Ascension River District Hospital

APPENDIX A - CREDENTIALING

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

1. APPLICATION FOR INITIAL APPOINTMENT

It is this hospital's policy to process all applications with equal standards only after the Medical Staff Office has obtained a completed, verified application. It is the intent of this policy to expedite applications that meet predefined, board-approved criteria.

1.1. Application Form

All applications for appointment to the medical staff shall be signed by the applicant and shall be submitted on a form prescribed by the board of trustees after consultation with the Medical Staff Executive Committee. The application shall require detailed information concerning the applicant's licensure and professional qualifications, shall include the name of at least three persons who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's professional competence and ethical character, and shall include information as to whether the applicant's membership status and/or clinical privileges have ever been limited, reduced or terminated, voluntarily or involuntarily at any other hospital or institution. The application will also ask the Practitioner whether their membership in local, state or national medical societies, or license to practice any profession in any jurisdiction, has ever been suspended, terminated or voluntarily relinquished and whether the applicants narcotic license has ever been suspended, revoked or voluntarily relinquished. The Practitioner's health status and information concerning the applicant's malpractice experience, including consent to release the information from their present and past malpractice insurance carrier(s) will be included. The form of application may be varied as appropriate for dentists and other non-physician practitioners.

1.2. Application Fee

An application fee shall be assessed and payment must accompany the application prior to processing.

1.3. Applicant's Burden

The applicant shall have the burden of producing adequate information for a proper evaluation of their competence, character, ethics and other qualifications, and for resolving any doubts about their qualifications. If this information is not produced within ninety (90) days from the time of the initial submission of the application, such that the Credentials Committee can meet to consider the application, the application will be considered to have been withdrawn and the applicant must resubmit the application and the application fee if the applicant wishes to pursue staff appointment. The Medical Staff Executive Committee may grant an additional 90 days for submission of the necessary information, but in no case shall more than 180 days lapse between initial submission of the application and consideration by the Credentials Committee.

1.4. Release, Consent and Immunity Provisions

By applying for appointment to the medical staff, each applicant thereby signifies their willingness to appear for interviews in regard to their application, authorizes the hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on their competence, character and ethical qualifications, consents to the hospital's inspection of all records and documents that may be material to an evaluation of their professional and ethical qualifications, releases from any liability all representatives of the hospital and its

medical staff for their acts performed in good faith and without malice in connection with evaluating the applicant's credentials, and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's character and qualifications. The term "character" includes reference to the applicant's mental and emotional stability. The application form shall contain a statement that fully informs the applicant of the scope and extent of these authorizations, release and consent provisions and of the immunity provisions contained in Article XI of the bylaws.

1.5. **Application Process**

1.5.1. **Submission of Application and Verification of Information**

The application shall be submitted to the Central Verification Office (CVO) , who shall then obtain licensure, reference and other pertinent information, and shall request information concerning the applicant from the National Practitioner Data Bank and other sources. Upon completion of the verification process, the completed application shall then be forwarded to the Medical Staff Office where the Department Chair will review each application and its associated additional information and will categorize the application according to the following criteria:

1.5.1.1. TYPE 1 I:

a. All requested information has been returned promptly.
b. There are no negative or questionable recommendations.
c. There are no discrepancies in information received from the applicant and information received from other sources.
d. The applicant completed a normal education/training sequence.
e. There have been no disciplinary actions or legal sanctions.
f. There have been no malpractice cases.
g. The applicant has an unremarkable medical staff/employment history.
h. The applicant has submitted a reasonable request for clinical privileges based on experience, training and competence and is in compliance with applicable criteria.
i. The applicant reports an acceptable health status.
j. The applicant has never been sanctioned by a third-party payer (e.g., Medicare, Medicaid, etc.).
k. The applicant has never been convicted of a felony.
l. The applicant is requesting privileges consistent with his or her specialty.
m. The applicant’s history shows an ability to relate to others in a harmonious, collegial manner.

1.5.1.2. TYPE 2 2:

a. There are gaps in work history the applicant has not accounted for.
b. There are discrepancies between information the applicant submitted and information received from other sources.
c. Additional information (other than Notices of Intent (NOI) was discovered by CMSS that was not disclosed by the practitioner.
d. Peer references and/or prior affiliations are unsatisfactory or indicate concerns and/or problems.
e. There are unsatisfactory peer references and/or prior affiliation references.
f. Open Complaints exist or Disciplinary actions have been taken by a state licensing board or a state or federal regulatory agency.
g. The applicant has experienced voluntary (other than change in practice pattern) or involuntary termination of medical staff membership, or

voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care organization. .

h. The applicant has experienced removal from a provider panel of a managed care entity for reasons of unprofessional conduct or quality-of-care issues.

i. The applicant has been the object of three or more malpractice claims/settlements/judgements in the past five years other than Notice of Intent (NOI). .

j. The applicant has been the object of one or more malpractice claims/settlements/judgments with a combined settlement value of $150,000 or greater in the past five years.

k. The applicant holds a substantial number of medical licenses (more than five licenses) across the United States (excludes Telemedicine).

l. The applicant has one or more affiliations in three or more geographic locations in the past five years (excludes Teleradiolgists).

m. The applicant has been convicted of, pled guilty to, pled no contest to or nolo contendere to, or been subject to deferred adjudication for a felony, misdemeanor, or other crime (other than minor traffic violations), including DUI/DWI.

n. The applicant has been charged with or convicted of any crime related to their clinical practice, including health care fraud and abuse or other Medicare and Medicaid-related crimes, or have been subject to civil monetary penalties related to the Medicare or Medicaid program. Recovery Program Participant.

1.6. **Processing of Applications**

1.6.1. **Type I)**:

1.6.1.1. The Medical Staff Office receives a completed application from CVO.

1.6.1.2. The Department Chair reviews the application and requested privileges, including meeting with the applicant and setting expectations involving the hospital and regulatory requirements and recommendations for appointment. The application is then reviewed by the Medical Staff Executive Committee. and if recommended forwarded to the Board of Trustees.

1.6.2. **Type II :**

1.6.2.1. The application is forwarded to the appropriate Department Chair for review and recommendation. The Department Chair reviews the application to make sure it meets the established standards for membership and clinical privileges and supports or does not support privileges as requested .

1.6.2.2. If supported, the Department Chair meets with the applicant and sets expectations involving the hospital, regulatory requirements and recommendations for appointment. The application is then reviewed by the Credentials Chair, the Medical Staff Executive Committee.

1.6.2.3. The Medical Staff Executive Committee forwards their recommendation to the Board for final action.

Note: In the event the Medical Staff Executive Committee's recommendation is negative, the hospital must review and follow its fair hearing plan.

1.7. **Effect of Medical Staff Executive Committee Action**

1.7.1. Deferral
When the recommendation of the Medical Staff Executive Committee is to defer the application for further consideration, it must be followed up within sixty (60) days with a subsequent recommendation for appointment or rejection.

1.7.2. Favorable Recommendation
When the recommendation of the Medical Staff Executive Committee is favorable to the practitioner, the administrator shall promptly forward it, together with all supporting documentation, to the board of trustees.

1.7.3. Adverse Recommendation
When the recommendation of the Medical Staff Executive Committee is adverse to the practitioner either in respect to appointment or clinical privileges, the administrator shall promptly notify the practitioner by certified mail, return receipt requested. No such adverse recommendation need be forwarded to the board of trustees until after the practitioner has exercised or has waived his right to a hearing as provided in Article VI of these bylaws.

If after the Medical Staff Executive Committee has considered the report and recommendation of the hearing committee and the hearing record, the Medical Staff Executive Committee's reconsidered recommendation is favorable to the practitioner, it shall be processed in accordance with Section 5.2. If such recommendation continues to be adverse, the administrator shall promptly notify the practitioner by certified mail, return receipt requested. The Chief of Staff shall also forward such recommendation and documentation to the board of trustees, but the board of trustees shall not take any action thereon until after the practitioner has exercised or waived his right to an appellate review as provided in Article VI of these bylaws.

1.8. **Board of trustees Action**

1.8.1. **Procedural Rights**
In the case of an adverse Medical Staff Executive Committee recommendation pursuant to an adverse board of trustee's decision, the board of trustees shall take final action in the matter at its next regular meeting, but only after the practitioner has exhausted or waived their procedural rights as provided in Article V or VI of the Ascension River District Hospital bylaws.

2. **REAPPOINTMENT PROCESS**
The Central Medical Staff Services, (CVO) Department will forward to each medical staff member a reappointment packet at least 6 months prior to their appointment expiration date. Each staff member who desires reappointment, shall within thirty (30) days after receipt, return the completed form to the CVO. Failure to return the completed form, without good cause, shall result in voluntary withdrawal of membership at the expiration of the member's current appointment. The CVO will primary source verify information concerning the applicant and query the National Practitioner Data Bank and other sources. The application will then be forwarded to the Medical Staff Office at Ascension River District Hospital at least 2 months prior to the appointment expiration date for committee review and approval.

2.1 **Medical Staff Executive Committee Review and Action**
At least thirty (30) days prior to the ***expiration of a member's appointment)***, the Medical Staff Executive Committee shall review all pertinent information available on each practitioner as the basis for its recommendations for reappointments to the medical staff and for the granting of clinical privileges for the ensuing period.

The report and recommendations to the board of trustees shall specifically indicate that appointment either be renewed, renewed with modified staff category, department and/or clinical privileges, or terminated. The Medical Staff Executive Committee may also defer action with a subsequent recommendation following in thirty (30) days. Where non-reappointment or a change in clinical privileges

is recommended, the reason for such action shall be stated and documented.

2.1.1 **Department Review**

The respective Department Chair shall review the information available on each practitioner requesting reappointment and exercising clinical privileges in the department. After review of the reappointment packet, the department chair shall submit a report and recommendation to the Credentials Chair and the Medical Staff Executive Committee for review The Medical Staff Executive Committee will then review the information provided and make their recommendation to the Board of T
Trustees.

2.3 **Basis for Recommendations**

Each recommendation concerning the reappointment and the clinical privileges to be granted upon reappointment shall be based upon their OPPE and clinical judgment in the treatment of patients, ethics and conduct and participating in staff affairs, compliance with medical staff bylaws, rules and regulations, cooperation with hospital personnel use of the hospital's facilities for his patients, relations with other practitioners and behavior toward patients, the hospital and the public, as determined by periodic appraisal of the professional activities of each member of the medical staff and of all other practitioners with clinical privileges in the hospital. Periodic appraisal will also include any final judgments or settlements resulting from malpractice action and the voluntary or involuntary relinquishment of clinical privileges or licensure by the Practitioner. A written record of all matters considered in each practitioner's periodic appraisal shall be kept on file.

If the applicant for reappointment does not have enough evidence to allow adequate assessment of clinical competency (i.e., lack of a significant number of admissions, consults or surgical procedures performed over the last reappointment cycle) and has similar privileges at another institution, the Medical Staff Executive Committee may use admission/procedure information from that institution to consider reappointment. This information must be substantiated by the Medical Leadership of that institution. It is the applicant’s responsibility to obtain this information.

Board Recertification: It is expected that if your Board mandates that you recertify, the medical staff requires that you do so. You have a three-year grace period to complete this recertification. If you do not complete this recertification, your continued staff membership will be predicated upon a recommendation by your department chairperson, the Medical Staff Executive Committee and approval by the Board of Trustees pending review of peer review and clinical performance data.

For those medical staff members who graduated prior to May 2003 and are not board certified, their continued staff membership will be predicated upon a recommendation by the department chairperson, the Medical Staff Executive Committee and approval by the Board of Trustees pending review of peer review and clinical performance data.

3 TELEMEDICINE APPROVAL VIA PROXY

3.1 As defined in the “Credentialing and Privileging Agreement” between Ascension River District Hospital “Originating Site” and Ascension St John Hospital “Distance Site” Telemedicine providers listed on the SCHEDULE 1 Practitioner list are approved via proxy approval.

3.1.1 Distant Site Credentialing and Privileging – Distant Site warrants that each Practitioner will be credentialed and privileged according to Distant Site’s credentialing and privileging process and standards in accordance with commonly accepted quality measures and the Joint Commission standards; and render Contracted services within the scope of the Practitioner’s respective privileges.

3.1.2 Distant Site to Provide Current List of Privileges. Distant Site has supplied Originating Site with Schedule 1, a list identifying each Practitioner and the scope of privileges granted by Distant Site. It is anticipated that Schedule 1 may change from time to time upon mutual agreement of the parties without requiring amendment of this Agreement. In that event the following procedures shall apply:

3.1.2.1 Distant Site shall provide Originating Site with a revised Schedule 1 indicating the name of any new Practitioners and an accompanying delineation of privileges for each new Practitioner. If Distant Site

has removed a Practitioner from the roster of Practitioners Distant Site will provide a revised Schedule 1. Originating Site shall confirm the Practitioners listed on the Schedule 1 can provide signing the Schedule 1.

4 **Credentialing-Related Materials**: distant Site shall provide electronic copies of the credentialing materials and other reasonable evidence of Distant Site's compliance with the Originating Site Standards. New Practitioners, Reappointments and Resignations will all be listed on the credentialing grids of the Originating Site for approval.

5 LEAVE OF ABSENCE

Any member of the medical staff desiring to take a leave of absence may do so for a period of up to 1 year. If they desire to continue their medical staff membership at the conclusion of the leave of absence, their privileges shall be at the discretion of the Department Chair. If the leave of absence exceeds 1 year, the Practitioner must reapply for staff privileges. This section shall apply only if the member makes written request to the chief of staff and the leave is approved by the Medical Staff Executive Committee, board of trustees prior to the commencement thereof. If the leave of absence occurs through a staff reappointment period, the staff member should apply for a reappointment of their privileges as would normally occur so that a 24 month maximum reappointment period would not be exceeded. If they do not apply for reappointment then their privileges would lapse and they would then have to reapply as a new appointment.

6 **CLINICAL PRIVILEGES**

6.1 **Clinical Privileges Restricted**

Every practitioner practicing at the hospital by virtue of medical staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to them by the board of trustees, except as provided in Sections 6 of Appendix A.

6.2 **Application for Initial or Increased Privileges**

Every initial application for staff appointment must contain a request for the specific clinical privileges desired by the applicant. Requests for additional clinical privileges must also be in writing and state the applicant's relevant recent training and/or experience. The evaluation of all such requests shall be based upon the applicant's education, training, experience, demonstrated competence, availability for treatment and follow up services, references and other relevant information, including an appraisal by the department in which such privileges are sought. The applicant shall have the burden of establishing his qualifications and competency for the clinical privileges he requests.

6.3 **Privileges of Dentists, Podiatrists and Non-Physician Practitioners**

Privileges granted to dentists, podiatrists and non-physician practitioners shall be based on their training, experience and demonstrated competence, availability and judgment. The scope and extent of surgical privileges that each dentist or podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chairperson of the department of surgery/anesthesia. All dental patients and patients of non-physician practitioners shall receive the same basic medical appraisal as other patients and shall be admitted to the hospital under the care of a member of the associate, or active medical staff willing to accept responsibility for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. The dentist or podiatrist is responsible for the dental/podiatry care of the patient, including the history. The dentist, podiatrist or non-physician practitioner may write orders within the scope of his license, as limited by the applicable statutes and as consistent with medical staff regulations. The procedures for delineation and granting of clinical privileges for dentists, podiatrists and non-physician practitioners shall be generally consistent with those established under Article IV, and shall be subject to the hearing and appeal rights set forth in Article V.

TEMPORARY PRIVILEGES:

5 Temporary privileges are granted for a limited period of time, on a case-by-case basis. There are two circumstances in which temporary privileges may be granted:

a. To fulfill an important patient care, treatment, and service need, or

b. For New Privileges, the applicant must have a completed application that raises no concerns (i.e., Type 1 = No Complex History) and is awaiting review and approval by the Medical Executive Committee (MSEC) and Board of Trustees.

5.1 Temporary Privilege Definitions:

a. **Important Care Need:** Temporary privileges may be granted when an important patient care, treatment, or service need is identified due to one of the following circumstances:

i. To teach/precept/proctor for an existing Medical Staff member; or

ii To perform procedures for which no current Medical Staff member is privileged, yet are needed for a specific patient, providing ARDH has adequate facilities, equipment, qualified support personnel and necessary support services; or

iii. To provide services or procedures when only one or very few Medical Staff members are privileged and are not available.

b. New Privileges: Temporary privileges may be granted to an "individual" applicant requesting new privileges while awaiting review and approval by the MEC and Board of Trustees. New privileges include:

i. An individual applying for clinical privileges at the Hospital for the first time; or

ii. An individual currently holding clinical privileges who is requesting one or more additional privileges; or

iii. An individual who is in the re-appointment/ re-privileging process when additional information and/or time is needed to assure due diligence.

5.2 ***NOTE:*** Locum Tenens and Occasional Coverage
Temporary privileges may be granted to an individual who is substituting for a medical staff member while the staff member is out of town or otherwise unavailable. Temporary privileges may also be granted to an individual who will temporarily be filling a vacancy created by a staff member's resignation or death. Temporary privileges for locum tenens shall be granted for a period of 120 days and may be reviewed for an additional 120-day period.

5.3. ***NOTE:*** In an emergency situation, any Medical Staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm – regardless of his or her medical staff status or clinical privileges – provided that the care, treatment, and services provided are within the scope of the individual's license.

5.4 The individual practitioner requesting temporary privileges has the burden to demonstrate that there are no current or previous successful challenges to licensure/registration, any involuntary termination of medical staff membership, or any involuntary limitation, reduction, denial, or loss of clinical privileges belonging to the "individual" seeking temporary privileges.

5.5 When temporary privileges are granted to **meet an important care need**, the organized

medical staff verifies current licensure and current competence.

5.6 Temporary privileges for **applicants for new privileges** may be granted while awaiting review and approval by the organized medical staff upon verification of the following:

a. A Complete Application (Type 1 = No Complex History)

b. Current Licensure

c. Relevant Training and/or Experience

d. Current Competence/Ability to Perform Privilege(s) Requested

e. Professional Liability Insurance

f. A Query and Evaluation of the National Practitioner Data Bank (NPDB)

5.7 All temporary privileges are recommended by the Chief of Staff (or designee, i.e. Department Chair).

5.8 All temporary privileges are granted by the Hospital President or designee .

5.9 The granting of temporary privileges is a courtesy and may be denied or terminated for any reason, by ARDH's Hospital President or designee (Medical Director) , upon consultation with the Chief of Staff (or designee). Neither a "denial" nor "termination" of temporary privileges entitles the "individual" to procedural rights afforded in the fair hearing or appeal process.

5.10 Temporary privileges shall automatically expire for an important patient need when the patient(s) care, treatment, or service has concluded.

5.11 Temporary privileges for either an important care need or for new privileges are granted for no more than 120 days.

5.12. A Medical Staff Member shall not be entitled to any procedural rights under these Bylaws because of their inability to obtain temporary privileges or for the termination of temporary privileges based on changes in the needs of ARDH. However, if privileges are reduced, limited, suspended, or revoked due to quality-of-care issues, the Medical Staff Member will be entitled to any procedural rights specified in these Bylaws.

6. Disaster Privileges

ARDH grants disaster privileges when an Emergency Management Plan has been activated and the hospital is unable to handle immediate patient needs. These privileges can be granted by the Hospital President or designee (Medical Director), Chief of Staff or their designee.

The hospital leader granting privileges will assign each disaster practitioner to a current member of the hospital's medical staff for supervision. The disaster practitioners will wear a specific badge identifying their temporary status and in accordance with the hospital's emergency management plan.

The care that the disaster practitioner will provide will be monitored through direct observation, mentoring, or clinical record review. To assist in this monitoring a list of patients that the practitioner treats will be kept by the Department.

The Hospital President or designee (Medical Director), Chief of Staff or Designee have the right to terminate a practitioner's disaster privileges immediately if it is discovered that the practitioner's ability to provide disaster privileges were impaired.

6.1 Procedure
The Hospital's President or designee (Medical Director), Chief of Staff, or their designee may grant disaster privileges to practitioners upon completion of the Disaster Privilege form and presentation of any one of the following listed identifications. Note that identification option 1.1.5 is only to be used when the other four (4) options are not available.

6.1.1 A government issued photo ID is a mandatory item; plus at least one of the following
6.1.1.1
a. A current picture hospital ID badge reflecting professional status, or
a. A current license to practice and a valid picture ID issued by the state, federal, or regulatory agency, or
b. Primary source verification of licensure or
c. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT),the Medical Reserve Corps (MRC), the Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group or Identification indicating that the individual has been granted authority by a federal, state or municipal entity to administer patient care in emergencies, or
d. Presentation by a current hospital or medical staff member(s) who can vouch for the practitioner's identity.
6.1.2. The Disaster Privilege Form must be completed and signed by the practitioner requesting disaster privileges and then reviewed and approved by one of the hospital leaders granting disaster privileges.

