Ascension St. John Hospital

Medical Staff Bylaws 2022

Amended 10/01/2023

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ASCENSION ST. JOHN HOSPITAL
MEDICAL STAFF BYLAWS

PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of medical care, medical education, medical research and both professional and ethical standards within Ascension St. John Hospital, it is mandatory for the Medical Staff to accept and assume this responsibility subject to the ultimate authority of and accountability to the Board of Trustees. Therefore, in order to promote optimal quality of patient care, the physicians, podiatrists, dentists and non-physician practitioners practicing in Ascension St. John Hospital have organized themselves in conformity with these Medical Staff Bylaws, Rules & Regulations, Medical Staff policies, in addition to the Hospital's Articles of Incorporation, Bylaws and policies. These Medical Staff Bylaws are not a contract of any kind between the Hospital Board of Trustees and the Medical Staff nor the Non-Physician Providers (NPPs), or any member thereof.

ARTICLE I
ORGANIZATION NAME

The Name of this organization shall be "The Medical Staff of St. John Hospital & Medical Center."

ARTICLE II
DEFINITIONS

In these Bylaws, and in the Rules & Regulations, the following terms are defined:

1. **ADMINISTRATOR** is the President of the Hospital or other individual charged with the management of executive organization of the Hospital.

2. **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 St. John Hospital is a subsidiary.

3. **BOARD CERTIFICATION** is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialists, the American Board of Oral and Maxillofacial Surgery, the Commission on Dental Accreditation of the American Dental Association, the American Podiatric Medical Association or the American Board of Foot and Ankle Surgery, and the Council on Medical Specialty Societies, or the Osteopathic equivalent.

4. **BOARD OF TRUSTEES** is the governing body of the corporation known as Ascension St. John Hospital. means the governing body of Ascension St. John Hospital which is

ultimately accountable for the safety and quality of care, treatment, and services performed at any of its locations, satellites, practices, and/ or clinics.

5. **CHIEF MEDICAL OFFICER (CMO)** is a physician selected and appointed by the Hospital President and is responsible for the administrative functioning of the Medical Staff. The CMO shall work with the Medical Staff and serve as the liaison between the Medical Staff and the Board of Trustees.

6. **CO-ADMISSION** shall refer to the practice whereby a hospital patient of a member of the Medical Staff, other than a Physician, is assigned for admitting purposes to a Physician member of the Medical Staff who shall thereafter be jointly responsible for the care and treatment of that patient as set forth below in Article VII, Section 1, paragraph 1.4.

7. **DENTIST** is a person licensed to practice dental medicine and dental surgery under the laws of the State of Michigan.

8. **HIGH-RISK PROCEDURE** shall be defined as a procedure involving the administration of moderate sedation, deep sedation, or anesthesia.

9. **HISTORY AND PHYSICAL (H&P)** is an important reference document that provides concise information about a patient's history and exam findings establishing a current baseline status to formulate an appropriate diagnosis and treatment plan.

10. **HOSPITAL** means Ascension St. John Hospital, 22101 Moross Road, Detroit, Michigan 48236, County of Wayne, State of Michigan, and/or any of the locations, satellites, practices, and/or clinics governed by the Board of Trustees.

11. **INVASIVE PROCEDURE** shall be defined as a procedure involving puncture or incision of the skin, insertion of an instrument, or insertion of foreign material into the body for diagnostic or treatment-related purposes. Examples include but not limited to central line and chest tube insertions, percutaneous aspirations/ biopsies, cardiac/vascular catheterizations, endoscopies, angioplasties, and implantations. Excluded are routine examinations (i.e., pap smears, cultures), venipunctures, parenteral therapy, injection of radiographic contrast media, and routine nursing procedures (i.e.: nasogastric tube insertion, Foley catheter insertion).

12. **MEDICAL STAFF** is the group of all licensed independent practitioners, who include every physician, dentist, podiatrist, and other practitioners including adjunct professional staff, who have been granted the privilege to practice in the Hospital and are subject to the Medical Staff Bylaws.

13. **MEDICAL STAFF BYLAWS** means the Hospital Medical Staff Bylaws governance the framework that establishes roles and responsibilities for, and its provisions set forth herein concerning the organization and functions of the Ascension St. John Hospital Medical Staff and its members.

14. **NON-PHYSICIAN PRACTITIONER** consists of all licensed practitioners who hold dependent privileges and provide direct patient care services in the Hospital under the supervision of a Medical Staff member with clinical privileges. Non-physician practitioners are designated, credentialed, and privileged according to these Bylaws and approved by the Board of Trustees. Types of Non-Physician Practitioners include physician assistants, nurse practitioners, certified registered nurse anesthetists, anesthesiologist assistant, clinical nurse specialists, nurse midwives and intake social workers. Non-physician practitioners are not members of the Medical Staff. They may be employed by or have contracts with the Hospital, or they may be employed, contracted, or sponsored by members of the Medical Staff. Thus, Non-physician practitioners are not entitled to the rights, privileges, and responsibilities of Medical Staff Membership.

15. **ORGANIZED MEDICAL STAFF** is the self-governing entity, consisting of the voting members of the Medical Staff, accountable to the Board of Trustees that operates under a set of bylaws, rules & regulations, and/or policies. The Medical Executive Committee (MEC) may act on behalf of the organized medical staff between medical staff meetings.

16. **PODIATRIST** is a person licensed to practice podiatric medicine under the laws of the State of Michigan.

17. **PHYSICIAN** is a person licensed to independently practice allopathic medicine or osteopathic medicine under the laws of the State of Michigan.

18. **RULES & REGULATIONS AND POLICIES OF THE MEDICAL STAFF** means the provisions concerning procedures, practices, and the professional conduct of the members of the Ascension St. John Hospital Medical Staff.

19. Any reference contained herein to the gender is intended to be gender neutral.

ARTICLE III
PURPOSE & RESPONSIBILITIES OF THE MEDICAL STAFF

SECTION 1 – THE PURPOSE OF THE MEDICAL STAFF:

1.1. The purpose of this Medical Staff is to organize the activities of physicians and other clinical practitioners who practice at the Hospital in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Hospital Board of Trustees.

1.2. Subject to the authority and approval of the Board of Trustees, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these Bylaws and under the corporate bylaws of the Hospital.

SECTION 2 – THE RESPONSIBILITIES OF THE MEDICAL STAFF:

2.1. To strive to improve the quality of care provided in the Hospital by participation in continuous quality assessment programs.

2.2. To strive for professional care for all patients of the Hospital, irrespective of sex, gender, race, creed, age, physical handicap, or national origin.

2.3. To comply with the terms of the Hospital and Ascension's Medical Staff Code of Conduct Policy.

2.4. To abide by Medical Staff Bylaws, Rules & Regulations, Medical Staff and Hospital policies adopted by the Board of Trustees, MEC, or the Organized Medical Staff, and policies adopted by individual Departments.

2.5. To respect the Mission, Vision and Values of the Hospital.

2.6. To maintain a continuing education and research program. In general, these programs are directed to and for the benefit of the Medical Staff, the residents, medical students and other students and to promote the general health of the community that the Hospital serves.

2.7. To participate in the on-call coverage of the Emergency Department or other Hospital coverage programs, consistent with their granted clinical privileges, as determined by the MEC and the Board of Trustees, after receiving input from the appropriate clinical department or specialty.

SECTION 3 – THE RESPONSIBILITIES OF THE ORGANIZED MEDICAL STAFF:

3.1. To make recommendations to the Board of Trustees concerning appointments, reappointments, clinical privileges, and scope of practice for the Medical Staff and recommend any corrective action deemed necessary.

3.2. To develop, maintain, and enforce compliance with the Medical Staff Bylaws, Rules & Regulations, Medical Staff policies, as well as Departmental Rules & Regulations, and Hospital policies.

3.3. To provide leadership in activities related to patient safety.

3.4. To provide oversight in the process of analyzing and improving patient satisfaction.

3.5. To participate in the Hospital's policy making and planning process.

3.6. To exercise the authority granted by these Bylaws as necessary to fulfill the foregoing and subsequent responsibilities in a proper and timely manner.

3.7. To provide good faith consultation to the administration of the Hospital before the forming or dismissal of a contract with an exclusive Hospital-based department physician group.

ARTICLE IV
STAFF MEMBERSHIP

SECTION 1 – GENERAL CONSIDERATIONS FOR APPOINTMENTS:

1.1. Appointments shall consider the needs of the Hospital in planning to meet the present and future needs of the community it serves:

a. To maintain a continuity of service by the Medical Staff considering projected resignations, transfers to inactive status and deaths of members of the Medical Staff.

b. To provide new skills as they may be developed by the constant and rapid evolution of medical science.

c. To meet the needs of continuous quality assessment programs of the Hospital, including participation in teaching programs at all levels, committee assignments, supervisory or administrative responsibilities.

d. The Board of Trustees, in order to serve the community, with respect of the resources available, may set limitations or develop a manpower plan related to the needs of the Medical Staff as a whole, or within a particular Department or Section of a Department.

1.2. Professionals under contract with the Hospital shall be required to apply for membership on the Medical Staff in the same manner as other applicants and must conform to the Medical Staff Bylaws, Medical Staff and Department Rules & Regulations, Medical Staff and Hospital policies, as well as their contracts.

SECTION 2 – QUALIFICATIONS:

2.1. Applications for membership on the Medical Staff shall be considered for those applicants who will promote quality and safe care for patients at the Hospital, as evidenced by the following:

a. Successful graduation from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology or applicable recognized course of training in a clinical profession, eligible to hold privileges.

b. Current unrestricted license to practice medicine in the State of Michigan (for anesthesiologist assistant must be certified by the National Commission for Certification of Anesthesiologist Assistant). Possession of a license to practice in the State of Michigan shall constitute a condition precedent to application but shall not be of itself determinative of the applicant's suitability for Medical Staff membership. Applications may be processed contingent upon obtaining a license to practice medicine in the State of Michigan, with primary source verification.

c. Current U.S. Drug Enforcement Administration (DEA) License, if applicable.

d. A record that is free from current Medicare/Medicaid sanctions, exclusions, and/or debarment and not be on the Office of inspector General's list of excluded individuals/entities.

e. 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 clinical privileges; any disciplinary action taken against them by any hospital,; any evidence of an "unusual pattern"; any professional liability actions resulting in final judgment against the applicant or any conviction of a criminal offense.

(Current members of the Medical Staff shall report, in writing, to the CMO within fourteen (14) days, any challenges to any licensure/registration, involuntary termination of medical staff membership; voluntary and involuntary limitation, reduction, restriction, suspension, reprimand, probation, fine, or loss of clinical privileges and any disciplinary action taken against him or her by any hospital or other health care organization (including HMOs), disciplinary proceedings, censure or negative actions taken by any professional society/organization, or any conviction of a criminal offense and the relevant circumstances thereof. Failure to report one of these above-listed issues to the CMO shall result in an immediate "precautionary suspension" (reference ARTICLE VII, Section 4.) pending further review by the CMO and the Medical Executive Committee (MEC).

f. Known professional competence based on background, education, training, experience, knowledge, judgment, and ability to perform all privileges requested.

g. Favorable peer recommendations regarding the practitioners' current professional performance based on the following the areas of "General Competencies" *(adapted from the ACGME and the ABMS):* Patient Care; Medical/Clinical Knowledge; Practice-Based Learning and Improvement; Interpersonal and Communication Skills Professionalism; and Systems-Based Practice.

h. An ability, willingness and interest to participate in and contribute to the Hospital's educational programs and medical committee assignments.

i. An ability, willingness, and interest to provide quality care to patients, including providing adequate coverage for patients.

j. Maintenance of current professional liability insurance for the credentialing Hospital with minimum limits of $100,000 per occurrence and $300,000 annual aggregate.

k. The ability to physically and mentally perform the requested privilege(s) and provision of a current documented health status.

l. Provision of relevant practitioner-specific clinical data, morbidity/mortality data, and patient outcome data (as applicable or requested).

m. Hospital provision of querying the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested .

n. **Board Certification:**

All new applicants to the Medical Staff who apply after January 1, 1995, must verify candidacy for board certification at the time of the initial application. The candidacy must be for certification in a specialty recognized by the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialists, the American Board of Oral and Maxillofacial Surgery, the Commission on Dental Accreditation of the American Dental Association, the American Board of Podiatric Medicine, the American Board of Foot and Ankle Surgery, and the Council on Medical Specialty Societies, or the Osteopathic equivalent. The specific board certification requirements that are referred to in this section must reflect the specific practice of the applicant; e.g., gastroenterology boards for a specialist practicing gastroenterology - not for internal medicine boards. Where there are two boards required to achieve final certification, each board certification must be considered in sequence. For those specialties that do not allow recent graduates to become candidates until a certain number of years have passed, their candidacy will have to be verified at the time of provisional reappointment. Applicants in any specialty who cannot demonstrate candidacy or the potential for candidacy at the time of application will not be eligible to become members of the Medical Staff.

All candidates must have achieved board certification in the primary specialty of the applicant's residency program, within 5 years following completion of training, or consistent with the time period specified by the specialty board and the individual Department Rules & Regulations. (The individual Medical Staff Departments may establish a more restrictive timeline for the achievement of board certification, as denoted in the Department's Rules & Regulations.) Failure to achieve board certification as stated shall result in the automatic surrender of Medical Staff membership.

Notwithstanding the above regarding Board Certification with respect to those Physicians, Podiatrists, and Dentists becoming a part of this Medical Staff based upon their status as active members of the Medical Staff of St. John North Shores Hospital, in conjunction with the merger of the Medical Staffs of St. John North Shores Hospital and St. John Hospital & Medical Center (currently referred to as Ascension St. John Hospital) effective on October 5, 2009 (the "Merger"), the date for initial board certification candidacy is June 1, 2001. This provision applies only to members of the St. John North Shores Hospital Medical Staff as of February 2009, and to no others.

o. **Board <u>Recertification</u>:**

Where board certification has been given in time limited fashion, all new applicants to the Medical Staff who apply after January 1, 1995, must re-certify in the specialties in which the member primarily practices at the time designated by such individual boards.

The individual Medical Staff Departments may establish an achievement standard for board recertification, as denoted in the Department's Rules & Regulations. A prerequisite for reappointment to the Medical Staff is the timely re-certification in those specialties in which the member primarily practices, unless an extension for recertification has been granted by the MEC.

Participation in Maintenance of Certification (MOC) is required by some specialty boards to confirm continuous learning and education activities.

In the event a candidate does not achieve board recertification within the specified timeframe, they may petition the MEC for a one (1) year extension. Failure to achieve board recertification during the extension period will allow the candidate to petition the MEC for a second extension, not to exceed eighteen (18) months.

Failure to achieve board recertification after exhausting two (2) extension periods, as stated, shall result in:

Surrender Medical Staff membership or as otherwise denoted in the Department's Rules & Regulations.

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Notwithstanding the above regarding Recertification, with respect to those Physicians, Podiatrists and Dentists becoming a part of this Medical Staff based upon their status as active members of the medical staff of St. John North Shores Hospital, in conjunction with the Merger, the date for purposes of the Recertification requirement set forth above is June 1, 2001. This provision applies only to members of the St. John North Shores Hospital medical staff as of February 2009, and to no others.

p. Understand that Ascension St. John Hospital is a health care organization that is sponsored by Ascension 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.

q. Are aware of the importance of caring for persons who are disadvantaged, which is fundamental to the mission of Ascension's health care ministry. Applicants must be reasonably willing to provide care for such persons.

r. To improve colleague to colleague communication and promote optimal patient care, all medical staff members 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 compliance with cellphone/text/office connections.

