranted, initiate and pursue corrective action.
- 2.2-4 To assist in identifying the health needs of the community served by the System and assist the Board in establishment of appropriate System goals which meet those community needs through the most qualified Members reasonably available to the System and maximize the efficiency of healthcare delivery by the System; and
- 2.2-5 To help meet requirements of such accrediting and licensing bodies whose approval, licensure or accreditation is essential to System and Hospital operations.

ARTICLE III

MEDICAL STAFF MEMBERSHIP AND PRIVILEGES

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege which shall be extended only to Practitioners/AHPs who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Appointment to and membership on the Staff shall confer on the Member only such Privileges and prerogatives as are specifically granted by the Board in accordance with these Bylaws.

3.2 BASIC REQUIREMENTS AND RESPONSIBILITIES FOR THOSE SEEKING OR HOLDING MEDICAL STAFF MEMBERSHIP

To be a Member and hold Privileges, a Practitioner/AHP must personally establish and thereafter, if appointed, must continuously fulfill the following basic requirements and responsibilities:

3.2-1 Education and Licensure. Graduation from a professional school or program generally recognized for its quality of education and licensure in good standing to practice said profession by the State of Michigan.

3.2-2 Background, Experience and Competency. Background, experience, training and competency which is sufficient to demonstrate to the satisfaction of the Board that the Practitioner/AHP can capably and safely exercise Privileges requested or held within the System. A Physician or Podiatrist who seeks to be or is a Member shall be Board Certified or Board Eligible. A Physician or Podiatrist, if not Board Certified or Board Eligible on the date of the adoption of this amendment, is exempt from this provision as long as he/she continues to be a Member in good standing. An Oral Surgeon must be specialty licensed as such. However, no Practitioner/AHP shall be entitled to become a Member or to exercise any particular Privileges in the System merely by virtue of the fact that the Practitioner/AHP is licensed to practice said profession in this or any other state, or because the Practitioner/AHP is a member of any professional organization, or because the Practitioner/AHP is certified by any specialty board or because the Practitioner/AHP had, or presently has, membership or clinical privileges at another health care facility or in another practice setting.

3.2-3 Ethics. Adherence to the ethics of the Practitioner/AHP's profession and good reputation regardless of profession.

3.2-4 Work Cooperatively With Others. Demonstrated interest and ability to work cooperatively with other Members, support staff, administration and the Board.

- 3.2-5 Physical and Mental Capacity to Practice. Freedom from physical or mental illness or chemical dependencies which would interfere with the Practitioner/AHP's ability to safely exercise Privileges. In this respect, the Board may pre-condition the exercise of Privileges upon the Practitioner/AHP undergoing a physical and/or mental health examination conducted by one or more health care professionals selected in accordance with these Bylaws and established System policies.
- 3.2-6 Recognized Quality of Care. Provision of professional care at the recognized professional level of quality and efficiency and within the scope of the Practitioner/AHP's Privileges.
- 3.2-7 Compliance With Bylaws, Rules and Policies. Compliance with the Bylaws, Rules and Medical Staff policies, as well as all announced rules and policies of the System, as applicable to Practitioners/AHPs.
- 3.2-8 Discharge of Medical Staff Responsibilities. Discharge of such Medical Staff and System functions for which the Member is responsible by appointment, election, or otherwise, including meaningful service upon Medical Staff, System, Hospital and interdisciplinary committees when so appointed to serve.
- 3.2-9 Timely Completion of Records. Preparation and completion in a timely manner of the medical and other required records for all patients for whom the Member provides care, consistent with these Bylaws, Rules and System policy.
- 3.2-10 Compliance with Law. Demonstrated compliance at all times with applicable local, Michigan and federal laws reflecting upon practice as a health care provider.
- 3.2-11 Minimum Activity. Meet requirements for minimum activity within the System (patient care and/or meeting attendance) established by the Board and MSEC after considering Department input, to meet expectations for the Practitioner/AHP's category, to assure awareness of current System procedures and, if holding Privileges, an opportunity to observe the Practitioner/AHP's professional conduct and practice for quality assurance and risk management purposes.
- 3.2-12 Risk Management. Meaningfully participate in System's programs for risk management and promotion of patient and staff safety and support activities designed to address issues identified by these programs.
- 3.2-13 Continuity of Care Responsibilities. Unless exempted by specific action of the Board in the interests of the System and/or its patients, meet proximity of practice and/or residency requirements established pursuant to these Bylaws by the MSEC and Board for continuity of care purposes.

- 3.2-14 Use of System Names. Shall not use the System's name or other service marks of the System, Hospital or Medical Staff in any commercial message, advertisement, or other writing for the purpose of promoting the services of the Member, or any entities of which the Member is owner, partner, shareholder or employee, without the advance written authorization of the CEO.
- 3.2-15 Evidence of Financial Responsibility. Shall provide evidence of professional liability insurance of a kind, type and limits prescribed by the Board if the Member holds Privileges. This requirement does not apply for Adjunct and Honorary staff who do not hold Privileges or hereinafter provided.
- 3.2-16 Preserve Confidentiality. Preserve and affirmatively protect the confidentiality of the patient, System and Medical Staff information except as otherwise requested by law or as authorized by the System.
- 3.2-17 Reporting of Resignations and Adverse Action Procedures. Report to the CEO relevant facts and documents: the institution of disciplinary proceedings by any health facility (including HMOs), professional society or licensing authority; limitations, suspension, revocation or resignation of clinical privileges at any health facility; suspension, restriction, probation or limitation of professional licensure by any licensing authority; or censure of any kind by any professional organization.
- 3.2-18 Continuing Education. Participate in continuing education programs and activities which relate, in part, to the Member's delineated Privileges.
- 3.2-19 On-Call and Consultation Requirements. Practitioners will participate in providing inpatient consultations, Emergency Department consultations and inpatient attending coverage for those patients who are not under the ongoing care of a Practitioner.
- 3.2-20 Participation in Medical Education. Participate in the education process for postgraduate trainees, medical students and Hospital staff who are involved in the care of the Member's patients.

3.3 SYSTEM-FOCUSED CONSIDERATIONS FOR APPOINTMENTS

In addition to the professional qualifications and competence of a Practitioner/AHP, appointments and granting of Privileges shall take into account the present and future needs of the System and the community it serves including the following:

- (a) Maintaining a continuity of service by the Medical Staff;
- (b) Adapting to changes in medical science, including the provision of new skills for the constant and rapid evolution of medical science and technology;
- (c) Supplying the medical skills and experience necessary for the continued ability of the System or Medical Staff to carry out the programs and projects of the

System;

- (d) Delivering quality of care in a cost-effective manner, taking into account the limited resources of Marquette General Health System, the Corporation;
- (e) Having adequate facilities and supportive services in the System for the Practitioner/AHP and the Practitioner/AHP's patients;
- (f) Needing the professional skills of the Practitioner/AHP in the System's delivery of care to its patients;
- (g) Having existing, available and sufficient services in the System which are redundant to the services offered by the Practitioner/AHP; and
- (h) Meeting System contractual obligations and organizational plans.

Denial solely for these reasons is not and will not be considered an expression as to the competence or professional conduct of the applicant.

3.4 SPECIAL RESPONSIBILITY REGARDING THE APPLICATION AND REAPPOINTMENT PROCESS - MATERIAL INACCURACIES OR OMISSIONS

Each Practitioner/AHP seeking or holding Medical Staff membership shall be required to produce adequate information in the application and reappointment processes for proper evaluation of the Practitioner's/AHP's experience, background, training, demonstrated ability, and physical and mental health status, as well as resolving any doubts about these or any other qualifications. This responsibility includes obtaining meaningful and timely responses to System reference requests from persons the System deems appropriate. The Practitioner/AHP shall further have the responsibility of completing any application or reappointment form in a full, complete and intellectually honest manner and to update any information which changes while the application is pending; in this respect, if the Practitioner/AHP has any doubt as to whether disclosure of any information is required during the application or reappointment process, the Practitioner/AHP shall disclose the information with an explanation of their uncertainty as to whether the information is required or not.

3.5 DURATION OF APPOINTMENT AND PRIVILEGES

3.5-1 Duration of Initial and Renewal Appointments or Reappointments. All initial appointments and reappointments for a Provisional Member shall be for not more than a period of one (1) year. After successful completion of service as a Provisional Member, reappointments, except those reappointments which continue to be specifically designated for annual review by the MSEC and Board of Trustees, shall be for a period of not more than one (1) year plus such additional time (less than a year) necessary to put the Provisional Member on the same reappointment cycle as others in their Department or Division. All other reappointments shall be for a period of not more than two (2) years and expiring at times designated by the MSEC or as set forth in the Policy Manual.

3.5-2 Extensions. The Board may extend an appointment term when it is in the best interest of the System.

3.6 LEAVE OF ABSENCE

A Member may seek a leave of absence by submitting a written notice to the MSEC and CEO which states the reason and the anticipated duration of the leave. The MSEC will recommend action to the Board, and the Board will take final action on the Member's request. A similar process shall govern the return of a Member from a leave of absence. The Policy Manual shall provide specifics of the procedure.

3.7 CONTRACT MEMBER

Regardless of category, a Contract Member must be fully credentialed as a Member. The Medical Staff membership and Privileges of any Contract Member , other than locum tenens, shall not be contingent on a continued contractual relationship between the Hospital and the Contract Member or the party employing the Contract Member, unless otherwise specified in a written contract.

ARTICLE IV

CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The Medical Staff is divided into the following categories: Provisional, Active, Senior Active, Courtesy, Consulting, Visiting, Adjunct, Honorary and Allied Health Professional.

4.2 GENERAL QUALIFICATIONS AND RESPONSIBILITIES OF MEMBERS

Each Member in the following categories (i.e., Provisional, Active, Senior Active, Courtesy, Consulting, Visiting and Allied Health Professional) must meet and fulfill the following requirements and responsibilities in addition to those set forth in 3.2:

4.2-1 Patient Care and Consultation. Participate in outpatient and inpatient care within System; retain responsibility within their area of competence for the daily care and supervision of each admitted patient the Member attends; timely follow through on requested consultations; arrange for suitable alternates when necessary; and when medically indicated, arrange for consultations by appropriate specialists.

4.2-2 Quality Improvement and Audits. Actively participate in patient care, audits and quality improvement activities of the System.

4.2-3 Attendance. Satisfy requirements set forth for attendance at meetings and educational conferences of the Medical Staff and those Departments, Divisions and committees of which apply to the Member.

4.2-4 Special Capability and Proficiency. Meet special capability and proficiency requirements if specified in the Department Rules and Policy Manual.

4.2-5 Patient Activity. Conform to minimum and maximum activity requirements (e.g., patient encounters) for the Member's category set forth in the Rules & Regulations.

4.3 PROVISIONAL CATEGORY

4.3-1 Threshold Qualification. Initial appointment Members in the following categories: Active, Courtesy, Consulting, Visiting and Allied Health Professional, must meet special capability and qualification requirements as outlined in Article III and as defined in respective categories.