6.2 Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents to the hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, all the following will be documented:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival
- Evaluation of the licensed practitioner's ability to provide adequate care, treatment, and services must be provided to the Medical Director or the Chief of Staff
- Evidence of attempts to perform primary source verification as soon as possible

6.3 **Definitions**
6.3.1 DMAT: The Disaster Medical Assistance Team card is issued by the National Disaster Medical System under the auspices of the US Public Health Service. A DMAT card expires every two years. The card includes a picture of the cardholder, as well as an expiration date and the DMAT team name. The PHS and National Disaster Medical System insignias appear on the front.
6.3.2 Emergency Management Plan: To be ordered by the Hospital President or designee (Medical Director) or designee according to each hospital's specific disaster plan criteria.
6.3.3 FEMA: Federal Emergency Management Agency whose badge contains the practitioner's name, picture and bar code or the State Medical Examiner's Office.
6.3.4 Hospital Leader: Hospital President or designee (Medical Director), Chief of Staff, or their designees.
6.3.5 Ascension Affiliated Practitioners: Practitioners who are currently on the staff of the Ascension hospitals: Ascension St. John Hospital & Medical Center, Ascension Macomb Oakland Hospital, Ascension River District Hospital, Ascension Providence Hospital and Brighton Hospital.

7. Emergency Provision of Care
In the case of an emergency, any practitioner, regardless of staff status or lack of it, shall be permitted

and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary. It is the obligation of the practitioner to call for any consultation necessary or desirable, to the extent feasible to do so.

7.1. Contract Practitioner's Privileges

Where privileges are granted in a department in which a Practitioner's services are provided pursuant to an exclusive contract with the hospital and are required to be maintained as a condition of the contract, such privileges shall be coterminous with the existence of the exclusive contract, or of the employment of the Practitioner granted such privileges by the entity holding such contract. The terminated Practitioner shall have hearing rights in accordance with Sections 6.1 through 6.4 of Article VI only when termination results from action taken by the Hospital President or designee or the board of trustees.

9. Ascension Credentialing Criteria for Moderate Sedation

9.1. Practitioners Requesting MODERATE SEDATION as *NEW* Privilege:

9.1.1 Request Moderate Sedation as a privilege
9.1.2 Department Chair/or Designee Recommendation
9.1.3 View the current sedation module, complete test, obtain certificate of completion and provide to CVO
9.1.4 Demonstrate "*Airway Management*" training (i.e. ACLS, ATLS, PALS, local airway management course)

9.2. Requesting MODERATE SEDATION as a CONTINUED Privilege:

9.2.1 Request Moderate Sedation as a privilege
9.2.2 Department Chair/or Designee Recommendation
9.2.3 Have Zero (0) Quality Concerns/Issues Related to Moderate Sedation
9.2.4 View the current sedation module, complete test, obtain certificate of completion and provide to CVO
9.2.5 Demonstrate "*Airway Management*" training (i.e. ACLS, ATLS, PALS, local airway management course)

9.3.For NEW and CONTINUED Moderate Sedation Privileges, the following exclusions are noted:

9.3.1 Current sedation module completion and test excluded for Practitioners Trained in:
9.3.1.1 Emergency Medicine
9.3.1.2 Critical Care
9.3.1.3 Pulmonary Medicine
9.3.1.4 Anesthesia
9.3.2 "*Airway Management*" Exclusions for Practitioners Trained In:
9.3.2.1 Emergency Medicine
9.3.2.2 Critical Care
9.3.2.3 Pulmonary Medicine
9.3.2.4 Anesthesia

Procedure for Appointment and Reappointment reviewed and approved by the Medical Staff Executive Committee.

Amended 10/25/02
12/19/02
5/03
2/05
4/08
9/09
2010
2013
Oct. 2014
Oct. 2016
May 2017

October 2017
May 2019
October 2019
May 2022
May 2023
October 2023

Ascension River District Hospital

BYLAWS

THE RIVER DISTRICT HOSPITAL MEDICAL STAFF

PREAMBLE

Recognizing the necessity for the joint practice of allopathic and osteopathic medicine and that the Medical Staff is responsible for the quality of medical care in the hospital, it is mandatory for the medical staff to accept and assume this responsibility subject to the authority of the hospital Board of Trustees. In order to promote optimal professional care of patients, the physicians practicing at Ascension River District Hospital have organized themselves in conformity with these Bylaws and Appendices.

DEFINITIONS

1. "Medical staff" refers to the organized professional staff, including members of the medical staff appointed in an adjunct capacity.

2. "Members of the medical staff" constitute physicians, dentists and podiatrists holding unrestricted licenses who have been appointed to membership on the medical staff by the Board of Trustees.

3. "Physician" is a person licensed independently to practice allopathic or osteopathic medicine, under the laws of the State of Michigan.

4. “Dentist” is a person licensed to practice dental medicine or dental surgery under the laws of the State of Michigan.

5. “Podiatrist” is a person licensed to practice podiatric medicine under the laws of the State of Michigan.

6. "Practitioner" means any appropriately licensed person who is a member of the medical staff or non-physician practitioner or has applied for such membership or been granted temporary clinical privileges.

7. BOARD OF TRUSTEES is the governing body of the corporation known as Ascension River District Hospital.

8. "Executive committee" means the executive committee of the medical staff unless specific reference is made to the executive committee of the Board of Trustees.

9. "Hospital President" means the individual appointed by Ascension as the highest-ranking executive responsible for setting expectations, developing plans, and implementing procedures to assess and improve the quality of Ascension River District’s governance, management, and clinical support functions and processes.”

10. “Medical Director” is a physician selected and appointed by the Administrator/Hospital President, responsible to the Hospital President for the administrative functioning of the Medical Staff. The Medical Director shall work with the Medical Staff and serve as the liaison between the Medical Staff and the Hospital Executive Leadership.

11. "Medical staff year" means the period of time commencing on the first day of January and ending on the thirty first day of December of each year.

12. "Clinical privileges" or "privileges" means the permission granted to a practitioner to render specific diagnostic, therapeutic, medical, dental or surgical services.

13. "Emergency" is defined as a situation in which delay in administering treatment might result in serious harm to the patient or an immediate threat to the life and limb of the patient.

14. "Non-Physician Practitioner" means practitioners other than physicians, podiatrists or dentists, to include but not limited to Nurse Practitioners (NP’s), Physician Assistants (PA’s), Certified

Registered Nurse Anesthetists (CRNA), who are graduates of an approved school in their discipline and are licensed by the State of Michigan in their respective fields.

15. "Prerogative" means a participating right granted, by virtue of staff category or otherwise, to a staff member and exercisable subject to conditions imposed in these bylaws and in other hospital and medical staff policies.

16. “Hospital” means Ascension River District Hospital (ARDH).

17. “Ascension” means the National Health System known as Ascension Health Alliance and its entities, affiliates, assigns, and subsidiaries doing business as Ascension; of which Ascension River District Hospital (ARDH) is a subsidiary.”

18. “Central Verification Office (CVO)” means Ascension Michigan’s Central Verification Office responsible for the credentialing and recredentialing activities of designated Ascension Michigan facilities, including Ascension River District Hospital.”

19. “Credentialing Office” means Ascension River District Hospital’s Medical Staff Office which has as a primary function the responsibility to support the credentialing and privileging functions of the Medical Staff.”

20. “Days” means calendar days.”

21. “Hospital President” means the individual appointed by Ascension as the highest-ranking executive.”

22. “”Medical Staff Bylaws” means the framework that establishes roles and responsibilities for the organization and functions of the Ascension River District Hospital Medical Staff and its members.”

23. “Rules and Regulations” means the provisions concerning procedures, practices, and the professional conduct of the members of the Ascension River District Hospital Medical Staff.”

ARTICLE I: NAME

I.I The name of this organization shall be the River District Hospital Medical Staff.

ARTICLE II: PURPOSES

2.I The Purposes of This Organization Are:

(a) To strive to insure that all patients admitted to or treated in the hospital shall receive the best possible care;

(b) To strive to insure that a high level of professional performance of all practitioners authorized to practice in the hospital through the appropriate delineation of the clinical privileges and through an ongoing review and evaluation of each practitioner's performance in the hospital;

(c) To provide an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill;

(d) To initiate and maintain bylaws, rules and regulations for the governance of the medical staff;

(e) To provide a means whereby issues concerning the medical staff and the hospital may be discussed by the medical staff with the governing body and the Hospital President or designee .

ARTICLE III: MEDICAL STAFF MEMBERSHIP

3.1 Nature of Medical Staff Membership

(a) Membership on the medical staff of Ascension River District Hospital is a privilege which shall be extended only to professionally competent physicians, dentists and podiatrists who continuously meet the qualifications, standards and requirements set forth in these bylaws.

(b) Appointments to the medical staff of Ascension River District Hospital shall not be discriminatory as to race, religion, national origin, age or sex.

3.2 Qualifications for Membership

(a) Basic Qualifications

Applications for membership on the medical staff shall be considered for those physicians, podiatrists and dentists who will promote quality care for patients at Ascension River District Hospital, as evidenced by the following:

1. Unrestricted license to practice in the State of Michigan.
2. DEA license as applicable.
3. Current malpractice insurance with minimum coverage of $100,000/$300,000.
4. Can document their background, experience, training and demonstrated competence.
5. Adherence to the ethics of their profession.
6. Ability to work with others.
7. Sufficient adequacy to assure the medical staff and the Board of Trustees that any patient treated by them will be given a high quality of medical care. Board Certification: All new applicants that apply to Ascension River District Hospital as of May, 2003 shall be required to produce board certification by a certifying Board recognized by the American Board of Medical Specialties, American Osteopathic Association, American Podiatric Medical Association, American Board of Podiatric Medicine, the American Board of Foot and Ankle Surgery, American Dental Association, or candidacy for board certification at the time of the initial application.

(b) Effect of Other Affiliations

No physician, dentist or podiatrist shall be entitled to membership on the medical staff or to the exercise of clinical privileges in the hospital merely by virtue of the fact that the practitioner is duly licensed to practice medicine, osteopathy, podiatry or dentistry in this or in any other state, or that the practitioner is a member of any professional organization, or that the practitioner had in the past, or presently has, such privileges at another hospital.

(c) Understand that Ascension River District Hospital is a healthcare organization that is sponsored by Ascension Health and that it is a faith-based and value-driven organization which provides holistic care with a multidisciplinary approach guided by a Catholic ethic which is expressed through the Ethical and Religious Directives for Catholic Health Care Services and agree to conduct themselves in a manner consistent with those principles.

3.3 Basic Responsibilities of Medical Staff Membership

Each member of the medical staff and where applicable, each non-physician practitioner appointed to the medical staff shall:

(a) Provide their patients with care of the generally recognized professional level of care and efficiency.

(b) Abide by the medical staff bylaws and by all other lawful standards, policies and rules of the hospital.

(c) Discharge such staff, department, committee and hospital functions for which the practitioner is responsible by appointment, election or otherwise.

(d) Prepare and complete in a timely manner the medical and other required records for all patients the practitioner admits or in any way provides care to in the hospital.
1. History and Physical examinations shall be completed and documented by a physician or, (PA or NP with validation by the supervising physician) for each patient no more than 30 days before or 24 hours after admission or prior to surgery or any other procedure requiring anesthesia services. The History and Physical should be available within 24 hours of admission or prior to surgery or a procedure requiring anesthesia services.
2. When the History and Physical are completed within 30 days prior to admission or surgery, it is required that a review of the History and Physical examination be performed and an updated medical record entry of any or no changes in the History and Physical be provided by a physician or (PA or NP with validation by the supervising physician). In all cases, the update must be provided prior to surgery or any procedure requiring anesthesia services.
3. The History and Physical shall include the chief complaint, details of the present illness, past medical and surgical history, social/behavioral history, family history, allergies, present medications, inventory by systems, a physical assessment, working diagnosis and plan of care.

(e) Abide by the code of ethics adopted by the American Medical Association, American Osteopathic Association. American Dental Association, the American Board of Podiatric Medicine and other recognized certifying bodies as referenced in Article III, 3.2 (a) 7., and amendments thereto, whichever is applicable.

(f) Refrain from fee splitting or other inducements relating to patient referral. Abide by regulatory and third party billing requirements.

(g) Be readily accessible to provide for the continuous care of their patients and call responsibilities. Failure to comply will result in corrective action as referenced in Article V.
:

- To improve colleague to colleague communication and promote optimal patient care, all practitioners are required to have and provide the Hospital with their current cell phone number and activate that cell phone number with the currently utilized digital communication system | (PerfectServe), including compliancy with cell phone/text/office connections.

(h) Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner who is not qualified to undertake this responsibility or who is not adequately supervised.

(i) Seek consultation whenever necessary.

(j) Each medical staff applicant and member has an ongoing duty to immediately report (within 14 days) to Medical Director relevant facts and documents: regarding the institution of disciplinary proceedings or taking of action by any health facility (including HMOs), professional society or licensing authority of any state or nation; fine, limitation, suspension, revocation or resignation of membership and privileges at any health facility; censure, reprimand, suspension, restriction, probation or limitation of professional licensure by the licensing authority of any state or nation; or censure of any kind by any professional organization. Failure to inform the Medical Director shall result in an immediate administrative suspension pending further review by the Medical Director and MSEC. Such reports shall be confidential and may only be disclosed in connection with professional review activities prescribed by these bylaws.

(k) Delineation of responsibilities between physicians and podiatrists/dentists are clarified in Rules and Regulations.

(l) To strive for professional care for all patients, irrespective of sex, race, creed, age, physical handicap or national origin.

(m) To comply with the terms of the Code of Conduct of Ascension and the Hospital.

(n) Provided information on challenges to any licensure/registration; voluntary and involuntary relinquishment of any licensure or registration; voluntary and involuntary termination of medical staff membership; voluntary and involuntary limitation, reduction, or loss of membership and privileges; any disciplinary action taken against them by any hospital, or licensing body; any evidence of an "unusual pattern"; any professional liability actions resulting in final judgment against the applicant or any conviction of a criminal offense.

3.4 Duration of Appointment

(a) Initial appointments and reappointments to the medical staff shall be made by the Board of Trustees. The Board of Trustees shall act on appointments only after there has been a recommendation from the medical staff as provided in these bylaws and appendices, provided that in the event of unwarranted delay on the part of the medical staff, the Board of Trustees may act without such recommendation on the basis of documented evidence of the applicant's or staff member's professional and ethical qualifications obtained from reliable sources other than the medical staff.

(b) Initial appointments shall be for a period extending to the end of the current reappointment period. Reappointments shall be made for a period of not more than twenty four months.

(c) Appointment to the medical staff shall confer on the appointee only such membership andl privileges as have been granted by the Board of Trustees, in accordance with these bylaws.

(d) Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment that the practitioner has read and agrees to be bound by the medical staff bylaws, rules and regulations and the acknowledgment of every medical staff member's obligations to provide continuous care and supervision of their patients, and to the extent required by the medical staff bylaws, rules and regulations, to accept committee assignments, to participate in staffing the emergency service area and other special care units.

ARTICLE IV: CATEGORIES OF THE MEDICAL STAFF

4.l Categories

The medical staff shall be divided into active, associate, consulting, ambulatory active, honorary categories and non-physician practitioner.

4.2 Active Staff

(a) Qualifications

The active staff shall consist of physicians, podiatrists and dentists who:

1. Meet the basic qualifications set forth in Section 3.2(a).

2. Members of the medical staff whose practice could involve the treatment of patients on an emergency basis must live and practice within a reasonable distance of the hospital to assure timely and adequate continuous care for his patients. Reasonable distance is defined as: the physician can see their patients daily, cover their regular emergency room call, and be present in emergency situations within forty five (45) minutes of initial notification.

3. Admit twelve patients in twelve months, perform twelve surgical procedures in twelve months or perform 24 consults in twelve months.

   Hospital based physicians who do not normally admit patients or do operative procedures will be excluded from this requirement.

4. Members who were previously on associate staff who admit six patients in a six month period or perform six operating room procedures. They may be advanced to the active staff upon the request of the physician.

(b) Prerogatives

The prerogatives of an active staff member shall be to:

l. Admit patients to the hospital. Podiatrists and dentists must refer to the Rules and Regulations.

2. Exercise such clinical privileges as are granted to them pursuant to Appendix A.

3. Vote on all matters presented at medical staff meetings and hospital committees of which the practitioner is a member.

4. Hold office in the medical staff organization and in the departments and committees of which the practitioner is a member.

5. Prerogatives 3 and 4 will be available to the active staff member after successful completion of their Focused Professional Practice Evaluation.

(c) Responsibilities

Each member of the active staff shall:

1. Discharge the basic responsibilities set forth in Section 3.3.

2. Retain responsibility within their area of professional competence for the daily care and supervision of each patient in the hospital for whom the practitioner is providing services, or to arrange a suitable alternative who has similar credentials/privileges for such care and supervision when unavailable unless a call schedule is routinely available and regularly presented to the Administrative Office.

3. Actively participate in quality assessment and performance improvement activities required of the staff.

4. Participate in staffing the emergency room when staffing pursuant to contract is not available.

5. Accept committee assignments.

6. Attend meetings of the medical staff in compliance with requirements set forth in Articles VIII and X.

7. Discharge other clinical and administrative functions as may from time to time be required.

8. Pay annual staff dues within 90 days of notice. Failure to pay dues in a timely manner will be referred to the Medical Staff Executive Committee for corrective action.

(d) The Board of Trustees, on the recommendation of the Executive Committee, may also appoint podiatrists and dentists to the active staff. Podiatrists and dentists of the active staff shall have the requisite licensure as required by the State of Michigan, but podiatrists and dentists shall not be permitted to admit patients.

4.3 Associate Staff

(a) Qualifications

The associate staff shall consist of physicians, podiatrists and dentists who:

1. Meet the qualifications specified in Section 4.2(a) 1, 2 for members of the active staff.

2. Do not meet the requirements of admissions or procedures as delineated in Section 4.2(a)3.

3. Were previously on active staff and do not meet the requirements of Section 4.2(a)3 for a twelve month period. They will automatically be moved into the associate staff status.

(b) Prerogatives
The prerogatives of an associate staff member shall be to:

1. Admit patients to the hospital. Podiatrists and dentists must refer to Rules and Regulations.

2. Exercise such clinical privileges as are granted to them pursuant to Appendix A.

3. Associate staff shall not be eligible to hold office in this medical staff organization except when no qualified active staff members are available to hold office and shall not have the right to vote at department or general staff meetings or participate in the voting process including making motions or voting.

(c) Responsibilities
Each member of the associate staff shall be required to discharge the same responsibilities as those specified in Section 4.2(c) for members of the active staff. Attend one General Medical Staff meeting and one Department meeting annually. Failure to fulfill those responsibilities shall be grounds for corrective action as specified in these bylaws. Where associate staff status is attained by failure to meet the utilization requirements of active staff specified in Section 4.2(a)3, this shall not be considered disciplinary action.

(d) The Board of Trustees, on the recommendation of the Executive Committee, may also appoint podiatrists and dentists to the associate staff. Podiatrists and dentists of the associate staff shall have the requisite licensure as required by the State of Michigan, but podiatrists and dentists shall not be permitted to admit patients.

(e) Pay annual staff dues within 90 days of notice. Failure to pay dues in a timely manner will be referred to the Medical Staff Executive Committee for corrective action.

4.4 Consulting Staff

(a) Qualifications
The consulting staff shall consist of physicians who are recognized specialists in their fields who:

1. Respond to calls for consultations from members of the active, associate staff and;

2. Meet the basic requirements set forth in Section 3.2(a).

(b) Prerogatives
1. Consult only on those patients referred by active and associate members.

2. Order and perform such minor diagnostic and therapeutic procedures as specifically granted to them under Appendix A, both invasive and noninvasive, necessary to provide an opinion.

3. Recommend therapeutic regimens for consideration by the attending physician.

4. Not admit or discharge patients.

5. May provide minor (non OR, except technical surgical assist) diagnostic and therapeutic procedures as specifically granted to them under Appendix A, both invasive and noninvasive. When active staff members who usually provide the service are

unavailable, consulting staff, if duly qualified, may perform major diagnostic and therapeutic procedures as specifically granted under Appendix A.

(c) Responsibilities

Each member of the consulting staff shall:

1. Discharge the basic responsibilities set forth in Section 3.3.

2. Attend departmental and committee meetings at their discretion without voting privileges.

3. Pay medical staff dues within 90 days of notice. Failure to pay dues in a timely manner will be referred to the Medical Staff Executive Committee for corrective action.