2.2. Membership on the Medical Staff shall be considered a privilege and not a right. Only those individuals who continuously demonstrate and document that they meet the qualifications, standards, and requirements set forth in these Bylaws and associated Rules & Regulations, and policies and procedures of the Medical Staff and the Hospital, and who demonstrate that they can provide quality patient care and exhibit appropriate professional behavior, shall be eligible to obtain and maintain medical staff membership and privileges at the Hospital. Because facilities and supportive services may not be available for all applicants desirous of Medical Staff membership, not all applicants meeting minimum qualifications can necessarily be appointed.

2.3. No applicant shall be denied consideration because of gender, race, creed, age, physical handicap, or national origin; or on the basis of license, registration or professional education as a Doctor of Medicine, a Doctor of Osteopathy, a Podiatrist or a Dentist.

2.4. Applicants for membership must be able to render continuous care and supervision of their patients and agree to accept and faithfully discharge staff and other committee assignments, and to provide emergency care and consultation for patients admitted to the Hospital.

2.5. The applicant shall agree to abide by the Medical Staff Bylaws and the Medical Staff and Department Rules & Regulations, Medical Staff and Hospital policies, as well as the code of ethics adopted by the appropriate professional organization.

SECTION 3 – PROCEDURE FOR APPOINTMENT:

3.1. A new applicant desiring to become a member of the Medical Staff shall complete and sign the application supplied to the applicant. The CMO shall also furnish the applicant with a copy of the Medical Staff Bylaws, Rules & Regulations and Medical Staff policies at the time of application. The application shall contain information relative to the applicant's current licensure and/or certification; specific relevant education and training; professional experience (including all hospitals at which the applicant has been a member of the medical staff); documented health status; provided relevant practitioner-specific clinical data (as applicable or requested); the applicant's consent to the inspection of all pertinent records (excluding those of patients); the applicants consent to communication by the Hospital or committees of its Medical Staff with any individual or institution having information pertinent to the applicant; and the names of at least two (2) professional references. One of these references must be from the Department Chair and/or program director, which had major responsibility for training or clinical supervision of the applicant while in training or practice. The applicant shall submit the application to the CMO, who shall obtain the necessary references, verifications, proof of licensure and other evidence of qualification deemed pertinent.

3.2. The new applicant will be interviewed by the Department Chair and Section Chief of the Department/Section the applicant is seeking privileges in.

3.3. If the applicant does not meet the qualifications (as outlined in Article IV, Section 2 of these Bylaws) or provide the necessary information (as listed in Article IV, Section 3.1. of these Bylaws), his or her application will not be processed, and he or she will not be entitled to a fair hearing, or any rights and due process provided under Article VIII of these Bylaws. The applicant agrees to hold harmless the Credentials Committee, MEC, and others involved in the application process.

Non-physician practitioners desiring to become associated with the Medical Staff shall submit a comparable application form containing information pertinent to the profession and function of the applicant.

3.4. Within thirty (30) days after the application is complete; the CMO shall transmit the application form and all supporting materials to the Credentials Committee for evaluation. The Credentials Committee shall examine the evidence of the current licensure, qualifications, education, relevant training, experience, ability, character, and current competence to perform the requested privileges. The Credentials Committee will request a recommendation from the Department Chair in which the applicant seeks clinical privileges. The Department Chair recommendation shall be based upon such qualification criteria as may be established by each Department and included in such Department's Rules & Regulations and policies. The Credentials Committee shall consider all findings and make a favorable or unfavorable recommendation to the MEC.

If additional information is requested to fully evaluate an applicant, the application will be considered incomplete until the requested information is received. The applicant will be notified and allowed sixty (60) days to complete an application. If the requested information is not received by sixty (60) days, the application will be considered withdrawn. The Credentials Committee may grant an additional defined period of extension to the sixty (60) days.

The Medical Staff and Hospital will not consider an application for a period of one (1) year post a withdrawn application.

3.5. Within thirty (30) days after receipt of the completed application, the Credentials Committee shall make a written report and recommendation to the MEC. If the recommendation is for appointment, the clinical privileges to be granted shall also be recommended. Along with its report, the Credentials Committee shall transmit to the MEC the completed application and other documentation considered in arriving at its recommendation. Within thirty (30) days after receiving the report of the Credentials Committee, the MEC shall consider such report and make a favorable or unfavorable recommendation to the Board of Trustees. A favorable recommendation shall refer to the staff category or categories, to the Department, and to the clinical privileges to be conferred; and shall be forwarded to the Board of Trustees.

3.6. In the case of an unfavorable recommendation, the CMO shall transmit the recommendation to the Board of Trustees. If the Board of Trustees agrees with the MEC's unfavorable recommendation, it shall become final, and the applicant shall be notified. Should the Board of Trustees have any concerns it may communicate back to the MEC within thirty (30) days. Unless reconsidered by the MEC, the unfavorable action shall be sent back to the Board of Trustees, the action shall become final, and the applicant shall be notified.

Along with this notification of the unfavorable recommendation, the applicant shall be given a copy of the reason(s) for the unfavorable recommendation, notice of the right to request a hearing on the unfavorable recommendation, and a copy of Article VIII of these Bylaws (or summary of the hearing rights conferred there by). The applicant has the right to a hearing and appeal in accordance with Article VIII of these Bylaws. A written request for a hearing and appeal must be submitted to the CMO within thirty (30) days from date of notification of the unfavorable recommendation. Failure to request such a hearing shall constitute waiver of the right thereto and any appeal. An unfavorable recommendation shall not be forwarded to the Board of Trustees until the applicant's right to a hearing has been waived or concluded.

3.7. At its next regular meeting, following receipt of the recommendation of the MEC pursuant to Section 3.4, or following waiver or exhaustion of the applicant's hearing and appeal rights, the Board of Trustees shall take final action on the recommendation. The CMO shall notify the applicant of such final action within thirty (30) days.

3.8. The new appointee shall receive notification of the decision to grant initial appointment to the medical staff and approval of requested privileges within fifteen (15) days of approval from the Board of Trustees. The new appointee shall also be informed that their work for the first year will be closely assessed according to the Focused Professional Practice Evaluation process.

3.9. The foregoing procedures of this section may be modified by an **expedited review process**, which must involve the Department Chair, Credentials Committee Chair, the Medical Staff President and CMO (or designee) and be approved by at least two members of the Board of Trustees. Applicants eligible for an expedited review process must have a complete application and be without a complex history.

3.10. All initial appointment to the Medical Staff shall be for a term not to exceed 24 months. Failure to apply for reappointment at least six (6) months prior to the expiration of the current appointment, after sufficient notification, is a voluntary resignation of privileges to be effective at the end of the current appointment.

SECTION 4 – REAPPOINTMENT AND BIENNIAL REVIEW:

4.1. Reappointment to the Medical Staff shall be based upon the member's professional competence, citizen requirements (which consists of abiding by of the Medical Staff Code of Conduct, committee assignments, and meeting attendance), adherence to the Medical

Staff Bylaws, Medical Staff and Department Rules & Regulations, Medical Staff policies and other requirements and responsibilities established by the MEC.

4.2. A member-applicant desiring reappointment to the Medical Staff shall complete and sign the reappointment application supplied to the applicant. The CMO shall furnish the applicant with a copy of the Medical Staff Bylaws, Rules & Regulations, and Medical Staff policies at the time of making application for reappointment. The reappointment application shall contain information relative to the applicant's current licensure and/or certification; specific relevant education and training; professional experience (including all hospitals at which the applicant has been a member of the medical staff); documented health status; favorable recommendations regarding the practitioners' current professional performance based on the following the areas of "General Competencies" *(adapted from the ACGME and the ABMS):* Patient Care; Medical/Clinical Knowledge; Practice-Based Learning and Improvement; Interpersonal and Communication Skills Professionalism; and Systems-Based Practice; provided relevant practitioner-specific clinical data, morbidity/mortality data, and patient outcome data (as applicable or requested); the applicant's consent to the inspection of all pertinent records, the applicant's consent to communication by the Hospital or committees of its Medical Staff with any individual or institution having information pertinent to the application. The applicant shall submit the application to the CMO, who shall obtain the necessary references, verifications, proof of licensure and other evidence of qualification deemed pertinent.

4.3. If the applicant does not meet the qualifications (as outlined in Article IV, Section 2 of these Bylaws) or provide the necessary information (as listed in Article IV, Section 4.2. of these Bylaws), his or her application will not be processed, and he or she will not be entitled to a fair hearing, or any rights and due process provided under Article VIII of these Bylaws. The applicant agrees to hold harmless the Credentials Committee, MEC, and others involved in the application process.

Non-physician practitioners desiring to remain associated with the Medical Staff shall submit a comparable reappointment form containing information pertinent to the profession and function of the applicant.

4.4. Within thirty (30) days after the application is complete; the CMO shall transmit the application form and all supporting materials to the Credentials Committee for evaluation. The Credentials Committee shall examine the evidence of the current licensure, qualifications, education, relevant training, experience, ability, character, and current competence to perform the requested privileges. The Credentials Committee will request a recommendation from the Department Chair in which the applicant seeks clinical privileges. The Department Chair recommendation shall be based upon such qualification criteria as may be established by each Department and included in such Department's Rules & Regulations and policies. The Credentials Committee shall consider all findings and make a favorable or unfavorable recommendation to the MEC.

If additional information is requested to fully evaluate an applicant, the application will be considered incomplete until the requested information is received. The applicant will be

notified and allowed sixty (60) days to complete an application. If the requested information is not received by sixty (60) days, the application will be considered withdrawn. (The Credentials Committee may grant an additional defined period of extension to the sixty (60) days.)

The Medical Staff and Hospital will not consider an application for a period of one (1) year post a withdrawn application.

4.5. Within thirty (30) days after its receipt of the completed application for reappointment, the Credentials Committee shall make a written report and recommendation to the MEC. If the recommendation is for appointment, the clinical privileges to be granted shall also be recommended. Along with its report, the Credentials Committee shall transmit to the MEC the completed application and other documentation considered in arriving at its recommendation. Within thirty (30) days after receiving the report of the Credentials Committee, the MEC shall consider such report and make a favorable or unfavorable recommendation to the Board of Trustees. A favorable recommendation shall refer to the staff category or categories, to the Department, and to the clinical privileges to be conferred; and shall be forwarded to the Board of Trustees.

4.6. In the case of an unfavorable recommendation, the CMO shall transmit the recommendation to the Board of Trustees. If the Board of Trustees agrees with the MEC's unfavorable recommendation, it shall become final, and the applicant shall be notified. Should the Board of Trustees have any concerns, it may communicate back to the MEC within thirty (30) days. Unless reconsidered by the MEC, the unfavorable action shall be sent back to the Board of Trustees, the action shall become final, and the applicant shall be notified.

Along with this notification of the unfavorable recommendation, the applicant shall be given a copy of the reason(s) for the unfavorable recommendation, notice of the right to request a hearing on the unfavorable recommendation, and a copy of Article VIII of these Bylaws (or summary of the hearing rights conferred there by). The applicant has the right to a hearing and appeal in accordance with Article VIII of these Bylaws. A written request for a hearing and appeal must be submitted to the CMO within thirty (30) days from date of notification of the unfavorable recommendation. Failure to request such a hearing shall constitute waiver of the right thereto and any appeal. An unfavorable recommendation shall not be forwarded to the Board of Trustees until the applicant's right to a hearing has been waived or concluded.

4.7. At its next regular meeting, following receipt of the recommendation of the MEC, pursuant to Section 4.5, or following waiver or exhaustion of the applicant's hearing and appeal rights, the Board of Trustees shall take final action on the recommendation. The CMO shall notify the applicant of such final action within thirty (30) days.

4.8. The reappointee shall receive notification of the decision to grant reappointment to the medical staff and approval of requested privileges within fifteen (15) days of approval from the Board of Trustees.

4.9 All reappointments to the Medical Staff shall be for a term not to exceed 24 months. Failure to apply for reappointment at least six (6) months prior to the expiration of the current appointment, after sufficient notification, is a voluntary resignation of privileges to be effective at the end of the current appointment.

ARTICLE V
CATEGORIES OF THE MEDICAL STAFF

SECTION 1 – MEDICAL STAFF:

1.1. The Medical Staff shall be divided into the following categories: Active Staff, Ambulatory Active Staff, Consulting Staff, Affiliated Staff, Adjunct Professional Staff, and Honorary Staff categories. All appointments and reappointments to the Medical Staff shall be designated a category, based on category criteria and applicant activity, at the discretion of the Department Chair.

1.2. All categories of the Medical Staff may be subjected to a Medical Staff Funds Dues Assessment, as set forth in the Rules & Regulations of the Medical Staff. The dues will be paid to "The Medical Staff of St. John Hospital & Medical Center".

1.3. Non-physician practitioners are not members of the Medical Staff. They may be employed by or have contracts with the Hospital, or they may be employed, contracted, or sponsored by members of the Medical Staff. Thus, Non-physician practitioners are not entitled to the rights, privileges, and responsibilities of Medical Staff Membership.

SECTION 2 – ACTIVE STAFF:

2.1. The Active Staff shall be limited to physicians, dentists, and podiatrists. Its members have the primary responsibility for the work of the Medical Staff. Physicians and dental surgeons have the privilege of admitting patients; podiatrists must co-admit with a physician (see Article VII). Dentists (practicing dental medicine) shall not be permitted to admit patients.

2.2. The Active Staff **shall:**

- Be subjected to biennial review and reappointment.
- Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.
- Contribute to the organizational and administrative affairs of the Medical Staff.
- Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk and utilization management, medical records completion, and the discharge of other staff functions as required.
- Attend Medical Staff/Department meetings of which a member.

2.3. The Active Staff **may**:

- Attend any Medical Staff or Hospital education programs.
- Be a member or chair of any Committee, in accordance with the Medical Staff Bylaws, Medical Staff Rules & Regulations, or Medical Staff policies.
- Vote on all matters presented by the Medical Staff, Department, or Committee(s) to which assigned.
- Hold office.

SECTION 3 – AMBULATORY ACTIVE STAFF:

3.1. The Ambulatory Active Staff shall be limited to physicians, oral surgeons, dentists, and podiatrists without admitting privileges.

3.2. The Ambulatory Active Staff **shall**:
- Be subjected to biennial review and reappointment.
- Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

3.3. The Ambulatory Active Staff **may**:
- Attend Medical Staff/Department meeting of which they are a member.
- Attend any Medical Staff or Hospital education programs.

3.4. The Ambulatory Active Staff **shall not**:
- Admit patients to the Hospital, unless otherwise noted in the Department's Rules & Regulations.
- Perform a consult, unless otherwise noted in the Department's Rules & Regulations.
- Be a member or chair of any Committee, in accordance with the Medical Staff Bylaws, Medical Staff Rules & Regulations, or Medical Staff policies.
- Vote on matters presented by the Medical Staff.
- Hold office.