4.3-2 Prerogatives. Provisional Members have the following prerogatives:

- (a) to admit patients to the Hospital, unless otherwise expressly provided, and to exercise Privileges;

- (b) to attend meetings of the Member's Department and Division and any Medical Staff or System education programs and vote in their respective Department and/or Division if rules so provide;
- (c) to attend and orally participate at Medical Staff meetings, but not vote at general and special Medical Staff meetings nor hold office in the general Medical Staff organization; and
- (d) to serve and vote on System and Medical Staff Committees but not serve as a committee chair.

4.3-3 Insufficient Activity. A Provisional Member must have sufficient activity in the System to permit adequate review and assessment of the Member's capabilities. As may be more fully explained in the Policy Manual, if a Provisional Member, after 12 months of appointment, has had insufficient activity in the System to meaningfully assess their professional capabilities, the MSEC may, after at least 90 days advance warning to the Member and an opportunity for the Member to correct the situation, and after obtaining recommendation of the relevant Department Chair, advise the Member that the MSEC has found that Member has effectively resigned and will recommend to the Board that it treat his/her lack of activity as a resignation. A Member may reapply as an initial applicant only when that Member can demonstrate to the satisfaction of the MSEC that they will meet minimum activity levels in the System necessary to assess the Member's professional capabilities if again appointed. Such action will not be considered disciplinary or an expression on the competence or professional conduct of the Member.

4.3-4 Extension and Termination of Provisional Appointment. If a Provisional Member fails, as determined by the MSEC or Board, to qualify for advancement within 2 (two) years (e.g., for lack of activity or professional capability), then the Member's Staff membership and Privileges shall automatically terminate unless otherwise acted upon by the Board in its discretion. The Provisional Member so affected shall be given written notice of such termination. Reapplication for membership and/or Privileges is subject to any restrictions specified in the Policy Manual.

4.4 ACTIVE CATEGORY

4.4-1 Threshold Qualification. Successful completion of service as a Provisional Member as specified in 4.3.

4.4-2 Prerogatives. Active Members have the following prerogatives:

- (a) to admit patients to the Hospital and exercise Privileges within the System, subject to the limitations which may be listed in the Department rules.
- (b) to vote on all matters presented at general and special meetings of the Medical Staff, at the Practitioner's Department meetings and Hospital

committees of which the Practitioner is a member; and

- (c) to hold office in the Medical Staff organization and in the Department, Division and committees of which the Practitioner is a member.

4.5 SENIOR ACTIVE CATEGORY

4.5-1 Threshold Qualification. To have been an Active Member for no less than 25 years, or attained age 65 and been an Active Member for 5 (five) years; and must have personally requested transfer to Senior Active status.

4.5-2 Prerogatives: Senior Active Members have the same prerogatives as Active Members.

4.5-3 Requirements and Responsibilities. In addition to the requirements and responsibilities specified in 3.2 and 4.2, Senior Active Members shall discharge the same responsibilities as described in 4.4-2 for Active Members. However, Senior Active Members are not required to accept Medical Staff, Department or Division committee appointments.

4.6 COURTESY CATEGORY

4.6-1 Threshold Qualification. Successful completion of service as a Provisional Member as specified in 4.3.

4.6-2 Prerogatives. Courtesy Members shall have the following prerogatives:

- (a) to admit patients to the Hospital and exercise Privileges within the System, subject to the limitations which may be listed in the Department rules.
- (b) to attend meetings of the Medical Staff but not vote at general and special Medical Staff meetings nor hold office in the Medical Staff organization;
- (c) to attend but not vote or serve as chair or vice-chair of their Department and Division.
- (d) to attend, serve as member or chair and vote on a committee of the Medical Staff, Hospital or the System.

4.6-3 Requirements and Responsibilities: In addition to the basic requirements and responsibilities of 3.2, each Courtesy Member shall:

- (a) retain responsibility within the Member's area of professional competence and the consultation request for the daily care and supervision of each patient in the Hospital for whom the Practitioner is providing services; and
- (b) stay within limits of patient encounters as established in the Policy Manual.

4.7 CONSULTING CATEGORY

4.7-1 Threshold Qualifications. Successful completion of service as a Provisional Member as specified in 4.3.

4.7-2 Prerogatives. A Consulting Member has the following prerogatives:

- (a) to consult on patients at the request of Active, Senior Active, Courtesy or Provisional (Active or Courtesy) Members;
- (b) to exercise such Privileges as are granted to the Member;
- (c) to be allowed, at the direction of the attending physician, to cover those patients who are jointly cared for;
- (d) to attend but neither vote at general or special Medical Staff meetings nor hold office in the general Medical Staff organization or the Departments; and
- (e) to serve on Medical Staff, Hospital or System committees, but not vote or chair those committees.

4.7-3 Requirements and Responsibilities. In addition to the basic requirements and responsibilities of 3.2, each Consulting Member shall:

- (a) retain responsibility within the Member's area of professional competence and the consultation request for the daily care and supervision of each patient in the Hospital for whom the Practitioner is providing services; and
- (b) stay within limits of patient encounters as established in the Rules & Regulations.

4.8 ADJUNCT CATEGORY

4.8-1 Qualifications. The Adjunct category shall consist of Practitioners/AHPs who, due to their membership on the Medical Staff of other hospitals, affiliation with universities, distance from the Hospital or other reasons acceptable to the MSEC and Board, are unable to satisfy the activity requirements for the Provisional category at the Hospital, but otherwise meet the basic requirements and responsibilities set forth in 3.2. An Adjunct Category Member must be subject to quality assurance review in another environment comparable to the review performed with respect to Active Category Members in the System. Each Adjunct Member must meet the basic requirements and responsibilities in 3.2, to the extent applicable to a person who does not practice the Practitioner's/AHP's profession within the System.

4.8-2 Prerogatives. Adjunct Members have the following prerogatives:

- (a) to visit the Member's patients referred to and admitted on, the service of Active, Senior Active, Provisional (Active or Courtesy) or Courtesy categories;
- (b) to have access to the records of these patients and to obtain copies of such records;
- (c) to attend educational programs at the Hospital and receive continuing medical education credit; and
- (d) attend and orally participate, but not vote or hold office on the Medical Staff Departments, Divisions or committees.

4.8-3 Requirements, Responsibilities and Limitations: Adjunct Members shall not be entitled to: have or exercise Privileges, write orders, make progress notes or render direct patient care.

4.9 VISITING CATEGORY

4.9-1 Threshold Qualifications. A Member:

- (a) who resides outside a 50 mile radius of the Hospital who provides a service to the System which is not normally provided by a Member living within a 50 mile radius; or who lives outside a 50 mile radius where local hospitals do not provide a specific service which is available in the System and whose patients cannot conveniently obtain that service outside the 50 mile radius; and
- (b) who has medical staff membership at another hospital where the Member regularly participates in quality improvement activities comparable to those of this Hospital.

4.9-2 Prerogatives. Visiting Members have the following prerogatives:

- (a) to co-admit patients with an Active, Senior Active, Courtesy, or Provisional (Active or Courtesy) Category Member (who has completed monitoring) and exercise Privileges granted;
- (b) to attend but not vote at general Medical Staff and Department meetings; and
- (c) to attend and vote at meetings of the Member's Division or committee;
- (d) attend any Staff or Hospital education programs.

4.9-3 Responsibilities. In addition to the responsibilities specified in 3.2, each Visiting Member shall provide, through the co-admitting Member, for the daily care and supervision of each inpatient for whom the Member is providing services; be available at the Hospital through the recovery period or have pre-arranged coverage with a Member with Privileges within the same specialty for outpatient services; and have an arrangement to respond to a post-services emergency with a covering System Practitioner in the same specialty.

4.10 HONORARY CATEGORY

4.10-1 Qualifications. The Honorary category shall consist of health and other professionals recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences or their previous longstanding service to the Hospital. Honorary Members are not eligible to admit patients to, or exercise Privileges in the Hospital. Each Honorary Member must meet the basic requirements and responsibilities in 3.2, to the extent applicable to a person who does not practice their profession within the System.

4.10-2 Prerogatives. Honorary Members have the prerogative to attend general Medical Staff, Department and Division meetings, and any Staff or Hospital educational meetings. Honorary Members are not eligible to vote or to hold office in the Medical Staff organization.

4.11 TELEMEDICINE – ACTIVE

4.11-1 Threshold Qualification. Successful completion of service as Provisional Member as specified in 4.3 with exceptions regarding prerogative as defined below in 4.11-2. This category include Teleradiology.

4.11-2 Prerogatives.

- (a) May attend Medical Staff Meetings but not vote at general and special Medical Staff meetings nor hold office in the Medical Staff organization.
- (b) May not vote or serve as chair or vice-chair of their Department.
- (c) May serve on Medical Staff, Hospital or System committees, but not vote or chair those committees.
- (d) Will not have admitting privileges to the hospital.

4.11-3 Requirements and Responsibilities

- (a) Shall meet qualifications for membership as set forth in the MGHS Credentials Manual section entitled "Medical Staff Telemedicine Policy Language".
- (b) Shall provide a high level of care consistent with the standards of care for

other hospital services.

- (c) Must maintain competency within the specialty for which privileges were granted.
- (d) Must be licensed in the State of Michigan.
- (e) Specifically, Teleradiologists:
 - (1) must maintain competence with the specialty of Diagnostic Radiology and/or Nuclear Medicine (Molecular Imaging)
 - (2) must conform to the guidelines for Core Privileging for Diagnostic Radiology
 - (3) may perform final interpretations of imaging and diagnostic studies as appropriately privileged, to include MRI, CT, X-Ray, Ultrasound, Mammography, and Nuclear Medicine examinations

ARTICLE V

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT TO STAFF, GRANT AND RENEWAL OF PRIVILEGES

5.1 GENERAL PROCEDURE

The Medical Staff through the action of its Departments, Divisions, committees and officers will investigate, review and make recommendations to the Board concerning all requests for appointment, reappointment and Privileges. Essential elements of the investigation and review process shall be set forth in the Policy Manual.

5.2 REQUIREMENTS FOR APPOINTMENT AND REAPPOINTMENT

For purposes of this section, the term "System representative" includes the Board, its Directors and committees, the CEO and all Medical Staff members, Departments, Divisions and committees which have responsibility for collecting or evaluating and acting upon the applicant's credentials and application, and any authorized representative of any of the foregoing.