4. Provide written and signed consultations within the timeframe set forth in the medical staff rules and regulations.

4.5 Ambulatory Active:

(a) Qualifications

The ambulatory active staff shall consist of Allopathic and Osteopathic physicians who do not have privileges and do not admit patients to the hospital and do not seek to exercise clinical privileges. They must have achieved board certification but are not required to maintain board certification. These may be fully licensed physicians who refer patients to members of the medical staff of Ascension River District Hospital or physicians who assist in the teaching of resident physicians.

(b) Prerogatives

Ambulatory active staff members shall be appointed by the Board of Trustees on recommendation of the Medical Staff Executive Committee. Ambulatory active staff members will be encouraged to attend department, general staff meetings and CME programs, but will not be eligible to vote or hold office. Ambulatory active staff members will be allowed to see their patients, who are in the hospital, will be allowed access to the patient medical record, but will not be allowed to write orders or admit patients.

(c) Responsibilities

Since an ambulatory active staff member has no clinical privileges in the hospital, the practitioner will not be required to fulfill the obligations of an active, associate, or consulting staff member, except for Section 3.3 Basic Responsibilities of Medical Staff Membership.

(d) Pay annual staff dues within 90 days of notice. Failure to pay dues in a timely manner will be referred to the Medical Staff Executive Committee for corrective action.

4.6 Non-Physician Practitioner:

Practitioners appointed to the non-physician practitioner staff must be graduates of an approved school in their discipline, licensed by the State of Michigan in their respective fields, live and practice within a reasonable distance of the hospital. They shall be assigned to a department appropriate to their discipline and supervised at least to the extent required by the laws of the State of Michigan. ***Physician Assistants, Nurse Practitioners Licensed Medical Social Workers and Certified Registered Nurse Anesthetists*** may treat ***but not admit*** hospitalized patients in their specialty, which patients must be admitted under the care of a member of the active or associate medical staff, within the scope of their licenses and the privileges granted them. They are not eligible to vote or hold office. They shall be required to attend at least one of the two scheduled general staff meetings during the medical staff year and department and at least one department meeting during the year.

Non-Physician Practitioners are not required to pay annual staff dues.

4.7 Telemedicine Staff:

Physicians performing telemedicine shall be defined as using electronic communication or other communication technologies to provide or support clinical care at a distance. Telemedicine privileges shall

include consulting, prescribing, rendering a diagnosis or otherwise providing clinical treatment to a patient using Telemedicine. Active medical staff are not required to apply for Telemedicine privileges in order to use electronic communication or other communication technologies in order to support clinical care at a distance.

4.7.1. Physicians requesting telemedicine privileges must meet the qualifications for Medical Staff membership as outlined in these Bylaws in section 3.3. An application for telemedicine privileges will be processed via proxy approval as outlined in Appendix A.

4.7.2 Will not be entitled to vote or hold office in any department or medical staff positions.

4.7.3 Responsibilities of Physicians with Telemedicine Privileges

4.7.3.1 Be responsible for providing services by Telemedicine at the request of the medical staff.

4.7.3.2. Shall not act as primary practitioner responsible for a patient's care.

4.7.3.3. Shall not be entitled to admit patients.

4.7.3.4. Participate in quality assessment or quality monitoring activities as assigned by the department or committee chairs and/or provide clinical cases from other institutions as requested.

4.7.3.5. Not required to attend quarterly medical staff meetings or departmental meetings.

4.7.3.6. Will be required to pay dues as outlined in these Bylaws.

4.7.3.7. Will provide documentation in electronic medical record of their findings, impressions and recommendations within two hours of completion of consultation.

4.8 Honorary Staff:

4.8.1.The Honorary Staff Category is restricted to those individuals recommended by the Department Chair and MSEC then approved by the Board of Trustees. Appointment to this category is entirely discretionary and may be rescinded at any time.

4.8.2. The Honorary Staff category shall consist of those members who:

- Have retired from active Hospital practice
- Are of outstanding reputation
- Have provided distinguished service to the Hospital

4.8.3. The Honorary Staff Category may:

- Attend the Medical Staff/Department meetings
- Attend continuing medical education activities
- Be appointed to the Medical Staff and/or Hospital committees in accordance with the Medical Staff Bylaws, Medical Staff Rules & Regulations, or Medical Staff policies.

4.8.4. the Honorary Staff category shall not:

- Hold privileges, conduct consults, or admit patients to the Hospital.
- Be required to attend Medical Staff meetings
- Vote on matters presented by the Medical Staff.
- Hold office.

ARTICLE V: CORRECTIVE ACTION

Section 5.1 - ROUTINE CORRECTIVE ACTION

5.1.1-1 Criteria for Initiation. Any officer of the Medical Staff, Department Chair or theHospital President or designee may initiate requests for investigation that ultimately could lead to corrective action for, but not limited to, the following grounds:

(a) The activities or professional conduct of any physician, dentist or podiatrist ("Member of the Medical Staff" which term does not include a non-physician practitioner) are or are reasonably probable of being:

(i) detrimental to patient safety;

(ii) detrimental to effective delivery of patient care; or

(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 the Bylaws, the Rules and Regulations or Policies and Procedures of the Medical Staff;

(f) failure to discharge the responsibilities of membership;

(g) unauthorized disclosure of System, Hospital or Medical Staff information deemed confidential under these Bylaws or noted orally or in writing as confidential;

(h) failure of a Member of the Medical Staff to comply with an agreement between the Hospital or Executive Committee and the Member intended to modify unacceptable behavior or practices of the Member; or

(i) any conduct which forms the basis of a summary action.

5.1.1-2 Requests and Notices. All requests for corrective action, in accordance with 1.1-1, shall be in writing, submitted to the Executive Committee and supported by reference to the specific activities or conduct, which constitute the grounds for the request. Hospital President or designee shall be kept fully informed of all action taken in conjunction there with which they are not personally managing.

5.1.1-3 Investigation When Appropriate and Report. The Executive Committee 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 thirty (30) days after the receipt of the designation, forward a written report of the investigation to the Executive Committee. If the corrective action request was preceded by an investigation, a report of that investigation may be used in lieu of a subsequent investigation.

5.1.1-4 Interview of Subject Member. At any point after a corrective action request is made, the Executive Committee, Department Chair or an investigator (person or committee) may, upon request, have the opportunity to interview the Member subject to the corrective action request.

5.1.1-5 Executive Committee Action. Within thirty (30) days following receipt of the request, or if an investigation is requested, receipt of the investigation report, the Executive Committee shall take action upon the request. Action taken by the Executive Committee may include without limitation:

(a) rejecting the request for corrective action with or without a warning letter or admonition;

(b) recommending to the Board of Trustees requirements of consultation, other than administrative consultations (as specified in 1.4-4)

(c) issuing a letter of reprimand;

(d) imposing probation without limitation of Privileges;

(e) recommending to the Board of Trustees reduction, suspension or revocation of membership and Privileges;

(f) recommending to the Board of Trustees reduction of category or limitation of any prerogatives directly related to patient care;

(g) recommending suspension or revocation of Membership; or

(h) recommending to the Board of Trustees that other action be taken.

5.1.1-6 Exercise or Waiver of Procedural Rights. Any recommendation or action taken pursuant to (b) through (h) of 5.1.1-5 will ordinarily be held in abeyance for a period of thirty (30) days or the timely and effective exercise of procedural rights applicable to the action in the Review Procedures Plan, whichever is longer. However, during such period, other actions including those described in Sections 5.1.2, 5.1.3 and 5.1.4 may still be taken, if appropriate. The Executive Committee 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 Review Procedures Plan.

5.1.1-7 Report to the Board of Trustees and Board of Trustees Action. All Executive Committee actions and recommendations regarding a corrective action request shall be reported promptly to the Board of Trustees. A rejection of a request for corrective action or the taking of actions specified in 5.1.1-5(c) and (d) shall not be final until affirmatively approved by the Board of Trustees. If not approved by the Board of Trustees, the Board of Trustees may, after due consultation with the Executive Committee, take any other action specified in 5.1.1-5. As to any corrective action taken or recommended by the Executive Committee for which the Member has timely and effectively pursued a formal hearing (basic or special), if applicable, Board of Trustees action will await the outcome or waiver of the Member's appeal. As to any corrective action taken or recommended by the Executive Committee which the Member is not entitled to or has waived a formal hearing, the Board of Trustees may expressly affirm, or after consultation with the Executive Committee, reject (or rescind) such action or recommendation with such special directives to the Hospital President or designee and/or the Executive Committee as it deems appropriate.

5.1.1-8 The Medical Director or their designee shall report to the National Practitioner Data Bank and/or the Michigan Department of Licensing and Regulatory Affairs (and/or other appropriate governmental authority or agency) any adverse action that must be reported to any said authority and/or agency under federal or state law and may submit any such reports as are authorized by applicable law.

Section 5.1.2 - SUMMARY ACTION

5.1.2-1 Criteria and Initiation. Any two (2) of the Chief of Staff, Hospital President or designee or Department Chair, acting jointly, or the Executive Committee or Board of Trustees of Ascension River District Hospital acting alone, will have the authority to summarily suspend or place conditions upon the exercise of all or any portion of the clinical privileges ("Privileges") of a Member of the Medical Staff, whenever:

(a) the Member of the Medical Staff's temporary or permanent mental or physical state is such that one or more patients under their care would be subject to imminent danger to their health as a result of their action or inaction if the practitioner is permitted to continue to exercise Privileges;

(b) there is substantial evidence that the Member of the Medical Staff has committed acts of an illegal or unethical nature while in the Hospital or in another setting which are of such gravity that, if proven, would justify revocation or permanent suspension of Medical Staff Membership, Privileges, professional licensure or prescribing authority;

(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 of the Medical Staff involved would be subject to imminent danger to their health, if the practitioner is permitted to continue to exercise Privileges;

(d) there is substantial evidence of an act, omission or pattern by the Member of the Medical Staff 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.

(e) non-compliance with an agreement between a Member of the Medical Staff and the Executive Committee or Hospital, where the agreement specifies non-compliance will result in suspension or the acts of non-compliance will place patient, staff, Member of the Medical Staff, or Hospital welfare at significant risk.

Such summary action shall become effective immediately upon imposition, and the Hospital President or designee shall promptly give written notice of the suspension to the Member of the Medical Staff.

5.1.2-2 Executive Committee Action. At an Executive Committee meeting no later than 10 days following such summary action, the Executive Committee shall review and consider the action to be taken. The Executive Committee, in consultation with the Hospital President or designee , may impose a modification, continuation or termination of the terms of the summary action. If an Executive Committee decision is other than to rescind the action in total within 14 days of imposition, the subject Member of the Medical Staff may make a request to pursue the procedures applicable in the Review Procedures Plan. If the Executive Committee should rescind the summary action, but refer the matter for routine corrective action as an alternative, any request for the procedures of the Review Procedures Plan, other than informal review, shall be pursued under 5.1.1-6 of the routine correction action section only after Executive Committee has taken action under paragraph 5.1.1-5 of that same section. In the event that the Executive Committee should recommend routine corrective action concurrent with summary action for the same Member of the Medical Staff, then any review procedures for both actions shall be consolidated in accordance with the provisions of the Review Procedures Plan.

5.1.2-3 Responsibilities. The medical coverage for the inpatients in the Hospital of the Member of the Medical Staff subject to emergency suspension shall be selected by the Head of the Division to which said Member of the Medical Staff is assigned. As much as possible, the wishes of the respective patient(s) shall be considered in the selection.

SECTION 5.1.3 - AUTOMATIC ACTION

In the following instances, the practitioner's membership and/or privileges will be considered relinquished or limited as individually described, and the action shall be final without a right to a hearing or appeal:

a. **Revocation or Suspension**: Whenever a practitioner's license or other legal credential authorizing practice in this or another state is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.
b. **Limited or Restricted**: Whenever a practitioner's license, or other legal credential authorizing practice in this or another state is limited or restricted by an applicable licensing or certifying authority, and clinical privileges that the practitioner has been granted at this Hospital that are within the scope of said limitations or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
c. **Expired or Relinquished"** Whenever a practitioner's license or other legal credential authorizing practice in this state is expired or voluntarily relinquished, Medical Staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.
d. **Probation**: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, their membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term."
e. **Medicare, Medicaid, or other Federal Programs:** Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, or other federal programs, Medical Staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of Inspector General's list of excluded individuals/entities will be considered to have automatically relinquished his or her membership and privileges."
f. **Drug Enforcement Agency (DEA) Certificate:** Whenever a practitioner's United States Drug Enforcement Agency certificate is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term."
g. **Probation of Drug Enforcement Agency (DEA) Certificate:** Whenever a prescriber's DEA is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term."
h. **Felony or Misdemeanor:** A practitioner who has been convicted of or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of moral turpitude in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately on such indictment, conviction, or plea, regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the board or through corrective action, if necessary."
i. **Professional Liability Insurance:** Failure of a practitioner to maintain professional liability insurance in the amount required by the Medical Staff shall result in immediate automatic relinquishment of a practitioner's clinical privileges and membership. The practitioner must notify the Medical Staff office immediately of any change in professional liability insurance carrier or coverage."
j. **Failure to Participate in an Evaluation:** A practitioner who fails to participate in an evaluation of their qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills), shall be considered to have automatically relinquished all membership and privileges. Membership and privileges will be restored when the practitioner complies with the requirement for an evaluation."

k. **Failure to Satisfy the Special Appearance Requirement:** A practitioner who fails without good cause to appear at a meeting where a special appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all membership and privileges with the exception of emergencies. Membership and privileges will be restored when the practitioner complies with the special appearance requirement."

l. **Failure to Execute a Release and/or Provide Document:** A practitioner who fails to execute a general or specific release and/or provide documents to the President of the Medical Staff (or designee) upon request, shall be considered to have automatically relinquished all privileges and membership. These documents are to help the Medical Staff President (or designee) evaluate the competency and credentialing / privileging qualifications of the involved practitioner."

m. **Medical Staff Dues:** A practitioner who fails to promptly pay medical staff dues shall automatically relinquish medical staff membership and privileges if the dues are not paid by the end of the calendar year (after receiving appropriate communications throughout the dues assessment phase)."

SECTION 5.1.4 - ADMINISTRATIVE ACTION

5.1.4-1 Circumstances. Administrative action shall be automatically imposed for any reasons enumerated in 5.1.4. 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.

5.1.4-2 Prescribing Authority. A Member of the Medical Staff s whose authority to prescribe and administer is revoked or suspended shall immediately and automatically be divested of their right to prescribe medications covered by such authority. After such administrative action, the Executive Committee at its next regularly scheduled meeting shall review and consider the facts under which the authority was revoked or suspended. The Executive Committee 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.

5.1.4-3 Medical Records. Members who do not complete their medical records within the time frames specified in the Medical Staff Rules shall, automatically have all admitting, consulting, and operative Privileges temporarily withheld. As provided in the Rules and/or Policy Manual, continued delinquency may result in corrective action, including termination of Membership and Privileges.

5.1.4-4 Administrative Consultations. The Hospital President or designee , Chief of Staff, or Department Chair may initiate an administrative consultation requirement as to a particular patient, certain particular patients or all patients of a Member of the Medical Staff, when it is determined that the interests of the Hospital or the welfare of a patient or patients of a Member of the Medical Staff require such action. Such consultation requirements may include proctoring, co-management or other conditions or limitations upon the practice.

Initiation of an administrative consultation should ordinarily be preceded by the concurrence of the Hospital President or designee or Department Chair. Where obtaining such prior concurrence is not possible because the matter requires immediate action, concurrence should be obtained as soon as reasonably possible thereafter.

The consultation requirement imposed may stay in effect, without institution of corrective action for thirty (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 of the Medical Staff immediately by written notification by the Chief of Staff . The result of the administrative consultation shall be reported back to the Department

Chair and Hospital President or designee . This information will be conveyed to the Executive Committee at its next regularly scheduled meeting for determination of an appropriate course of action, which may include corrective action pursuant to 5.1.1.

5.1.4-5 Professional Liability Insurance. In the event that a Member of the Medical Staff fails to:

(a) maintain in force professional liability insurance in prescribed amounts; or

(b) report any change in the status of their professional liability insurance to the Medical Staff Office within seven (7) days subsequent to the change;

The Privileges of Members of the Medical Staff 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 professional liability requirement shall continue to be withheld until the requirement is satisfied. Continued failure to be in compliance may result in corrective action pursuant to 5.1.1 and/or non-reappointment.

5.1.4-6 Technical Non-Compliance with Bylaws, Rules or other System Policies. In the event a Member is found to have violated a provision of the Bylaws, Rules, the System's Corporate Compliance Policies or Code of Conduct, or other System policy (written or unwritten) which does not directly or immediately involve patient well-being, the Hospital President or designee , after consultation with the Executive Committee or the Board of Trustees, is empowered to issue a letter to the Member giving notice of non-compliance and advising the Member of the importance of future compliance. The Member involved shall be required, within thirty (30) days after receipt of such notice, to acknowledge in writing, their receipt, and to pledge the practitioner will thereafter comply with the policy involved, and provide any mitigating factors practitioner feels are warranted. A copy of such Notice of Non-Compliance and the Member's response shall be placed in the credentials file. Such notice and response may be considered, for two (2) reappointment periods after issuance and in any corrective action proceedings involving the Member. If no further Notices of Non-Compliance are issued within two (2) reappointment cycles for similar infractions, it will, at the request of the Member, be permanently expunged from their Medical Staff review file.

SECTION 5.1.5 - ALTERNATIVE ACTION

5.1.5-1 Alternative Action Defined. Alternative Action is an alternative means of remedying a problem of a Member of the Medical Staff for which corrective action or other traditional means of behavioral modification are either not feasible or not as appropriate.

5.1.5-2 Basis for Alternative Action. The basis for requesting Alternative Action shall be a state of mind, course of conduct, or condition (physical, mental or emotional), which may potentially impair the ability of a Member of the Medical Staff to safely and skillfully practice their profession. By way of example, and not in limitation, circumstances which indicate Alternative Action include substance abuse, excessively compulsive behavior, inability to interpersonally relate to patients and/or staff, or onset of a debilitating illness or condition. Manifestations of the foregoing justifying Alternative Action need not be observed on Hospital premises, but rather can be based on reasonably supportable observations about the Member of the Medical Staff at any time.

5.1.5-3 Procedures. The Executive Committee shall establish procedures for Alternative Action.

5.1.5-3.1 Applicability. If any recommended or taken Alternative Action is covered by another corrective action process in this Article, then the Member will have the same opportunity for procedure and hearing as described in the relevant section under this Article.

CORRECTIVE ACTION PROCEDURES

SECTION 5.2. - APPLICATION OF REVIEW PROCEDURES

5.2.1 DEFINITIONS

The following definitions shall apply to this Plan, in addition to other definitions set forth in these Bylaws:

Affected Member of the Medical Staff: means a Member or Initial Applicant as to whom a Staff or Board of Trustees recommendation was made or action taken.

Initial Applicant: means a physician, dentist, or podiatrist making an application for initial appointment to the Medical Staff.

Administrator: means for all purposes, herein, theHospital President or designee of the hospital, or designee,absent a contrary written notice by the Hospital President or designee .

5.2.2 GENERAL APPLICATION

The procedures set forth in this Plan are intended to be utilized with regard to certain types of disciplinary and administrative actions taken or about to be taken with Members and Initial Applicants who make a timely request for the same.