SECTION 4 – CONSULTING STAFF:

4.1. The Consulting Staff shall consist of selected recognized specialists, recommended by the Department Chair to provide consultation in the area of the consultant's expertise to another member of the Medical Staff.

4.2. The attending or emergency practitioner is primarily responsible for requesting the Consulting Staff.

4.3. The Consulting Staff is responsible for rendering the services requested by the emergency or attending practitioner and record findings, opinions, and recommendations within the patient's medical record.

4.4. The Consulting Staff **shall**:
- Be subjected to biennial review and reappointment.
- Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

4.5. The Consulting Staff **shall not:**
- Be required to attend Medical Staff meetings.
- Be a member or chair of any Committee, in accordance with the Medical Staff Bylaws, Medical Staff Rules & Regulations, or Medical Staff policies.
- Vote on matters presented by the Medical Staff.
- Hold office.

SECTION 5 – AFFILIATED STAFF:

5.1. Affiliated Staff shall consist of physicians, podiatrists and dentists who utilize special equipment or the facilities of the Hospital, or who provide limited services at the request of the Hospital, as recommended by the MEC and approved by the Board of Trustees from time to time. The Affiliated Staff shall meet the requirements under Sections 2.1 of Article IV and must submit evidence of professional liability coverage.

5.2. The clinical privileges of a member of the Affiliated Staff shall be determined by the Department of the member's specialty and are limited to the use of the special equipment or facility requested by the member or the Hospital.

5.3. The Affiliated Staff **shall**:

- Be subjected to biennial review and reappointment.
- Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

5.4. The Affiliated Staff **shall not:**

- Admit patients to the Hospital.
- Be required to attend Medical Staff meetings.
- Be a member or chair of any Committee, in accordance with the Medical Staff Bylaws, Medical Staff Rules & Regulations, or Medical Staff policies.
- Vote on matters presented by the Medical Staff.
- Hold office.

SECTION 6 – ADJUNCT PROFESSIONAL STAFF:

6.1. The Adjunct Professional Staff shall be limited to doctoral level scientists whose fields of expertise, are required by the Medical Staff for patient care. Wherever required by law or regulation, the Adjunct Professional Staff must possess appropriate licensure or national credentials relative to their specialty. Adjunct Professional Staff would include, for example, psychologists, microbiologists, and biochemists. Adjunct Professional Staff provide services only under the supervision of a member of the Medical Staff.

6.2. The Adjunct Professional Staff shall be assigned to one of the Departments which shall delineate the member's privileges. These privileges shall be submitted to the Credentials Committee who, after appropriate action, shall submit their recommendations to the Medical Executive Committee.

6.3. The Adjunct Staff **shall:**

- Be subjected to biennial review and reappointment.
- Fulfill or comply with any applicable Medical Staff or Hospital policies or procedures.

6.4. The Adjunct Professional Staff **may:**

- Attend Medical Staff meetings by invitation of the MEC, Medical Staff President or the Department Chair.

6.5. The Adjunct Staff **shall not:**

- Admit patients to the Hospital.
- Vote on matters presented by the Medical Staff.
- Hold office.

SECTION 7 – HONORARY STAFF:

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

7.2. 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.

7.3. The Honorary Staff category **may:**

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

7.4. The Honorary Staff **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.

SECTION 8 – NON-PHYSICIAN PRACTITIONERS (NPP):

8.1. The Board of Trustees, upon recommendation of the MEC, will determine the types of NPP's that may request authorization to provide direct patient care services at the Hospital, under the supervision of a Medical Staff member with clinical privileges. The Board of Trustees approve of the qualifications, clinical duties, and responsibilities of each NPP through the appointment, reappointment, and privileging process.

8.2. NPPs are employed by or have contracts with the Hospital, or they may be employed, contracted, or sponsored by a member of the Medical Staff. NPPs are assigned to an appropriate, individual Department. The assigned Department is responsible for determining and supervising the scope of practice for each individual. NPPs have only the appellate rights as set forth in Article VII, Section 7.

8.3. At all times, the NPP is responsible for demonstrating the following qualifications:

a. Continued employment by the Hospital or an employment, contract, or sponsorship with a member of the Medical Staff.

b. Requisite professional education and training, licensure and/or certification and registration as applicable.
c. Known professional competence based on background, education, training, experience, knowledge, judgment, and ability to perform all privileges requested.
d. Continuous professional liability coverage in the prescribed amounts and an acceptable professional claims history.
e. The ability to physically and mentally perform the requested privilege(s) and provision of a current documented health status.
f. Hospital provision of querying the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.
g. Adherence to the lawful ethics of the NPP profession.
h. The ability to work cooperatively with others in the Hospital in a consistently cordial and productive manner.
i. To improve colleague to colleague communication and promote optimal patient care, all NPPs 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 compliance with cellphone/text/office connections.

8.4. The basic responsibilities of each NPP are to:

a. Provide patients with quality care at the recognized level to the extent authorized by his or her license, certification, or other legal credentials.
b. Abide by all applicable state and federal laws that regulate healthcare practitioners, as well as the Medical Staff's Bylaws, Rules & Regulations, and the Hospital's policies.
c. Perform functions assigned by the MEC, including but not limited to, quality improvement, peer and professional review, patient care (within the approved delineation of privileges) utilization review, case management and other requested responsibilities.
d. Utilize the Hospital's resources appropriately.
e. Document in the medical record completely and in a timely fashion, to the extent authorized.
f. Seek consultation and coordination under the direction of the Sponsoring Medical Staff Member for the provision of health care to patients (see Article V, Section 8.5. for further detail).
g. At all times, observe and promote the confidentiality of patient-identifiable information.
h. Immediately report to the Department Chair and CMO, any action taken affecting licensure, certification, and/or registration, including but not limited to probation, restriction, suspension, termination and voluntary or involuntary relinquishment of privileges.

8.5. NPPs must be assigned to a Medical Staff member (Sponsoring Medical Staff Member) who serves as a supervisor, collaborator, and sponsor and is deemed acceptable by the Medical Staff. The Sponsoring Medical Staff Member must be a member of the Active Medical Staff and in good standing. The Sponsoring Medical Staff Member agrees to:

a. Accept full responsibility and accountability for the NPP's performance in the Hospital with respect to patients under their supervision.
b. Agrees and assures that the NPP will not exceed the scope of practice defined by law and within the NPP's collaborative practice agreement, as applicable.
c. For the hospitalized patient, deliver daily care in person to the patient apart from the care delivered by the NPP.
d. For the non-hospitalized patient, provide continuous geographic proximity and/or direct communication via telephone availability to enable cooperation, coordination, and consultation via provision of health care to patients.
e. Ensure coverage by another Sponsoring Medical Staff Member during any absence, incapacity, infirmity, or emergency situation of the original Sponsoring Medical Staff Member.
f. Accept responsibility for the proper conduct of the NPP within the Hospital, and for the NPP's observation of all Medical Staff Bylaws, Rules & Regulations, and policies of the Hospital.
g. Comply with all regulations of the State of Michigan Licensing Board with respect to their supervision of the NPP.
h. Provide input into the NPP's evaluation of performance and competency.
i. Review medical records and provide further education of practice trends, medical literature, predetermined procedures, and drug protocols, on a formal or informal basis.
j. Immediately notify the relevant Department in the event of any one of the following occurrences:

    i. Their approval to supervise the NPP is revoked, limited or otherwise altered by action of a State of Michigan Licensing Board.

    ii. Notification is given of the investigation of either the Sponsoring Medical Staff Member or the NPP by the State of Michigan Licensing Board.

    iii. The employment status of the NPP changes or the NPP authorized scope of practice changes.

    iv. There is a change and/or termination of the sponsoring physician.

    v. The employer member's professional liability insurance coverage is changed insofar as coverage of the acts of a dependent NPP is concerned.

8.6. NPPs are not members of the Medical Staff. They are not eligible to vote or hold office. They may attend general Medical Staff meetings by invitation of the MEC, Medical Staff President or Department Chair.

SECTION 9 – LEAVE OF ABSENCE:

9.1. Any member may request a voluntary leave of absence from the Medical Staff by submitting a written request to the Department Chair, which states the reason and period of time for the leave, which may not exceed one year, except for military service. A leave of

absence request will then be recommended to the Credentials Committee and the MEC, subject to such conditions or limitations as they shall determine appropriate. The MEC shall submit the recommendation to the Board of Trustees for affirmation.

9.2. During the period of a leave, the staff member's privileges and prerogatives shall be suspended, but dues shall still be paid.

9.3. The staff member may apply for a second leave of absence prior to the completion of the first. However, no member may have more than two consecutive leaves, or more than two years of leave. Requests for a leave of absence beyond two years will be made only in exceptional circumstances, as determined by the MEC.

9.4. At least 60 days prior to the termination of a leave of absence, which has exceeded 180 days, member may request reinstatement by submitting a completed reappointment application. When a leave of absence was less than 180 days, the member may make a written request for reinstatement. With respect to each request for reinstatement, regardless of the duration of the leave, the MEC shall make a recommendation to the Board of Trustees.

9.5. Failure, without good cause, to request reinstatement or to provide requested information shall be construed as the member's voluntary resignation from the Medical Staff, and they shall have waived all hearing and appeal rights otherwise afforded by these Bylaws. Any request for reinstatement from a member after the leave has lapsed shall be submitted and processed as if it were an initial appointment.

9.6. Leave of absence will be granted for the full duration of a medical education fellowship in an ACGME accredited program. Dues will be waived by the MEC for the duration of the fellowship program.

ARTICLE VI
DEPARTMENTS

SECTION 1 – CLASSIFICATION:

1.1. There shall be the following Departments:

(1) Department of Anesthesiology
(2) Department of Emergency Medicine
(3) Department of Family Medicine
(4) Department of Medicine with Sections of:
    a. General Medicine
    b. Allergy & Immunology
    c. Cardiology
    d. Dermatology
    e. Endocrinology and Metabolism
    f. Gastroenterology
    g. Hematology and Oncology
    h. Infectious Disease
    i. Neurology
    j. Nephrology
    k. Pulmonary & Critical Care Medicine
    l. Physical Medicine & Rehabilitation
    m. Radiation Oncology
    n. Rheumatology
(5) Department of Obstetrics and Gynecology
(6) Department of Psychiatry and Behavioral Medicine
(7) Department of Pathology
(8) Department of Pediatrics with Sections of:
    a. General Pediatrics
    b. Pediatric Cardiology
    c. Pediatric Critical Care Medicine
    d. Pediatric Endocrinology and Metabolism
    e. Pediatric Gastroenterology
    f. Pediatric Hematology and Oncology
    g. Pediatric Infectious Disease
    h. Neonatology
    i. Pediatric Nephrology
    j. Pediatric Neurology
(9) Department of Radiology, with Section of Nuclear Medicine
(10) Department of Surgery with Sections of:
    a. General Surgery
    b. Cardiovascular Surgery
    c. Hand Surgery
    d. Neurosurgery
    e. Oncological Surgery

f. Ophthalmology
g. Oral Surgery and Dentistry
h. Orthopedics
i. Otolaryngology
j. Neuroendovascular
k. Pediatric Surgery
l. Peripheral Vascular Surgery
m. Plastic Surgery
n. Podiatric Surgery
o. Thoracic Surgery
p. Transplant Surgery
q. Urology Surgery

SECTION 2 – ORGANIZATION OF DEPARTMENTS:

2.1. Each Department shall be organized as a division of the staff as a whole. Each shall have a Department Chair who shall be responsible to the CMO and the MEC. Each shall have a Vice Chair(s) who is responsible to the Department Chair.

2.2. Each Department shall hold meetings in accordance with Article XI of these Bylaws.

ARTICLE VII
PRIVILEGES

SECTION 1 – GRANTING PRIVILEGES:

1.1. A practitioner providing clinical services at the Hospital may exercise only those privileges granted to him or her by the Board of Trustees or through emergency provision of care temporary or disaster privileges as described in these Bylaws. Privileges are granted to individual members of the Medical Staff as well as identified non-members. Such non-members include Non-physician practitioners and others as deemed appropriate by the Board of Trustees.

1.2. When applicable, each application for appointment or reappointment to the Medical Staff must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges. Privileges are different and distinct from membership.

1.3. Privileges will be considered and approved by the Board of Trustees, upon recommendation of the MEC with reference to recommendations by the Credentials Committee. In any case where the Board of Trustees does not accept the recommendations of the MEC, the matter shall be referred back to the Credentials Committee, then to the MEC for review and recommendation before final action by the Board of Trustees.

1.4. Only a member of the Medical Staff with admitting, or, as appropriate, co-admitting, privileges shall be permitted to admit patients to the Hospital. Each patient of a Podiatrist shall be co-admitted by a Physician staff member with admitting privileges, and the co-admitting Physician and/or Podiatrist shall take a medical history and perform a comprehensive physical examination.

1.5. **Medical History and Physical Examination (H&P):**

a. A H&P is completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services.
b. An updated examination of the patient, including any changes in the patient's condition, shall be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the H&P is completed within 30 days before admission and registration.
c. The minimum criteria for a H&P include Chief Complaint; Present Illness; Past Medical History; Social History; Pertinent Physical Examination (clinically appropriate/symptom focused); and Diagnostic Impression(s).
d. A **pre-operative medical clearance** may suffice as a "medical history"; providing it meets the appropriate timeframe requirements (ARTICLE VII, 1.5.a) and minimum criteria (ARTICLE VII, 1.5.c) **and shall include an updated examination of the patient** (ARTICLE VII,1.5.b).
e. Outpatient surgeries, high-risk procedures, and invasive procedures (as defined in ARTICLE II) shall be subjected to these H&P requirements.

1.6. Only an appropriately licensed independent practitioner with clinical privileges shall be directly responsible for a patient's diagnosis and treatment within the area of their privileges, and the co-admitting Physician shall be responsible for the overall supervision of the patient's medical care including any medical problem that may be present at the time of admission or that may arise during hospitalization. Each patient's general medical condition shall be the responsibility of a physician member of the Medical Staff. Members of the house staff under the appropriate degree of supervision by a member of the Medical Staff shall provide direct medical care of patients. Podiatrists may write orders within the scope of their licenses as limited by applicable statutes and regulations and consistent with these Bylaws.

1.7. When members of the Medical Staff desire to delegate the performance of certain practices related to medicine to specified professional personnel, the MEC of the Medical Staff shall review and make a recommendation to the Board of Trustees.

1.8. A Medical Staff member may, either in connection with reappointment or at any other time, request that their staff category, Department assignment, or clinical privileges be changed or modified by submitting a written request to the CMO along with appropriate documentation of education, training and experience. Such information shall be processed in the same manner as provided for application for appointment and reappointment. In case of voluntary resignation from the Active Staff, the member must submit a written notification thirty (30) days prior to resignation to the CMO. The thirty (30) days may be waived at the discretion of the CMO.

SECTION 2 – REVIEW OF PRIVILEGES:

2.1. The Credentials Committee, with the assistance of Departmental Credentials Committees (as applicable) shall conduct a thorough biennial review of each member of the Medical Staff and make appropriate recommendations to the MEC regarding continued competency for Medical Staff membership and any appropriate changes in privileges.

2.2. Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence, according to the areas of "General Competencies" developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.