5.2-1 Authorizations. By applying for appointment or reappointment to the Medical Staff or requesting Privileges, the Practitioner/AHP:

- (a) Signifies willingness to appear for interviews in regard to their application.
- (b) Authorizes System representatives to consult with former associates or others who may have information bearing on the applicant's previous performance.
- (c) Consents to the inspection by System representatives of all quality improvement materials, including medical records of patients cared for or treated by the applicant, that may be material to an evaluation of applicants professional qualifications and ability to carry out the Privileges they request, as well as the applicant's professional and ethical qualifications for Staff membership.
- (d) Releases from any liability all System representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and the applicant's credentials.
- (e) Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to System representatives in good faith and without malice concerning the applicant's ability, professional ethics, character, physical and mental health, emotional stability and other qualifications for Medical Staff appointment and/or Privileges.

- (f) Acknowledges and accepts that all information acquired through the Health Care Quality Improvement Act of 1986 will be collected, verified and reviewed.

5.2-2 Special Definitions for Review of Appointment and Reappointment

- (a) "Favorable," as used in an MSEC recommendation or Board action on a Medical Staff application is "favorable" if the recommendation or action supports appointment, and the same Privileges which are ordinarily possessed by Members of like training, experience, System activity, and Medical Staff category.
- (b) "Unfavorable," as used in these Bylaws means an MSEC recommendation or Board action which is not "favorable."

5.2-3 Responsibility of Applicant to Appear or Answer Questions. Because the applicant shall have the responsibility of producing adequate information for a proper evaluation of the basic requirements for Medical Staff Membership, at any time in the appointment or reappointment review process, the applicant may be required by the Credentials Committee, MSEC or the Board to:

- (a) appear before such body to answer questions posed by that body, or;
- (b) prepare and submit a signed statement answering questions posed by the body then considering the applicant's qualifications.

5.3 INITIAL APPLICATION

5.3-1 Application Form. An application for Medical Staff appointment, staff category and privileges shall be in writing and signed by the applicant. The contents of the application and privilege forms will be set forth in the Policy Manual.

5.3-2 Significant Inaccuracies in the Application Process. Any significant omission or inaccuracy of information attributable to the applicant, during the application process shall result in the immediate rejection of the application without further consideration and shall prevent reapplication until the MSEC or Board decides a new application will be accepted.

5.4 PROCESSING THE APPLICATION

The initial application process shall have certain elements, as described in the Policy Manual:

5.4-1 Preliminary Review. The CEO and Member designated by CEO shall conduct a preliminary review of the application, which involves a determination as to whether the information in the application is consistent with threshold qualifications (e.g., licensure, minimum training) to be a Member or hold the Privileges sought in the application and in the judgment of CEO consistent with Practitioner/AHP manpower plans for the System and other 3.3 criteria.

5.5 REQUESTS FOR MODIFICATION OF APPOINTMENT OR PRIVILEGES

- (a) A Practitioner or AHP may, at the time of reappointment or renewal of Privileges, submit a written request on the prescribed form for modification of Staff category or additional or modified Privileges due to the introduction of new technology, techniques or procedures. The request shall be processed as provided in the Policy Manual.
- (b) A Practitioner or AHP requesting additional or modified Privileges due to introduction of new technology, techniques or procedures is required to present a new privilege request and training plan in writing to the Chief Executive Officer on a prescribed application form, and including:
 - 1. Specific description of privilege,
 - 2. A plan for obtaining training and competencies (or documentation of training if already done),
 - 3. Relevant articles and national training/competency standards, and
 - 4. Quality indicators proposed for monitoring proficiency and outcomes.
- (c) Initial review of applications for additional or modified Privileges shall be conducted through the same process as applications for initial Privileges as set forth in Section 6.2. If the applicant is eligible for the Expedited Process in Section 6.6-1, the request will be considered through that process as specified in the Policy Manual.

5.5-1 Requests for Deletion of Clinical Privileges.

A Practitioner or AHP requesting deletion of a clinical privilege(s) during the term of an appointment to the Medical Staff, shall notify in writing the Chief Executive Officer. The Chief Executive Officer shall forward the request to the Department Chair. Thereafter, it will be considered through the same approval process (Credentials Committee, Medical Staff Executive Committee, and Board of Trustees) as an application for initial Privileges as set forth in Section 6.2.

5.6 CONDITIONAL GRANTS OF PRIVILEGES

If the Board decides to appoint or reappoint a Member but grants Privileges conditionally, on account of a concern whether a Member can safely exercise Privileges with or without accommodation, the Member will be notified of the condition and how it will apply to the Member's Privileges in the letter granting appointment or reappointment. The Member shall not exercise Privileges which are subject to that condition until such time as the condition has been removed or fulfilled, as confirmed in writing by the CEO. A Member whose Privileges are subject to such a condition may either request removal of the condition or offer a plan for fulfillment of the condition. Such a condition is not automatically deemed to be unfavorable.

The Member may request a hearing pursuant to the Hearing & Appellate Review Policy, which shall thereafter be processed as if a timely request had been made following notice of an unfavorable appointment recommendation or action. For purposes of applying the Hearing & Appellate Review Policy: if the MSEC recommended the

condition, then the hearing will be deemed to be from an MSEC recommendation or action; if the Board imposed the condition without prior recommendation of the MSEC, the hearing will be considered to be from an unfavorable Board action.

Amendments: Section 5.5 was amended and 5.5-1 was added by Board of Trustees action on March 27, 2006.

ARTICLE VI

DETERMINATION OF PRIVILEGES

6.1 EXERCISE OF PRIVILEGES

Every Member holding Privileges shall be entitled to exercise only those Privileges specifically granted by the Board. The decision to confer Medical Staff membership status and the decision to grant Privileges are separate and distinct. Acceptance of an applicant's request for Staff membership does not automatically confer Privileges.

6.2 DELINEATION OF PRIVILEGES IN GENERAL

6.2-1 Requests for Privileges. Each Practitioner/AHP seeking Privileges shall include a request for such Privileges as may be desired to exercise at System facilities with documentation of training and/or experience supportive of the request in a form prescribed by the Medical Staff or its Departments. The initial request for Privileges or any request for increased or modified Privileges shall be considered through the same process as an initial application for Medical Staff appointment.

6.2-2 Basis for Privileges Determinations. Requests for Privileges shall be evaluated on the basis of System-focused considerations (3.3), the Practitioner's/AHP's education, training, experience, demonstrated ability and judgment, including observed clinical performance, documented results of any patient care evaluations and quality assessment/improvement activities in the System. Determinations of Privileges may be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where the Practitioner/AHP exercises Privileges. When Privileges are sought to perform services involving new or advanced technology not previously approved and used in the System, in addition to showing the Practitioner's/AHP's individual skill, knowledge and experience practicing with the technology, the Member seeking Privileges shall have the obligation to demonstrate that using the technology will be beneficial to Hospital patients, reasonably safe, adequately supported by existing System staff, and an improvement over existing technologies. All information shall be added to and maintained in the Medical Staff confidential file established with respect to a Practitioner/AHP.

6.2-3 Procedure. All requests for Privileges shall be processed pursuant to the procedures outlined in Article V and the Policy Manual, unless otherwise provided in the Bylaws.

6.3 DEPARTMENTAL ASSIGNMENT OF PRIVILEGES

6.3-1 Privileges Outside of Assigned Department. A Member or applicant may request Privileges in a Department other than the Department to which the Practitioner/AHP has been appointed or is applying. Requests must specify the Departments in which additional Privileges are desired, and must be in

accordance with the rules of Department.

- 6.3-2 Required Documentation. Requests for Privileges shall be accompanied by documentation of training and/or experience necessary to perform such requested Privileges regardless of Departmental assignment.
- 6.3-3 Uniformity of Criteria. Where a procedure or class of procedures is performed by members in more than one Department, the Credentials Committee will be responsible for ensuring substantially uniform qualification criteria are applied. The Credentials Committee may itself or assign to a subcommittee, the responsibility of performing an investigation in order to establish the appropriate criteria and minimum qualifications. Where appropriate, one Department or Division may be assigned the responsibility of making recommendations and engaging in the monitoring of Practitioners/AHP concerning the delineation of such Privileges.

6.4 SPECIAL CONDITIONS FOR NON-PHYSICIAN PRIVILEGES

Requests for Privileges from dentists or podiatrists shall be processed in a manner specified in 6.2. Surgical procedures performed by all dentists or podiatrists shall be under the overall supervision of the Department of Surgery. In addition:

- (a) Medical Assessment. A medical assessment shall be done and recorded by a physician before dental surgery is performed, and shall include a history and physical examination. A qualified podiatrist may specifically apply for privileges to perform and document a history and physical.
- (b) Co-admission with Physician. Patients admitted by a podiatrist without necessary privileges or dentist shall be co-admitted by a physician.
- (c) Physician Responsibility. A physician co-admitting with a dentist or podiatrist shall be responsible for pre-operative and post-operative medical evaluation and management of the admitted patient, which are not within the scope of co-admitting dentist's or podiatrist's license and Privileges. The Rules, as well as Department rules, may further specify the respective responsibilities of co-admitting dentists and podiatrists.

6.5 TEMPORARY PRIVILEGES

Temporary Privileges are an extraordinary measure utilized to provide skills of a Practitioner or AHP needed by or at the Hospital on an expedited basis. They shall not be granted solely for the convenience of a Member.

6.5-1 Circumstances. Upon concurrence of the Chair of the Department in which the Privileges will be exercised, the COS and CEO, acting on behalf of the Board, temporary Privileges may be granted in, but not limited to, the following circumstances:

- (a) Locum Tenens: When the service of a Practitioner or AHP in the joint judgment of the CEO and COS is necessary to continue appropriate

operation of the Hospital or a Service Line, a Practitioner/AHP qualified to provide such services may be granted Temporary Privileges for a period not to exceed 90 days. The Practitioner/AHP shall be subject to all requirements as to contract limitations and obligations, residence and availability during the period of Temporary Privileges as were required of others the Practitioner or AHP is temporarily replacing or of whom is working as peer. Each Department where locum tenens practice is authorized may establish its own additional requirements in the Department rules. The credentialing process will be set forth in the Policy Manual.

- (b) Emergency: For the purposes of this Section, an "emergency" is defined as a condition in which serious or permanent harm could result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger or harm. In the case of emergency, any Practitioner/AHP, to the degree permitted by their license and regardless of Department, Staff status or Privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm. When an emergency situation no longer exists, such Practitioner/AHP will turn the patient's care over to an appropriately Privileged Member. The credentialing process will be set forth in the Policy Manual.

6.5-2 Supervision and Termination. Practitioners or AHPs who are performing services in the Hospital pursuant to temporary Privileges granted in accord with this section shall be under the supervision of the assigned sponsor. The COS, the CEO or Department Chair, or the MSEC shall be entitled to suspend or revoke such temporary Privileges when the performance and/or conduct of the Practitioner or AHP holding such temporary Privileges so indicates, and such suspension or revocation of Privileges shall not be subject to the formal hearing procedures.

In the event of any such termination, the assigned sponsor responsible for supervising that Practitioner or AHP shall assign any of his/her patients in the Hospital to another Member. The wishes of the patient shall be considered when choosing a substitute Member.