5.2.3 – HEARING EVENTS:

Hearings will be **triggered** only by the following adverse actions or recommendations when the basis for such action is related to clinical competence or professional conduct:

A. Denial of Medical Staff appointment or reappointment;
B. Revocation of Medical Staff appointment;
C. Denial or restriction of requested membership and clinical privileges, as recommended by the MSEC;
D. Involuntary reduction or revocation of membership and clinical privileges for a period of exceeding fifteen (15) days;
E. Application of a mandatory requirement for proctoring or consultation, with consent of the proctor or consultant being required before the member can provide care to any patient when such requirement only applies to an individual Medical Staff member and is imposed for more than fifteen (15) days;
F. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fifteen (15) days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

5.2.4 Events that **do not trigger** a hearing include, but are not limited to:

A. The MSEC issues a practitioner a letter of guidance, warning, or reprimand;
B. The MSEC requires the practitioner to be proctored or consulted (with the consent of the proctor or consultant not being required before the practitioner provides care to patients) with no restriction on privileges;
C. The Organized Medical Staff fails to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
D. The MSEC conducts an investigation into any matter or appoints an ad hoc investigation committee;
E. Medical Staff leaders require the practitioner to appear for a special meeting under the provisions of these Bylaws;
F. The practitioner automatically relinquishes or voluntarily resigns appointment or privileges;
G. The MSEC imposes a precautionary or other restriction that does not exceed fifteen (15) calendar days;
H. The practitioner is denied a request for leave of absence or an extension of a leave;

I. The Organized Medical Staff determines that an application is incomplete or untimely;
J. The Organized Medical Staff office determines that an application will not be processed due to misstatement or omission;
K. The Organized Medical Staff makes a decision not to expedite an application;
L. The MSEC denies, terminates, or limits temporary privileges, unless for demonstrated incompetence or unprofessional conduct;
M. The Medical Staff office determines that an applicant for membership does not meet the requisite qualifications/criteria for membership;
N. The practitioner is ineligible to request membership or privileges or continue privileges because a relevant specialty is closed under a Medical Staff development plan or covered under an exclusive provider agreement;
O. The MSEC requires the practitioner to be supervised (without restriction of privileges or the consent of the supervisor being required before the practitioner provides care to patients) pending completion of an investigation to determine whether corrective action is warranted;
P. A practitioner's contract with or employment by the Hospital is terminated, or the practitioner's privileges are automatically terminated upon termination of the contract and/or employment;
Q. The MSEC requires that a practitioner be monitored, and/or imposes other performance monitoring requirements to fulfill any Joint Commission standards regarding FPPE;
R. A Medical Staff member voluntarily accepts any recommendation from the Board or the MSEC;
S. A practitioner's membership and privileges expire as a result of the practitioner's failure to submit an application for reappointment within the allowable time period;
T. A practitioner's assigned staff category changes ;
U. The Credentials Committee or the MSEC refuses to consider a request for appointment, reappointment, or privileges within five years of a final adverse decision regarding such request, unless otherwise specified in the terms of the specific corrective action or otherwise determined by the MSEC;
V. A practitioner's ED call obligations are removed or limited;
W. The practitioner is required to complete an educational assessment or offering;
X. A peer review committee or other individual conducts retrospective chart review as part of peer review;
Y. The practitioner is required to complete a health and/or psychiatric/psychological assessment under these bylaws;
Z. A practitioner is granted conditional appointment or appointment for a limited duration;
AA. The duration of a practitioner's appointment or reappointment is less than twenty-four (24) months.
BB. Denial of a request for leave of absence, or for an extension of a leave, or involuntary resignation of membership for failure to timely request reinstatement while on leave of absence.
CC. Removal from any committee for failure to fulfill the responsibilities of membership; -or-
DD. Withholding of Privileges on account of violation of medical records completion requirements.

5.2.5 APPLICATION OF SPECIAL HEARING PROCEDURES

The special hearing procedures as set forth in Section 5.2.5 of this Plan shall apply to the following recommendations or actions:

(a) Non-reappointment, except for: failure to timely submit a recredentialing form; document financial responsibility; failure to timely request reinstatement following an expiration of leave of absence; or termination of a written contract with the Member and/or their employer; recurrent non-compliance with medical records requirements; failure to comply with a written agreement between the Executive Committee or Hospital and the Member which provides for non-reappointment for failure to comply; and recurrent failure to work cooperatively with others after disruptive Member of the Medical Staff or alternative action procedures have been undertaken;

(b) Denial, involuntary reduction or suspension of Privileges of an Active or Associate category Member which are ordinarily possessed by a Member of like or similar training or Medical Staff duration, for fifteen (15) days or more for reasons related to professional competence or professional conduct in the care of patients, except for failure to comply with a written agreement between the Executive Committee or Hospital and the Member which provides for denial, involuntary reduction or suspension of Privileges for failure to comply;

(c) Revocation or suspension of Membership or Privileges for 15 days or more except for: failure to timely submit a recredentialing form; failure to document professional liability; expiration or termination of a written contract with the Member and/or their employer; failure to comply with a written agreement between the Executive Committee or Hospital and the Member which provides for revocation or suspension for failure to comply; and recurrent failure to work cooperatively with others after disruptive Member of the Medical Staff or alternative action procedures have been undertaken; or any other ground which is not based on professional conduct or competence in the care of patients;

(d) Denial of an initial application for appointment to the Medical Staff except by reason of: the application being incomplete; the application containing material inaccuracies or omissions; absence or termination of a written contract with the Member and/or their employer where required for Membership or Privileges; or any reason unrelated to the professional competence or professional conduct in the care of patients of the Initial Applicant; and

(e) Such other recommendations or actions as the Executive Committee or Board of Trustees may direct, in its discretion, after consultation with the other.

SECTION 5.3. - ADVERSE RECOMMENDATION OR ACTION

5.3.1 NOTICE OF RECOMMENDATION OF ACTION

When a recommendation is made or action taken by the Executive Committee or the Board of Trustees which, according to this Plan, entitles an Affected Member of the Medical Staff to a basic hearing (5.4.1) or special hearing (5.5.1) prior to a final decision of the Board of Trustees on that recommendation or action, the Affected Member of the Medical Staff shall be promptly given Special Notice by the Hospital President or designee . The Special Notice shall contain:

(a) A statement of the recommendation made and the general reasons for it;

(b) A statement that the Affected Member of the Medical Staff has the right to request a hearing on the recommendation within thirty (30) days of their receipt of the notice;

(c) A statement of the kind of hearing (basic or special) to which the Affected Member of the Medical Staff is entitled; and

(d) A copy of this Plan, unless it has already been provided to the Affected Member of the Medical Staff.

5.3.2 REQUEST FOR ORIGINAL HEARING

The Affected Member of the Medical Staff shall have thirty (30) days following receipt of the Special Notice pursuant to section 5.3.1 to file a written request for a hearing. The request shall be made in writing and delivered in person or by certified mail to the Hospital President or designee .

5.3.3 WAIVER BY FAILURE TO REQUEST A HEARING

An Affected Member of the Medical Staff who fails to request a formal hearing within the time and in the manner specified in Section 5.3.2 waives any right to such hearing and to any possible appellate review. When such waiver is in connection with:

(a) a proposed or actual adverse action by the Board of Trustees, it shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board of Trustees;

(b) an adverse recommendation or action by the Executive Committee, it shall constitute acceptance of that recommendation, which shall thereupon become and remain effective pending the final decision of the Board of Trustees. In this event, the Board of Trustees shall consider the Executive Committee's recommendation at its next regular meeting following waiver. In its deliberations, the Board

of Trustees shall review and consider the recommendation and supporting documentation of the Executive Committee and may consider any other relevant information received from any source. The Board of Trustees' action on the matter shall constitute the final decision of the Board of Trustees.

The Hospital President or designee shall promptly send the Affected Member of the Medical Staff notice of each official action taken pursuant to this Section 5.3.3 and shall notify the Medical Director or designee of each such action.

SECTION 5.4. - BASIC HEARING PROCEDURES

5.4.1 NOTICE OF TIME AND PLACE FOR HEARING

Upon receipt of a timely request for hearing, the Hospital President or designee shall deliver such request to the Medical Director or designee or the Board of Trustees, depending on the body whose recommendation or action prompted the request for hearing. The Medical Director or designee or the Board of Trustees, as appropriate, shall promptly schedule and arrange for a basic hearing. At least thirty (30) days prior to the hearing date, the Hospital President or designee shall notify the Affected Member of the Medical Staff of the date, time and place of the commencement of the hearing by Special Notice. Such notice shall include a list of witnesses (if any) expected to testify at the hearing on behalf of the Hospital. The hearing date should not be more than forty-five (45) days from the date of receipt of the request for hearing. A hearing for an Affected Member of the Medical Staff who is under suspension then in effect shall ordinarily be held as soon as the arrangements and preparations for it may be reasonably made and requirements for same met. The notice may also furnish hearing rules, including time limits, prepared by the Medical Director or designee or Board of Trustees Chairperson, that take into account the anticipated nature and scope of the hearing, as well as the interests of both parties and the hearing committee.

5.4.2 STATEMENT OF REASON

If the reason(s) for the action or recommendation have not already been stated to the Affected Member of the Medical Staff seeking a hearing, the reasons shall be sent via certified mail and/or electronically to the Affected Member of the Medical Staff at least three (3) days before the scheduled date for the hearing. The statement of reasons may be amended at any time, provided the Affected Member of the Medical Staff is given a reasonably sufficient opportunity to prepare to meet any added reasons.

5.4.3 APPOINTMENTS OF HEARING COMMITTEE

5.4.3-1 By Medical Staff. A hearing occasioned by recommendation of the Executive Committee shall be conducted by an ad hoc committee composed of no less than three and no more than five Members of the Medical Staff, appointed by the Medical Director or designee in consultation with the Chief of Staff. The Medical Director or designee and the Chief of Staff, who shall not be members of the committee, shall appoint a member of the committee to serve as its Chair.

5.4.3-2 By Board of Trustees. A hearing occasioned by proposed or actual adverse action of the Board of Trustees shall be conducted by a hearing committee appointed by the Board of Trustees. This committee shall be composed of not less than three persons, at least one of whom shall be a Member. The Chairperson of the Board of Trustees, who shall not be a member of the hearing committee, shall designate a member of the committee to serve as its chair.

5.4.3-3 Service on Hearing Committee. A Medical Staff or Board of Trustees member shall not be disqualified from serving on a hearing committee merely because of prior participation in the investigation of the underlying matter at issue or because of knowledge of facts involved. In any event, all members of a hearing committee shall be required to consider and decide the case with good faith objectivity.

5.4.4 APPEARANCE AND REPRESENTATION

5.4.4-1 Appearance of Member. The Affected Member of the Medical Staff requesting the hearing must be present for the hearing; their failure to appear at the date and time set forth in the notice shall constitute a waiver of the right to a hearing.

5.4.4-2 Representation. At any Basic Hearing:

(a) An Affected Member of the Medical Staff shall represent themself.

(b) If the hearing committee is the Executive Committee or a subcommittee thereof, the Medical Director or designee may, in their discretion, appoint themself or another Member to present the position adverse to the Affected Member of the Medical Staff.

(c) If the hearing committee is a committee appointed by the Board of Trustees, the Chairperson of the Board of Trustees may, in their discretion, appoint a Member or other person to present the position adverse to the Affected Member of the Medical Staff. This person shall be called the "Advocate".

(d) No Affected Member of the Medical Staff nor Advocate may participate in deliberations of the hearing committee.

5.4.5 HEARING CONDUCT AND EVIDENCE

5.4.5-1 Hearing Conduct. The chairperson of the hearing committee shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure and the considerations of evidence. The presiding officer may also promulgate hearing rules including reasonable time limits, pursuant to Section 6.4 of this Plan, which may modify any rules provided by the Medical Director or designee or Board of Trustees Chairperson under Section 5.4.1. The hearing shall be conducted in such a manner that both the Affected Member of the Medical Staff and the Advocate (if any) has an opportunity to have their position fairly heard and considered. Members of the hearing committee may ask questions of the Affected Member of the Medical Staff and the Advocate (if any).

5.4.5-2 Evidence. The Affected Member of the Medical Staff and the Advocate (if any) may submit to the hearing committee for consideration:

(a) Written statements, letters and documents, which are relevant to the subject matter of the hearing, including relevant portions of the file maintained by the Hospital regarding the Affected Member of the Medical Staff;

(b) Oral statements by the Affected Member of the Medical Staff and the Advocate (if any);

(c) Only when deemed essential to a meaningful hearing, the presiding officer may, in their discretion, authorize the appearance, examination and cross-examination of witnesses, consistent with supplemental hearing rules; unless, so authorized, neither the Affected Member of the Medical Staff nor the Advocate (if any) shall have a right to present witnesses, or cross-examine in person.

Evidence admitted in the hearing need not strictly meet the requirements of admissibility of a court of law, and the hearing committee may consider any evidence customarily relied upon by responsible persons in the conduct of serious affairs.

5.4.6 BURDEN OF PROOF

The Affected Member of the Medical Staff shall have the burden of proof and must demonstrate that the grounds for the action or recommendation are not supported by the evidence or the conclusions drawn therefrom are arbitrary or capricious.

5.4.7 RECORDING OF HEARING

The hearing shall be recorded by minutes prepared by a recording secretary selected by the Hospital President or designee , which minutes shall be subject to approval and amendment by the hearing committee.

5.4.8 RECOMMENDATION

5.4.8-1 Notice. Within thirty (30) days after completion of the hearing, the hearing committee shall meet, deliberate, and then issue its report in writing to the Hospital President or designee . The report shall be submitted by the Medical Director or designee to the Chief of Staff or Board of Trustees, as appropriate, and to the Affected Member of the Medical Staff (by Special Notice).

5.4.8-2 Action on Recommendation.

(a) If the hearing committee was a subcommittee of the Executive Committee, its report shall be submitted to the Executive Committee for consideration. Thereafter, the Executive Committee shall make its final recommendation, subject to approval by the Board of Trustees.

(b) If the hearing committee was the Executive Committee, its report shall become the final recommendation of the Executive Committee, subject to Board of Trustees action.

(c) If the hearing committee was a committee appointed on behalf of the Board of Trustees, its report shall become its final recommendation, subject to Board of Trustees action. If timely requested, final Board of Trustees action may be subject to reconsideration on appeal.

5.4.9 NOTICE OF AFFECTED PRACTITIONER

Within seven (7) days after the Board of Trustees action or approval, the Medical Director or designee shall send written notice to the Affected Member of the Medical Staff regarding its decision, and the basis therefore.

5.4.10 APPEAL

If, following a basic hearing pursuant to this Section, the Affected Member of the Medical Staff believes that the hearing committee's recommendation was arbitrary, capricious, or lacks any evidence in support, which shall be the sole grounds for appeal, the Affected Member may, within fifteen (15) days of receipt of notice of the recommendation, submit a written appeal of the recommendation consisting of not more than ten (10) pages of text (not including exhibits) concisely stating the basis therefor to the Hospital President or designee . If such an appeal is filed, the hearing committee or a representative thereof may submit a written response in opposition within fifteen (15) days after the appeal is received. The appeal shall be considered by the Board of Trustees, which shall, within forty-five (45) days after receipt of the appeal, take one of the following actions:

(a) Refer the matter back to the hearing committee for further review or supplemental findings; if this is done, the hearing committee shall respond in writing to the Board of Trustees request within fifteen (15) days of request, and the Board of Trustees shall then take the actions in (b), (c) or (d) below within thirty (30) days after receipt of the response; or

(b) Uphold the recommendation of the hearing committee and take final action accordingly;

(c) Reverse the recommendation of the hearing committee, with or without the requirement that further hearings be conducted by the hearing committee; or

(d) Reverse the recommendation of the hearing committee and require a special hearing be held in accordance with the provisions of Section 5.5 of this Plan.

TheHospital President or designee shall advise in writing the Affected Member of the Medical Staff, by Special Notice of the outcome of the appeal.

Section 5.5. - SPECIAL HEARING PROCEDURES

5.5.1 NOTICE OF TIME AND PLACE FOR HEARING

5.5.1-1 Scheduling of Hearing. Upon the receipt of a timely and proper request for a special hearing, the Hospital President or designee shall promptly schedule and arrange for the hearing. The hearing date shall ordinarily be not less than thirty (30) days or more than sixty (60) days from the date of receipt of the request for hearing.

5.5.1-2 Shortened Time Limit for Hearing. A hearing for a Member who is under suspension then in effect may be held in less than thirty (30) days after the request is made, provided such Member's request for the hearing includes a specific request that the hearing be held in less than thirty (30) days; in the event such a special request for a shorter period is made by a Member who is under suspension, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and requirements for same met, subject to Section 5.5.1-3 below.

5.5.1-3 Lengthened Time Limit for Hearing. If pursuant to section 5.5.3 the Affected Member of the Medical Staff objects to the composition of an ad hoc hearing committee, or a determination is made that a hearing officer who is not a Member shall conduct the hearing, the sixty (60) day maximum limitation shall be deemed waived by the Affected Member of the Medical Staff. In such an event, the hearing shall be held as soon as the arrangement and preparations for it may reasonably be made and the requirements for the same met. The Hospital President or designee shall give written notice of the new scheduled date, time, and place of the hearing to the Affected Member of the Medical Staff, hearing committee or officer, and the Medical Director or designee or Board of Trustees, once the questioning and objection processes are complete and the hearing committee or officer has been finally selected.

5.5.2 HEARING NOTICE, RESPONSE AND WITNESS LISTS

5.5.2-1 Hearing Notice. The Hospital President or designee shall issue a notice of hearing by Special Notice to the Affected Member of the Medical Staff and by any suitable means of notice to others involved in the hearing process. The notice of hearing shall specify:

(a) Time and Location - The scheduled date, scheduled time and location of the hearing, as well as a statement of reasons and list of witnesses (as provided in 5.5.1-2 and 5.5.1-3). Such date shall be at least 30 days out from the notice of hearing.

(b) Statement of Reasons - As applicable, a statement of the alleged acts or omissions of a Member, a list by number of the specific or representative patient medical records in question and/or other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.

(c) List of Witnesses - A list of witnesses, if any, that the body which took or proposed adverse action (or its designated representative) believes will be called as witnesses to testify in support of the recommendation or action at the time of the hearing.

5.5.2-2 Response and List of Witnesses of Affected Member of the Medical Staff. Within fourteen (14) days after receipt of the notice of hearing, the Affected Member of the Medical Staff shall furnish to the Hospital President or designee their written response to the Statement of Reasons and a list of the individuals (and their addresses) who may or will be called as witnesses in support of the Affected Member of the Medical Staff's position at the time of the hearing.

5.5.2-3 Amendments. The statement of reasons, the response, or the list of witnesses of either party may be amended at any time by the party furnishing them, provided that the opposite party is given a reasonable period in which to prepare to meet the substance of the testimony of additional witnesses. For the purpose of this provision, a time period of one week or more, shall be presumed to be a "reasonable period". The permissibility of a shorter period of notice shall be subject to the discretion of the presiding officer for the hearing.

5.5.3 APPOINTMENTS OF HEARING COMMITTEE

5.5.3-1 By Medical Staff. A special hearing occasioned by recommendation of the Executive Committee pursuant to Section 5.3.1 shall be conducted by an ad hoc committee composed of no less than three and no more than five Members of the Medical Staff, appointed by the Medical Director or

designee in consultation with the Chief of Staff. The Medical Director or designee and the Chief of Staff, who shall not be hearing committee members, shall appoint the presiding officer of the hearing committee who may, but need not be a Member of the Medical Staff; an attorney may be appointed as a hearing officer but if this is done, while the attorney may participate in committee deliberations and assist in the preparation of the hearing committee report, (s)he shall not have a vote for or against adoption of the final hearing committee report. The appointments are subject to the procedures of Sections 5.5.3-3, 5.5.3-4, 5.5.3-5 and 5.5.3-6.

5.5.3-2 By Board of Trustees. A hearing occasioned by adverse action of the Board of Trustees pursuant to Section 5.3.1 shall be conducted by a hearing committee of three or more persons appointed by the Chairperson of the Board of Trustees, at least one of which must be Member in the same profession as the Affected Member (e.g., physician, dentist), and at least one of which must be a Board of Trustees member. One of the appointees to the hearing committee shall be designated as presiding officer. The appointments are subject to the procedures of Sections 5.5.3-3, 5.5.3-4, 5.5.3-5 and 5.5.3-6.

5.5.3-3 Service on Hearing Committee. A Member or other person appointed to serve on an ad hoc hearing committee shall not be disqualified from serving on a hearing committee merely because of prior participation in the investigation of the underlying matter and issue, because of knowledge of the facts involved, or because of participation in an earlier disciplinary hearing involving the Affected Member of the Medical Staff. However, if after objection timely submitted, the Medical Director or designee, in their good faith discretion, determines that there is reasonable evidence to support the conclusion that a proposed member of an ad hoc hearing committee is either in direct economic competition with the Affected Member of the Medical Staff, or could not decide the matter with good faith objectivity, the proposed member of the ad hoc hearing committee shall be removed and, except as provided in Section 5.5.3-6, replaced before the hearing.

5.5.3-4 Notice of Appointment to Hearing Committee. Within seven (7) days after the Affected Member of the Medical Staff is given notice of those who are proposed to serve on the hearing committee, the Affected Member of the Medical Staff shall be entitled to submit reasonable written questions (except in extraordinary circumstances only of the "short answer" type) of not more than 10 in number limited to the issues of direct economic competition or bias to all or any one or more of the proposed hearing committee members through the Hospital President or designee . The Hospital President or designee shall, in their good faith discretion, determine whether questions are unreasonable or irrelevant to the issues of direct economic competition or bias, and shall strike such questions which are unreasonable or irrelevant. The questions, except those which are deemed by the HospitalPresident or designee to be unreasonable or irrelevant, will then be submitted to the proposed hearing committee member(s) to whom directed, who shall then each submit their response(s) within thirty (30) days to the Hospital President or designee . The Hospital President or designee shall in turn forward the answers on a prompt basis to the affected Member of the Medical Staff or Board of Trustees Chairperson, depending upon the body which took the adverse action or made the recommendation which is the subject of the hearing.