2.3. Requests for clinical privileges will be evaluated on the basis of current licensure and or certification (as appropriate) verified with primary source; relevant continuing education and training; experience and utilization practice patterns; current physical ability to perform the privileges requested; and demonstrated current competence, ability, and judgment. Additional factors that may be used when determining privileges are patient care needs, the hospital's ability to support the type of privileges being requested, and the availability of qualified coverage in the applicant's absence. The basis for determining privileges in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the

staff's performance improvement program activities. Privileges determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and healthcare settings where the practitioner exercises clinical privileges.

SECTION 3 – ADMITTING PRIVILEGES: EMERGENCY MEDICINE, ANESTHESIA, PATHOLOGY & RADIOLOGY:

3.1. Members of the Department of Emergency Medicine, Anesthesia, Pathology, & Radiology shall not have admitting privileges by virtue of appointment to those Departments.

SECTION 4 – PRECAUTIONARY RESTRICTION/SUSPENSION OF MEMBERSHIP OR PRIVILEGES:

4.1. A precautionary restriction/suspension may be imposed where the failure to take immediate action may result in imminent danger to the health of any individual; when Medical Staff leaders and/or the President of the Hospital/CMO determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to affect patient or employee safety or the effective operation of the institution; or when the reputation of the Medical Staff or Hospital is at stake. Under such circumstances, the President of the Hospital, or designee, Medical Staff President or designee, CMO, or the MEC may restrict or suspend the Medical Staff membership or clinical privileges of such practitioner as a precaution. (A suspension of all or any portion of a practitioner's clinical privileges or any other adverse action against a practitioner's clinical privileges, at another Hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this Hospital.)

4.2. Unless otherwise stated, a precautionary restriction/suspension shall become effective immediately, and the person or body responsible shall promptly notify in person and give written notice of the suspension to the practitioner within three (3) days, and to the MEC, the President of the Hospital, and the Board of Trustees. The restriction /suspension may be limited in duration and shall remain in effect for a period not to exceed fourteen (14) consecutive calendar days. The precautionary restriction /suspension is not a complete professional review action in and of itself and shall not imply any final finding regarding the circumstances that caused the restriction/suspension.

4.3. Unless otherwise indicated by the terms of the precautionary restriction/suspension, the practitioner's patients shall be promptly assigned to another Medical Staff member by the Medical Staff President or designee, considering, where feasible and appropriate, the wishes of the affected practitioner and the patient when choosing a substitute practitioner.

4.4. As soon as practicable and within fourteen (14) calendar days after a precautionary restriction/suspension has been imposed, the MEC shall meet to review and consider the action and, if necessary, begin the investigation process specified in Section 6 of this Article of these Bylaws. The MEC shall invite the practitioner to attend the meeting and address the

MEC concerning the action, on such terms and conditions as the MEC may impose. Under no circumstances shall any MEC meeting, with or without the practitioner, constitute a "hearing" under Article VIII of these Bylaws, nor shall any procedural rules with respect to hearing and appeal apply. As such, the practitioner may not be accompanied by legal counsel, nor shall the member's legal counsel be otherwise present at the meeting. The MEC may modify, continue, or terminate the precautionary restriction or suspension at the meeting, but in any event, it shall furnish the practitioner with notice of its decision within three (3) calendar days.

4.5. **Procedural rights:** Unless the MEC promptly terminates the precautionary restriction/suspension, the practitioner shall be entitled to the procedural rights afforded by the hearing and appeal process, as applicable, (see Article VIII) once the restriction /suspension lasts more than fifteen (15) calendar days.

SECTION 5 – AUTOMATIC RELINQUISHMENT OF MEMBERSHIP OR PRIVILEGES:

5.1. 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, any clinical privileges that the practitioner has been granted at this Hospital that are within the scope of said limitation 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, his or her 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 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 practitioners' 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. 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 his or her 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 privileges. These 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 clinical privileges with the exception of emergencies. These 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. 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 or special assessments shall automatically relinquish medical staff membership and privileges if the dues are not paid by the end of the calendar year (after receiving appropriate reminder communications throughout the dues assessment phase).

SECTION 6 – CORRECTIVE ACTION:

6.1. Whenever the MEC receives information that a practitioner's activities or professional conduct may not adhere or comport with the standards set forth in these Bylaws, or with any

Medical Staff Rules & Regulations, Medical Staff or Hospital policies or standards, the MEC may consider whether corrective action is appropriate.

6.2. If the MEC determines that the information is sufficient to warrant an immediate recommendation, or that it warrants other immediate action, the MEC may make a recommendation immediately or take immediate action pursuant to ARTLE VII (PRIVILEGES) Section 4 (PRECAUTIONARY RESTRICTION/SUSPENSION OF MEMBERSHIP OR PRIVILEGES) of these Bylaws.

6.3. If the MEC determines that the information does not warrant an immediate recommendation or action, or in addition to taking immediate action/recommendation, the MEC may decide to arrange for an investigation of the matter. If it decides that the matter should be investigated, the MEC may:

a. investigate the matter itself or appoint an ad hoc subcommittee which shall include at least one MEC member; or

b. direct the Chair of the appropriate Medical Staff department to investigate the matter, either personally or through an ad hoc investigating committee; or

c. order an external review of a physician's care as part of either (a) or (b) above;

d. order a physician to undergo a physical or mental evaluation as part of either (a) or (b) above;

e. undertake other action consistent with these Bylaws.

The practitioner who is under investigation shall be given the opportunity to be interviewed by the investigating party, or if the investigation is undertaken by the MEC itself, shall be given the opportunity to appear before the MEC to give an account of the matter(s) under investigation. Neither the interview nor the appearance before the MEC shall be considered to be a hearing under Article VIII of these Bylaws, nor shall any procedural rules with respect to hearing and appeal apply. As such, the practitioner may not be accompanied by legal counsel, nor shall the practitioner's legal counsel be otherwise present, at any such interview or appearance.

6.4. If the investigating party is anyone other than the MEC itself, such party shall submit a written report to the MEC within thirty (30) days after the investigating party has been appointed by the MEC. Upon receipt of the investigating party's written report or upon completing its own investigation, the MEC shall consider whether corrective action is warranted. The MEC may, without limitation:

a. decide that corrective action is not warranted;

b. issue a letter of warning, guidance, or reprimand, or take other action, including but not limited to any action specified in Article VIII, Section 2.2 of these Bylaws that does not result in a reduction, restriction, limitation or revocation of privileges or Medical Staff membership exceeding fifteen (15) days;

c. recommend to the Board of Trustees:

1. reduction, restriction, limitation, suspension or revocation of clinical privileges;

2. suspension or revocation of a practitioner's Medical Staff membership;

3. any other form of discipline that materially limits the practitioner's right to provide direct patient care and/or limits his or her ability to exercise his or her own independent judgment in providing such care (such as a recommendation to require proctoring or consultation, with consent of the proctor or consultant being required before the member can provide care to any patient); and/or,

d. suspend all or any portion of the practitioner's clinical privileges where the failure to take immediate action may result in imminent danger to the health of any individual.

SECTION 7 – REVIEW OF CONDUCT AND CORRECTIVE ACTION FOR NON-PHYSICIAN PRACTITIONERS (NPP):

7.1. Review of conduct and/or corrective actions may be instituted for NPPs regarding issues, as specified in the Medical Staff Bylaws, Rules & Regulations or the Hospital's policies.

7.2. Whenever the activities or professional conduct of an NPP adversely affects or is likely to adversely affect patient safety or the delivery of quality patient care, or if the NPP's professional conduct is disruptive to the organization's operations, the matter shall be reported to the CMO, who may refer the matter to the Credentials Committee.

(With regards to Hospital-employed NPPs - instead of being referred to the Credentials Committee, the matter may be handled by the Hospital as described in established Hospital-specific policies and procedures).

7.3. The Credentials Committee, where applicable, shall review the matter or designate an ad hoc or existing peer review body to investigate. The Credentials Committee may use external third parties to conduct all or part of the investigation or to provide information to the investigating body. The investigation may involve an interview with the NPP involved and his or her Sponsoring Medical Staff Member and an interview with other individuals or groups.

7.4. Within thirty (30) days of the NPP review, the Credentials Committee shall transmit their recommendation to the MEC.

7.5. The MEC shall make its recommendation in writing to the Board of Trustees. If the MEC's recommendation is for corrective action, then the CMO will forward that recommendation to the Board of Trustees who shall review the record and take action. At any step in the process, the Board of Trustees may refer the matter back to the MEC or Credentials Committee with directions for further review or report the Board deems appropriate. The Board's action shall be final.

7.6. When the Board's action is determined; the CMO will notify the affected NPP in writing within thirty (30) days. The action shall be final.

7.7. Automatic Relinquishment of Privileges: The privileges and status of an NPP shall terminate immediately, without right to a fair hearing or appeal, in the event that:

a. Employment of the NPP with the Hospital is terminated for any reason. *(NPP privileges may continue if NPP was not terminated with cause and is contiguously employed with a Sponsoring Physician who is a member of the Medical Staff and has privileges.)*
b. Employment, contract, or sponsorship of the NPP with a member of the Medical Staff is terminated for any reason.
c. License or another legal credential of the NPP expire or is revoked.
d. Exclusion from Medicare/Medicaid participation.
e. Failure to meet basic qualifications of the NPP.

SECTION 8 – TEMPORARY PRIVILEGES:

8.1. 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 MEC and Board of Trustees.

8.2. 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 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 the Hospital 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 reappointment/ re-privileging process when additional information and/or time is needed to assure due diligence.

8.3. ***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.

8.4. 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.

8.5. When temporary privileges are granted to **meet an important care need**, the organized medical staff verifies current licensure and current competence.

8.6. 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)

8.7. All temporary privileges are recommended by the Medical Staff President (or designee, i.e., Department Chair).

8.8. All temporary privileges are granted by the President of the Hospital (or designee, i.e., Chief Medical Officer {CMO}).

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

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

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

8.12. 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 the Hospital. 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.

SECTION 9 – EMERGENCY PROVISION OF CARE:

9.1. For the purpose of this section, an "emergency" is defined as a sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (MCL550.1418). Any Physician, Podiatrist, or Dentist who is or is not a member of the Medical Staff may exercise emergency provision of care, assuring privileges performed are within the scope of the individual's license.

9.2. When the emergency situation no longer exists, the patient shall be reassigned to their attending physician or be routed to the Emergency Department, as appropriate, considering the wishes of the patient.

SECTION 10 – DISASTER PRIVILEGES:

10.1. For the purpose of this section, a "disaster" is defined as a type of emergency that, due to its complexity, scope or duration, threatens the Hospital's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

10.2.1 If the Hospital's Emergency Management Plan has been activated and the organization is unable to meet immediate patient needs, the President of the Hospital, CMO, Medical Staff President, Department Chair and/or other individuals identified in the Hospital's Emergency Management Plan with similar authority, may, on a case-by-case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected licensed independent practitioners.

10.3. At a minimum, these licensed independent practitioners will be required to present specific, valid government-issued photo identification (i.e., driver's license or U.S. passport) and at least one of the following:

- A current Hospital identification card that clearly identifies professional designation
- A current license to practice.
- Primary source verification of the licensure.
- An identification certifying that the practitioner is a member of a recognized state or federal disaster medical assistance team (i.e., Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), and/or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)).
- An identification that certifies the practitioner has been granted authority by a federal, state or municipal entity to administer patient care in disaster circumstances.
- Identification by a current hospital or medical staff member who possesses personal knowledge of the practitioner's ability to act as a licensed independent practitioner during a disaster.

10.4. After granting of privileges, the Hospital Incident Commander will assign each disaster practitioner to a current member of the Hospital's Medical Staff for supervision. The disaster practitioner will be given a temporary pictured-ID badge. 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.

10.5. Primary source verification will continue as soon as the immediate disaster situation is under control and will be completed within 72 hours from the time the disaster practitioner presents to the organization. As soon as possible after the initial implementation of the Emergency Management Plan, additional information on all disaster practitioners who have requested disaster privileges will be verified as indicated in Article VII, Section 8.

10.6. If primary source verification of a disaster practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the Hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival.
- Evidence of practitioner's demonstrated ability to continue to provide adequate care, treatment, and services.
- Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

10.7. If any adverse information is uncovered during this verification process or if unfavorable professional practice is determined, it will be brought to the attention of the President of the Hospital, CMO, the Medical Staff President, Department Chair and/or other individuals identified in the Hospital's Emergency Management Plan with similar authority. A determination will be made at that time whether or not to immediately terminate the disaster privileges for that practitioner. If disaster privileges are terminated, the Hospital will notify the appropriate Departments, as well as the Incident Command Center. Such termination of disaster privileges will not give rise to a right to a fair hearing or an appeal.

10.8. When the Hospital determines that the Emergency Management Plan is no longer needed, all disaster privileges will be immediately terminated.

SECTION 11 – TELEMEDICINE PRIVILEGES:

11.1. Telemedicine is the exchange of medical information from one site to a distant site via electronic communications for the purpose of improving and facilitating patient care, treatment, and services. The Board of Trustees shall determine the clinical services that may be provided through telemedicine after considering the recommendations of the appropriate Department Chair and the MEC.

11.2. Practitioners providing solely telemedicine services shall be credentialed and privileged in accordance with Articles IV and VII of these Bylaws. In addition, the contractual arrangement that authorizes these practitioners to provide services at the Hospital shall address quality review and assessment mechanisms that are designed to promote the provision of safe and competent services.

SECTION 12 – REPORTING OF SUSPENSION, REVOCATION, OR SURRENDER OF PRIVILEGES:

12.1. The CMO or 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.

ARTICLE VIII
HEARINGS AND APPEALS

SECTION 1 – RIGHT TO HEARING:

1.1. Applicants to and members of the Medical Staff shall be entitled to request a hearing only when an unfavorable recommendation or other adverse action specified under Section 2.0 of this Article with regard to clinical competence or professional conduct has been made by the MEC. This person shall be referenced as the "affected individual".

1.2. In the event the affected individual does not request a hearing in the time and manner required by these Bylaws, the individual shall be deemed to have waived the right to such hearing and may appeal in connection thereto, and to have accepted the recommendation made. Such recommended action shall become effective immediately on final board action.

1.3. The privileges and status of a Non-Physician Practitioner shall terminate immediately without any hearing/appeal rights, in the event that the employment of the Non-Physician Practitioner with the Hospital is terminated for any reason or if the employment, contract, or sponsorship of the Non-Physician Practitioner with a member of the Medical Staff organization is terminated for any reason. (See ARTICLE VII, SECTION 7 for details.)

SECTION 2 – HEARING EVENTS:

2.1. 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 clinical privileges, as recommended by the MEC;
d. Involuntary reduction or revocation of 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.

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

a. The MEC issues a practitioner a letter of guidance, warning, or reprimand;

b. The MEC 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 MEC 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 MEC 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 MEC 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 MEC 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 MEC 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 MEC;
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 MEC 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 MEC;

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;

SECTION 3 – NOTICE OF ADVERSE ACTION/RECOMMENDATION AND RIGHT TO A HEARING:

3.1. The CMO shall notify the affected individual in writing within seven (7) days when an adverse action/recommendation described in Section 2.1 of this Article has been recommended or initiated. Notice shall be delivered in person or sent by certified mail, addressee only, return receipt requested.