6.6 EXPEDITED PROCESS

An expedited process may be used for initial appointments to membership and granting of clinical Privileges, reappointment to membership, or renewal or modification of clinical Privileges when specific criteria are met. Applications are processed through the Department Chair, Vice Chief of Staff (acting on behalf of the Credentials Committee), and Chief of Staff (acting on behalf of the Medical Staff Executive Committee) or their respective designees, and the Chief Executive Officer (acting on behalf of the Board of Trustees).

6.6-1 Eligibility of Applicants.

- (a) An applicant is eligible for the expedited process if he/she is eligible for

appointment or reappointment and in accordance with Article III, Section 3.2, 3.3, and 3.4, if system-focused need has been established by the Chief Executive Officer and Chief of Staff, and if the appropriate Department Chair recommends the applicant for appointment or reappointment, or modification of clinical Privileges.

- (b) An applicant is ineligible for the expedited process if any of the following has occurred:
 - 1. The applicant submits an incomplete application.
 - 2. The Chief of Staff makes a final recommendation that is adverse or has limitations.

- (c) The following situations shall be evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:
 - 1. There is a current challenge or a previously successful challenge to licensure or registration;
 - 2. The applicant has received an involuntary termination of medical staff membership at another organization;
 - 3. The applicant has received involuntary limitation, reduction, denial, or loss of clinical Privileges; or
 - 4. There have been no less than favorable reports from medical staff leaders concerning quality of care or professional behavior concerns reflected in verifications of credentials and competencies; or
 - 5. There has been a final judgement adverse to the applicant in a professional liability action.

6.6-2 Expedited Appointment Process.

Initial review of applications and verifications shall be done as specified in the Policy Manual for all applicants to the Medical Staff. Thereafter, the approval process shall be conducted in accordance with the Expedited Process set forth in the Policy Manual.

6.7 DISASTER PRIVILEGES

Disaster privileges may be granted to volunteers eligible to be licensed independent practitioners.

6.7-1 Circumstances. When the MGHS Emergency Operation Plan has been activated and the immediate needs of patients are best met with the assistance of additional trained personnel, a disaster credentialing and privileging process may be implemented as specified in the Policy Manual.

Amendments: Sections 6.6, 6.6-1 and 6.6-2 were added by Board of Trustees action on March 27, 2006.

ARTICLE VII

CORRECTIVE ACTION

7.1 ROUTINE CORRECTIVE ACTION

7.1-1 Criteria for Initiation. Any officer of the Medical Staff, Department Chair, the CEO, or designee, may initiate requests for corrective action for, but not limited to, the following grounds:

- (a) The activities or professional conduct of any Practitioner/AHP with Privileges are reasonably probable of being:
 - (i) detrimental to patient safety;
 - (ii) detrimental to effective delivery of patient care;
 - (iii) disruptive to Hospital or System operations;
- (b) unethical practice;
- (c) institution of formal charges for, or conviction of, a felony or any other crime involving or affecting professional practice;
- (d) incompetency (to include mental, judgmental and physical);
- (e) violation of these Bylaws or the Rules (including, but not limited to, falsification of application or credential documents, and failure to report a change in the professional liability insurance record within 7 (seven) days of said change);
- (f) failure to discharge basic responsibilities of Medical Staff membership as provided in 3.3; or
- (g) unauthorized disclosure of confidential System, Hospital or Medical Staff information.

7.1-2 Requests and Notices. All requests for corrective action shall be in writing, submitted to the MSEC and supported by reference to the specific activities or conduct which constitute grounds for the request. The COS or designee shall keep the CEO fully informed of all action taken in conjunction therewith.

- 7.1-3 Investigation When Appropriate and Report. The MSEC may designate a person or an ad hoc committee to investigate, if an investigation is deemed necessary and appropriate. When so designated, the investigator (person or committee) shall promptly investigate the matter and within 45 days after the receipt of the designation, forward a written report of the investigation to the MSEC. If the corrective action request was preceded by an investigation, a report of that investigation may be used in lieu of a subsequent investigation.
- 7.1-4 Interview of Subject Member. At any point after a corrective action request is made, the MSEC, Department Chair or an investigator (person or committee) may, upon request, have the opportunity to interview the Member subject to the corrective action request.
- 7.1-5 MSEC Action. Within 45 days following receipt of the request, or if an investigation is requested, receipt of the investigation report, the MSEC shall take action upon the request. The MSEC may recommend to the Board the following actions:
- (a) rejecting the request for corrective action with or without a warning letter or admonition;
 - (b) recommending to the Board requirements of consultation, other than administrative consultations (as specified in 7.4-4) or consultation required for Provisional Staff members;
 - (c) issuing a letter of reprimand;
 - (d) imposing a probation without limitation of Privileges;
 - (e) recommending to the Board reduction, suspension or revocation of Privileges;
 - (f) recommending to the Board reduction of category or limitation of any prerogatives directly related to patient care;
 - (g) recommending suspension or revocation of Medical Staff membership; or
 - (h) recommending to the Board that other action be taken .
- 7.1-6 Exercise or Waiver of Procedural Rights. Any MSEC action taken (not including Summary and/or Administration Action) pursuant to (b) through (h) of 7.1-5 (but not 7.2 or 7.4) will ordinarily be held in abeyance for a period of 30 days for the timely and effective exercise of procedural rights applicable to the action in the Hearing & Appellate Review Policy, whichever is longer. However, during such period, other actions including those described in 7.2, 7.3 and 7.4 may still be taken, if appropriate. The MSEC may, based on the outcome of any informal or formal hearing revise its action or recommendation. Failure of the subject Member to timely request and pursue exercise of procedural rights shall

constitute acquiescence to an adverse action or recommendation as provided in the Hearing & Appellate Review Policy.

7.2 SUMMARY ACTION

7.2-1 Criteria and Initiation. Any two (2) of the following: COS, CEO or designee and/or Department Chair, acting jointly, or the MSEC or Board acting alone will have the authority to summarily suspend or place conditions upon the exercise of all or any portion of the Privileges of a Member whenever:

- (a) the Member's temporary or permanent mental or physical state or gross dereliction of duty is such that one or more patients under the Member's care would be subject to imminent danger to their health as a result of the Member's action or inaction if the Member is permitted to continue to exercise Privileges; or
- (b) there is substantial evidence that the Member has committed acts of an illegal or unethical nature which are of such gravity that, if proven, would justify revocation or permanent suspension of Medical Staff membership, Privileges, professional licensure or prescribing authority; or
- (c) there is substantial evidence of a gross dereliction of duty which relates to the assurance of a patient's well-being, or in the management of a patient, which, in the judgment of those having the authority to summarily act, indicates one or more patients under the present and/or future care of the Member involved would be subject to imminent danger to their health, if the Member is permitted to continue to exercise Privileges. (Unusually high frequencies of unexpected deaths or morbidity shall constitute sufficient ground to invoke this provision.); or
- (d) there is substantial evidence of an act, omission or pattern by the Member which has the potential of materially damaging the System's or Hospital's reputation, licensure status, or the ability to effectively function as a provider of services.

Such summary action shall become effective immediately upon imposition, and the CEO shall promptly give written notice of the suspension to the Member.

7.2-2 MSEC Action. At the next regularly scheduled MSEC meeting, but no later than 14 days following such summary action, the MSEC shall review and consider the action to be taken. The MSEC, in consultation with the CEO, may impose a modification, continuation or termination of the terms of the summary action. If an MSEC decision is other than to rescind the action in total within 14 days of imposition, the subject Member may make a request to pursue the procedures applicable in the Review Procedures Appendix.

7.2-3 Responsibilities. Medical coverage for the inpatients in the Hospital of the Member subject to emergency suspension shall be selected by the Chair of the Department to which said Member is assigned. The wishes of the respective

patient(s) shall be considered in the selection.

7.3 AUTOMATIC ACTION

If the license of a Member is revoked or suspended, the Member shall immediately and automatically be suspended from practicing in the Hospital. Such action shall not be exclusive of any other corrective action that may be imposed.

7.4 ADMINISTRATIVE ACTION

Administrative action shall be automatically imposed for any reasons enumerated in this section. Administrative action, under the provisions of this Section, may not constitute a reportable Medical Staff action in accordance with State and Federal reporting requirements, as it is considered to be a non-disciplinary and non-professional review action for purposes of those reporting requirements.

7.4-1 Prescribing Authority. A Member with Privileges whose authority to prescribe and administer is revoked or suspended shall immediately and automatically be divested of the Member's right to prescribe medications covered by such authority. After such administrative action, the MSEC at its next regularly scheduled meeting shall review and consider the facts under which the authority was revoked or suspended. The MSEC may then take corrective action as is appropriate to the facts disclosed in its review and report the action taken to the Board of Trustees.

7.4-2 Medical Records. Members who do not complete their medical records within the time frames specified in the Medical Staff Rules may be subject to Administrative Action as described in the Rules.

7.4-3 Administrative Consultations. The CEO, CMO, COS or Chair of a Department may initiate an administrative consultation requirement for a particular patient, certain particular patients or all patients of a Practitioner, when it is determined that the interests of the Hospital or the welfare of a patient or patients of a Member require such action. Such consultation requirement may include proctoring, co-management or other conditions or limitations upon the practice.

Initiation of an administrative consultation should be preceded by the concurrence of the CEO and COS or Department Chair. Where obtaining such prior concurrence is not possible due to the matter requiring that immediate action be taken, concurrence should be obtained as soon as reasonably possible thereafter.

The consultation requirement imposed may stay in effect, without institution of corrective action for 30 days, or if corrective action proceedings are in process, for the duration of those proceedings.

Imposition of an administrative consultation requirement, in accordance with this provision, shall be communicated to the affected Member immediately by written notification by the person initiating the administrative consultation. The result of

the administrative consultation shall be reported back to the COS, Department Chair and CEO. This information will be conveyed to the MSEC at its next regularly scheduled meeting for determination of an appropriate course of action, which may include corrective action.

7.4-4 Professional Liability Insurance. In the event that a Member with Privileges fails to:

- (a) maintain in force professional liability insurance in prescribed amounts; or
- (b) secure a special exemption from those requirements specified in 15.1 from the MSEC and Board; or
- (c) report any change in the status of his/her professional liability insurance to the CEO within 7 (seven) days subsequent to the change;

The Privileges of Member shall be withheld until the requirement is met. While Privileges are withheld, the Member may not see, treat, consult with respect to, or admit a patient at the Hospital. Privileges which are withheld for failure to comply with the financial responsibility requirement shall continue to be withheld until the requirement is satisfied.

7.4-5 Technical Non-Compliance with Bylaws, Rules and Regulations or Other System Policies. In the event a Member is found to have violated a provision of the Bylaws, Rules, or other System policy (written or unwritten) which does not directly or immediately involve patient well-being, the CEO, after consultation with the MSEC or the Board, is empowered to issue a letter to the Member giving notice of non-compliance and advising the Member of the importance of future compliance. A copy of such Notice of Non-Compliance and the Member's response shall be placed in the file with respect to the Member.