5.5.3-5 Objections to Proposed Hearing Committee Members. Within seven (7) days after receipt of notice of the proposed hearing committee membership or, if the procedure set forth in section 5.5.3-4 was elected by the Affected Member of the Medical Staff, seven (7) days after their receipt of the responses to the written questions, the Affected Member of the Medical Staff shall be entitled to submit their written objections, if any, to those proposed members of the hearing committee which (s)he believes are in direct economic competition with them or are so biased against them as to prevent a fair hearing if they serve as a hearing committee member. Such objections, if any, will be reviewed by the Hospital President or designee who shall determine in their good faith discretion as to whether or not the objections are meritorious.

(a) If none of the objections are deemed to be meritorious by the Hospital President or designee , the practitioner shall so advise the Affected Member of the Medical Staff who requested the hearing, in writing, and the hearing committee shall be constituted in the manner proposed.
(b) If the Hospital President or designee determines that the objections to any or all of the hearing committee membership have substance, the practitioner shall confer with the Chairperson of the Board of Trustees, depending upon the body whose recommendation or action is the subject of the hearing, as to possible alternative proposed members of the hearing committee.
(c) If the Medical Director or designee or Chairperson of the Board of Trustees believes that there are other alternative persons who may satisfactorily meet the requirements of membership on the

hearing committee, the process set forth in section 5.5.3-4 and this 5.5.3-5 regarding written questions and objections, shall be repeated as necessary until an appropriate hearing committee can be constituted.

(d) If, however, the Medical Director or designee or Chairperson of the Board of Trustees believe that there is no person available at the Hospital or in the community, who meets the committee membership requirements for participation on a hearing committee, the requirements of Section 5.5.3-1 and 5.5.3-2 shall not apply.

5.5.3-6 Waiver of Rights. In the event the Affected Member of the Medical Staff who requested the hearing fails to, within seven (7) days' to timely submit written questions or raise objections to proposed members of the hearing committee, the practitioner shall be deemed to have waived their right to submit such questions and/or make objections to the composition of the hearing committee.

5.5.4 PERSONAL PRESENCE

The personal presence of the Affected Member of the Medical Staff who requested the hearing shall be required. An Affected Member of the Medical Staff who fails without good cause to appear and to proceed at such hearing shall be deemed to have waived such rights or review in the same manner and with the same consequence as provided in section 5.3.3 and 5.6.2.

5.5.5 PRESIDING OFFICER

The presiding officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present appropriate oral and documentary evidence. The presiding officer shall determine the order of procedure during the hearing and shall make all rulings on the matters of law, procedure, and the considerations of evidence.

5.5.6 REPRESENTATION

The Affected Member of the Medical Staff who requested the hearing shall be entitled to be accompanied and represented at the hearing by a Member in good standing or by a member of their local professional society. The Executive Committee or Board of Trustees, as may be applicable, shall appoint a person to present the facts in support of its adverse recommendation or action who shall be referred to as "Advocate". The Advocate may present evidence but, even if an Executive Committee or Board of Trustees member, shall not participate in deliberations nor vote on the matter at issue. Representation of either party by an attorney at law shall be governed by the provisions of Section 5.6.1.

5.5.7 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:

(a) call and examine witnesses and cross-examine witnesses called by the other party;

(b) introduce exhibits;

(c) question witnesses on matters relevant to the issues; and

(d) rebut any evidence,

within the scope of supplemental hearing rules, including time limits, established pursuant to Section 6.4.

If the Affected Member of the Medical Staff does not testify, the practitioner may be called and examined as if under cross-examination.

5.5.8 PROCEDURE AND EVIDENCE

5.5.8-1 The hearing will not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence, and shall not, without the consent of the hearing committee or required by the Medical Director or designee or Board of Trustees for good cause shown, extend beyond twelve hours of in person hearing and presentation (six hours allocated to each party). If there is a perceived need to present more than can reasonably be presented within the allotted time, the matter shall be submitted to the hearing officer prior to the issuance of hearing rules under 6.4 so that alternative procedures (e.g., depositions and abstracts) can be authorized and timely used.

5.5.8-2 Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to, during, at the close of or if specifically requested and authorized by the presiding officer, within seven (7) days of the hearing, be entitled to submit a memoranda concerning any issue of procedure, fact, or conclusions drawn from fact, and such memoranda shall become part of the hearing record. The presiding officer may, but shall not be required, to order that oral evidence be only taken on oath or affirmation.

5.5.9 MATTERS CONSIDERED

In addition to relevant evidence formally presented at the hearing, the hearing committee shall be entitled to consider any pertinent material contained on file in the Hospital and all other information which can be considered in connection with applications for appointments or reappointments to the Staff and a request for Privileges. In this respect, to facilitate the hearing efficiency, subject medical records, investigative reports, pertinent correspondence, committee minutes, and the statement of reasons, may be furnished by the Hospital President or designee in their discretion, to the hearing committee, provided the Affected Member of the Medical Staff is advised same have been furnished to the hearing committee, receives a copy, and may challenge its relevance at the hearing. The hearing committee shall be entitled to conduct independent review research and interviews, or retain an independent consultant to do so, but may utilize the products of such in its decision, only if the Affected Member of the Medical Staff and the Advocate are aware of such, and have an opportunity to rebut any information so gathered. A party providing materials to the hearing committee for consideration shall also provide a copy to the other party in advance of the hearing and affording the other party reasonable time for review.

5.5.10 BURDEN OF PROOF

The body whose adverse recommendation or action occasioned the hearing shall have the initial obligation to present evidence in support of its position. The Affected Member of the Medical Staff shall thereafter be responsible for supporting a challenge to the adverse recommendation or action by evidence that the grounds therefore are not supported by the evidence or the conclusions drawn therefrom are arbitrary or capricious.

5.5.11 RECORD OF HEARING

A record of the hearing shall be kept that is of sufficient accuracy to assure that an informed and valid judgment can be made by any person or group that may later be called upon to review the record and render a recommendation or decision in the matter. If the Hospital President or designee and the Affected Member of the Medical Staff cannot agree on method, the presiding officer shall select the method to be used for making the record such as a court reporter, electronic recording unit or detailed transcription. The Affected Member of the Medical Staff who requested the hearing, shall be entitled to obtain a copy of the record upon payment of the reasonable charges associated with the preparation of same. If the Affected Member of the Medical Staff who requested the hearing elects an alternate method of recording, the practitioner shall bear the primary cost thereof.

5.5.12 POSTPONEMENT

Requests for postponements of a hearing shall be granted by the presiding officer only upon a showing of good cause.

5.5.13 RECESSES AND ADJOURNMENT

The hearing committee or officer may recess the hearing and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation.

5.5.14 DELIBERATIONS AND RECOMMENDATION OF THE HEARING COMMITTEE OR HEARING OFFICER

5.5.14-1 Deliberations. Upon conclusion of the presentation of evidence, the hearing shall be closed. Within 30 days thereafter, the hearing committee, outside the presence of any other person, shall conduct deliberations and consider the admitted evidence and prepare a written report.

5.5.14-2 Contents of Report. The hearing committee shall prepare a report which shall contain a concise statement of recommendations and the reasons justifying the recommendations made. This report shall be delivered to the Hospital President or designee .

5.5.15 DISPOSITION OF HEARING COMMITTEE REPORTS

Upon receipt, the Medical Director or designee shall forward the hearing committee report and recommendation, along with all supporting documentation, to the Board of Trustees for further action. The Medical Director or designee shall also send a copy of the report and recommendation by Special Notice to the Affected Member of the Medical Staff. A copy of the report of the hearing shall be delivered by the Medical Director or designee to anybody other than the Board of Trustees that made the adverse recommendation for informational purposes.

5.5.16 NOTICE AND EFFECT OF RESULTS

5.5.16-1 Effect of and Action Upon Favorable Hearing Committee Report. If the hearing committee's report pursuant to 5.14 is favorable to the Affected Member of the Medical Staff, the Medical Director or designee shall promptly forward it, together with all supporting documentation, to the Board of Trustees for its final action.

(a) The Board of Trustees may, before taking final action thereon, refer the matter back to the hearing committee or the Executive Committee for further consideration or information. Any such referral back shall state the reasons therefore, set a time limit within which a subsequent recommendation to the Board of Trustees must be made, and may include a directive that an additional hearing or other review be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board of Trustees shall take final action.

(b) If the Board of Trustees action on the matter is favorable to the Affected Member of the Medical Staff it shall become the final decision of the Board of Trustees, and the matter shall be closed.
(c) If the Board of Trustees' action would result in any of the recommendations or actions listed in 5.2.4 or 5.2.5, the Special Notice shall inform the Affected Member of the Medical Staff of a right to request an appellate review by the Board of Trustees as provided in 5.5.17 of this Plan, as if the hearing committee's report had been adverse. In such circumstances, the Board of Trustees' tentative position adverse to the Affected Member of the Medical Staff shall be represented by a person, selected by the Chairperson of the Board of Trustees for appellate review. All references in 5.5.14 through 5.5.26, of this Plan to the "hearing committee" would instead refer to the Board of Trustees, as the context requires.

5.5.16-2 Effect of Adverse Hearing Committee Report. If the report and recommendation of hearing committee pursuant to 5.5.14 is adverse to the Affected Member of the Medical Staff in any of the respects listed in 5.2.4 or 5.2.5, Special Notice shall be given of the report and recommendation and their right to request appellate review by the Board of Trustees as provided in 5.5.17 of this Plan.

5.5.17 REQUEST FOR APPELLATE REVIEW

An Affected Member of the Medical Staff shall have 10 days following receipt of a notice pursuant to 5.16-1(c) or 5.16-2, to file a written request for an appellate review. Such request shall be delivered to the Hospital President or designee either in person or by certified mail and may include a request for a copy of the report and record of the hearing committee and all other material, favorable or unfavorable, which was considered in making the adverse action or result.

5.5.18 WAIVER BY FAILURE TO REQUEST APPELLATE REVIEW

An Affected Member of the Medical Staff who fails to request an appellate review within the time and in the manner specified in 5.5.17 waives any right to such review. Such waiver shall have the same force and effect as that provided in 5.3.3 and 5.6.2 of this Plan.

5.5.19 NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the Hospital President or designee shall deliver such request to the Board of Trustees. The Board of Trustees shall schedule and arrange for an appellate review which shall be not more than 45 days from the date of receipt of the appellate review request; provided, however, that an appellate review for a Member who is under a suspension then in effect shall be held as soon as the arrangements and preparations for it may reasonably be made. The Hospital President or designee shall send the Affected Member of the Medical Staff notice of the time, place and date of the review. The time for the appellate review may be extended by the Board of Trustees for good cause.

5.5.20 APPELLATE REVIEW BODY

The Board of Trustees shall be the appellate review body; one Board of Trustees member shall be designated as chairperson of the appellate review proceedings.

5.5.21 NATURE OF APPELLATE REVIEW PROCEEDINGS

The appellate review proceedings of the Board of Trustees shall be an appellate review based solely upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The Board of Trustees shall also consider the written statements as may be presented and accepted under this Section.

5.5.22 WRITTEN STATEMENTS

The Affected Member of the Medical Staff shall submit a written statement detailing those findings of fact, conclusions and procedural matters with which the practitioner disagrees, and the reason for such disagreement. This written statement may cover any matters raised at any step in the hearing process. The statement shall be submitted to the Board of Trustees through the Hospital President or designee at least five days prior to the scheduled date of the appellate review. A written statement in reply may be submitted by the Executive Committee, or if Board of Trustees action is being appealed, the person

selected by the Board of Trustees to take the position adverse to the Affected Member of the Medical Staff. If submitted, the Hospital President or designee shall provide a copy thereof to the Affected Member of the Medical Staff at least two (2) days prior to the scheduled date of the appellate review.

5.5.23 PRESIDING OFFICER

The chairperson of the appellate review proceedings shall be presiding officer for any appellate hearing and shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

5.5.24 ORAL STATEMENT

The Board of Trustees, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to them by any member of the Board of Trustees.

5.5.25 CONSIDERATION OF NEW OR ADDITIONAL MATTERS

Subject to 6.3 below, new or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in their record shall be introduced at the appellate review only under unusual circumstances. The Board of Trustees in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.

5.5.26 RECESSES AND ADJOURNMENT

The Board of Trustees may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the proceedings shall be closed. The Board of Trustees shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared adjourned.

5.5.27 ACTION TAKEN BY BOARD OF TRUSTEES ON APPEAL

The Board of Trustees may affirm, modify or reverse the adverse result or action taken by the hearing committee or officer pursuant to 5.5.1, in its discretion, may refer the matter back to the hearing committee or officer for further review and recommendation to be returned to it within 45 days and in accordance with its instructions. Within 15 days after receipt of such recommendation after referral, the Board of Trustees shall make its final decision.

5.5.28 FINAL BOARD OF TRUSTEES ACTION AFTER APPELLATE REVIEW

Unless the matter is referred back to a hearing committee or officer pursuant to 5.5.27, within 15 days after the conclusion of the appellate review, including referrals back to the hearing committee or officer, the Board of Trustees shall render its decision in the matter in writing and shall send notice thereof to the Affected Member of the Medical Staff by Special Notice, to the Medical Director or Designee, and to the Executive Committee.

5.5.29 HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

Those actions or recommendations which entitle an Affected Member of the Medical Staff to a special hearing pursuant to Section 5.5, are those matters the Hospital and Staff reasonably believe represent "professional review action" and "professional review activity" which may "adversely affect" a "physician" pursuant to the Health Care Quality Improvement Act of 1986. In this respect, it is the intent and purpose of this Plan that the initiation and conduct of professional review actions hereunder comply with all material respects with the provisions of § 412 of the Act.

SECTION 5.6. - *GENERAL PROVISIONS APPLICABLE TO BASIC AND SPECIAL HEARINGS*

5.6.1 ATTORNEYS

5.6.1-1 The Parties

(a) Basic Hearings. If the Affected Member of the Medical Staff who requests a hearing desires to be represented by an attorney at any basic hearing or at any appellate review pursuant to the provisions of Section 5.4 of this Plan, the request for such hearing or appellate review must so state. The hearing committee or appellate review body shall, in its sole discretion, determine whether to permit such representation at the hearings. If and only if it allows the Affected Member of the Medical Staff to be so represented, the Executive Committee or the Board of Trustees may also be represented by an attorney at the hearing.

(b) Special Hearings. If the Affected Member of the Medical Staff desires to be represented by an attorney at any special hearing or at any appellate review appearance pursuant to the provisions of Section 5.5 of this Plan, the request for such hearing or appellate review must so state. The Affected Member of the Medical Staff shall have an unqualified right to be represented by an attorney at any such special hearing or appellate review appearance. If the Affected Member of the Medical Staff chooses to be so represented, the Executive Committee or the Board of Trustees may also be represented by an attorney at the hearing.

(c) Consultation. Notwithstanding the foregoing, however, an attorney may be contacted at appropriate times during the proceedings by any party for advice, provided such contact does not unduly interfere with the conduct of a hearing as determined by the presiding officer.

5.6.1-2 The Hearing Committee, Appellate Review Body, or Hospital President or designee . A hearing committee, appellate review body, or Hospital President or designee may, in its discretion, consult with legal counsel at any stage of the proceedings for advice on appropriate hearing conduct or the drafting of its report(s). Hospital counsel may serve as counsel to Hospital, the hearing committee and the Advocate in the same proceeding.

5.6.2 WAIVER

If at any time after receipt of Special Notice of an adverse recommendation, action or result, an Affected Member of the Medical Staff fails to make a required request or appearance or otherwise fails to comply with this Plan, the Affected Member of the Medical Staff shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights under the Medical Staff Bylaws then in effect or under this Plan with respect to the matter involved.

5.6.3 INDEPENDENT CONSULTANTS

At any stage of hearing proceedings, a hearing committee or the Board of Trustees may retain an independent consultant, who may or may not be a Member. The consultant may be provided with medical records, films, slides, reports, or such other materials the practitioner and the requesting body may deem appropriate for their review. The consultant shall present a written or oral report to the requesting body which shall be made available to the parties. A consultant so elected should not be deemed a witness for any of the parties, but an independent advisor whose opinions represent evidence which may be considered.

5.6.4 SUPPLEMENTAL HEARING RULES

The presiding officer of any hearing or appellate review body may promulgate, with or without the advice of legal counsel, hearing rules to supplement those contained in this Plan. Such rules shall be fundamentally fair to all parties and generally consistent with the provisions of this Plan. The supplemental rules may set forth the order of presenting evidence and oral statements as well as time limits for presentations for the in-person aspects of the hearing. In this respect, the hearing rules may require that certain testimony be taken in deposition format and submitted to the hearing committee in the form of transcript, videotape, and/or abstracts of relevant testimony. When feasible, the presiding officer may in their discretion arrange a pre-meeting with the parties (or their representatives) to decide upon such rules or ask the parties (or their representatives) to meet and propose rules subject to their approval. When such rules are promulgated by the presiding officer, they shall be furnished to the parties before the hearing. Written objections by any of the parties shall be considered and, when deemed meritorious, amendments shall be made in the rules to address the objections.

5.6.5 NUMBER OF REVIEWS

Notwithstanding any other provision of the Bylaws or of this Plan, no Affected Member of the Medical Staff shall ever be entitled as a right to more than one hearing and appellate review with respect to an adverse recommendation or action. Further, the Executive Committee and the Board of Trustees need not conduct additional hearings or reviews upon reapplication or request for reconsideration by the Affected Member of the Medical Staff, absent a clear and convincing indication of new or additional information which has a substantial probability of changing the outcome of the previous hearing or appeal.

5.6.6 RELEASE

By requesting a hearing or appellate review under this Plan, an Affected Member of the Medical Staff agrees to be bound by the provisions of the Bylaws, this Plan, and the rules established for hearing, in all matters relating thereto.

5.6.7 TIME LIMIT MODIFICATION

Any procedural rule or time limit specified in this Plan may be modified or waived by agreement between the presiding officer of the hearing committee, and the Affected Member of the Medical Staff, or the duly authorized designate of any of them. The Board of Trustees or the presiding officer at a hearing may, in its/his discretion, grant an extension of any time limits when required for fundamental fairness to any party. A request by an Affected Member of the Medical Staff who for a hearing for an extension of any time limits, which is granted, waives any right to insist on the time limits specified herein being complied with.

5.6.8 EXECUTIVE COMMITTEE REVIEW

If at any time during the Board of Trustees consideration and review of a recommendation or action with respect to an Affected Member of the Medical Staff, the Board of Trustees deems it necessary or advisable, the Board of Trustees may refer the matter to the Executive Committee. Within fifteen (15) days of its receipt of a matter referred to it by the Board of Trustees pursuant to the provisions of this Plan, the Executive Committee shall convene and consider this matter and submit its written recommendations to the Board of Trustees for final action.

5.6.9 GOOD FAITH ALTERNATIVE SPECIAL NOTICE

5.6.9-1 Good Faith. In addition to those duties imposed in the Bylaws, it shall be the duty of each Affected Member of the Medical Staff who requests a formal hearing to act with utmost good faith before and during the hearing process. Such good faith shall include, but not be limited to, timely compliance with requirements, cooperation in the receipt of required notices, and the exercise of procedures in this Plan without intent to cause undue delay. In addition to other automatic hearing and appeal right waivers for non-compliance with time limits or appearance requirements, upon a finding by a hearing committee, hearing officer, or the Board of Trustees that an Affected Member of the Medical Staff is not acting or has not acted in good faith with regard to the hearing process of this Plan, the hearing committee, hearing officer or Board of Trustees may limit or deem waived the Affected Member of the Medical Staff's rights to hearing, appeal, or use of particular procedures in a hearing or appeal.

5.6.9-2 Alternative Mailing. If, in attempting to give Special Notice, despite reasonable efforts, either postal authorities are unable to deliver or obtain signature on a return receipt for registered or certified mail, or a representative of the Hospital is unable to make personal delivery, at the designated place of mail delivery for the Affected Member of the Medical Staff, such Special Notice may alternatively be given by regular mail that is mailed at least five days before any deadline to the last home address and last office address provided by the Affected Member of the Medical Staff to Administration.

5.6.9-3 Time Limits Constructive Receipt. For the purpose of time limits of this Plan, if the alternative mailing procedure of section 5.6.9-2 is used, the document mailed shall be deemed to have been received at the time the first attempt at registered or certified mail by postal authorities or personal delivery by Hospital personnel was attempted, as documented by the written statement of either. This presumption of receipt shall be binding on the Affected Member of the Medical Staff, even if it means rights to hearing, appeal, or objection are waived by failure to comply with time limits. This presumption

may be overcome only by a clear and convincing showing to the presiding officer that the failure to make delivery or sign a receipt, was due to error, neglect, or unreasonable delay, of the postal authorities or Hospital representatives, and not the Affected Member of the Medical Staff.