3.2. The written notice referenced in Section 3.1 of this Article shall specify:

a. the nature of the adverse action that has been recommended or initiated;

b. the reasons for the adverse action;

c. that the affected individual has the right to request a hearing on the adverse action, and that he or she shall have thirty (30) days following the date of receipt of the notice within which to submit a written request for a hearing, and that the failure to submit a request for hearing in the manner specified herein shall constitute a waiver of the affected individual's right to a hearing and to any appellate review of the matter;

d. a summary of the affected individual's rights in the hearing, and/or a copy of this Article of these Bylaws.

SECTION 4 – REQUEST FOR HEARING:

The affected individual shall have thirty (30) days following his or her receipt of a notice of adverse action/recommendation in which to request a hearing. Such request shall be in writing and delivered to the CMO either in person or via certified mail. The request for hearing shall contain a written response to the statement of reasons for the adverse recommendation and/or action and a list of witnesses who may or will be called as witnesses in support of the affected individual. The request for hearing shall not be deemed valid and complete unless it includes the written response and list of potential witnesses. The failure to request a hearing within the time and manner specified herein shall constitute a waiver of the right to hearing and appeal in accordance with Section 1.2 of this Article of these Bylaws.

SECTION 5 – HEARING PANEL:

5.1. When a hearing is requested, the CMO, acting for the Board, with concurrence of the Medical Staff President shall appoint a Hearing Panel that shall be composed of no fewer than three individuals. No individual appointed to the Hearing Panel shall have actively participated in the consideration of the matter involved at any previous level. Mere knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by or a contract with the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Panel. Up to one (1) member of the Hearing Panel need not be a member of the Hospital Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

5.2. The Hearing Panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner. This restriction on appointment shall apply to any individual designated as the chair or Presiding Officer.

5.3. The CMO shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must oppose, if at all, the appointment of any member(s) pursuant to Section 6.1 of this Article of these Bylaws. Any opposition to any member of the Hearing Panel or to the Hearing Officer, or to the Presiding Officer shall be made in writing to the CMO by the date her/she has specified. Although the affected individual who is the subject of the hearing may oppose any panel member, he or she is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the CMO.

5.4. In lieu of a Hearing Panel Officer, the CMO acting for the Board and after considering the recommendations of the Medical Staff President may appoint an individual experienced in due process, as Presiding Officer. The Presiding Officer will not act as a prosecuting officer or as an advocate for either side at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and may serve as a legal advisor to it but shall not be entitled to vote on its recommendation.

5.5. If no Presiding Officer has been appointed, a chair of the Hearing Panel shall be appointed by the CMO and shall be entitled to one vote.

SECTION 6 – NOTICE OF HEARING:

6.1. Within thirty (30) days of the timely receipt of a valid, completed written request for a hearing, the CMO or the Presiding Officer shall schedule the hearing. The CMO shall give written notice to the affected individual who requested the hearing. The notice shall be delivered in person, or via certified mail, addressee only, return receipt requested and shall include:

a. The time, place, and date of the hearing.
b. A list of proposed witnesses (as known at that time, but which may be modified) who may or will give testimony or evidence in support of the MEC or the board at the hearing.
c. The names of the Hearing Panel members, if known and a date that any opposition to any said members must be made in writing by the affected individual.
d. A statement of the specific reasons for the recommendation as well as the list of patient records supporting the recommendation. This statement, and the list of supporting patient record numbers may be amended or added to at any time, even during the hearing, so long as the additional material is relevant to the subject matter of the hearing, on such terms and conditions imposed by the Hearing Panel and/or the Presiding Officer.

6.2. The hearing date shall not be less than thirty (30) and generally no more than sixty (60) days from the date of receipt of the request. The hearing may be scheduled beyond the 60-day limitation if the CMO or the Presiding Officer determines that such a date is more practicable for the participants, including the Hearing Panel members. If the practitioner is under current suspension and requests a hearing as soon as reasonably possible and waives the thirty (30) day notice of hearing otherwise provided for, the CMO may set an earlier hearing date.

SECTION 7 – AMENDMENT:

The statement of reasons and the response thereto, and 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 written notice of the amendment at least seven (7) days prior to the first or continued hearing date.

SECTION 8 – CONDUCT OF HEARING:

8.1. The hearing is a review of professional conduct by the peers of an affected individual, not a court proceeding. As such, the affected individual has no right to discovery or production of information prior to the hearing. In furtherance of his or her responsibilities under Section 8.5 of this Article of these Bylaws, the Presiding Officer or Chair may direct the parties to provide expected exhibits to be introduced as evidence to

the opposite party within a reasonable time prior to the hearing. No information, however, regarding other members or practitioners shall be required to be produced as evidence during the hearing unless such evidence has already been introduced by the MEC in support of the adverse action or recommendation.

8.2. A majority of the members of the Hearing Panel shall be present when the hearing takes place.

8.3. The Hearing Panel shall keep an accurate record of the hearing and shall establish a means for doing so. The mechanism employed may be a (court) reporter, electronic recording unit, detailed transcription, or minutes. The CMO or designee shall make the necessary arrangements.

8.4. The personal presence of the affected individual shall be required. The affected individual who fails to appear and proceed at such hearing as directed by the Presiding Officer or the Hearing Panel shall be deemed to have waived their right to a hearing and appeal. Failure to appear in person within thirty (30) minutes of the scheduled time of the hearing or a postponed or continued hearing shall constitute a failure to appear.

8.5. Only the Hearing Panel shall have the authority to postpone a hearing beyond the time set forth in these Bylaws. The granting of such postponements shall be only for good cause shown and in the sole discretion of the Hearing Panel.

8.6. The Presiding Officer (or Hearing Panel chair) shall do the following:

a. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.
b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than 15 hours.
c. Maintain decorum throughout the hearing.
d. Determine the order of procedure throughout the hearing.
e. Have the authority and discretion to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence, including but not limited to, exclusion, or sequestration, of witnesses or other individuals.
f. Act in such a way that all admissible information reasonably relevant to the continued appointment or clinical privileges of the affected individual requesting the hearing is considered by the Hearing Panel when formulating its recommendations.
g. Conduct argument by counsel on procedural points.
h. Seek legal counsel when he or she feels it is appropriate. Legal counsel to the Hospital may advise the panel chair if no Presiding Officer is appointed.
i. Have the authority to arrange a pre-hearing conference and require the representatives of the parties to attend such conference, for the purpose of

arranging for the expeditious and efficient disposition of matters before the Hearing Committee, including but not limited to evidentiary and testimonial matters, so as to avoid unnecessary proofs and to streamline the hearing process.

8.7. It shall be the initial obligation of the MEC to present appropriate evidence in support of the unfavorable recommendation. The affected individual who requested the hearing shall thereafter have the burden of supporting their challenge to the adverse action/ recommendation by showing by a preponderance of the evidence that the charges or grounds involved lack substantial factual basis or that the adverse action/recommendation is arbitrary or capricious.

8.8. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which reasonable persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any rule of law which might make such evidence inadmissible in a court of law. The Presiding Officer or the Hearing Panel will have the authority to rule on admissibility of the evidence.

8.9. The affected individual may be represented by an attorney or by a member of the Medical Staff in good standing. If the affected individual requests representation by an attorney, he or she shall notify the CMO in writing of such request and the name of the attorney no later than seven (7) days after providing the Request for Hearing specified in Section 4 of this Article of these Bylaws. The MEC may also decide to have one of its members be present during the entire hearing and/or to be represented by legal counsel at the hearing.

8.10. The parties to the hearing shall have the following rights:

a. to call and examine witnesses;

b. to introduce written or documentary evidence determined to be admissible by the Presiding Officer or the Hearing Panel in accordance with the provisions of this Article of these Bylaws;

c. to cross-examine any witness who testifies on behalf of the opposing party;

d. to submit a written statement upon the conclusion of the oral testimony and documentary evidence.

8.11. If the affected individual does not testify on their own behalf, members of the Hearing Panel may examine them as if under cross-examination.

8.12. At its discretion, the Hearing Panel may order that oral evidence be taken only on oath or affirmation administered by any person entitled to notarize documents in the state where the hearing is held.

8.13. Without giving special notice, the Hearing Panel may recess and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional

evidence or consultation. Upon conclusion of the presentation of oral and documentary evidence, the chair or Presiding Officer shall close the hearing. The Hearing Panel shall thereafter conduct its deliberations outside the presence of the affected individual for whom the hearing was convened at a time or times convenient to itself.

8.14. The affected individual may ask for and shall have the right to receive a copy of the record of the hearing upon payment of the reasonable charges of duplicating the record. Within fifteen (15) days after receipt of the hearing record, the Hearing Panel shall make a written report and recommendation and shall forward the same together with the hearing record and all other documentation to the MEC. The report may recommend confirmation, modification, or rejection of the original adverse action or recommendation of the MEC and shall contain a statement of the basis for the Hearing Panel recommendation. A copy of the report and recommendation shall be delivered to the affected individual.

8.15. At its next regular meeting following receipt of the report and recommendation of the Hearing Panel, the MEC shall consider the matter and make its final recommendation to the Board of Trustees. The CMO shall notify the affected individual by certified mail, addressee only, return receipt requested, of the final recommendation of the MEC. The final recommendation shall be forwarded to the Board of Trustees for action in the matter, subject to the right of appeal to the Board of Trustees as hereinafter provided.

SECTION 9 – APPEAL TO THE BOARD OF TRUSTEES:

9.1. Within fifteen (15) days after the affected individual receives notice of an adverse recommendation or decision made or adhered to after a hearing as above provided, they may, by written notice to the Board of Trustees delivered through the CMO by certified mail, (return receipt requested), request an appellate review by the Board of Trustees. Failure of the affected individual to request appellate review within the time and in the manner prescribed shall constitute waiver of their right thereto. The recommendation or decision of the MEC shall then be forwarded by the CMO to the Board of Trustees for final action in the matter.

9.2. At its next regular meeting after receipt of a timely request for appellate review, the Board of Trustees shall schedule a date not more than sixty (60) days hence for such review, except that when the affected individual requesting the review is under a suspension which is then in effect, the Board must schedule such review as soon as the arrangements for it may reasonably be made, but not more than thirty (30) days hence. The CMO shall notify the affected individual in writing of the time and place of the review.

9.3. The Board of Trustees or a duly appointed Appellate Review Panel including not less than three (3) members of the Board of Trustees shall conduct the appellate review. The Appellate Review Panel may also include physicians and other persons, but members of the Board of Trustees must constitute a majority of the committee. (Members of the Appellate Review Panel shall be free from direct economic competition with the affected individual, and neither professionally associated nor personally related to the affected individual. Also,

no member of the Appellate Review Panel should have been part of the original hearing or a member of the Hearing Panel.)

9.4. The affected individual may submit a written statement in their own behalf in which they specify those factual and procedural matters with which they disagree and their reasons for such disagreements. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation. The affected individual shall submit such written statement by certified mail, (return receipt requested), to the Board of Trustees through the CMO at least fourteen (14) days prior to the scheduled date of the appellate review. The MEC may submit a similar statement at least seven (7) days prior to the appellate review, with a copy sent by certifie3d mail, addressee only, return receipt requested, to the affected individual.

9.5. The Board of Trustees or its appointed Appellate Review Panel shall act as an appellate body. It shall review the record created in the proceedings, examine the written statements submitted, consider the oral arguments, if offered, and determine whether the unfavorable recommendation was justified and was not arbitrary or capricious.

9.6. The affected individual shall have the right to appear, accompanied and represented by his or her legal counsel, before the Board of Trustees or its appointed Appellate Review Panel to present oral or written argument bearing solely on the issues of (1) whether the Medical Staff Bylaws were substantially complied with during the hearing process; and/or (2) whether the adverse action/recommendation lacked any factual support or was arbitrary or capricious. New evidence may not be submitted by the affected individual, Medical Staff, and/or Hospital, whether documentary or oral, unless the Board of Trustees or its appointed Appellate Review Panel determines that extraordinary circumstances justify the consideration of such new evidence.

9.7. An individual representing the MEC, which may be legal counsel, shall be present to speak in favor of the adverse action/recommendation and to answer questions addressed to them by any member of the Appellate Review Panel.

9.8. The Board of Trustees or its appointed Appellate Review Panel shall decide said appeal on the basis of the Hearing Panel record and any additional oral or documentary argument presented by the affected individual and by the MEC. The Board of Trustees shall make, or its appointed Appellate Review Panel shall recommend, a decision consistent with that of the MEC unless the Board of Trustees or its appointed Appellate Review Panel makes a finding that: the (1) Medical Staff Bylaws were not substantially complied with during the hearing, which non-compliance prejudiced or substantially interfered with the rights of the affected individual; or (2) the adverse action/recommendation is without factual support or the adverse action/recommendation is arbitrary or capricious.

9.9. At its next regular meeting following the conclusion of the appellate review, the Board of Trustees shall make its decision in the matter, and act on the recommendation of the Appellate Review Panel, if such a Panel has been appointed.

a. If the decision is in accordance with the MEC's last recommendation, this decision shall be considered final.
b. If the decision is not in accordance with the MEC's last recommendation, the Board of Trustees shall refer the matter to a Joint Conference Panel composed of two (2) members of the Board of Trustees and two (2) members of the MEC, as appointed by the Chair of the Board of Trustees, for further review and recommendation within ten (10) days.
c. After receipt of the recommendation of the Joint Conference Panel, the Board of Trustees shall make its final decision on this matter at its next regular meeting.

9.10. The Board of Trustees shall send notification of the Board's final decision to the MEC, and to the affected individual by certified mail, addressee only, return receipt requested. The final decision shall be in writing and shall include a statement of the basis for said decision.

9.11. Notwithstanding any other provision of these Bylaws, no applicant or Medical Staff member shall be entitled to more than one hearing and one appeal on any matter which shall have been the subject of action by the MEC or by the Board of Trustees.

9.12. Any report, information, or accusation filed, or any action recommended by a committee or officer of the Medical Staff or representative of the Board of Trustees, including the Hearing Panel and Appellate Review Panel shall be deemed a peer review privileged communication. Each applicant for membership on the Medical Staff and each member of the Medical Staff waives any right of personal redress against any individual member of the Medical Staff, the MEC, any Hearing Panel, the Board of Trustees, the Appellate Review Panel, or any other committee of the Board of Trustees or Medical Staff, (including those individuals participating in and/or gathering information for any Medical Staff, panels, committees, or Board of Trustees) for any participation in any action or recommendation which is adverse or unfavorable to the applicant or Medical Staff member, to the full extent permitted by applicable law.

ARTICLE IX
OFFICERS AND DEPARTMENT CHAIRS

SECTION 1 – OFFICERS:

1.1. Officers of the Medical Staff shall be the Medical Staff President, Medical Staff President-Elect, the Medical Staff Immediate Past-President, and Secretary-Treasurer. The terms of office of the Medical Staff President, Medical Staff President-Elect, and the Medical Staff Immediate Past-President shall be two (2) years. They may not succeed themselves. The term of office of the Secretary-Treasurer--shall be a maximum of three (3), two-year successive terms.