7.4-6 Failure to Comply with Special Attendance Requirement. A Member who fails to attend a special meeting of the Medical Staff, a Department, Division or committee without advance permission by the chair of the body involved, after having been given written notice of a special requirement to attend such meeting shall, upon written notice by the CEO, have all Privileges withheld until the matter is resolved by MSEC review.

7.4-7 Unavailability - Resignation. A Member with Privileges, unless exempted in advance by the MSEC, or on an authorized leave of absence, who has not participated in patient care or Medical Staff activities for more than 90 days or removes the Member's office address and phone number from publication in the usual manner, shall be automatically deemed to have resigned from the Medical Staff without expression upon the Member's professional conduct or competence.

7.4-8 Failure to Meet Minimum Activity Requirements - Resignation. A Member, not on an authorized leave of absence, who fails to meet minimum activity requirements established pursuant to 3.2-11 for any one year may be deemed to have resigned from the Medical Staff without reflection upon the Member's professional conduct or competence. Exceptions may be made by the CEO and MSEC to the foregoing on an individual or category-wide basis, if the Member is: (a) in the Consulting category and has an unusual sub-specialty which is otherwise unavailable at the Hospital and represents an invaluable and essential resource to the Medical Staff and/or its patients when needed; or (b) a Member of a category which does not involve Privileges.

ARTICLE VIII

REVIEW PROCEDURE

8.1 HEARINGS AND APPELLATE REVIEW

An aggrieved Member, or applicant for Membership, shall be provided an opportunity for review of a decision of the MSEC or the Board. The procedures described in the Hearing and appellate Review Policy (Section 7.4 of the Medical Staff General Rules) shall apply. If the decision concerns the conditional grant of Privileges, then the Hearing and Appellate Review Policy shall be subject to any modifications required by Article V (5.6) of these Bylaws.

ARTICLE IX

MEDICAL STAFF DEPARTMENTS AND DIVISIONS

9.1 ORGANIZATION OF MEDICAL STAFF DEPARTMENTS AND DIVISIONS

Each Department shall be organized by practice area and shall have a Chair who is selected and has the authority, duties and responsibilities as specified in 9.4. Each Department may organize itself by practice sub-area or specialty which shall be directly accountable to the Department within which it functions and shall have a Division Chief who is selected and has the authority, duties and responsibilities as specified in 9.5.

9.2 DESIGNATION

9.2-1 Current Departments. The Medical Staff shall be organized into the following Departments:

- (i) Department of Emergency Medicine;
- (ii) Department of Family Medicine;
- (iii) Department of Medicine;
- (iv) Department of Obstetrics and Gynecology;
- (v) Department of Pathology;
- (vi) Department of Pediatrics;
- (vii) Department of Psychiatry;
- (viii) Department of Radiology; and
- (ix) Department of Surgery.

Additional Departments may be created or existing Departments combined by action of the MSEC and Board when it would improve the quality and efficiency of care by Members in the Department involved. Departments with 3 (three) or less voting members shall be combined with another Department.

9.2-2 Divisions: Divisions may be created or removed within an existing Department by the MSEC, upon recommendation of the respective Department, by the adoption of Department rules setting forth the role and function of the Division and Division Chief and approved by the MSEC. The Division may be disbanded or combined with another Division, by the Department with the approval of the MSEC or by action of the MSEC alone.

9.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

Each Member must be assigned by the MSEC to one Department and may be required to be a member of a Division relating to the Member's primary area of practice. A Member who holds Privileges in but is not assigned as a member of another Department shall be required to attend those meetings which the Member is specially requested to attend or, as required by the Department, meetings involving quality review of the exercise of the kind of Privileges the Member holds in the Department.

9.4 DEPARTMENT CHAIR AND VICE-CHAIR

9.4-1 Qualifications: Each Department Chair and Vice-chair shall be a member of the Senior Active or Active category who is capable of effectively leading the Department as determined by Administration.

9.4-2 Selection and Appointment: Department Chairs and Vice-chairs of the Departments will be selected at the Department meeting held prior to the "Annual" general Medical Staff meeting subject to approval by the Board.

9.4-3 Term of Office: A Chair or Vice-chair in a Department shall serve from the beginning of the calendar year until the end of the calendar year when the successor is chosen. An officer may be removed during the term of office by the COS, with concurrence of the MSEC, or by the Board after consultation with the MSEC.

9.4-4 Vacancies in Office: In the event the Chair or Vice-chair of any Department is unable to complete the term of office, an election will be undertaken at the next meeting of the Department.

9.4-5 Responsibilities of Department Chairs: Each Department Chair, or in the Department Chair's absence, the Vice-chair, shall:

- (a) chair Department meetings;
- (b) represent Department at the MSEC and present reports regarding Department functions to the MSEC;
- (c) review applications, credentials, and Privilege request forms of Practitioners and AHP's seeking to be members of the Department, and make recommendations to the Department and Credentials Committee;
- (d) review reappointment applications and Privilege request forms of existing Department members and make recommendations to the Department and the Credentials Committee;
- (e) annually review, update, and present for approval Department rules.
- (f) perform special functions commensurate with the office as may, from time to time, be requested by the COS;

- (g) maintain current familiarity with relevant requirements of external licensing and accrediting agencies, and carry out the various duties necessary to meet those requirements;
- (h) appoint or remove Chief of each Division within the Department;
- (i) enforce System policies, Bylaws, Rules, Department rules and initiate corrective action or administrative consultation where appropriate; and
- (j) serve as a role model for other Members within the Department in areas of clinical skill and Medical Staff leadership.

9.5 CHIEF OF DIVISION

- 9.5-1 Qualifications: Each Division Chief shall be a member of the Active or Senior Active Categories, or other Staff Category as deemed appropriate by Department Chair with concurrence of the MSEC, actively practicing in the area covered as the Division relates. The Division Chief shall be qualified by training, experience, interest and demonstrated current ability in the area covered by the Division and shall be willing and able to discharge the administrative responsibilities of the office.
- 9.5-2 Selection and Appointments: A Division Chief in a Department which is a contract area shall be appointed and removed by the CEO after consultation with the appropriate Department Chair. A Division Chief in a Department which is not a contract area shall be appointed and removed by the Department Chair.
- 9.5-3 Terms of Office: Each Division Chief shall serve from the date of appointment until the end of the calendar year.
- 9.5-4 Duties: Each Division Chief will:
- (a) account to the Department Chair for the effective operation of the Division and for the Division's discharge of all tasks delegated to it by the Department;
 - (b) implement, in cooperation with the appropriate Department Chair or Chairs, and System Quality Representative designated by the CEO, programs to carry out the quality of care functions assigned to the Division;
 - (c) conduct investigations and submit reports and recommendations to the Department Chair, if requested, regarding the Privileges to be exercised within the Division by Members or applicants to the Medical Staff;
 - (d) act as, or designate, the presiding officer at all Division meetings;
 - (e) submit reports on a timely basis as required to the Department Chair on the activities of the Division;

- (f) perform such other duties commensurate with the office as may, from time to time, be reasonably requested or delegated by the Department Chair, by the MSEC or by the COS.

9.6 FUNCTIONS OF DEPARTMENTS

9.6-1 Care Review Responsibilities: Utilizing information provided by Administration, each Department is to develop, implement and conduct an ongoing process of monitoring, reviewing and evaluating in order to promote quality care by those Members who practice under the Department's jurisdiction.

9.6-2 Administrative Responsibilities: Each Department shall:

- (a) meet at least four times per year in Departments with Management Committees and approximately monthly in Departments without Management Committees for the purpose of:
 - (i) reviewing quality reports, peer review information and the results of the Department's other review and educational activities; and
 - (ii) performing and/or receiving reports on other Medical Staff functions;
- (b) establish work groups or other mechanisms necessary to properly perform the functions delegated or assigned to it;
- (c) develop guidelines for recommending Privileges within the Department;
- (d) submit to the Credentials Committee the recommendations required under Articles V and VI regarding the specific Privileges each Member in, or applicant to, the Department may exercise;
- (e) conduct, participate in, and make recommendations for continuing education programs pertinent to changes in the state-of-the art of medicine, quality improvement/risk management and to methods of review and evaluation of activities of its Members; and
- (f) coordinate the patient care provided by Members in the Department with nursing and ancillary patient care services and with administrative support services.

9.7 DEPARTMENT MANAGEMENT COMMITTEE

A Department may have a management committee. The existence, composition and duties of the committee shall be defined in Department rules consistent with these Bylaws.

9.8 FUNCTIONS OF DIVISIONS

Each Division shall, upon the approval of the MSEC and the Department, perform the Department functions delegated to it by the Department Chair which may include credentials review and Privileges delineation. The Division shall transmit regular reports to the Department Chair on the conduct of its delegated functions. Divisions of the Medical Staff shall meet at the call of the Division Chief, Department Chair or as required in the Department Rules.

9.9 SPECIAL PROFESSIONAL REVIEW

9.9-1 Special Professional Review Limitation. A professional review study or investigation at the Department or Division level may be initiated by: joint request of the COS and CEO; request of the MSEC; request of the Board; or a request of a Department Chair, Division Chief or the Department Management Committee with the concurrence of the CEO and notice to COS.

9.9-2 Purpose of Special Professional Review. A confidential special professional review, study or investigation of the practice of one or more Members may be initiated for the purpose of formulating Medical Staff policy or resolving concerns regarding patient care, cooperation, and collegiality among the Medical Staff and System staff, or the reputation of the Hospital and/or its Medical Staff.

9.9-3 Professional Review Scope and Protocol. The scope of the professional review shall be specified in a written review protocol agreed upon by those initiating the review, or if those individuals do not agree, by the COS with input from the Department Chair. The protocol may direct that Members, System staff, and others shall be interviewed in the process if so specified. All those from whom an interview is requested shall comply. The protocol may be amended, as needed, by those who established it.

9.9-4 Reviewing Committee Composition. The review committee composition shall be specified in the protocol. The committee may be the Department's executive committee, or composed of any other persons who are determined to best carry out the investigation or study (e.g., legal counsel, independent physician consultant, etc.), provided there must always be at least one Member in the Department on the review committee, unless so doing would result in a serious irreconcilable conflict of interest.

9.9-5 Reporting. Upon completion of its study or investigation, the reviewing committee shall report its findings to the Department Chair, MSEC through the COS and the CEO. Confidentiality shall be maintained consistent with these Bylaws.

ARTICLE X

OFFICERS

10.1 OFFICERS OF THE MEDICAL STAFF

10.1-1 Identification. The officers of the Staff shall be:

- (a) Chief of Staff (COS);
- (b) Vice-Chief of Staff (Vice-COS);
- (c) Immediate Past Chief of Staff (Immediate Past COS); and
- (d) Secretary/Treasurer.