5.6.9-4 Designated Place of Mail Delivery. The designated place of mail delivery shall be the office address last provided by an Affected Member of the Medical Staff to Administration and any person who signs a receipt for mail there shall be deemed as authorized by the Affected Member of the Medical Staff to do so. In the event of their absence, each Affected Member of the Medical Staff shall either: (a) authorize their office Members to receive and sign receipts for mail on their behalf, or alternatively,

(b) if their office shall be closed for more than two successive business days or the practitioner does not wish their office staff to authorized to receive and sign a receipt for mail on their behalf, the practitioner must in a writing sent by certified mail to the Hospital President or designee , designate the name and address of an alternate designated place of delivery (e.g., a law or accounting firm) and provide a statement that any person who receives and signs for mail there is authorized to do so on their behalf.

5.6.9-5 Purpose -Good Faith. The purpose of the foregoing provisions of sections 5.6.9-2, 5.6.9-3 and 5.6.9-4 are to assure reasonable efforts to give required notices and proceed forward with requested hearings are not thwarted or delayed by refusal to accept delivery, refusal to sign receipts, office closure, absence from the community, or the bad faith on the part of an Affected Member of the Medical Staff.

5.6.10 CONSOLIDATION

If two or more hearings and/or appeals with respect to the same Member are proceeding simultaneously, (e.g., summary suspension and non-reappointment), the Board of Trustees, at the request of the Affected Member of the Medical Staff, the Medical Director or designee, the Hospital President or the Executive Committee, may order the two proceedings consolidated into a single hearing or appeal. In this respect, the Board of Trustees shall have the authority to suspend or modify time limits and take whatever action most reasonably and fairly to all concerned to accommodate the consolidation.

SECTION 5.7. - AMENDMENT AND APPLICATION -

5.7.1 AMENDMENT

This Plan may be amended or repealed, in whole or in part, by a resolution of the Medical Staff recommended to and adopted by the Board of Trustees subject always to the bylaws of the respective bodies.

5.7.2 APPLICATION

Any matter subject to review or hearing pursuant to the Medical Staff Bylaws after adoption of this Plan shall be governed by its terms; any prior review and hearing procedures shall be deemed superseded by the terms of this Plan.

REVIEW PROCEDURES FOR NON-PHYSICIAN PRACTITIONERS

SECTION 6.1. NON-PHYSICIAN PRACTITIONERS (NPP)

6.1.1 INITIATION

6.1.1-1 Grounds. Corrective or administrative action may be instituted as to an NPP for any of the grounds that are specified in 5.1.1-1, 5.1.2-1, 5.1.3, and 5.1.4 of the Bylaws.

6.1.1-2 Initiation of Corrective Action for Hospital Employees. Any Member who reasonably believes that one or more of the grounds set forth in Article V of the Bylaws are present with respect to a NPP employed by the Hospital shall report that belief to the office of the Hospital President or designee . Any action on the foregoing shall be in a manner which is consistent with

established Hospital personnel policies and procedures. The action in accordance with such personnel practices shall be final.

6.1.1-3 Corrective Action for Non-Employees of the Hospital. Any two of the following: the Hospital President or designee or designee; a Department Chair; or Chief of Staff; who reasonably believe that the grounds set forth in Article V of the Medical Staff Bylaws are present may jointly initiate corrective action by suspending the Service Authority of the NPP with a written notice to the NPP of such action, or if immediate action is not required, issuing a written notice of the pendency of the corrective action to the NPP. If not involved in the corrective action, a copy of the written notice shall be promptly given to the Executive Committee, the Medical Director or designee and, where applicable, the Supporting Member of the Medical Staff for the NPP.

6.1.1-4 Investigation and Hearing. Within thirty (30) days of notice of suspension or the notice of pendency of a corrective action, the Executive Committee shall designate a qualified person or ad hoc committee to conduct an investigation. The investigator (person or committee) shall then provide an opportunity for the persons initiating corrective action, witnesses to any events and the affected NPP to appear and make informal presentations of the respective positions and/or observations. Minutes shall be kept of this informal hearing.

6.1.1-5 Investigator (Person or Ad Hoc Committee). Following the investigation, the investigator (person or ad hoc committee) shall then make any one or more of the following recommendations:

(a) rejecting corrective action;

(b) issuing a written warning;

(c) issuing a letter of admonition or reprimand;

(d) imposing a probationary period;

(e) imposing reduction, suspension or revocation of membership and/or privileges;

(f) issuing suspension or revocation of NPP status;

(g) other action deemed appropriate.

The report of the investigation, the minutes of any hearing and the recommendation of the investigator (person or ad hoc committee) shall then be provided to the affected NPP, the Chief of Staff, the Executive Committee and the Board of Trustees. The affected NPP may submit a written statement for consideration by the Executive Committee within 30 days after receipt of the reports, minutes and recommendations. The investigator (person or ad hoc committee) may issue a separate written statement concerning the investigator's recommendation to the Executive Committee.

Section 6.2. - EXECUTIVE COMMITTEE AND BOARD OF TRUSTEES ACTION

6.2.1 The Executive Committee shall make its recommendation to the Board of Trustees upon receipt of the investigator's (person or ad hoc committee) recommendation, the informal hearing minutes and any written statement which the initiators of the corrective action, the affected NPP or the investigator's (person or ad hoc committee) elect or provide.

6.2.2 If the Executive Committee's recommendation is for corrective action, then the Chief of Staff will forward that recommendation to the Board of Trustees who shall review the record and take action.

6.2.3 If the Board of Trustee's proposed action would have the effect of substantially changing the Executive Committee's recommendation, it shall call for a meeting of the Quality Committee of the Board of Trustees, the action of which shall be the final action when ratified by the Board of Trustees.

6.2.4 At any step in the process, the Executive Committee or the Board of Trustees may refer the matter back to the investigator (person or ad hoc committee) with directions for further review, report and/or the conducting of any further hearing procedures the Board of Trustees deems appropriate. The Board of Trustees action shall be final.

SECTION 6.3. - NOTICE TO THE NPP

When the Board of Trustees action is determined, it shall be final. The Hospital President or designee shall promptly notify in writing the NPP, the Medical Director or designee and, if applicable, the Sponsor Member of the Medical Staff for the NPP.

SECTION 6.4. - AMENDMENT AND APPLICATION

6.4.1 AMENDMENT

This Plan may be amended or repealed, in whole or in part, by a resolution of the Members of the Medical Staff recommended to and adopted by the Board of Trustees subject always to the bylaws of the respective bodies.

6.4.2 APPLICATION

Any matter subject to review or hearing pursuant to the Medical Staff Bylaws after adoption of this Plan shall be governed by its terms; any prior review and hearing procedures shall be deemed superseded by the terms of this Plan.

6.5 Termination of Members in MedicoAdministrative Positions

The termination of employment of or contract relationship with a physician or dentist who is a member of the medical staff serving in a medical administrative position shall be subject to review, if requested by the terminated practitioner, by the Quality Committee to determine the reason for the action, and whether the action affects medical staff membership or privileges as well as the practitioner's administrative position. When the Quality Committee determines that the action relates in substantial part to the practitioner's professional competence, the practitioner shall be entitled to a hearing in accordance with the provisions of Sections 6.l through 6.4 of this Article; and the recommendation of the executive committee shall be considered in connection with any action taken by the Hospital President or designee or the Board of Trustees with respect to termination. When the reason for the action is determined by the Quality Committee to be primarily administrative in nature, not involving the practitioner's professional competence, the practitioner shall not have any right to a hearing or other rights created by these bylaws; and the hospital and its Board of Trustees will be presumed to act in accordance with applicable hospital personnel and administrative policies and/or the terms of any contract with the practitioner.

ARTICLE VII: OFFICERS

7.l Identification

The officers of the medical staff shall be:

l) Chief of Staff
2) Vice Chief of Staff
3) SecretaryTreasurer

7.2 Qualifications

Officers must be members of the active medical staff at the time of nomination and election and must remain members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

7.3 Nominations

Nominations shall be made through an ad hoc committee consisting of not less than three (3) members of the active medical staff appointed by the chief of staff. This committee shall offer one or more nominees for each office. The names of such nominees shall be reported to the staff at least thirty (30) days prior to the annual meeting. If, before the election, all of the individuals nominated for an office shall refuse, be disqualified from or otherwise be unable to accept nomination, then the nominating committee shall submit one or more substitute nominees at the annual meeting. Nominations shall also be accepted from the floor at the annual meeting.

7.4 Election

Officers shall be elected at the annual meeting in October in each odd numbered year. Only active staff members shall vote for staff officers. Voting shall be by secret written ballot if two or more candidates are nominated, and voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two candidates receiving the highest number of votes. The election of officers shall be subject to ratification by the Board of Trustees.

7.5 Term of Elected Office

Each officer shall serve a two (2) year term, commencing on the first day of January following their election at the October meeting. Each officer shall serve until the end of their term and until a successor is elected provided any elected officer may be removed from office with cause at any duly called meeting of the staff by the affirmative vote of a majority of all active staff members subject to ratification by the Board of Trustees. With cause can include but not be limited to failure to perform duties of the office as described in 7.7 and unprofessional conduct.

7.6 Vacancies in Elected Office

Vacancies in office occurring during the medical staff year, except for the chief of staff, shall be filled by the executive committee. If there is a vacancy in the office of the chief of staff, the vice chief of staff shall serve out the remaining term.

7.7 Duties of Elected Officers

(a) Chief of Staff

The chief of staff shall serve as the chief administrative officer and principal elected official of the staff. As such, the practitioner shall:

1. Act in coordination and cooperation with the Hospital President or designee in all matters of mutual concern within the hospital;

2. Remain accountable for the policies of the Board of Trustees to the medical staff and be accountable to the Board of Trustees for the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care;

3. Be responsible for the enforcement of medical staff bylaws, rules and regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance with procedural safeguards in corrective action cases;

4. Be responsible for the educational activities of the medical staff;

5. Be the spokesman for the medical staff in its external professional and public relations;

6. Except as otherwise provided by these bylaws, appoint committee members to all standing, special and multidisciplinary medical staff and hospital management committees other than the executive committee;

7. Represent and communicate the views, policies, needs and grievances of the medical staff to the Board of Trustees and to the Hospital President or designee ;

8. Call, preside at, and be responsible for the agenda of all general meetings of the medical staff;

9. Serve on the executive committee as its chairperson, as a medical staff representative to the Hospital Quality Committee, and as an ex officio member without vote of all other staff committees.

10. Attend and participate in discussion at the applicable Board of Trustee meetings.

(b) Vice Chief of Staff

The vice chief of staff shall be a member of the medical staff executive committee and of the Hospital Quality Committee. In the absence of the chief of staff the vice chief of staff shall assume all the duties and have the authority of the chief of staff. The practitioner shall automatically succeed the chief of staff when a vacancy occurs in that office.

(c) SecretaryTreasurer

The secretary-treasurer shall be a member of the Medical Staff Executive Committee and the Hospital Quality Committee. Their duties shall be to:

1. Provide proper notice of all staff meetings on order of the appropriate authority;
2. Assure the preparation of accurate and complete minutes for all meetings;
3. Supervise the receipt and disbursement of medical staff funds;
4. Perform such other duties as ordinarily pertain to their office.

7.8 Recall, Resignation, or Dismissal of Officers and Medical Staff Executive Committee (MSEC) Members:

7.8.1 Any Officer or MSEC member of the Medical Staff may be recalled for cause for failure to uphold the duties of the office or failure to comply with the Medical Staff Bylaws, Medical Staff Rules & Regulations or Medical Staff policies by petition of two-thirds of the Active Staff. Should an Officer or MSEC member be recalled, the Chief of Staff will call a special election for the filling of such vacancy.

7.8.2 Should the Chief of Staff be unable to complete their term of office for any reason, the Vice Chief of Staff shall serve out the remaining term as Chief of Staff.

7.8.3 Should the Vice Chief of Staff be unable to complete their term of office, the Nominating Committee will be requested by the Chief of Staff to select two (2) candidates for the Vice Chief of Staff position and the election process will proceed.

8.0 ARTICLE VIII: DEPARTMENTS

8.l Identification

a. Departments of the medical staff shall be as follows:

b. Department of Emergency Medicine
c. Department of Medicine/Family Medicine
d. Department of Pathology
e. Department of Radiology
f. Department of Surgery/Anesthesia

Each department shall be headed by a departmental chairperson and shall function under the executive committee.

8.2 Organization of Departments

(a) Departmental Chairperson

A chairperson of each department shall be appointed by the Board of Trustees upon the recommendation of the medical staff executive committee.

1. Selection Process

Each department whose membership includes two or more physicians shall elect a candidate from the active staff membership for chairperson by a majority vote of the active staff who are members of the department. Upon selecting a candidate for chairperson, the department shall recommend the candidate to the executive committee, who, upon a majority vote, shall recommend the candidate to the Board of Trustees for appointment. The executive committee shall recommend to the Board of Trustees a candidate for chairperson in each department represented by less than two active staff members. The Board of Trustees shall appoint departmental chairpersons who are qualified by education, experience, competence and administrative ability.

2. Qualifications

Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

3. Roles and Responsibilities

The chairperson of each department shall be responsible to the executive committee for the proper functioning of the department. The department chairperson's responsibilities shall include, but not be limited to the following:

- Clinically related activities of the department
- Administratively related activities of the department, unless otherwise provided by the hospital
- Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
- Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
- Recommending clinical privileges for each member of the department
- Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or organization
- Integration of the department or service into the primary functions of the organization
- Coordination and integration of interdepartmental and intradepartmental services
- Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
- Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
- Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
- Continuous assessment and improvement of the quality of care, treatment, and services
- Maintenance of quality control programs, as appropriate
- Orientation and continuing education of all persons in the department or service.
- Recommending space and other resources needed by the department or service.

(b) Vice Chairperson

A vice chairperson of each department whose membership includes two or more physicians shall be appointed by the Board of Trustees upon the recommendation of the executive committee.

1. Selection Process

The department will elect a candidate from the active staff membership for vice chairperson by a majority vote of the active who are members of the department. Upon selecting a candidate for vice chairperson, the department shall recommend the candidate to the medical staff executive committee, who, upon a majority vote shall recommend the candidate to the Board of Trustees for appointment. The medical staff executive committee shall select a candidate for vice chairperson in the departments represented by two or less active staff members and recommend the candidate to the Board of Trustees for appointment. The Board of Trustees shall appoint departmental vice chairpersons who are qualified by education, experience, competence, and administrative ability.

2. Responsibilities

The vice chairperson of each department shall be responsible to the chairperson. The vice chairperson shall, in the absence of the chairperson, assume all the authority and responsibilities of the chairperson.

(c) Term of Office

The chairpersons and vice chairpersons shall be appointed by the Board of Trustees upon the recommendation of the executive committee prior to the end of the medical staff year and shall assume office for two (2) year terms initiated at the beginning of the medical staff year immediately following their appointment. The chairperson and vice chairperson may be removed from office with cause, at any duly called department meeting by affirmative vote of a majority of all active staff members of said department subject to ratification by the executive committee and the Board of Trustees. Terms of physicians who provide specialty services pursuant to contract with the hospital shall terminate upon termination of their contracts.

8.3 Assignment to Departments

Each member of the active, associate and consulting staff of the medical staff as well as non-physician practitioners with a sponsoring medical staff member shall be assigned to a department. Physicians assigned to the departments of family and general practice, radiology or pathology may also be assigned to other departments as representatives of their own departments.

The exercise of clinical privileges within any department shall be subject to the rules and regulations of that department and the defined authority of the departmental chairperson. A member of the medical staff may be granted privileges in more than one department commensurate with their education, experience, and competence as evaluated by the appropriate department and approved by the executive committee and the Board of Trustees. A physician having clinical privileges in more than one department shall be subject to the rules and regulations and shall be under the direction of the chairperson of the department in which the privileges are exercised.

8.4 Meetings and Attendance

Departments shall hold at least **semi-annual** meetings at which time the significant findings of ongoing quality assurance reviews will be discussed. Active and associate staff members shall attend at least **1** of these **semi-annual** meetings per year and 50% of their committee assignments as outlined in Section 9.9.e. Failure to meet attendance requirements may lead to corrective action. Associate and Non-Physician Practitioners are required to attend at least 1 department meeting per year. Consulting staff members are not required but are encouraged to attend department meetings. Minutes of each departmental meeting shall be prepared and shall include a record of attendance and significant findings of quality assurance reviews. Each department shall maintain a permanent file of such minutes, and forward copies to the executive committee.

8.5 Voting Privileges

Only Active Staff members shall have departmental voting privileges. Associate, Consulting, Ambulatory Active, Telemedicine and Non-Physician Practitioners have no voting privileges.

Physicians assigned to other departments as representatives of the departments of Family Medicine, Radiology, and Pathology shall have voting privileges at the discretion of the department to which assigned.

8.6 Quorum

A quorum shall be defined as those members of the organized active staff present for the General, and Special meetings of the Medical Staff.

The individual Departments of the Medical Staff will define a quorum for the purpose of the Departmental meetings.

A quorum shall be defined as the voting members present at the meetings of the MSEC.

ARTICLE IX: COMMITTEES

Also, the Quality Committee is a hospital committee with Medical Staff membership.

9.1 Executive Committee

(a) Composition

The executive committee shall be a standing committee consisting of the medical staff officers and departmental chairpersons. The Hospital President or designee of the hospital or their designee shall attend each meeting ex-officio.

(b) Voting Privileges

Each member of the executive committee, with the exception of the Chief of Staff and Hospital President or designee , shall have full voting privileges. The Chief of Staff shall exercise voting privileges only in the event of a tie vote, at which time he will cast the deciding ballot. The Hospital President or designee shall have no voting privileges.

(c) Meetings

The executive committee shall meet at least monthly and maintain a permanent record of its proceedings and action.

(d) Functions and Responsibilities

i. Clinically related activities of the department.
ii. Administratively related to activities of the department, unless otherwise provided by the hospital.
iii. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.
iv. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.
v. Recommending clinical privileges for each member of the department.
vi. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.
vii. Integration of the department of service into the primary functions of the organization.
viii. Coordination and integration of interdepartmental and intradepartmental services.
ix. Development and implementation of policies and procedures that guide and support the provision of care, treatment and services.
x. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services.
xi. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners who provide patient care, treatment and services.
xii. Maintenance of quality control programs as appropriate.

9.2 Credentials Committee

(a) Composition

The Credentials Committee shall be a standing committee consisting of active staff members consisting of the Department Chairs or their designee from the Departments of Family Medicine, Medicine, Surgery, Emergency Medicine, Pathology and Radiology.

(b) Voting Privileges

Each member of the credentials committee and the departmental representative shall have full voting privileges. Voting members of the credentials committee shall not sit on any hearing or appellate review committee considering an application for staff membership reviewed by that committee. The Hospital President or designee or their designee shall have no voting privileges.

(c) Meetings

The credentials committee shall meet as often as necessary at the call of the chairperson.

(d) Functions and Responsibilities

The functions and responsibilities of the credentials committee shall be to meet with all prospective applicants and investigate the credentials and qualifications of all prospective applicants, and their ability to adhere to the responsibilities of medical staff membership. An alternative to an in person meeting with the committee is for the respective department chair to meet and interview the prospective candidate and present their findings/recommendations to the Credentials Committee at the scheduled Credential Committee meeting. The Credentials Committee will then forward their recommendations to the Medical Staff Executive Committee for approval.

9.3 Other Committees

The executive committee may authorize and create such other standing and special committees of the medical staff as may in its judgment be necessary or appropriate to the functioning of the medical staff. The duties and responsibilities and the size of such committees shall be as specified in the action authorizing the committee. Except as otherwise specified in these bylaws the chairperson of the executive committee shall appoint the members of each such committee and designate its chairperson.

9.4 Committee Meetings

(a) Regular Meetings

Committees may, by resolution, determine the time for holding regular meetings without notice other than such resolution.

(b) Special Meetings

A special meeting of any committee may be called by its chairperson, by the chief of staff, or by one third of its members, but not less than two. Written or oral notice stating the time and place of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee not less than 2 days before the time of such meeting, by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

(c) Quorum

A quorum shall be defined as those members of the organized active staff present at any meeting. The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the committee. Action may be taken without a meeting by unanimous consent in writing (setting forth the action so taken) signed by each member entitled to vote.

(d) Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. Each committee shall maintain a permanent file of the minutes of each meeting. Copies of minutes shall be forwarded to the executive committee.

(e) Attendance Requirements

Each committee member shall be required to attend not less than fifty percent of all meetings of their committee in each year. The reasons provided for any absences and the action of the committee chairperson thereon shall be shown in the minutes. The failure to meet the foregoing

attendance requirements, unless excused by the committee chairperson for good cause shown, shall be grounds for corrective action. The committee assignments are determined by the chief of staff. Each active and associate staff member has the responsibility to accept committee assignments as determined by the chief of staff.