1.2. The Medical Staff President shall represent the interests of the Medical Staff to the MEC and the Board of Trustees and as such shall have responsibility to report back to the Medical Staff and to develop ways and means of maintaining good communications. The Medical Staff President shall call and preside at all of the General Medical Staff meetings and shall be Chair of the MEC and ex-officio member of all other committees. The Medical Staff President will have signature authority for documented and MEC approved requests posed to The Medical Staff of St. John Hospital & Medical Center funds account and will have independent signature authority for requests up to $1,000.

1.3. The Medical Staff President-Elect, in the absence of the Medical Staff President, shall assume all of the Medical Staff President's duties and functions. The Medical Staff President-Elect shall also be expected to assist the Medical Staff President and to perform such other duties as may be assigned to him. The Medica Staff President-Elect shall be the Chair of the Medical Staff Professional Practice Committee. The Medical Staff President-Elect shall be a member of the Credentials Committee and the MEC.

1.4. The Secretary-Treasurer shall perform the following functions: collaborate with the Medical Staff Office to ensure the maintenance of minutes of all Medical Staff meetings; serve as Chair of the Medical Staff Fund Committee; keep accurate accounts of all funds received and disbursed; prepare a financial statement of the Medical Staff fund for presentation at the annual meeting of the Medical Staff; assure a review of the Medical Staff fund is conducted by a certified public accountant, at least annually; have signature authority for MEC approved (documented) requests posed to The Medical Staff of St. John Hospital & Medical Center funds account; assist the Medical Staff President as requested to perform such other duties as normally pertain to that office; and be a member of the MEC.

1.5. The Medical Staff Immediate Past-President will serve as a consultant to the Medical Staff President and the Medical Staff President-Elect and assist the Medical Staff President as requested. The Medical Staff Immediate Past-President shall be the Chair of the Credentials Committee. The Medical Staff Immediate Past-President shall be a member of MEC and will have signature authority for documented and MEC approved requests posed to The Medical Staff of St. John Hospital & Medical Center funds account and when the Medical

Staff President is unavailable, will have independent signature authority for requests up to $1,000.

1.6 Officers and MEC members must be members of the Active Staff, in good standing, and be actively involved in patient care in the hospital. They must indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have demonstrated an ability to work well with others, be in compliance with the Medical Staff conduct policy, and have excellent administrative and communication skills.

SECTION 2 – ELECTION OF OFFICERS:

The procedure for nomination and election of Officers and MEC Members shall be as follows:

2.1. At the beginning of the calendar year, each Department as set forth in Article VI shall elect one (1) member to a nominating committee for Medical Staff officers and specified committee members. The Nominating Committee's Focus, Chair, Purpose, Composition, Responsibilities, Structure & Reporting are found in the Medical Staff Rules & Regulations.

2.2. The Nominating Committee shall meet at least one (1) month before the first General Medical Staff meeting of the calendar year.

2.3 The Nominating Committee shall propose at least two (2) candidates for each Officer position (Medical Staff President-Elect, Secretary-Treasurer) as well as Undesignated MEC Members. Additional nominations may be made from the floor of the General Medical Staff meeting, by any member of the Active staff.

2.4. Each nomination shall be posted in the Hospital for ten (10) days after nominations are closed, following which ballots shall be sent to all staff members eligible to vote. Ballots may be sent out via an electronic voting process.

2.5. All ballots must be returned to the Medical Staff President at least four (4) weeks from the date sent.

2.6. The Medical Staff President and two (2) other elected officers of the Medical Staff, and any other persons named by the Medical Staff President, shall serve as tellers.

2.7. The procedure to be followed in the counting of ballots shall be determined by the tellers.

2.8. The Medical Staff President shall communicate the results of the election to the members of the Medical Staff.

SECTION 3 – DEPARTMENT CHAIRS AND VICE CHAIRS:

3.1. Department Chairs shall be members of the Active Staff qualified by training, experience, have relevant clinical privileges and professional and administrative capability for the position. Department Chairs shall be board certified.

3.2. Department Chairs shall be recommended by a search committee composed of three (3) members of the Department concerned, elected by secret ballot by the members of the Department; the President of the Hospital or designee; and three (3) members of the Board of Trustees or their designees. Recommendation of the search committee shall be provided to the Board of Trustees for approval or recommitment.

3.3. The Department Chair shall be responsible for the supervision of the quality of care given by all categories of Medical Staff in their Department. Department Chairs shall be members of the MEC. Department Chairs shall be responsible to:

a. Oversee clinically related activities of the Department
b. Oversee administratively related activities of the Department, in cooperation with the Hospital
c. Provide ongoing continuing surveillance of the professional performance of all individuals in the Department who have delineated clinical privileges
d. Recommend to the Credentials Committee the criteria for clinical privileges that are relevant to the care provided by the Department
e. Recommend clinical privileges for each member of the Department
f. Assess and recommend to the MEC and relevant Hospital administration off-site sources for needed patient care, treatment and services not provided by the Department or the Hospital
g. Integrate the Department or services into the primary functions of the Hospital
h. Coordinate and integrate of interdepartmental and intradepartmental services and communication
i. Development and implement Medical Staff and Hospital policies and procedures that guide and support the provision of care, treatment and services
j. Recommend to the Hospital administration the sufficient number of qualified and competent persons to provide care, treatment and services.
k. Determine and provide input to the Hospital administration of the qualifications and competence of Department service personnel who are not licensed independent practitioners and who provide patient care, treatment and services
l. Continuously assess and improve of the quality of care, treatment and services
m. Maintain quality control programs, as appropriate
n. Orient and continuing education of all persons in the Department or service
o. Make recommendations to MEC and Hospital administration for space and other resources needed by the Department to provide patient care services.

3.4. Interim Department Chair appointments will be recommended to the Board of Trustees by the Chief Medical Officer, following consultation with the President of the Hospital, the

Medical Staff President and the Department Vice Chair (who will consult with members of the Department).

3.5. The Department Vice-Chairs shall be appointed by the Department Chair with the approval of the MEC.

3.6. Department Vice Chairs shall assist their Chair and shall perform the duties of Department Chairs in the event of their absence.

SECTION 4 – SECRETARIES OF DEPARTMENTS:

4.1. The Department Chair shall appoint a Department Secretary to ensure the maintenance of minutes of all Department meetings and assist the Chair as requested to perform such other duties as normally pertain to that office.

SECTION 5 – RECALL, RESIGNATION, OR DISMISSAL OF OFFICERS AND MEC MEMBERS (*Not a Department Chair):*

5.1. Any Officer or MEC member (who is not a Department Chair) 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 MEC member (who is not a Department Chair) be recalled, the Medical Staff President will call a special election for the filling of such vacancy.

5.2. Should the Medical Staff President be unable to complete their term of office for any reason, the Medical Staff President-Elect shall serve out the remaining term as Medical Staff President.

5.3. Should the Medical Staff President-Elect be unable to complete their term of office, the Nominating Committee will be requested by the Medical Staff President to select two (2) candidates for the Medical Staff President-Elect position and the election process will proceed, according to the Rules & Regulations.

SECTION 6 – RECALL, RESIGNATION OR DISMISSAL OF DEPARTMENT CHAIR:

6.1. Recall of a Department Chair for cause may be proposed by petition of two-thirds of the Department concerned. On receipt of such a petition, the Board of Trustees shall authorize the formation of a recall committee composed of three (3) members of the Department concerned elected by secret ballot by the members of that Department, the President of the Hospital, and three (3) members of the Board of Trustees or their designees.

6.2. The Medical Staff President and the Medical Staff President-Elect shall be consulted in good faith by the administration of the Hospital before the dismissal of a Department Chair for cause or failure to uphold their duties. The good faith consultation should also occur if the reason for the Department Chair dismissal is a consequence of the non-renewal of a contract with an exclusive Hospital-based department physician group.

ARTICLE X
COMMITTEES OF THE MEDICAL STAFF

SECTION 1 – GENERAL CONSIDERATIONS FOR COMMITTEES:

1.1. Committees of the Medical Staff shall assist in providing governance and infrastructure to the Medical Staff and the Hospital. They shall be considered either "Standing" or "Special".

1.2. All "Standing" Committees, Charters, and their Chairs shall be appointed by the Medical Staff President with the approval of the MEC, except as otherwise provided in these Bylaws. "Special" Committees and their Chairs shall be appointed by the Medical Staff President when authorized by either the Medical Staff at a General or Special meeting, or by the MEC.

1.3. The President of the Hospital and the CMO (or their designees) shall be ex-officio members of all committees without a vote except in the following circumstances where they shall have a vote:

- The President of the Hospital: All Search Committees.
- CMO: All Search Committees, Graduate Medical Education Committee, Continuing Medical Education Committee, Medical Staff Professional Practice Committee, Committee on Committees, Utilization Management Committee, Special Committees with multi-disciplinary representation, and other committees chaired.

1.4. The Medical Staff President may be a member of all "Standing" or "Special" Committees.

SECTION 2 – STANDING COMMITTEES:

2.1. The Standing Committees shall be as follows:

A. Medical Executive Committee (MEC)
B. Credentials Committee
C. Other Standing Committees

2.2. Each Standing Committee shall create a Charter and submit an annual report to the Medical Staff via the MEC. The Charter shall contain the committee's purpose, membership, and responsibilities.

2.3. The Medical Staff President shall appoint, after consulting with the MEC, the Chair of each Standing Committee. The Medical Staff President, in consultation with Hospital administration may also appoint Medical Staff members to Hospital committees or to serve as Medical Staff physician advisors or liaisons to carry out specific functions.

2.A. MEDICAL EXECUTIVE COMMITTEE (MEC)

2.A.1. The purpose of the MEC is to make specific recommendations directly to the Board of Trustees, as well as receiving and acting on reports and recommendations from

the Medical Staff committees, clinical departments, or services and to ensure that all medical staff functions are achieved.

2.A.2. All members of the Active Medical Staff with unrestricted licenses, of any discipline or specialty are eligible for membership on the MEC. The MEC is empowered to act on behalf of the Organized Medical Staff between Medical Staff meetings.

2.A.3. The MEC membership shall consist of Active Medical Staff with unrestricted licenses, to be determined as follows: the elected Officers of the Medical Staff (4)**;** the Medical Staff Immediate Past-President (1)**;** the Department Chairs of Anesthesiology, Emergency, Family Medicine, Medicine, Psychiatry/Behavioral Medicine, Obstetrics/Gynecology, Pathology, Pediatrics, Radiology, and Surgery (10)**;** At-Large Members by Department, to be elected (5) - one At-Large Member from each of the following Departments: Family Medicine, Medicine, Obstetrics/ Gynecology, Pediatrics, and Surgery**;** At-Large Members – Undesignated, to be elected (2), - at least one of the At-Large Members – Undesignated shall be from the following Departments not otherwise represented (Psychiatry/Behavioral Medicine, Emergency Medicine, Pathology, Radiology, and Anesthesiology). The President of the Hospital, the CMO, Chief Nurse Officer (CNO) and the Director of Medical Education will be ex-officio members of the MEC, without a vote.

2.A.4. The term of office for elected At-Large Members by Department will be for two (2) years, no more than two (2) consecutive terms. The term of office for elected At-Large Members – Undesignated will be for two (2) years; no more than two (2) consecutive terms. The specific terms are as follows:

2.A.4.1. At-Large Members by Department: The Departments of Family Medicine, Medicine, and Obstetrics/Gynecology will be nominated by a secret ballot within the respective department, during an "odd" year. The Departments of Pediatrics and Surgery will be nominated by a secret ballot within the respective department during an "even year. This process will allow for membership staggering.

2.A.4.2. At-Large Members – Undesignated (from Psychiatry/Behavioral Medicine, Emergency Medicine, Pathology, Radiology, and Anesthesiology): One (1) At-Large Member - Undesignated will be nominated during an "odd" year and one (1) At-Large Member – Undesignated will be nominated by a secret ballot during an "even" year. This process will allow for membership staggering.

2.A.5. The Medical Staff President shall be Chair of the MEC; the Secretary-Treasurer of the Medical Staff shall be the recording secretary of the MEC. The minutes of each meeting shall be signed by the Chair and the Secretary-Treasurer.

The responsibilities of the MEC shall be to:

1) Serve as the final decision-making body of the medical staff in accordance with the medical staff bylaws and provide oversight for all medical staff functions.
2) Coordinate the implementation of policies adopted by the Board of Trustees.
3) Submit recommendations to the Board of Trustees concerning all matters relating to appointment, reappointment, staff category, Department/clinical Section assignments, clinical privileges, and corrective action.
4) Report to the Board of Trustees and to the Medical Staff the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities.
5) Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members, including collegial and educational efforts and investigations when warranted.
6) Make recommendations to the Board of Trustees on medical, administrative, and Hospital management matters.
7) Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the Hospital.
8) Participate in identifying community health needs and setting Hospital goals and implementing programs to meet those needs.
9) Review and act on reports from Medical Staff committees, Departments, and other assigned activity groups.
10) Formulate and recommend Medical Staff Rules & Regulations, policies, and procedures to the Board of Trustees.
11) Request evaluations of practitioners privileged through the medical staff process when there is question about an applicant's or member's ability to perform privileges requested or currently granted.
12) Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures.
13) Oversee the portion of the corporate compliance plan that pertains to the Medical Staff.
14) Hold Medical Staff leaders, committees, and Departments accountable for fulfilling their duties and responsibilities.
15) Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws.
16) Advise Hospital administration and the Board of Trustees on matters pertaining to clinical organization, medical equipment, and other relevant medico-administrative matters.
17) Review the recommendation of Department Chairs in assessing the need for use of off-site resources for needed for patient care, treatment, and services not provided by the Department or the Hospital.
18) May act on behalf of the organized medical staff between medical staff meetings.

2.B. CREDENTIALS COMMITTEE

2.B.1. The purpose of the Credentials Committee is to review the credentials, recommendations, and qualifications of all applicants for: appointment, reappointment, membership and privileges on an ongoing basis.

2.B.2. The Credentials Committee membership shall consist of one (1) member of each Medical Staff Department, other than the Department Chair or the Department Vice Chair, the Medical Staff President, the Medical Staff Immediate Past-President and the Vice President of Nursing (or designee).

2.B.3. The Medical Staff Immediate Past-President shall be Chair of the Credentials Committee and will assure that the minutes of each meeting are recorded.

The responsibilities shall be as follows:

1) To review and recommend action on all appointments and reappointments for membership on the Medical Staff, including assignments of medical staff category.
2) To review and recommend action on all requests regarding privileges from eligible practitioners.
3) To recommend eligibility criteria that practitioners need to fulfill before the Medical Staff will consider granting the Medical Staff membership and privileges.
4) To develop, recommend, and consistently implement policies and procedures for all credentialing and privileging activities.
5) To review and, when appropriate, take action on reports that are referred to the Credentials Committee from other Medical Staff Committees or Medical Staff or Hospital leaders.
6) To identify when delineation of privileges criteria is needed and assist Departments in developing credentialing criteria necessary to determine competency.
7) To perform other functions as requested by MEC.
8) To meet at least monthly and transmit a report of each meeting to the MEC.

2.C. OTHER STANDING COMMITTEES

All other Standing Committees of the Medical Staff will be appointed by the President of the Medical Staff, approved by the MEC, and have its charter listed in the Medical Staff's Rules & Regulations.

SECTION 3 – SPECIAL COMMITTEES:

3.1. Special Committees shall consist of members of the Medical Staff and may include Hospital associates, appropriate to the function to be performed. The Medical Staff President shall appoint the Committee Chair. These committees shall report to the MEC.