10.1-2 Qualifications. Officers must have been Members for at least 5 (five) years, must possess leadership capability, and must be Members in good standing, with voting privileges, of the Active or Senior Active categories at all times. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.1-3 Time of Election of the COS, Vice-COS and Secretary/Treasurer. The COS, Vice-COS and Secretary/Treasurer of the Medical Staff shall be routinely elected at the Annual Meeting of the Medical Staff from nominees selected in accordance with 10.1-6.

10.1-4 Regular Election Process of the COS, Vice-COS and Secretary/Treasurer. Subject to 10.1-7 below, the COS, Vice-COS and Secretary/Treasurer of the Medical Staff shall be elected by majority vote of the Active and Senior Active Members, in good standing. If there are two (2) or more official nominees, they will be alphabetically listed on a written ballot. The ballot for each position shall be exercised secretly. In the event there are more than two candidates for an office, the two candidates receiving the most votes on the first ballot will be placed on a second ballot; the candidate receiving the majority of votes on the second ballot will win the election. Voting by proxy shall not be permitted, and a quorum must be present.

10.1-5 Attainment of the Offices of Immediate Past COS. The Immediate Past COS shall attain that office by successful completion without removal or resignation of a term as COS. If an Immediate Past COS is removed or resigns, the preceding COS shall serve as Immediate Past COS.

10.1-6 Nomination Process.

- (a) There shall be a Staff Nominations Committee composed of the 3 (three) most recent Chiefs of Staff and the current COS, provided that if any member of the Nominating Committee is seeking nomination for an officer position, the Practitioner shall not participate in the nominating process for that office. In addition, the CEO shall serve on the committee as ex-officio without vote. The current COS shall serve as Chair.
- (b) The Staff Nominations Committee shall be responsible to meet and choose 1 (one) or more candidates for Chief of Staff, and 1 (one) or more candidates for election to the offices of Vice-COS and Secretary/Treasurer prior to the annual meeting of the Medical Staff in which the election is to be held.
- (c) After the Staff Nominations Committee has issued its nominations, supplemental nominations for the offices of COS, Vice-COS and Secretary-Treasurer will be solicited from the Members in the Active and Senior Active Categories. Those qualified persons nominated by at least five voting Members who provide a written statement that they will conscientiously serve if elected will be considered nominees for the office to which the Member is nominated. Supplemental nominations will be closed two weeks prior to the election and the list of nominees distributed to the Members.

10.1-7 Term of Elected Office. Each officer shall serve a 2 (two) year term to commence serving on the first day of the calendar year following the officer's election. Each officer shall serve a 2 (two) year term or until the officer's successor is elected, unless earlier removed.

10.1-8 Removal of Elected Medical Staff Officials. Except as otherwise provided, removal of an elected official (including the Immediate Past COS) shall be effected by a two-thirds (2/3) vote of all the voting Members or by the Board, with the concurrence of the MSEC. Voting of Members shall be by secret written ballot after the submission to the CEO of a petition signed by 25% of the voting Members. Voting by proxy shall not be permitted, and a quorum must be present.

10.1-9 Vacancies in Elected Office. If there is a vacancy in the office of COS, the Vice-COS shall serve out the remaining term. In the event the Vice-COS is unable to fill the unexpired term of the COS, the Immediate Past COS will assume the function of COS until a special election can be held, within 60 days, to fill the vacant position of COS. If the Vice-COS does not complete his/her term of office for any reason, candidates for the office of Vice-COS will be nominated and announced to the Medical Staff prior to the meeting at which the election will take place. Special meetings of the Nominating Committee and the Medical Staff may be called for these purposes at the discretion of the MSEC.

If the Secretary/Treasurer does not complete the term of office for any reason, a

replacement shall be elected by the MSEC.

10.1-10 Duties of Elected Officers

- (a) Chief of Staff (COS): The COS shall serve as Chief Medical Officer of the Medical Staff and shall:
- (i) Have direct responsibility for the organization and administration of the Medical Staff, in accordance with the terms of the Bylaws, the Rules and the Policy Manual;
 - (ii) Be responsible to the Board for the effectiveness of medical care review and policy enforcement;
 - (iii) Convey to the Board recommendations of appointment and reappointment to the Medical Staff, granting or restricting Privileges of individual Practitioners/AHPs, disciplinary action to take against individual Practitioners/AHPs, or amendments or additions to the Bylaws and the Rules and should, on invitation, advise the Board of these recommendations;
 - (iv) Act in coordination and cooperation with the CEO in matters of mutual concern within the Hospital;
 - (v) Call and preside at and be responsible for the agenda of all MSEC and general Medical Staff meetings and shall give proper notice of said meetings;
 - (vi) Be an ex-officio member of all Medical Staff committees including the Nominating Committee except when the Practitioner is seeking candidacy for that office;
 - (vii) Take action to enforce the Bylaws and the Rules;
 - (viii) Serve as chair of the MSEC;
 - (ix) Appoint, or remove with approval of the MSEC, the members and the Chairs and Vice-Chairs of all Medical Staff committees with the exception of the MSEC; such appointments shall be made within the first 30 days after the COS has taken office;
 - (x) Act as Medical Staff liaison to Administration and the Board.
 - (xi) Serve as a voting member of the Board, subject to the provisions of the Hospital's corporate bylaws.
- (b) Vice-Chief of Staff: The Vice-COS shall be a voting member of the MSEC. In the absence of the Chief of Staff, the Vice-COS shall assume all the duties and have the authority of the COS. The Vice-COS shall

chair the Credentials Committee and shall perform such additional duties as may be assigned by the COS, the MSEC or the Board.

- (c) Immediate Past Chief of Staff: The Immediate Past Chief of Staff shall be a voting member of the MSEC, and Credentials Committee and shall perform such other duties as are assigned by the COS, MSEC or the Board. In the absence of the COS and Vice-COS, the Immediate Past COS shall serve as COS.
- (d) Secretary/Treasurer: The Secretary/Treasurer shall be a voting member of the MSEC. He/She shall be responsible for Medical Staff finances and provide a report at all General Staff meetings. The Secretary/Treasurer shall perform such other duties as assigned by the COS, MSEC or the Board.

ARTICLE XI

COMMITTEES AND FUNCTIONS

11.1 GENERAL DESIGNATION AND PURPOSE The MSEC, in conjunction with the Board, may establish standing committees, arrange Member participation in Hospital-wide or System-wide committees, or establish conference procedures to address clinical and professional review functions.

11.1-1 Designation. The COS in consultation with the Immediate Past COS and the CEO or designee shall:

- (a) Appoint Practitioners to all Medical Staff committees, except as otherwise provided, and name the chairs;
- (b) Establish special committees or Performance Action Teams of the Medical Staff and name their chairs for the purpose of accomplishing specific objectives; and
- (c) Dissolve special committees or Performance Action Teams of the Medical Staff when their charges have been completed.

The CEO will appoint the administrative staff/Hospital personnel to committees. The chair of each committee, except the MSEC, shall designate a vice chairperson, and all committees will record minutes and make reports and recommendations to the MSEC.

11.1-2 General Purpose and Duties of Hospital Committees. An essential purpose of all the committees which have clinical or professional review functions is to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at the level of quality and efficiency available by the state of the healing arts and the resources locally available. The duties of Medical Staff committees shall include, but are not necessarily limited to:

- (a) Review of professional practices of the Hospital in an effort to reduce morbidity and mortality;
- (b) Review of professional practices in an effort to improve the care and treatment provided patients in the Hospital, which shall include monitoring System, Hospital and Medical Staff policies and procedures, requirements for alternate coverage and consultations, and recommending methods of enforcement and changes when appropriate;
- (c) Review of quality and necessity of care provided patients in the Hospital;
- (d) Review of preventability of complications and deaths occurring in the Hospital;

- (e) Directing, ordering and requiring the collection of records, data and knowledge in furtherance of its duties; and
- (f) Submittal of reports to the MSEC concerning:
 - (i) Findings of the committee's review and evaluation activities, actions taken thereon, and the results of such action;
 - (ii) Recommendations for maintaining and improving the quality of care provided in the Hospital; and
 - (iii) Such other matters as may be requested from time to time by the MSEC.

Committee members shall have access to the minutes of committees of which they are a member. All data, knowledge and records of these committees shall and must be kept in a confidential manner and shall not be subject to being subpoenaed or produced in legal proceedings consistent with the provisions of Michigan and federal statutes (including but not limited to the Michigan Public Health Codes.

11.1-3 The composition, duties and frequency of meetings of standing committees, other than the MSEC and Credentials Committee, shall be specified in the Committee manual, maintained by Administration.

11.2 MSEC

11.2-1 Composition. (a) The MSEC shall be a standing committee and shall consist of the COS, Vice-COS, Secretary/Treasurer, Immediate Past COS, and the Chair of each Department. If a Department has 15 or more voting Active Category Members including, for the purpose of count only, Provisional Category Members that are designated for eventual assignment to Active category, the Department may elect an additional representative, serving a one year term, provided total Department representation on the MSEC by any Department shall not exceed three (3), including the Department Chair and Medical Staff officers. The count shall be determined as of the last Department meeting preceding the Annual Medical Staff meeting in December. These additional MSEC members shall be elected from within their respective departments in accordance with Departmental rules. Duties will be assumed January 1, following the election.

In addition to the foregoing voting committee members, the CEO or designee (if any) and the Medical Director of Quality Management (or equivalent designated by the CEO), and CMO shall serve in an ex officio capacity, without vote.

11.2-2 Duties. The duties of the MSEC shall be to:

- (a) Advise the Board and Administration on matters involving patient care, quality and cost, and administration of Medical Staff relationships;

- (b) Exercise full responsibility for the functions of all standing or special committees of the Medical Staff, reviewing all reports and minutes of such committees, and provide support or direction to these committees as necessary;
- (c) Coordinate the activities and general policies of the various Departments and Divisions of the Medical Staff and act for the Medical Staff as a whole;
- (d) Report through the COS at each Medical Staff meeting its actions that may affect or be of interest to the Medical Staff as a whole with consideration of the confidential nature of some of the actions of the Committee which may be omitted as indicated by good order and judgment;
- (e) Take reasonable steps in an effort to maintain professional, ethical conduct and competent clinical performance on the part of all Members including the initiation and/or participation in Medical Staff corrective action, non-reappointment or special review measures when warranted;
- (f) Formulate and implement policies of the Medical Staff not otherwise the responsibility of the Departments or Divisions;
- (g) Review and, as applicable, recommend or approve rules of the Departments and Divisions and amendments to the Medical Staff Rules and the Policy Manual, subject to approval of the Board;
- (h) Receive and act upon, on a regular basis, reports submitted by Departments. Departmental Reports shall encompass reports from all Divisions within the Department;
- (i) Consider and recommend to the Board those matters which are of a professional nature and require Board action;
- (j) Review the qualifications of prospective Members and current Members seeking reappointment and Privileges and submit recommendations to the Board in accordance with these Bylaws.