ARTICLE X: GENERAL STAFF MEETINGS

10.1 Regular Meetings

General Staff meetings shall be held biannually each year.

l0.2 Special Meetings

(a) Request for Special Meeting

Special meetings of the medical staff may be called at medical staff executive committee or not less than 25% of the members of the active staff by written notice to the chief of staff. The executive committee shall designate the time and place of any special meeting.

(b) Notice of Special Meeting

Written or printed notice stating the time, place and purpose of any special meeting of the medical staff shall be delivered, either personally by mail or electronic means, to each member of the active staff not less than 2 days before the date of such meeting by or at the discretion of the chief of staff. Notice may also be sent to members of other medical staff groups who have so requested. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.3 Order of Business and Agenda

(a) Regular Meetings

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

l. Reading and acceptance of the minutes of the last regular and or all special meetings held since the last regular meeting;

2. Administrative reports from the Hospital President or designee , the chief of staff, departments and committees;

3. The election of officers when required by these bylaws;

4. Reports by responsible officers, committees and departments on the overall results of quality assessment and assurance activities of the staff and on the fulfillment of the other required staff functions;

5. Recommendations for improving patient care within the hospital;

6. New business.

(b) Special Meetings

The agenda at special meetings shall include the reading of the notice calling the meetings and the transaction of business for which the meeting was called. No business shall be transacted at any special meeting except that stated in the meeting notice.

10.4 Quorum

A quorum shall be defined as those members of the organized active staff present for the General, and Special meetings of the Medical Staff.

The individual Departments of the Medical Staff will define a quorum for the purpose of the Departmental meetings.

A quorum shall be defined as the voting members present at the meetings of the MSEC.

10.5 Attendance Requirements

Each member of the active and associate medical staff and non-physician practitioner staff shall be required to attend at least one of the two general staff meetings each year. Members of the consulting medical staff are not required but are encouraged to attend at least one general medical staff meeting each year. A member who is compelled to be absent from any regular staff meeting shall promptly submit to the chief of staff, in writing, their reason for such absence. Unless excused for cause by the executive committee, the failure to meet the foregoing annual attendance requirements shall be grounds for corrective action leading to revocation of medical staff membership. Reinstatement of staff members whose membership has been revoked because of absence from staff meetings shall be made only upon application, and all such applications shall be processed in the same manner as applications for original appointment except where associate staff automatically revert to active staff status.

10.6 Special Appearance

A practitioner whose patient's clinical course is scheduled for discussion at a regular or special staff meeting excluding UR Committee meetings shall be notified and shall be expected to attend such meeting. If such practitioner is not otherwise required to attend the regular or special staff meeting, the chief of staff shall inform the Hospital President or designee who shall give the practitioner advance written notice of the time and place of the meeting at which their attendance is expected. Whenever apparent or suspected deviation from standard clinical practice is involved, the notice to the practitioner shall be given by certified mail, return receipt requested, and shall include a statement that their attendance at the meeting at which the alleged deviation is to be discussed is mandatory.

Failure by a practitioner to attend any meeting with respect to which the practitioner was given notice that attendance was mandatory, unless excused by the executive committee upon a showing of good cause, shall result in the corrective action up to and including suspension of all or such portion of the practitioner's membership and clinical privileges as the executive committee may direct, and such suspension shall remain in effect until the matter is resolved. If the practitioner shall make a timely request for postponement supported by an adequate showing that their absence will be unavoidable, such presentation may be postponed by the chief of staff or by the executive committee if the chief of staff is the practitioner involved, until not later than the next regular staff meeting; otherwise the pertinent clinical information shall be presented and discussed as scheduled.

10.7 Minutes

Minutes of meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees, forwarded to the medical staff executive committee and maintained in a permanent file of the minutes for each meeting.

10.8 Voting

Only active staff members shall have voting privileges at General Staff Meetings. Associate , Consulting, Ambulatory Active, Telemedicine and Non-Physician Practitioner staff have no voting privileges.

Physicians assigned to other departments as representatives of the departments of family and general practice, radiology and pathology shall have voting privileges at the discretion of the department to which assigned.

ARTICLE XI: CONFIDENTIALITY, IMMUNITY AND RELEASES

11.1 Special Definitions

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

(a) INFORMATION means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 11.5(b).

(b) MALICE means the dissemination without legal justification or excuse, of a knowing falsehood or of information with a reckless disregard for whether or not it is true or false.

(c) PRACTITIONER means a staff member or applicant.

(d) REPRESENTATIVE means a Board of Trustees and any member or committee thereof; the Hospital President or designee ; the medical staff organization and any member, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

(e) THIRD PARTIES means both individuals and organizations providing information to any representative.

11.2 Authorizations and Conditions

By applying for, or exercising, clinical privileges or providing specified patient care services within this hospital, a practitioner:

(a) Authorized representatives of the hospital and the medical staff to solicit, provide and act upon information bearing on their professional ability and qualifications;

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

(c) Acknowledges that the provisions of this Article are express conditions to their application for, or acceptance of, staff membership, or their exercise of clinical privileges or provision of specified patient services at the hospital.

(d) Agrees to be bound by any restrictions, limitations, and conditions with regard to their application for or acceptance of medical staff membership and the continuation of such membership, or their exercise of clinical privileges or provision of specified patient services at the hospital.

11.3 Confidentiality of Information

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative nor used in any way except as provided herein, or except as otherwise required by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general hospital records.

11.4 Immunity from Liability

(a) For Action Taken

No representative of the hospital or medical staff shall be liable for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as a representative, if such representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement or recommendation is warranted by such facts.

(b) For Providing Information

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

11.5 Activities and Information Covered

(a) Activities

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

1. Applications for appointment, clinical privileges, or specified services;

2. Periodic reappraisals for reappointment, clinical privileges, or specified services;

3. Corrective action;

4. Hearings and appellate reviews;

5. Patient care audits;

6. Utilization reviews;

7. Other hospital, department, service or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct.

(b) Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

11.6 Releases

Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of Michigan. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

11.7 Cumulative Effect

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

ARTICLE XII: RULES AND REGULATIONS

12.1 Medical Staff Rules and Regulations

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws, subject to the approval of the Board of Trustees. These shall relate to the proper conduct of medical staff administrative activities, non-physician practitioner rules and responsibilities, as well as embody the required level of practice in the hospital. Such rules and regulations shall be a part of these bylaws, except that they may be amended by the Medical Staff Executive Committee. Such changes shall become effective when approved by the Board of Trustees.

12.2 Departmental Rules and Regulations

Subject to the approval of the executive committee and the Board of Trustees, each department may formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these bylaws, the general rules and regulations of the medical staff, or other policies of the hospital.

ARTICLE XIII: ADOPTION AND AMENDMENT BYLAWS

Medical staff bylaws may be adopted, amended, or repealed by vote of two thirds of the active staff members who are present at a meeting at which a quorum is present or via electronic vote such as email or electronic survey, provided at least 2 weeks written notice, accompanied by the proposed bylaws and/or alterations, has been given of the intention to take such action. ***Proposed amendments must be sponsored by at least 2 members of the medical staff.*** Any proposed amendment not developed by the bylaws committee shall be referred to the bylaws committee for recommendation. The Bylaws Committee will send the recommendation to the Medical Staff Executive Committee for review before submitting the request to the Medical Staff for vote either at the next General Medical Staff Meeting or via electronic vote such as email or electronic survey. Amendments so made shall be effective when approved by the Board of Trustees.

Medical Staff adoption or amendment may not be delegated. However, the Medical Staff Executive Committee has been delegated the authority to propose amendments to the bylaws and may provisionally adopt/approve an urgent amendment to bylaws, after approval of the Board, without prior medical staff notification when necessary to comply with accreditation and regulatory agencies and or current law. In such cases, the medical staff will be immediately notified by the MSEC.

1. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the medical staff and MSEC, the provisional amendment stands.
2. If conflict arises within the medical staff regarding medical staff bylaws, rules and regulations, or policies, a meeting will be called with the Medical Staff Executive Committee, the involved Medical Staff member(s) and one member of the Joint Conference Committee of the Board of Trustees to discuss the issue(s) of concern. If no resolution is reached the outcome will be determined by a majority vote of the Active Medical Staff at a specially called meeting. If necessary, a revised amendment will then be submitted to the Board.

ARTICLE XIV: ADOPTION

These Bylaws, when duly adopted, shall replace any previous bylaws and shall become effective when approved by the Board of Trustees of the hospital.

Bylaws adopted by River District Hospital Medical Staff on December 18, 1984.
Pablo B. Martinez, M.D., Chief of Staff
Tae Hong Chung, M.D., Secretary/Treasurer

Approved by Board of Trustees on January 24, 1985.
Edwin J. Steinmetz, Chairman
Anthony J. Pizzo, Secretary

Amendments to the Bylaws approved by Medical Staff and Board of Trustees made on:

01/21/86	11/29/90	5/29/98
05/20/86	05/23/91	5/28/99
12/05/86	10/20/92	10/22/99
05/28/87	04/22/93	11/1/2000
10/27/88	10/19/93	5/18/2001
10/17/89	05/26/94	10/26/2001

05/24/90	05/18/95	5/2003
5/07	10/07	10/08
10/22/13	05/27/14	10/14
05/26/15	10/18/16	5/24/17
10/25/17	10/16/18	5/21/19
10/15/19	10/20/20	5/18/21
10/19/21	5/19/22	10/18/22
5/16/23	6/18/24	

RULES AND REGULATIONS

THE RIVER DISTRICT HOSPITAL MEDICAL STAFF

ADMISSION AND DISCHARGE OF PATIENTS

1. All patients must be admitted to the hospital by a member of the Medical Staff with admitting privileges. All practitioners shall be governed by the official admitting policies of the hospital.

2. A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital and provide for prompt, complete and accurate keeping of the medical record, necessary special instructions, and transmitting reports of the condition of the patient to the referring practitioner and responsible relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be noted on the order placed in the electronic medical record unless an on-call schedule is routinely available and presented to Administration.

3. Before any patients with known or suspected contagious diseases are admitted to the hospital, the attending physician shall, when possible, first contact Admitting to inform them of the infectious nature of the disease and ascertain if the appropriate facilities are available.

4. Ordinarily, patients suffering from acute psychosis will not be admitted to the hospital. Patients suffering from acute psychosis will be referred to an appropriate facility capable of caring for this type of patient. Patients suffering from acute psychosis may be admitted to the hospital on a temporary basis for the treatment of a primary medical problem but will be referred to the proper psychiatric facility as soon as the patient is physically capable of being transferred.

5. Patients suffering from acute and chronic alcoholism or drug overdose may be admitted to Ascension River District Hospital for care of their acute medical problems. When it is indicated, they will be transferred for continued care or referred to the appropriate treatment facility for follow up care.

6. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated.

   Emergency Admissions. Any patient admitted as an emergency must be sent from the Emergency Department. An individual who comes to the Emergency Department in need of or requesting medical services is entitled to and will receive, regardless of diagnosis, race, religion, gender, ethnicity, national origin, age, handicap, marital status, sexual orientation, or source of payment, an appropriate Medical Screening Exam (MSE) by a Qualified Medical Person (QMP) to determine if the patient has an Emergency Medical Condition (EMC). If the patient is determined to have an EMC, ARDH must either stabilize the patient (which may include admitting the patient) or arrange for an appropriate transfer to an accepting facility.

   A QMP is defined as an individual who is licensed or certified as a Physician, an Non-Physician Practitioner, (who is supervised by a physician as defined in the RDH Medical Staff Bylaws.

7. Fulfillment of Emergency Department, ED, on-call assignment is a requirement for Active, Associate and Provisional staff membership. Additionally, some Consulting staff members may have requirement for ED call coverage as well.

   If the Emergency Department physician requires and requests the services of an on-call physician to assist with stabilization or management of a patient in the Emergency Department, the on-call physician is responsible to respond, examine and treat the patient. The on-call physician shall respond and be physically present within 60 minutes from the time of the initial request, unless the physician is unavailable because of situations beyond his or her control.

The on-call physician's responsibility to the dedicated ED is to assist in the medical screening exam, to assist in providing appropriate ongoing stabilization and treatment and/or assist in the appropriate transfer of the patient to an accepting facility, if necessary.

8. Emergency patients may be admitted without data required aforesaid but the attending or managing physician will be expected to evaluate patient and furnish such data as soon as possible for critically ill patients and ICU admissions but not more than 12 hours after admission of the patient.

10. In an emergency case in which it appears the patient will have to be admitted to the hospital, the practitioner shall, when possible first contact the admitting office to ascertain whether or not there is an available bed.

11. Practitioners admitting emergency cases shall be prepared to justify to the Chairperson of the department and the administration of the hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings recorded in the patient's chart.

12. A patient to be admitted on an emergency basis who does not have a private practitioner will have a member of the active, associate or provisional staff on duty in the service assigned to the patient. The Chairperson of each department shall provide a schedule for such assignment. It is the medical staff member's responsibility to arrange for emergency room call coverage on the date he/she is assigned. This arrangement must be communicated to the Medical Staff Office. Each member of the medical staff shall fulfill responsibilities associated with emergency services as determined by the appropriate clinical department with approval by the Executive Committee. Each department has the responsibility to provide an on-call list of physicians assigned on a daily basis for consultation and/or admission of emergency patients and at least one follow up visit for the emergency room patient.

13. Each member of the medical staff shall name another staff member with similar privileges to provide alternative coverage for his/her patients in the event of unavailability because of emergency, vacation, illness or otherwise. The arrangement must be communicated to the Medical Staff Office.

14. The attending physician is required to document the need for continued hospitalization as required by the current utilization review plan.

15. Patients shall be discharged only on an order of the attending physician, and ordinarily not later than 11 a.m., unless other arrangements have been made. Should a patient leave the hospital against the advice of the attending physician or without proper discharge, a notation of the incident shall be made in the patient's medical record noting the date, time and explanatory narrative. The patient or a representative of the patient will be requested, whenever possible, to sign a statement acknowledging that he/she is leaving against his attending physician's advice or without proper discharge.

16. In the event of death, the deceased shall be pronounced dead by the attending physician or a member of the medical staff within a reasonable time thereafter. The body shall not be released until after approval has been given by the attending physician or a member of the medical staff. Policies with respect to release of the deceased shall conform to local law.

17. Podiatric and Dental Care

A patient admitted for dental or podiatric care is a dual responsibility involving the dentist or podiatrist and a physician member of the Medical Staff.

A. Dentist's Responsibilities

1) A detailed dental history justifying hospital admission.
2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.

3) A complete operative report describing the finding and technique. All tissue shall be sent to the hospital pathologist for examination.
4) Progress notes as are pertinent to the oral condition.
5) Clinical summary statement.

B. Podiatrist's Responsibilities

1) A detailed podiatric history justifying hospital admission.
2) A detailed description of the examination of the foot and preoperative diagnosis.
3) A complete operative report, describing the finding and technique. All tissue shall be sent to the Hospital pathologist for examination.
4) Progress notes as are pertinent to the podiatric condition.
5) Clinical summary statement.

C. Physician's responsibilities

1) Medical history pertinent to the patient's general health.
2) A physical examination to determine the patient's condition prior to anesthesia and surgery.
3) Supervision of the patient's general health status while hospitalized.

D. The discharge of the patient shall be on the concurrence of both the podiatrist and the physician involved.

MEDICAL RECORDS

1. A medical record shall be maintained for every patient admitted to the hospital, emergency room or seen as an outpatient. The attending physician is responsible for the preparation of a complete medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data, complaint, personal history, , history of present illness, physical examination pertinent to complaint, special reports such as consultation, clinical laboratory and radiology services and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note and autopsy report when performed. All entries shall be dated and timed.

2.. Diagnostic and therapeutic orders for treatment shall be entered in the electronic medical record. A ***telephone***/verbal order can be obtained by any of the following:
• Registered Nurse; • Registered Pharmacist; • Physical Therapist;
• Registered Occupational Therapist; • Physician Assistant; • Respiratory Therapist;
• Registered Dietitian ▪ Nurse Practitioner
as long as the order is authenticated by the responsible physician or his/her designee within 48 hours. All ***telephone/***verbal orders are to be entered by the person by whom it was dictated. The person who receives the ***telephone/***verbal order must also indicate the name of the practitioner.

3. CLINICAL OBSERVATIONS

A. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Authentication means to establish authorship by electronic signature.

B. Patients shall be examined and seen daily. Pertinent progress notes shall be recorded daily and shall give a pertinent chronological report of the patient's course in the hospital and shall reflect any change in condition and the results of treatment. Each of the patient's clinical problems shall be clearly identified in the progress notes, correlated with specific orders as well as the results of tests and treatments. Progress notes shall be recorded at least daily at the time of evaluation.

C. Nursing notes shall be informative and descriptive of nursing care given and include information and observation of significance so that they contribute to the continuity of patient care. All shift entries are to be authenticated in the following manner: first initial, last name, nursing classification, date and time.

When oxygen is prescribed for newborn infants, its use shall be recorded as oxygen concentration percentage and at regular defined intervals, in accordance with written policy of the Newborn Nursery.

D. Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved abbreviations shall be kept on file in the Medical Record Department.

E. Consultations shall reflect evidence of a review of the patient's record by the consultant, pertinent findings or examination of the patient and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations, be recorded prior to operation. Initial impressions and recommendations should be noted on the Progress Note. Consultation must be performed by the credentialed physician, (or his or her partner), from whom the consultation is requested. Physician Assistants, Certified Nurse Midwifes and Nurse Practitioners may provide final impressions and recommendations with oversight by his/her sponsoring Medical Staff Member.

F. Any respiratory care services provided to a patient must be made a documented part of the patient's medical record. Documentation shall include reference to at least the following: type of therapy, dates and times of administration, specifications of the prescription, effects of therapy including adverse reactions and therapeutic objectives. The responsible physician shall record a timely, pertinent clinical evaluation of the results of therapy in the patient record.

G. Any rehabilitation services provided to a patient shall be made a documented part of the patient's medical record. Documentation shall include the following: assessment of patient's medical condition; functional limitations with establishment of long and short term goals; prognosis; any possible need for corrective surgery or devices; attitude of patient and/or family toward rehabilitation and the existence of any social psychological problems affecting rehabilitation. The medical record should also document regular and frequent assessment of patient's progress, results of treatment including revision of goals as indicated and estimation of further rehabilitation potential. Justification for continued rehabilitation care shall require either evidence of problems necessitating active treatment or evidence of observed or expected improvement in functional ability.

H. Operative notes shall be entered in the electronic medical record immediately after surgery and should contain:

- The names of the licensed independent practitioner(s) who perform the procedures and his/her assistants
- The name of the procedure(s) performed.
- Findings of the procedure(s)
- Estimated blood loss
- Specimen(s) removed
- Post-operative diagnosis

Operative reports shall be provided for inpatients as well as outpatients and the report promptly authenticated by the surgeon and made a permanent part of the patient's medical record. The responsible physician shall record and authenticate a preoperative diagnosis prior to surgery.

I. Reports of pathology and clinical laboratory examination, radiology, anesthesia records and any other diagnostic or therapeutic procedures shall be completed promptly and filed in the record.

J. The medical record should not be a forum for airing disagreements with departments or individuals.

1) Disagreements between physicians and departments and with any report from another physician or department should be handled by telephoning or writing a memo to the responsible physician. Notations as such on the report in the chart is not an appropriate method for disagreement.

2) Medical reports from Pharmacy, Radiology, Emergency Room, Laboratory, Pathology and all other departments that are part of the active medical record should not be defaced or altered.

4. A written, signed informed consent shall be obtained prior to the following procedures except in emergency situations where suitable signature consent cannot be obtained due to the condition of the patient and a responsible relative is not immediately available.

a. Major or minor surgery that involves an Invasive Procedure
b. All procedures involving the administration of moderate sedation, deep sedation or anesthesia
c. Non-surgical invasive procedures that involve entry into the body (i.e. arteriograms, myelograms, paracentesis, thoracentesis)
d. All forms of Radiation therapy and oncologic chemotherapy
e. Administration of blood and blood products
f. When licensure or regulatory bodies require Informed Consent for specific procedures
g. Participation in research, unless approved by the Institutional Review Board indicates that no consent is required

In emergencies involving a minor or unconscious patient in which consent cannot be obtained immediately from parents, guardian or a responsible relative, these circumstances shall be fully documented in the patient's medical record. If time permits, a consultation in such instances may be desirable before the emergency surgery procedure is undertaken. Should a second procedure be required during the patient's stay in the hospital, a second consent specifically worded shall be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.

Where the attending physician feels that a patient is incapable (due to age, nature of illness, heavy medication, mental impairment, language barrier, etc.) of giving informed consent to a nonemergent surgical procedure, which seems necessary or advisable, a potential legal problem may exist as to which Administration should be consulted as well as the patient's responsible relatives.

The Physician/Practitioner has to document that he/she has informed the patient of the benefits, potential risks, complications and alternatives of the proposed procedure. This can be accomplished by documenting this in the progress note or history and physical. Documentation must occur prior to the performance of surgery.