3.2. A Hearing Panel provided for in Article VIII of these Bylaws shall be deemed a Special Committee and its members shall be appointed as therein provided.

ARTICLE XI
MEETINGS

SECTION 1 – ANNUAL MEETING:

There shall be an annual meeting of the Medical Staff held in June. Notice of such meeting shall be sent to each staff member at least thirty (30) days prior to the meeting. At this meeting, an agenda will be prepared, and results of elections held for officers for the ensuing year shall be announced. Minutes shall be recorded and assured by the Medical Staff President.

SECTION 2 –GENERAL STAFF MEETINGS:

In addition to the annual staff meeting, there shall be at least two (2) General Medical Staff meetings held at a time and place determined by the Medical Staff President. At each of these meetings, an agenda will be prepared, which may include any scientific presentations, a report on the continuing evaluation of the clinical practice within the Hospital, and of the work of the MEC. Minutes shall be recorded and assured by the Medical Staff President.

SECTION 3 – DEPARTMENTAL MEETINGS:

Each Medical Staff Department shall meet at according to their Department Rules & Regulations to review/analyze the clinical work of the Department.

SECTION 4 – SPECIAL MEETINGS:

Special meetings of the Medical Staff may be called at any time by the Medical Staff President, the Board of Trustees, or the MEC or on petition of any twenty (20) members of the Active Staff. At any special meeting, no business shall be transacted except that stated in the notice calling such meetings. Notice of any such meeting shall be sent at least seventy-two (72) hours prior to the time set for the meeting.

SECTION 5 – ATTENDANCE AT MEETINGS:

Attendance at General Medical Staff and Department meetings shall be encouraged and considered in reappointment to the Active Staff. The Department Rules & Regulations shall set forth the requirements for Department, General Medical Staff, and committee meetings.

SECTION 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 MEC.

SECTION 7 – VOTING:

7.1. Only Active Medical Staff members shall be eligible to vote at Departmental and general staff meetings.

7.2. Voting for elections of officers of the Medical Staff shall be conducted by written or electronic secret ballot.

7.3. Unless otherwise expressly required by these bylaws, every question shall be decided by a majority vote of the Organized Medical Staff present.

7.4. Written ballot shall be held on the request of any member eligible to vote and duly seconded.

7.5 Any matter requiring a Medical Staff member's vote may be sent out as an electronic ballot.

ARTICLE XII
AUTHORITY TO MAKE RULES & REGULATIONS

The MEC shall adopt and may amend Rules & Regulations and policies of the Medical Staff for the proper conduct of the work of the Medical Staff. Such Rules & Regulations and policies of the Medical Staff shall become effective when approved by the Board of Trustees.

Any active member of the Medical Staff at a staff meeting may propose amendments, additions and repeals of the Rules & Regulations and policies of the Medical Staff.

ARTICLE XIII
AMENDMENT OF THE BYLAWS

The Medical Staff shall develop and adopt its own Bylaws. Amendments, additions and repeals of the Bylaws may be proposed by the MEC or by any active member of the Medical Staff.

Any request for amendment, addition or repeal of the Bylaws will be submitted to the CMO, who in turn will submit the request to the Bylaws Committee for a recommendation. The Bylaws Committee will send its recommendation to the MEC for review before submitting the request to the Medical Staff for vote at the next General Medical Staff meeting. Voting may occur electronically. After the approval by the Medical Staff, the Bylaws will go to the Board of Trustees for final approval.

Amendments proposed to be adopted shall be made available to each member of the Organized Medical Staff at least two (2) weeks prior to the next General Medical Staff meeting. The adoption of such proposals shall require a two-thirds vote of the Active Medical Staff members present at the meeting. The proposals, if adopted, shall be submitted to the Board of Trustees for final approval.

These Bylaws shall be reviewed at least every three (3) years. Neither the Organized Medical Staff nor the Board of Trustees may unilaterally amend the Medical Staff Bylaws, Rules & Regulations or policies of the Medical Staff.

ARTICLE XIV
ADOPTION

These Bylaws shall have been adopted when approved by a two- thirds vote of the Active members of the Medical Staff present. They shall become effective when approved by the Board of Trustees. The adoption and approval of these Bylaws shall constitute a repeal of all prior Bylaws of the Medical Staff; provided that all incumbent officers of the Medical Staff shall continue to serve for the balance of the terms for which they were elected under prior Bylaws. The Medical Staff Bylaws shall not constitute a contract between the Medical Staff and the Hospital.

DELEGATED AUTHORITY
SECTION 1 – MEDICAL STAFF RULES & REGULATIONS, POLICIES:

The Medical Executive Committee (MEC) has delegated authority to adopt and amend Medical Staff Rules & Regulations and policies concerning procedures, practices and the professional conduct of the members of the Medical Staff. Such Medical Staff Rules & Regulations and polices shall become effective when approved by the Board of Trustees.

A. If the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, the Medical Staff will first communicate the proposal to the MEC.
B. When the MEC adopts a rule, regulation or policy or an amendment thereto, the MEC will communicate this to the medical staff.

SECTION 2 – MEDICAL STAFF BYLAWS:

Medical Staff Bylaws adoption may not be delegated. However, when necessary to comply with accreditation, regulatory agencies and/or current law, the MEC has the delegated authority to propose urgent amendment(s) to the Bylaws and may provisionally adopt/approve such urgent amendment(s), without prior Medical Staff notification. In such cases, the Board of Trustees will be notified for provisional review and approval. The Medical Staff will then be notified by the MEC.

A. The Medical Staff will have the opportunity for retrospective review of and comment on the provisional amendment(s). If there is no conflict between the Medical Staff and MEC, the provisional amendment(s) stands.

B. If conflict arises within the Medical Staff regarding the provisional amendment(s), a meeting will be called with the MEC, the involved Medical Staff member(s) and one member 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 of Trustees.

ARTICLE XV
ROBERT'S RULES OF ORDER

The provisions of Robert's Rules of Order shall apply to the conduct of all staff meetings except where specifically prohibited by these Bylaws.

ARTICLE XVI
MEDICAL STAFF YEAR

A Medical Staff year is the period of time between July1st and June 30th {twelve (12) consecutive months}.

ARTICLE XVII
CONFIDENTIALITY, IMMUNITY, AND RELEASES

1. Definitions: For the purposes of Article XVII of these Bylaws, the following definitions shall apply:

   A. The term "information" means documentation of proceedings, minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures, whether in written or oral form.

   B. The term "malice" means the dissemination of a falsehood: (i) with knowledge it was false, or (ii) with a reckless disregard for whether it was true or false.

   C. The term "representative" means the Board, and any trustee, director, member or committee thereof; Medical Staff President, medical staff, 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.

   D. The term "other parties" means any entity other than a representative of the Hospital and the Medical Staff providing information to a representative of the Hospital or the Medical Staff and includes both individuals and organizations.

2. By applying for or exercising clinical privileges or providing specified patient care services within the Hospital, a Medical Staff Member:

   A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing on his or her professional ability and qualifications;

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

C. Agrees to be bound by the provisions of these Bylaws inclusive of any restrictions, limitations, and conditions with respect to his or her application for or acceptance of Medical Staff membership and the continuation of such membership or his or her exercise of clinical privileges or provision of specific patient services at the Hospital.

3. No representative of the Hospital or the Medical Staff shall be liable to a Medical Staff Member for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a representative, if he or she acts in good faith and without malice.

4. No representative of the Hospital or Medical Staff and no other party shall be liable to a Medical Staff Member for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning a Medical Staff Member who is or has been an applicant to or Member of the Medical Staff or did or does exercise clinical privileges or provides specified services at the Hospital, provided that such representative or other party acts in good faith and without malice.

5. The confidentially and immunity provided by this Article XVII of these Bylaws shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's or any other health care facility or organization's activities including, but not limited to: application for appointment, clinical privileges or specified services; periodic reappraisals for reappointment, clinical privileges or specified services; corrective action and summary suspension; hearings and appellate review; patient care audits and medical care evaluations; utilization reviews; independent "outside" peer review evaluations; and other hospital, department or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct. These are confidential professional/peer review and quality assurance documents of the Hospital and protected from disclosure pursuant to the provisions of state and federal laws.

6. The information referred to in this Article XVII of these Bylaws may relate to a Medical Staff Member's professional qualification, clinical ability, judgment, character, professional ethics, health status, or any other matter that might directly or indirectly affect patient care.

7. Each Medical Staff Member shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this Article XVII of these Bylaws in favor of the individuals and organizations specified in Article XVII of these

Bylaws. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

8. Provisions in these Bylaws and in application forms relating to consents, authorizations, releases, rights, privileges, confidentiality of information and immunities from liability shall be in addition to the protection provided in this Article XVII of these Bylaws and by law and not in limitation thereof.

AMENDMENT HISTORY

Amended: l/l998
Amended: 2/2000
Amended: 1/2001
Amended: 3/2002
Amended: 10/22/02(MEC)
Amended: 1/27/03(Cancer Committee)
Amended: 9/03 Professional Affairs Committee now named Quality Committee per Board/Hospital Bylaws
Amended: 12/16/04 by the Quality Committee of the Board of Trustees
Amended: 1/25/2008 by the St. John Hospital Quality Committee of the Board of Trustees
Amended 10/5/2009 by the Hospital Board of Trustees upon merger of the St. John North Shores Hospital and the St. John Hospital and Medical Center Medical Staffs.
Amended 10/26/2010 by the Quality Committee of the Board of Trustees
Amended 10/28/2010 by the East Region Board of Trustees
Amended 04/24/2012 by the East Region Quality Committee of the Board of Trustees
Amended 04/23/2013 by the East Region Quality Committee of the Board of Trustees
Amended 04/22/2014 by the East Region Quality Committee of the Board of Trustees
Amended 10/28/2014 by the East Region Quality Committee of the Board of Trustees
Amended 04/28/2015 by the East Region Quality Committee of the Board of Trustees
Amended 06/23/2015 by the East Region Quality Committee of the Board of Trustees
Amended 09/23/2015 by the Joint Conference Committee of the Board of Trustees
Amended 03/23/2016 by the Joint Conference Committee (JCC) of the Board of Trustees
Amended 03/29/2017 by the Joint Conference Committee of the Board of Trustees
Amended 03/28/2018 by the Joint Conference Committee of the Board of Trustees
Amended 09/01/2018 (Naming Convention Change to Ascension St. John Hospital; previously considered by the JCC 03/23/2018)
Amended *(provisionally)* 02/13/2019 by Medical Executive Committee of Trustees
Amended 04/24/2019 by the Joint Conference Committee of the Board of Trustees
Amended 11/27/2019 by the Joint Conference Committee of the Board of Trustees
Amended 06/24/2020 by the Joint Conference Committee of the Board of Trustees
Amended 04/28/2021 by the Joint Conference Committee of the Board of Trustees
Amended 10/27/2021 by the Joint Conference Committee of the Board of Trustees
Amended 03/30/2022 by the Joint Conference Committee of the Board of Trustees

Ascension St. John Hospital

Medical Staff
Rules & Regulations

2023

Amended 08/01/2023

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Ascension St. John Hospital

MEDICAL STAFF RULES & REGULATIONS

PREAMBLE

These Medical Staff Rules & Regulations have been adopted in accordance with Article XII of the Medical Staff Bylaws of Ascension St. John Hospital (previously known as St. John Hospital & Medical Center) ("hereinafter, defined as "the Hospital"). The Medical Staff policy & procedures referenced herein are considered either part of the Medical Staff Rules & Regulations. For purposes of these Medical Staff Rules & Regulations "collectively" all physicians, dentists, podiatrists, and adjunct professional staff granted membership and/or privileges shall be defined as the "practitioner", otherwise will be individually mentioned. Non-Physician Practitioners (NPPs) include physician assistants, nurse practitioners, certified registered nurse anesthetists, anesthesiologist assistant, clinical nurse specialists, nurse midwives and intake social workers. The Medical Staff of the Hospital is organized to oversee the quality of care, treatment, and services provided by practitioners with privileges. These Medical Staff Rules & Regulations help to create a framework to provide accountability for professional performance. Each practitioner and non-physician practitioner, by signing the Medical Staff application, shall agree to abide by the current Medical Staff Bylaws, Medical Staff Rules &Regulations, Medical Staff policy & procedures, and individual Department/Section Rules & Regulations.

These Medical Staff Rules & Regulations may be amended or repealed by the Medical Executive Committee (MEC), which are then subject to approval by the Board of Trustees (BOT). Such changes shall become effective upon approval of the BOT.

ADMISSION, TRANSFER, AND DISCHARGE OF PATIENTS

1. **Patient Admissions**. The Hospital shall accept patients for medical care, treatment, and services in all disease categories, except those requiring highly specialized care, equipment, or evaluation not available at the Hospital.

2. A patient may be admitted to the Hospital only by a practitioner who is a member of the Medical Staff, with admitting or co-admitting privileges. Each patient of a podiatrist shall be co-admitted by a physician member of the Medical Staff, with admitting privileges. Dentists shall not be permitted to admit patients.

3. Direct admissions may be facilitated by contacting **1-888-MY-ADMIT.**

4. All patients admitted to the Hospital will have an attending practitioner (the practitioner with primary responsibility for the care of a patient in a particular case), an admitting diagnosis, and will be assigned to a specific department and/or division.

5. The attending practitioner should be notified when the patient is admitted. If it is not possible to speak personally with the attending practitioner, a message will be left on the currently utilized digital communication system (PerfectServe).

6. The attending practitioner (or a covering practitioner) will provide admitting orders for the care of the patient by entering the orders into the electronic health record within six (6) hours of the admission and will see patients admitted to their service at the earliest time consistent with the

urgency of the patient's condition, but no later than twenty-four (24) hours after admission, unless the patient is admitted by the practitioner directly from the office.

7. The attending practitioner is to be available at all times or shall provide for an alternate (covering) practitioner with same or similar privileges to provide the patient with medical care, treatment, and services. It is incumbent upon every practitioner to ensure that the Hospital staff has full and accurate knowledge of the means to contact them or their alternative, utilizing the currently utilized digital communication system (PerfectServe). If a practitioner does not respond for necessary medical involvement, the chain of clinical responsibility should be used by starting with: Attending (Covering) Practitioner→Section Chief→Department Chair→Chief Medical Officer. Documentation of all contacts should occur in the medical record. The hospital's electronic event reporting system shall be utilized for any unanticipated outcomes or identified gaps.

8. **Utilization Review.** The attending practitioner will ensure effective utilization of healthcare resources and ongoing monitoring for all patients admitted. This will include but not limited to the necessity for admission, the appropriate level of care, and need for continued inpatient stay, plans for post discharge care, as guided by the Utilization Review Committee and supported by the Utilization Management Plan.

9. Attending practitioners and consultants are expected to work collaboratively with the care management staff (case managers, discharge planners, and social workers) in order to provide the right care to the right patient at the right time.

10. Testing, procedures, and evaluation of patients should be done in a timely manner and only if pertinent to the working diagnosis or if impacts the treatment of the working diagnosis. Practitioners should have clear reasons for testing, procedures and/or evaluations requested. Testing, procedures, and/or evaluations that can be safety accomplished as an outpatient should not be ordered or completed as an inpatient.