11.2-3 Meetings. The MSEC shall meet at least ten times per year and shall maintain a permanent record of its proceedings and actions.

11.3 CREDENTIALS COMMITTEE

- 11.3-1 Composition. The Credentials Committee shall consist of the Vice Chair of all Departments, the Medical Director of Quality Management, the Immediate past COS and the Vice-COS who shall serve as its Chair. The CMO shall be a member of the committee as Ex-Officio, without a vote. The major specialty that the applicant is applying for may be represented by ad hoc (specific specialty) appointment if not already on the committee. The ad hoc appointee shall have a vote.
- 11.3-2 Duties. The duties of the Credentials Committee shall be to investigate the character and qualifications of all initial applicants for membership on the Medical Staff to review the current competence and qualifications of Members who are subject to reappointment, and, in conjunction with the Department Chair, to make recommendations to the MSEC regarding the initial appointments and reappointments. Other duties or modification of the foregoing duties may be prescribed in the Committee or Policy Manual.
- 11.3-3 Meetings. The Credentials Committee shall meet as necessary and maintain a permanent record of its proceedings.

ARTICLE XII

MEETINGS

12.1 GENERAL STAFF MEETINGS

12.1-1 Regular Meetings. The Medical Staff shall hold live meetings in March and December and Web-based meetings in June and September. The December meeting will be considered the Annual meeting.

The COS shall preside at all regular quarterly meetings. In his/her absence, the Vice-COS shall preside. In the absence of the Vice-COS, the Immediate Past COS shall preside. The purpose of the regular meetings shall be to conduct the business of the Medical Staff.

12.1-2 Agenda at Regular Meetings. The agenda of any regular meeting shall be established and made available to the Medical Staff Members.

12.2 SPECIAL MEDICAL STAFF MEETINGS

12.2-1 Special Meetings. Special meetings may be called by or at the request of the relevant Chair, the Board, the CEO or the COS.

12.2-2 Agenda. The agenda at special meetings shall be published in advance.

12.3 NOTICE OF MEETINGS

Notice of regular meetings of the Medical Staff, Department, Divisions and committees is sufficient if the notice is placed in the physician mailboxes. Notice of special meetings of the Medical Staff shall require written notice sent to the office of each voting Member at least 10 (ten) days before the meeting. Notice of meetings of a Department, Division or committee scheduled in less than 10 (ten) days' advance notice shall require specific written, oral, or telephone notice to each member or each body.

12.4 QUORUM

12.4-1 General and Special Staff Meetings. Bylaw amendments or removal of officers shall require 50% of the voting Active Category Membership as a quorum. If a quorum is not met, a provision may be made for mail ballots. For purposes of transaction of all other business, the presiding officer shall determine the quorum.

12.4-2 Department, Division and Committee Meetings. The Chair of a Department or committee, the Chief of each Division, or designee, as presiding officer shall determine a quorum at any meeting of such Department, Division or committee unless otherwise indicated.

12.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the Members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken between meetings by a Department, Division or committee without a meeting by a written notice setting forth the action proposed and signed and returned by two-thirds positive vote of the members entitled to vote there at.

12.6 MINUTES OR REPORTS

Minutes or reports of meetings shall be prepared under the direction of the body's secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Minutes or reports, when approved, shall be signed by the presiding officer.

12.7 ATTENDANCE REQUIREMENTS

12.7-1 Regular Attendance. Attendance at Medical Staff meetings shall be encouraged for all Members. Each Member of the Provisional, Active and Senior Active categories shall be required to attend 50% of Medical Staff meetings, with attendance at one meeting being live. The MSEC may determine equivalents to meeting attendance for the Medical Staff.

12.7-2 Absence from Meetings. Any Member who is to be absent from any Medical Staff, Department, Division or committee meeting which the Member is required to attend, shall promptly provide notice to the regular presiding officer thereof of the reason for such absence. Unless excused for good cause, failure to attend the 50% of Medical Staff meetings, with one being live, and at least 50% of Department or Primary Committee meetings by Provisional, Active and Senior Active category Members results in loss of voting privileges in the general medical staff meetings for the next Medical Staff Year. Additionally, Provisional category Members who fail to attend 50% of Medical Staff meetings, with one being live, unless excused for good cause, in the year preceding consideration for advancement shall not be advanced to a category with greater prerogatives. Active participation by a Member in activities deemed appropriate by the MSEC may serve as an equivalent to the attendance requirement.

12.7-3 Attendance by Telephonic Means. A person who is the Member of a Medical Staff body (i.e., the general Medical Staff, committee) may, with the advance permission of the presiding officer of the meeting, participate in a meeting of such body by a conference telephone or similar communications equipment by which all persons participating in the meeting may hear each other. Authorized participation in a meeting in this manner constitutes "presence in person" at the meeting for purposes of a quorum, voting, and attendance requirements.

12.8 RULES GOVERNING MEETINGS

All meetings will be conducted in accordance with Robert's Rules of Order unless otherwise specified in these Bylaws.

ARTICLE XIII

CONFIDENTIALITY, IMMUNITY, AND RELEASES

13.1 DEFINITIONS

For the purpose of this Article, the following special definitions shall apply:

"Representative" means a person, committee, Medical Staff organization, board or entity which has the obligation to: conduct professional review; undertake professional review actions; or collect, or prepare, hold or disclose professional review information concerning a Health Professional.

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

"Professional review" means the review of the health, clinical ability, ethics, education, and/or morality of a Practitioner or other health care provider and includes, but is not limited to: morbidity and mortality review; utilization review; patient care and audits; performance reviews in an academic or practice setting; insurance underwriting reviews; credential investigations; appraisals for Medical Staff appointment or reappointment; review of applications for employment at a facility (as defined); or initiation or corrective action proceedings or appellate reviews in the course of a facility's Medical Staff affairs.

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

"Professional review action" means an action taken in the process of a professional review or on account of professional review information. Professional review actions include, but are not limited to: appointment, non-appointment, reappointment and non-reappointment to a Medical Staff of a facility; corrective action proceedings or appeals in a facility; preparation of reports upon conduct of a Health Professional's activities in a facility; and a recommendation or imposition of discipline or restrictions upon the professional activities of a Member.

"Health Professional" means a Practitioner, AHP or other health care provider who has applied for or has clinical privileges and/or specified service authority in the Hospital.

13.2 AUTHORIZATIONS AND CONDITIONS

By applying for or exercising Privileges or specified Service Authority, within the Hospital, a Health Professional:

- (a) authorizes representatives of the System, the Hospital and the Medical Staff to

solicit, provide and act upon professional review information;

- (b) agrees to be bound by the provisions of this Article and to waive and release 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 his/her application for, or acceptance of, membership, Privileges or provision of specified patient services at the Hospital.

13.3 CONFIDENTIALITY OF PROFESSIONAL REVIEW INFORMATION

Professional review information regarding a Health Professional held by the Hospital shall, to the fullest extent permitted by law, be confidential. Professional review information regarding a Health Professional shall not be disclosed to anyone other than a representative or facility which is conducting professional review involving the Health Professional or, as required by law, to a governmental agency. Professional review information concerning a Health Professional shall not be part of a patient's medical record nor the Hospital's general business records. The Board, the MSEC, the COS, a Department Chair, and the CEO (including his/her designee) shall each have the authority to enforce this Section.

13.4 IMMUNITY FROM LIABILITY

13.4-1 Good Faith Immunity. No representative nor facility shall be liable, in damages or otherwise, for any professional review action taken, or for the disclosure of professional review information, with respect to any Health Professional. There shall be a presumption of good faith, and truth shall be an absolute defense, in any legal proceeding charging a representative, or facility with liability for professional review actions taken or for professional review information disclosed, in one's capacity as a representative or facility, concerning a Health Professional.

13.4-2 Total Immunity for Community to Governmental Agencies or Compliance with Law or Court Procedures. Neither a representative of the System, the Hospital nor the System or the Hospital itself shall have any liability, in damages or otherwise, to a Health Professional for any information communicated to a governmental agency under the assumption or belief that the representative or the Hospital had a legal or moral obligation to do so. Moreover, neither a representative affiliated with the Hospital, nor the Hospital itself, shall have any liability to a Health Professional for communication of any information in accordance with a court order and/or court subpoena, or in accordance with the directive, in any form, of a governmental agency. The provisions of this Section, however, do not waive the rights of confidentiality of the Hospital or its representatives under Section 13.3.

13.5 WAIVER OF PRIVILEGE BY HEALTH PROFESSIONAL

Any Health Professional who shall bring legal action against a facility or representative for a professional review action or disclosure of professional review information, shall, by bringing such legal action, waive any legal confidentiality privilege they may have respecting professional review information concerning the Health Professional.

13.6 RELEASES AND AUTHORIZATIONS

Each Health Professional shall, to facilitate professional review and professional review actions, execute written releases and/or authorizations consistent with this Article upon request of the Hospital or a Hospital representative. However, execution of a release or authorization is not a prerequisite to the effectiveness of this Article.

13.7 CUMULATIVE EFFECT

Provisions in these Bylaws, in the Rules, the Policy Manual, 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 of such legal protections.

ARTICLE XIV

ALLIED HEALTH PROFESSIONALS ("AHP")

14.1 DEFINITIONS AND GENERAL SCOPE OF PRACTICE

Allied Health Professionals are health care providers by virtue of their special training are able to provide services deemed necessary by the Medical Staff.

Independent Allied Health Professionals are health care providers who are granted Service Authority to provide treatment and consulting services without supervision, within the scope of their license and Department guidelines and policies. Independent AHP's include, but are not limited to, Licensed Psychologists and Nurse Midwives, the latter of whom must be employed by a physician(s) and/or Marquette General Health System as part of an established collaborative practice which includes a physician Member of the Active Medical Staff of Marquette General Health System or other physician Member deemed appropriate by the Medical Staff Executive Committee.

Dependent Allied Health Professionals are health care providers who are granted Service Authority to provide services under supervision, within the scope of their license and Department guidelines and policies. Dependent AHPs include, but are not limited to, Nurse Practitioners, Physician Assistants and Limited Licensed Psychologists.

14.2 MEDICAL STAFF MEMBERS' OBLIGATIONS:

In requesting that a Dependent AHP be authorized to practice in the Hospital to participate in the care of patients, the sponsoring Practitioner agrees:

- (a) to accept full legal and ethical responsibility for the AHP's performance in the Hospital with respect to patients under the Practitioner's new supervision;
- (b) to accept responsibility for the proper conduct of the AHP within the Hospital, and for the AHPs observance of all Bylaws, policies and rules of the Hospital and Medical Staff;
- (c) to abide by all Bylaws, policies and rules governing the use of AHPs in this Hospital including refraining from requesting that the AHP provide services beyond, or that might reasonably be construed as being beyond, the AHP's authorized scope of practice in the Hospital;
- (d) to immediately notify the relevant Department in the event of any of the following occurrences:
 - (i) the Practitioner's approval to supervise the AHP is revoked, limited or otherwise altered by action of a State of Michigan Licensing Board;
 - (ii) notification is given of an investigation of either the supervisory Practitioner or the AHP by the State of Michigan Licensing Board;

- (iii) the employment status of the AHP changes or the AHP's authorized scope of practice changes;
- (iv) the employer Practitioner's professional liability insurance coverage is changed insofar as coverage of the acts of a Dependent AHP is concerned; and
- (e) to comply with all regulations of the State of Michigan Licensing Board with respect to the Practitioner's supervision of the AHP; and
- (f) Submit evaluations as requested.