5. Final diagnoses shall be recorded in full, as well as operative procedure performed, without the use of symbols and abbreviations by the responsible physician at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

6. A discharge summary shall be provided for all medical records of patients hospitalized over 48 hours. The discharge summary shall recapitulate concisely the reason for hospitalization, significant findings, procedures performed and treatment rendered, condition of the patient on discharge, and specific instructions given to the patient and/or family, particularly in relation to physical activity, medication, diet and follow up care. The condition of the patient on discharge should be stated and in terms that permit specific measurable comparison with the condition on admission.

When preprinted instructions are given to the patient or family, the record should so indicate and a sample of the instruction sheet in use at the time should be on file in the Medical Record Department.

A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a 48 hours period of hospitalization The final progress note shall include instructions to patient particularly in relation to physical activity, medication, diet and follow up care.

7. In the event of death, a summation of treatment should be added to the record either as a final progress note or as a separate discharge summary. This final note shall include reason for admission, the findings and the course in the hospital and events leading to death.

When an autopsy is performed, a provisional anatomic diagnosis shall be recorded within 3 days and a complete report shall be made part of the record within 90 days.

8. In the event that a medical record remains incomplete 10 days physician(s) will be contacted by the Medical Records Department and will be given 7 additional days to complete the records. If the records remain incomplete after 7 additional days, the physician will be placed on the 'delinquent' list (on day 17) until the records have been brought up to date.

If the records remain incomplete **4** days after being placed on the 'delinquent' list (day 21), the physician will be notified via fax that, if the record remains incomplete for another **4** days (day 25), the physician will be notified by fax that he/she will have 24 hours to complete the charts. If the charts have not been completed within 24 hours, the physician will be placed on automatic suspension (meaning loss of emergency and elective admission privileges and surgical privileges). While suspended, a physician can attend to patients already in house, but cannot admit, schedule for perform surgery. Call responsibility assigned to a suspended physician will fall on the department chief. Reinstatement will occur upon completion of all records for which automatic suspension is imposed.

CHRONIC DELINQUENCY -

If a physician receives automatic suspension **two times in a calendar year, a letter will be forwarded from the Professional Practice Excellence Committee encouraging them to improve their medical record completion performance. If they are placed on automatic suspension four** times in a calendar year, record delinquency will be considered a chronic problem. The physician will be afforded an interview with the Medical Staff Executive Committee at their next meeting. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to the hearings. If the physician fails to attend this interview or offer an acceptable plan or commitment to correct the chronic delinquency, corrective action will be taken which may include summary suspension of the physician's privileges in accordance with 5.2 of the Medical Staff Bylaws. Chronic medical record deficiencies also will be considered at the time of medical staff reappointments.

If a physician remains on suspension for two weeks or more, **he/she will receive notification from the Chairman of the Medical Staff Executive Committee that they need to** appear at the next Medical Staff Executive Committee meeting or provide a written Performance Improvement Plan one week prior to the next Medical Staff Executive Committee meeting. If he/she fails to appear or provide a written Performance Improvement Plan, the Medical Staff Executive Committee will be empowered to determine what action, up to and including termination of privileges, will be taken. In the case of termination, after completion of the delinquent charts, he/she can reapply for privileges as a new applicant.

VACATIONS/SICK

When a physician leaves on vacation or sick leave and appropriately notifies the Medical Staff Secretary the process outlined above stops and his/her status remains exactly where it is upon notification of his/her leave. Upon his/her return, the status resumes where it left off. In other words, if a physician has incomplete records eight days old, prior to a properly notified vacation or sick leave, the record will still be considered eight days old until the physician returns from vacation or sick leave.

9. A medical record shall not be permanently filed until it is completed by the responsible physician or is ordered filed by the Utilization Review and Medical Record Committee. All medical records of patients admitted 24 months prior to December 31, of each year will be microfilmed. After all film has been checked for completeness and accuracy and is placed in fiche form, the original medical record is to be destroyed. Microfilm viewing equipment will be made available for physicians who wish to view microfilmed copies of patient records.

10. Written consent of the patient or his legally qualified representative is required for release of medical information to persons not otherwise authorized to receive this information. When a patient wishes to see his hospital medical record or procure copies of same, the patient's physician is to be informed. If the patient wishes to view his record only, an appointment will be made for viewing during the normal working hours of the Medical Record Department. The attending physician will be notified of the date and time.

11. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be removed from the hospital.

    In the case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient be attended by the same physician or another.

12. Unauthorized removal of patient records from the hospital by a physician is grounds for suspension of the physician for a period to be determined by the Executive Committee of the Medical Staff.

13. Free access to all medical records of all patients shall be afforded to members of the medical staff for bona fide study and research. Confidentiality shall be preserved. All such projects shall be approved by the Chief of Staff and administrator before records can be studied. Subject to the discretion of the administrator, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

QUALITY OF CARE

All medical staff members have the responsibility to ensure that care provided to patients at Ascension River District Hospital is of the highest quality. This shall be accomplished through the appropriate utilization of resources, timely order of diagnostic evaluations and consultations and recognition of the participation in ongoing quality improvement initiatives. Utilization of inpatient care protocols, clinical pathways and standing orders is encouraged.

CONDUCT OF CARE

1. A general consent form, signed by or on behalf of every patient admitted to the hospital must be obtained at the time of admission. The admitting office shall notify the attending physician whenever such consent has not been obtained. When so notified, it shall, except in emergency situations be the physician's responsibility to obtain proper consent before the patient is treated in the hospital.

2. In addition to obtaining the patient's general consent for treatment, the medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate. This information shall include:

   - The name of the patient and the date.
   - The procedure or treatment to be rendered.
   - The name or names of the individual or individuals who will perform the procedure or administer the treatment.
   - Authorization for anesthesia if indicated.
   - An indication that alternate means of therapy and the possibility of risks or complications have been explained to the patient.
   - Authorization for disposition of any tissue or body parts as indicated.

3. If an adult is unconscious or otherwise unable to sign an authorization for treatment, the rule of succession for signature shall be as follows:

   - Spouse (unless legally separated or divorced)
   - Children (if of legal age)
   - Parents of patient
   - Brothers or sisters of patient (if legal age)
   - Grandparents of patient
   - Aunts and uncles (if of legal age)
   - Cousins (if of legal age and blood relative)

   If none of these are available, a court appointed guardian may be sought through the Probate Court (985-9631).

4. In the case of an unaccompanied unemancipated minor, the consent of a parent or other relative (see rule of succession in paragraph #3) shall be sought. If a relative is not available, a legal guardian is necessary in order to provide emergency treatment or surgery. A legal guardian may be acquired through Protective Services (985-7161) or the Probate Court (985-9631).

5. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the State of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

   A. Medical Time Limit Orders

      1) Narcotics, sedatives and corticosteroids that are ordered without time limitation of dosage shall automatically be discontinued after 72 hours (3 days).

      2) Antibiotics and sulfa medications ordered without time limitations of dosage shall automatically be discontinued after 120 hours (5 days).

      3) Drugs shall not be discontinued without notifying the physician. If the order expires in the night, it shall be called to the attention of the physician the following morning.

   B. Medication orders shall be entered in the electronic medical record.

   C. Orders for intravenous fluids shall be absolutely specified as to the type, quantity and rate of flow. Blood transfusions are to be initiated by a registered nurse. They may be monitored by a registered nurse or and LPN II trained for this responsibility.

Intravenous continuous infusions and IV push medications are to be administered by a registered nurse or an LPN II trained for this responsibility as specified in the medication administration policies approved by the Pharmacy and Therapeutics Committee.

D. All P.R.N. medication orders shall include the maximum frequency of dosage, as well as the intended use of the drug.

6. Any qualified practitioner with clinical privileges in the hospital can be called upon for consultation within his/her area of expertise. **Routine consultations should be completed by end of next calendar day after initial notification.**

7. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in the qualified consultant. He will provide written authorization to permit another attending physician to attend or examine his patient except in an emergency.

8. If a nurse has sufficient reason to doubt or question the care provided to a patient or believes that appropriate consultation is needed and has not been obtained, she shall call to the attention of her supervisor who in turn may refer the matter to the Director of Nursing. If warranted, the Director of Nursing may bring the matter to the attention of the Chairperson of the department wherein the practitioner has clinical privileges. When circumstances justify such actions, the Chairperson of the department may himself request a consultation.

TB TESTING

Annual TB testing, which is mandated by MIOSHA, is required of all physicians. Testing may be done at Ascension River District Hospital or may be administered and read by another institution; however, it is the responsibility of each physician to see that the test results are forwarded to the Medical Staff Office on a yearly basis.

NON-DISCLOSURE FEE

Any physician, dentist, podiatrist, or non-physician practitioner who fails to disclose indications of a complex history as part of their new appointment/reappointment credentialing application may be subject to a one-hundred dollar ($100) non-disclosure fee, after adjudication by the Medical Staff Executive Committee. The non-disclosure fee will be collected as part of the Medical Staff Funds.

RESIDENT PHYSICIAN ROTATION

Residents will be part of an established residency program through Ascension Health. Residents will abide by the hospital bylaws, general rules and regulations as well as department specific rules and regulations. On all rotations the resident is under the direct supervision of the attending physician(s). Patients will have the opportunity to decline resident care and will have their wishes respected.

The resident may perform H&P's, provide discharge summaries, progress notes and consults at the discretion of the attending physician with review and authentication of the attending physician. The attending physician shall be notified of all admissions and significant changes in the patient's condition. Any invasive procedures or deliveries require the direct supervision of the attending physician. Residents may provide diagnostic and therapeutic orders after reviewing the case with the attending physician.

The program director(s) will be responsible for the overall educational experience of the residents as well as coordinating communication between the residency program and the Medical Executive Committee of the hospital. On a yearly basis the Residency Program Director, or his/her designee, will provide a report to the Medical Staff regarding the residency program activities at Ascension River District Hospital.

COMMITTEES

Utilization Review Committee

(a) Composition

The utilization review committee shall be a standing committee consisting of representatives from the medical staff and the hospital. Physician members shall be appointed by the chief of the medical staff to serve on the utilization review and medical records committee.

Non-physician members shall be appointed by the President or designee of the hospital and should be representatives of at least administration, nursing, medical records and social services.

The chairperson of the utilization review and medical record committee shall be a physician member of the active staff appointed by the chief of the medical staff and approved by the executive committee.

(b) Voting Privileges

Voting privileges shall be limited to physician members of the utilization review and medical record committee.

(c) Meetings

The utilization review and medical record committee shall meet at least quarterly and maintain a permanent record of its proceedings and actions.

(d) Functions and Responsibilities

The utilization review and medical record committee shall be responsible for the coordination and the formulation, implementation, and maintenance of ongoing programs related to the utilization of the hospital's resources and the adequacy of patient records, including:

- Utilization review -- a utilization review program to assure the appropriate allocation of the hospital's resources in striving to provide high quality patient care in a cost effective manner. The utilization review program shall address over-utilization, underutilization, and inefficient scheduling of resources. The hospital shall implement a written plan that describes the utilization review program and governs its operation. The utilization review plan shall be approved by the medical staff, administration and governing body. The utilization review program shall be renewed and evaluated to reflect the findings of utilization review activities. Appropriate findings shall be reported to the medical staff executive committee and the governing body.

Pharmacy & Therapeutics Committee

(a) Composition

The pharmacy & therapeutics committee shall be a standing committee consisting of representatives from the medical staff and the hospital. Three physician members shall be appointed by the chief of the medical staff, who shall include but not be limited to members representing the departments of medicine and surgery.

Non-physician members shall be appointed by the President or designee (CMO) and shall include but not be limited to representatives of administration, nursing, and pharmacy.

The chairperson of the pharmacy and therapeutics committee shall be a physician member of the active staff appointed by the chief of the medical staff and approved by the executive committee.

(b) Voting Privileges

Voting privileges shall be limited to physician members of the committee.

(c) Meetings

The committee shall meet semi-annually and maintain a permanent record of its proceedings and actions.

(d) Functions and Responsibilities

The committee shall be responsible for the development and surveillance of pharmacy and therapeutics policies and practices, particularly as they relate to utilization within the hospital. The committee shall assist the pharmacist in the formulation of policies and procedures related to the selection, intra-hospital distribution and handling, and safe administration of drugs. The executive committee shall be responsible for approving the policies and procedures formulated by the pharmacist and the committee. The committee shall be responsible for the development of a formulary that is reviewed on an annual basis for currentness, review of all untoward drug reactions, and the evaluation and approval of all protocols concerned with the use of investigational or experimental drugs.

Professional Practice Excellence Committee (PPEC)

(a) Composition

The Professional Practice Excellence Committee shall be a standing committee consisting of members from active members of the medical staff. At large members can be chosen to provide appropriate balance and expertise to the committee. Practitioners from other specialties may be invited to the meeting as needed.

The Medical Director, the CNO or designee, and the support staff as determined by the chair are ex-officio members of the PPEC.

(b) Voting Privileges

The voting PPEC members will be appointed by the Chief of Staff based on the recommendations from the department chairs and the PPEC chair and approved by the MEC. Voting members will be appointed for a three year term except for initial committee members who will have staggered terms to initiate the process (i.e. 1/3 for 2 years, 1/3 for 3 years and 1/3 for 4 years). Voting members may serve up to two consecutive terms and are eligible for reappointment to the committee after one year after their last term is completed. However, voting members may serve more than two consecutive terms if no one else is available to serve from that specialty with the approval of the MEC for each additional term.

(c) Meetings

The PPEC will meet at least Bimonthly, and as needed. A quorum (consists of members present)for purposes of making final determinations or recommendations for individual case review or improvement opportunities based on aggregate data. A majority will consist of a majority of voting members present.

(d) Functions and Responsibilities

The primary responsibilities of the PPEC are to:

1. Define practitioner performance indicators and targets for the General Competencies in collaboration with the appropriate departments and specialties and approved by the Medical Staff Executive Committee as outlined in the PPEC charter.
2. Monitor practitioner performance for these indicators to determine if improvement opportunities exist either through case review or using aggregate data for patterns and trends.
3. Assure accountability by the medical staff departments for the development of improvement plans when appropriate.
4. Oversee any other medical staff specialty specific peer review activities.
5. Provide oversight for FPPE and OPPE processes.

Bylaws Committee

(a) Composition

The bylaws committee shall be a standing committee consisting of not less than four members of the medical staff appointed by the chief of staff and not less than 1 administrative representative. The chairperson of this committee shall be a member of the active staff appointed by the chief of staff and approved by the executive committee.

(b) Voting Privileges

All members of the bylaws committee shall have full voting privileges within the committee.

(c) Meetings

The bylaws committee shall schedule meetings as needed, but not less than bi-annually, and shall maintain a permanent record of its proceedings.

(d) Functions and Responsibilities

The bylaws committee shall be responsible for periodically reviewing and revising the medical staff bylaws, rules and regulations to insure that they adequately reflect the current practices of the medical staff and comply with Federal and State regulations, where applicable, and the standards of the Joint Commission on Accreditation of Hospitals. The committee shall make appropriate recommendations for revisions to the executive committee.

PHYSICIAN POLICY OF CONDUCT

1. All individuals within the hospital must be treated with courtesy, respect, and dignity. Physicians and other independent practitioners are expected to conduct themselves in a professional and cooperative manner, even in situations of disagreement and frustration.

2. Disruptive conduct may include, but is not limited to, behavior such as:

   A. Verbal or physical attacks leveled at medical staff, patients or hospital employees.
   B. Inappropriate comments made in official documents that impugn the quality of hospital care or attack members of the hospital staff.
   C. Non-constructive criticism that attempts to intimidate, belittle or imply incompetence.
   D. Refusal to cooperate with assignments or departmental affairs or to do so in a disruptive manner.

3. Any physician, patient, visitor or hospital employee may report potentially disruptive conduct. The report shall be submitted to the hospital President, Hospital Administrator or designee and forwarded to the chief of staff and respective departmental chief.

4. A report will be investigated by the chief of staff and departmental chief. The individual initiating such report must be appraised and the accused party must be questioned before any action is taken. Reports which are not founded may be dismissed by the chief of staff.

5. The first incident of disruptive behavior warrants a discussion with the offending physician. The departmental chief shall emphasize that such conduct is inappropriate and must cease. The initial approach shall be collegial and designed to be helpful to both the physician and hospital. The Medical Staff Executive Committee will be informed in writing of the meeting and of any action required with a copy sent to the accountable individual. Following the above, if the report has merit, the person who initiated the report will be apprised that action has been taken but the specifics will not be divulged.

6. If it appears to the chief of staff that a pattern of disruptive behavior is developing, the Hospital President or designee (CMO) and chief of staff shall meet with and advise the physician that such conduct is intolerable and must stop. The involved physician may submit a rebuttal to the charge, which will be maintained as a permanent part of the record.

7. If such behavior continues, the hospital President or designee (CMO), hospital board representative and the chief of staff shall again meet with and advise the physician that such conduct will not be tolerated and must stop. This meeting is not a discussion but rather constitutes the physician's final warning. It shall be followed with a letter reiterating the warning.

8. Additional occurrences will result in medical staff membership suspension by the Medical Staff Executive Committee and/or other disciplinary action as determined by the Medical Staff Executive Committee.

ADOPTION AND APPROVAL

The Rules and Regulations shall be considered an Appendix to the Medical Staff Bylaws according to Article XII, Section 12.1. The Executive Committee shall adopt and may amend rules and regulations for the proper conduct of the work of the medical staff. Such rules and regulations shall become effective when approved by the Board of Trustees.

The Rules and Regulations may be amended by the Medical Staff Executive Committee. Such changes shall become effective when approved by the governing body.

In the adoption of additions/amendments to these Rules and Regulations, the Medical Staff Executive Committee (MSEC) will work to resolve all conflicting issues related to a rule, regulation or policy update/amendment in the best interest of Ascension River District Hospital, its patients and the Medical Staff.

Each "Active" staff member has a right to discuss a conflict with the MSEC, regarding an issue with a newly adopted rule, regulation or policy amendment to these Rules and Regulations:

- The Active staff member is encouraged to initially attempt to resolve the issue/concern with his/her Department Chair.
- If this is unsuccessful, he/she may request a meeting with the MSEC to discuss the issue. This must be accomplished through a written request provided to the Chief of staff two weeks in advance of a regular meeting of the MSEC to schedule and appearance before the MSEC.

If an issue arises regarding a current Medical Staff Rule and Regulation process/policy, the Active staff member may submit a petition signed by at least 10% of all Active staff members requesting a review/challenge to the process as follows:

- Upon receipt of the petition, the MSEC will schedule an Ad Hoc Committee to review with the petitioners and further clarify and discuss the issue.
- The meeting will be scheduled within 30 days of the regularly scheduled MSEC meeting at which the petition is reviewed.
- The Ad Hoc Committee shall be comprised of 50% of Active Medical Staff members and 50% MSEC members as selected by the Chief of Staff.
- The Ad Hoc Committee will work to achieve resolution of the conflict presented in the petition.

If the processes outline above fail to provide a resolution to the conflict the Active staff member may communicate his/her concerns to the Board of Trustees in writing. In the event this level of appeal occurs, the Chief of Staff shall also provide a written summary of the conflict resolution process to the Board of Trustees.

The Board of Trustees may seek to resolve the conflict through informal discussions. If this is unsuccessful in resolving the conflict, the Chair of the Medical Staff or the Chair of the Board of Trustees, or his/her designee, may request a formal conflict resolution process.

The formal conflict process will begin with a meeting of a Joint Medical Staff/Board Conference Committee within 30 days of the initiation of the formal conflict resolution process to address the conflict. The joint Medical Staff/Board Conference Committee shall be comprised of equal

representatives from the Active medical staff, (non MSEC members), MSEC members and Board of Trustee members. The President or designee (Medical Director) of the Hospital and Chief Medical Officer may also be present as determined by the Board of Trustees Chair.

Adopted by the River District Hospital Medical Staff on 12/18/84.
Pablo B. Martinez, M.D., Chief of Staff Tae Hong Chung, M.D., Secretary/Treasurer

Approved by the Governing Body on 1/24/85.
Edwin J. Steinmetz, Chairman of the Board Anthony J. Pizzo, Secretary of the Board

Rules and Regulations reviewed and approved by the Medical Staff Executive Committee: 05/90

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Amended 3/22/05
Amended 3/26/10
Amended 2/22/11
Amended 4/19/11
Amended 5/17/11
Amended 8/16/11
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Amended 8/18/15
Amended 10/18/16
Amended 7/25/18
Amended 10/16/18
Amended 12/18/18
Amended 1/15/19
Amended 2/19/19
Amended 3/19/19
Amended 11/19/19
Amended 3/16/21
Amended 5/26/21
Amended 2/21/23
Amended 8/1/24