14.3 SYSTEM CREDENTIALING AND PROCEDURES

In addition to the foregoing requirements applicable to AHPs granted Service Authority in the Hospital, the Policy Manual may include policies governing AHP practice outside the Hospital, but within the System.

ARTICLE XV

GENERAL PROVISIONS

15.1 PROFESSIONAL LIABILITY INSURANCE

Each Member granted privileges in the Hospital shall meet the financial responsibility requirements as may from time to time be established by resolution of the MSEC and ratification by the Board. Any bona fide questions as to whether a particular means of assurance of financial responsibility meets the requirements of the Hospital shall be resolved by the MSEC with approval by the Board.

Proof of the current status of professional liability insurance or other proof of financial responsibility shall annually be submitted to and maintained by the CEO. Any change in the status of the professional liability insurance of a Member, including the name of the professional liability carrier and the amount of coverage, shall be reported to the CEO within 7 (seven) days subsequent to the change or the respective Member shall be subject to administrative action.

15.2 PHYSICAL AND MENTAL HEALTH QUALIFICATIONS REVIEW

Each Practitioner or AHP who is a Member or has been granted Privileges or Service Authority to practice in the System may be requested by the CEO or COS or a committee assigned responsibility for their health and well-being, acting in consultation with the relevant Department Chair to voluntarily submit to, or be required by the MSEC or the Board to receive a physical or mental health examination(s). The purpose of the examination(s) is to assist the System in determining the ability of the Practitioner or AHP to continue competently and safely to exercise any Privileges or Service Authority granted to them. If such examination(s) should be required, the person requesting, or the body requiring, the examination(s) shall select the Practitioner(s)/AHP(s) to perform said examination(s). The expense for the examination(s) shall be the responsibility of the System. The findings of the examination(s) shall be directly reported to the person requesting, or the chair of the body requiring, the examination(s).

15.3 INDEMNITY

Members who serve in good faith as officers of the System or Medical Staff, or upon committees of the Hospital or Medical Staff, to the fullest extent permitted by law, shall have and be entitled to the same level of corporate indemnity protection that a System officer or employee would have under the Articles and Bylaws of the System in similar circumstances.

15.4 TIME LIMITS

The time limits for committee or Administration action in all parts of these Bylaws may be waived or adjusted by the MSEC (at the Medical Staff level) or Board (all levels) for what, in their discretion, is good cause. In addition, the MSEC may alter the scheduling for reappointment (i.e., the number of days before expiration of appointment certain actions must be taken) provided persons subject to reappointment are given reasonable notice of the changes in scheduling.

15.5 DATA BANK REPORTING

The Medical Staff and CEO shall report, consistent with applicable legal requirements, disciplinary and other professional review actions taken with respect to a Member, to the Data Bank and/or State licensing authorities.

15.6 INTERNAL REPORTING.

Any action taken concerning a Member's membership or clinical privileges, including at time of appointment, reappointment, or corrective or other action, shall be reported if not already known, to the COS, CEO, Board Chair, and on a need-to-know basis, to Members and Hospital staff (e.g., reduction in surgical privileges would have to be reported to the operating room supervisor).

ARTICLE XVI

ADOPTION AND AMENDMENT AND INTERPRETATION OF BYLAWS, RULES AND THE POLICY MANUAL

16.1 NATURE OF MEDICAL STAFF BYLAWS, RULES AND THE POLICY MANUAL (INCLUDING APPENDICES) DISTINGUISHED

16.1-1 Contents of General Medical Staff Bylaws. The Bylaws provide for the statement of objectives, organization, governance, and basic prerogatives and responsibilities of Membership to fulfill regulatory and accreditation requirements and form the framework for other Medical Staff policies (in the form of the Rules and the Policy Manual) governing Members' conduct. However, the Bylaws, Rules, the Policy Manual (including Appendices), and any other documents issued thereunder (e.g., application forms), do not constitute a contract or an agreement upon which any individual or entity may claim contractual rights.

The Medical Staff Bylaws or its amendments shall not conflict with the Bylaws of the Board of Trustees. In any circumstance where any provision of the Medical Staff Bylaws or its amendments are in conflict with the Bylaws or Corporate Policies of the Board of Trustees, the Bylaws and corporate policies of the Board of Trustees shall prevail.

16.1-2 Contents of Medical Staff Rules. The Rules shall, consistent with the applicable Bylaws, provide special methods and procedures related to patient care activity as well as conduct of Medical Staff organizational activities and embodies the level of practice required of each Member. Medical Staff rules may clarify and/or enhance general principles found in these Bylaws relating to professional practice protocol within the System.

The General Rules of the Medical Staff or its amendments shall not conflict with the Bylaws of the Board of Trustees. In any circumstance where any provision of the General Rules of the Medical Staff or its amendments are in conflict with the Bylaws or Corporate Policies of the Board of Trustees, the Bylaws and corporate policies of the Board of Trustees shall prevail.

16.1-3 Contents of Policy Manual. The Policy Manual (including Appendices to the Bylaws) are designed to clarify, amplify or supplement general principles of the Bylaws and, as such, shall be consistent with the Bylaws. The Policy Manual may include policies on Review Procedures Committees and Allied Health Professional governance.

16.1-4 Contents of Department Rules. Department rules, in a manner consistent with the Bylaws, the Policy Manual and Rules, are formulated for the conduct of the Department's affairs and the discharge of its responsibilities, i.e., rules relating to specific patient care and administrative procedures.

16.2 MEDICAL STAFF RESPONSIBILITY AND AUTHORITY

The Medical Staff shall have the responsibility and authority to formulate, adopt and recommend to the Board of Trustees Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, so as to have Bylaws, Rules and a Policy Manual of the Medical Staff of generally recognized quality, to provide a basis for acceptance by accreditation agencies, to comply with supervising licensing authorities, and to provide a system of ongoing effective professional review.

16.3 ONGOING BYLAWS AND RULES REVIEW PROCESS

As a permanent mechanism for ongoing review of the Bylaws, Rules and the Policy Manual, the COS, Vice-COS, other Members who are appointed by the COS and the CEO shall convene at least biennially. They shall make a written report to the MSEC and the Board of the committee's recommendations for revision of the Bylaws, Rules and Policy Manual, taking into account its observations, JCAHO review suggestions, JCAHO policy changes, legal changes and the current needs of the Hospital, Members and the patients of the System.

16.4 METHODOLOGY FOR ADOPTION, AMENDMENT AND REPEAL

16.4-1 Medical Staff Bylaws. Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:

- (a) Review of any proposed amendment or restatement of the Bylaws by the MSEC and MSEC recommendation thereon; and
- (b) The affirmative vote of a majority of the Members eligible to vote on this matter who are present at the next general medical staff meeting at which a quorum is present, provided at least 10 days written notice, accompanied by the proposed Bylaws and/or alterations have been given; and
- (c) The affirmative vote of a majority of the Board.

16.4-2 Medical Staff and Departmental Rules.

Medical Staff and Departmental Rules (including, except as otherwise provided herein, Appendices to the Bylaws) may be adopted, amended, or repealed by the MSEC at any meeting at which a quorum is present by a majority vote of those present and eligible to vote. The action of the MSEC to adopt, amend, or repeal Rules (including Appendices) shall take effect upon notification of membership and concurrence of the Board; or

- (a) The affirmative vote of a majority of the Members eligible to vote on the matter who are present at a general medical staff meeting; and
- (b) Upon the recommendation from a Department to amend their Departmental Rules, the change will become effective following MSEC and Board review and approval.
- (c) By Medical Staff or Board: Medical Staff Rules (including Appendices) may also be adopted, amended or repealed in the same manner the Bylaws may be amended.

16.4-3 Notice to Medical Staff. When Bylaws, Rules or Policy Manual provisions are adopted, materially amended or repealed, notice of the action and copies of any

materially changed provisions shall be made available to all Members.

16.5 INTERPRETATION

- 16.5-1 Conformance with Law. These Bylaws, Rules and Policy Manual shall be interpreted in a manner consistent with applicable law. In the event the provisions of these Bylaws, Rules or the Policy Manual (including Appendices) promulgated hereunder shall not be in conformance with Michigan or federal law, the Bylaws, Rules and Appendices shall be deemed automatically amended to comply with such law. As soon thereafter as may be practicable, such change shall be made in writing in the Bylaws or the Rules. A finding that any article, section, or subsection is legally invalid shall not invalidate the effectiveness of all other portions of the Bylaws, Rules or Policy Manual which are consistent with law. Nothing contained in these Bylaws, Rules or Policy Manual thereunder shall in any manner restrict or limit the authority of the Board to exercise its responsibilities as the governing body of the Hospital pursuant to the provisions of the Michigan Public Health Code. The methodology for adoption, amendment and repeal shall be specified in the Medical Staff Bylaws provided, however, in the event that the Medical Staff shall fail to exercise its responsibility and authority as required by Section 16.4-1, and after written notice from the Board to such effect including a period of 60 days for response, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws. In such event, Medical Staff recommendations and views shall be carefully considered by the Board during its deliberations and in its actions.
- 16.5-2 Modification by Formal Agreement of Medical Staff and Board. The provisions of the Bylaws may be modified or superseded by an agreement or policy adopted by the Medical Staff and approved by the Board in a manner which meets the voting requirements of an amendment to these Bylaws.
- 16.5-3 Emergency Action. In the event there is a bonafide need for immediate action by the Medical Staff, any procedural rule or requirement in these Bylaws, Rules or Policy Manual (e.g., a meeting notice requirement) may be modified by joint written action of the CEO, the COS, and authorized representative of the Board, subject to prompt submission thereafter of a proposed amendment to the provision so modified on an emergency basis.
- 16.5-4 Miscellaneous. Article and section captions used in these Bylaws are solely for convenience and are not to be considered in the interpretation of the Bylaws.

Amendments: 16.1-1 and 16.1-2 were amended (added second paragraph) by action of the Board of Trustees on March 27, 2006.

ADOPTED by the Medical Staff December 12, 2000:

David M. Luoma, M.D., Chief of Staff

Date

Kenneth A. Davenport, M.D. Secretary/Treasurer of the Staff

APPROVED by the Board of Trustees December 18, 2000:

Ellwood A. Mattson, Chairperson, Board of Trustees

Date

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