11. Practitioners shall be responsible for the patient's medical care, treatment, and services in the Hospital which are within the practitioner's delineation of privileges and scope of practice.

12. Practitioners will utilize and follow power plans, standing orders, and pathways, where appropriate, as approved by the MEC.

13. **Medication reconciliation** shall be completed and documented accurately and completely across the continuum of care. It is an interdisciplinary process among physicians, nursing and pharmacy designed to decrease adverse drug events for patients. The practitioner reconciles medications at three points in the Hospital encounter:
    a. Upon admission to the hospital the patient's home medication therapy is reconciled with the admission medication orders.
    b. With each change in level of care the patient's current in-hospital medication therapy is reconciled with medication orders on the receiving unit.
    c. At time of discharge the patient's home medication list and the current in-patient medication list is reconciled with the planned discharge medication orders.

14. The admitting practitioner shall be responsible for giving advance notice to the Hospital, such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever the patient may be a source of danger for any cause whatsoever.

15. **Infectious Diseases**. Before any patients with known or suspected infectious diseases are admitted to the Hospital, the admitting practitioner shall, when possible, first inform Registration of the infectious nature of the disease and ascertain if the appropriate facilities, resources, and precautions are available.

16. **Psychiatric Admissions.** Patients with psychiatric symptoms (including but not limited to suspect of being a danger to self or others) will receive a medical screening sufficient to determine that a medical condition that mimics a psychiatric condition is not present. If psychiatric hospitalization is warranted, the patient may be admitted to the Psychiatric/Behavioral Services unit. Voluntary admission shall be offered, subject to the provisions of the Michigan Mental Health Code, State of Michigan, and the Department of Psychiatry and Behavioral Medicine.

17. **Rehabilitation Admissions.** Appropriateness of admission of a patient onto the Inpatient Rehabilitation ("IPR") unit is to be determined by a Physiatrist practitioner. Patients will not be admitted onto the IPR unit unless they have a concomitant medical or surgical condition requiring acute care. A patient may be admitted directly to the IPR unit from outside the Hospital if approved by the Physiatrist Medical Director (or designated Physiatrist practitioner) of the IPR unit. All patients admitted to the IPR unit are admitted directly under the care of the Physiatrist Medical Director (or designated Physiatrist practitioner) of the IPR unit.

18. **Emergency Admissions.** Any patient admitted as an emergency must be sent from the Emergency Department (which includes the Obstetrical 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, the Hospital 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, a Resident (who is supervised by a physician) or a Non-Physician Practitioner (who is supervised by a physician). (For definition of a Non-Physician Practitioner, see the Ascension St. John Hospital Medical Staff Bylaws).

    After the MSE has been completed and a provisional diagnosis has been determined, establishing that the patient requires an admission to the Hospital, the Emergency Department practitioner shall document the findings and contact the attending practitioner or designee (which may be a resident). A surgeon may directly admit a patient for emergency surgery if the patient has been examined immediately prior to admission by the surgeon. Obstetrical Admissions will be admitted through the OB/GYN Department. For patients who do not have an established practitioner they will be admitted to the Staff A medicine service (resident teaching service) if they require hospitalization. If the Staff A service is capped in terms of admissions allowed according to the ACGME, the patient will then be admitted to an attending practitioner on the Staff B service (non-teaching service call rotation).

19. **Surgical Admissions.** Patients with surgical conditions are best cared for by a surgeon as the admitting hospital physician to a surgical floor where perioperative care is managed by a team experienced with these conditions. In an effort to assure optimal patient care, the following primary diagnoses should be admitted to the department of surgery. The primary care physician (internal medicine or family medicine) must be consulted for medical management.

a. Fractures that require casting surgery or traction
b. Any hernia case
c. Patients for elective surgery
d. Patients for emergency surgery
e. Trauma
f. Burns
g. Outlet obstruction to the urinary tract
h. Hemorrhagic pancreatitis, gall stone pancreatitis (if known at the time of admission)
i. Acute abdomen
j. Peripheral vascular ischemia
k. Bowel obstruction
l. Intracranial hemorrhage requiring surgical intervention (neurosurgery admission).

20. Patients will be admitted to the Hospital according to the following **priorities**:

a. Emergency Admissions. For the purpose of this section an "Emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
b. Urgent Admissions. For the purpose of this section, "Urgent" is defined as a condition that requires prompt attention but does not pose an immediate, serious threat to the health of the individual.
c. Preoperative Admissions. This includes all patients already scheduled for surgery.
d. Routine Admissions. This includes elective admissions involving all services.

20. **Patient Transfers**. Where patient transfer is necessary, the transfer will occur in accordance with Hospital policy.

Types of transfers include:

a. Internal: Patients transferred from unit to unit or to a diagnostic area within the Hospital.
b. External: Patients transferred out of or into the Hospital to or from an outside facility.
c. Transfer to Another Practitioner: Patients physically remaining in the Hospital whose care is being transferred from one practitioner to another practitioner.

Whenever the responsibilities for the patient's medical care, treatment, and/or services are transferred to another practitioner, an order covering the transfer of responsibility shall be entered the medical record.

21. **Discharges.** It is the responsibility of the attending practitioner to make appropriate and timely arrangements for the patient's discharge, including provision of necessary prescriptions, instructions, and follow-up care.
a. Discharge orders will be documented within the medical record.
b. Although discharges occur around the clock, it is recommended that discharges transpire prior to 11:00am, or as soon as the patient's condition permits.
c. The patient's medical record shall be completed at the time of discharge.
d. **Against Medical Advice.** If a competent adult wishes to leave the Hospital without practitioner approval, the attending practitioner should be notified. The patient should be asked to sign a form designated by the Hospital to document the discharge is against medical advice and the patient acknowledges understanding the risks. If the patient refuses to sign the form, the practitioner or nurse should document the refusal and place the

unsigned form in the medical record. Patients on suicide precautions should not be allowed to leave against medical advice until a psychiatric evaluation, including the patient's capacity to make decisions, is completed. Adult patients who are not able to fully understand and appreciate the consequences of their actions due to intoxication, drugs, illegal substances, illnesses, or chronic conditions shall not be released without a practitioner's order and should be released only to a responsible adult. Minors may not leave AMA, even if it is the parent's wish. (If a parent insists, a minor may be transferred to another institution, via ambulance. Ambulance will either be called for medical necessity (the Hospital assumes cost) or parent preference (parent assumes cost).

22. **Patient's Death**. In the event of a patient's death, the Hospital shall notify the attending practitioner. The pronouncement of death shall be made by the attending practitioner or other licensed practitioner authorized by Hospital policy. The body shall not be released until an entry recording the death has been made in the medical record and authorization for such release has been obtained from the next of kin.

23. **Autopsy**. The Hospital will attempt to secure autopsies in all cases of unusual deaths and of medical, legal, and educational interest, and informs the attending practitioner of autopsies it intends to perform. Situations where an autopsy may be indicated:

a. Deaths in which an autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
b. Deaths of patients who participated in clinical trials approved by the Institutional Review Board.
c. Unexplained/unexpected deaths which are apparently natural and not subject to a forensic medical jurisdiction.
d. Natural deaths which are ***subject to, but waived by, a forensic medical jurisdiction*** such as:
    - Persons dead on arrival at the Hospital.
    - Deaths occurring in the Hospital within 24 hours of admission
    - Deaths in which a patient sustained or apparently sustained injury while in the Hospital.
    - Any unexplained/unexpected deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
    - Known or suspected deaths arising from environmental or occupational hazards
e. Deaths resulting from high-risk infectious and contagious diseases.
f. All obstetric deaths.
g. All neonatal and pediatric deaths.
h. Death at any age when it is believed that autopsy would disclose a known or suspected illness which may have importance to survivors or recipients of transplanted organs.

An autopsy may be performed only with a written consent signed in accordance with State Law. All autopsies shall be performed by the Hospital's pathologist. Provisional anatomic diagnosis shall be recorded in the medical record within 48 hours. The final autopsy report shall be submitted to the attending practitioner in compliance with the American College of Pathologist standards.

REPORTING OF CORONER CASES, DEATH AND UNUSUAL CIRCUMSTANCES

The mandatory reporting of deaths and of such conditions as battered child syndrome, rape, assault and gunshot wounds is required by state laws. It is incumbent upon each practitioner to know these requirements and comply. Special forms for reporting these conditions are available in the Emergency Department.

CONCERNS, COMPLAINTS, SUGGESTIONS

1. Practitioners who have a concern, complaint, or constructive suggestion may share it with the Hospital via the Physician Assistance Line by calling **313.343.4362** or emailing at **PhysicianProcessImprovement@stjohn.org**. The assigned Hospital associate receiving the call or email will triage each concern, complaint, or suggestion and transfer it to the appropriate department leader for follow-up. The department leader (or designee) will own the concern, complaint, or suggestion until it is resolved of otherwise acted upon. The assigned Hospital associate will assure feedback is provided to the practitioner.

2. Any Hospital associate who receives a concern, complaint, or constructive suggestions from a practitioner will notify the appropriate department leader for follow-up. The department leader (or designee) will own the concern, complaint, or suggestion until it is resolved of otherwise acted upon and follow-up with the practitioner.

3. Practitioners are accountable for reporting patient events including sentinel events, adverse events, patient safety concerns, medication variances, adverse drug reactions, and near miss/close calls. These types of events shall be submitted in the hospital's electronic event reporting system.

CONSENTS

1. Informed Consent is a communications process. The process provides an opportunity for the patient/surrogate decision-maker to understand the benefits, risks and alternatives to the operation, procedure or treatment the patient is considering, and for the Physician/Practitioner to explain these in detail. It is the responsibility of the Physician/Practitioner to obtain Informed Consent.

2. Except in cases of emergencies, Informed Consent must be obtained before the following:

    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 procedure that involve entry into the body (i.e., arteriograms, myelograms, paracentesis, thoracentesis)
    d. All forms of radiation therapy and oncological chemotherapy
    e. Administration of blood components
    f. Electroconvulsive therapy
    g. When licensure or regulatory bodies require Informed Consent for specific procedures
    h. Participation in research, unless approval by the Institutional Review Board indicates that no special consent is required

3. General consent to treatment obtained at the time of admission or the time of the first visit to an outpatient facility is not Informed Consent. A general consent to treatment does not replace or eliminate the need for obtaining Informed Consent for an operation, procedure or treatment. For specific details about the process and requirements refer to policy titled General Consent.

4. Informed Consent must be obtained with the completed consent form placed in the medical record. The patient cannot be allowed to sign the Informed Consent form until the Physician/Practitioner has explained the risks, benefits, and reasonable alternatives of a proposed operation, procedure or treatment.

5. One (1) Informed Consent form may be utilized for a series of procedures or treatments provided the series/number of procedures or treatments are identified on the order. Examples of series of procedures or treatments may include, but are not limited to radiation therapy, oncologic chemotherapy, administration of blood components, and electroconvulsive therapy.

6. In an emergency where treatment is necessary to preserve the patient's life or to prevent serious impairment of the patient's health, the Physician/Practitioner must document the nature of the emergency and the rationale for the decision to proceed. This emergency exception applies to all patients regardless of their age.

7. For specific details about the Informed Consent Process, refer to the Hospital Policy entitled, "Informed Consent".

8. Additional consents may be required for Behavioral Health patients. Refer to Hospital Policy entitled, "Consent to Treatment and Services".

9. For specific details about the process and requirements related to Informed Consent in the context of medical research, contact your Institutional Review Board Coordinator

CONSULTATIONS

For Consultations, refer to Ascension St. John Hospital Medical Staff "Consult Etiquette" Policy.

MEDICAL RECORDS

1. Attending Practitioner Responsibilities:
   The attending practitioner is responsible for the preparation of a complete, timely, and legible medical record for each patient. All entries within the medical record shall be signed, dated, and timed. Only Hospital approved abbreviations, acronyms and symbols should be used. The contents of the medical record shall include:
   a. Patient's name, address, date of birth, and the name of any legally authorized representative;
   b. Patient's legal status, for patients receiving mental health services;
   c. Emergency care provided to the patient prior to arrival, if any;
   d. Findings of the patient's assessment, including the documentation of known allergies;

e. Conclusions or impressions drawn for the history and physical examination;
f. Diagnosis or diagnostic impressions;
g. Reasons for admission or treatment;
h. Goals of treatment and the treatment plan;
i. Evidence of known advanced directives, including code status form(s);
j. Evidence of informed consent, when required by Hospital policy;
k. Diagnostic and therapeutic orders;
l. Diagnostic and therapeutic procedures/tests results;
m. Operative and other invasive procedures performed;
n. Progress notes;
o. Reassessments and any revisions to the treatment plan/code status;
p. Clinical observations;
q. Patient's response to care;
r. Consultation reports;
s. Every medication ordered or prescribed;
t. Every medication dispensed to an ambulatory patient or an inpatient on discharge;
u. Every dose of medication administered;
v. Drug reaction;
w. Relevant diagnoses established during the course of care;
x. Referrals and communications made to external or internal care providers/agencies;
y. Discharge instructions and/or transfer summary.

2. History and Physical Examinations (H&P): ***Refer to Medical Staff Bylaws for complete process and components necessary for completion of H&Ps for inpatient and outpatient procedures.***
3. Care Documentation/Progress Note:
    a. The attending practitioner, covering practitioner, and/or non-physician practitioner will provide daily care to the Hospital-admitted patient.
    b. The attending practitioner, covering practitioner, and/or non-physician practitioner, will document all daily care in the medical record, which should accurately reflect the day and time the patient was seen.
    c. This documentation/progress note should record clinical observations, medical necessity, continuity of care, and/or revisions in the patient's clinical course/treatment plan (including code status).
    d. When a resident is assigned to assist in the care of a patient, the attending/covering practitioner (teaching practitioner) should document being physically present during critical or key portions of the service furnished by the resident and his/her own participation in the management of the patient. (A resident is defined as an individual who participates in an approved GME Program.)
    e. When a non-physician practitioner is assigned to assist in the care of the patient, the attending/covering/sponsoring practitioner does not need to co-sign the care documentation/progress note, unless it is considered a "shared-visit".
    f. Any contribution and/or participation of a medical student must be performed in the physical presence of a teaching practitioner or resident. Should the medical student document within the patient's medical record, the teaching practitioner or resident must verify and re-document any findings from the medical student. (A medical student is defined as an individual who participates in an accredited educational program (i.e., medical school) that is not an approved GME program and who is not considered a resident.)
4. Consultations: See Ascension St. John Hospital Medical Staff Consult Etiquette Policy.
5. Operative Report/High-Risk Procedure Note:
    a. Surgeries, invasive procedures, and high-risk procedures shall be performed only after an H&P is completed and documented in the patient's medical record.

b. A pre-anesthesia assessment shall be completed and documented on each patient receiving anesthesia services.
c. A **high-risk procedure** shall be defined as a procedure involving the administration of moderate sedation, deep sedation, or anesthesia
d. An **invasive procedure** shall be defined as a procedure involving puncture or incision of the skin, insertion of an instrument, or insertion of foreign material into the body for diagnostic or treatment-related purposes. Examples include but not limited to central line and chest tube insertions, percutaneous aspirations/ biopsies, cardiac/vascular catheterizations, endoscopies, angioplasties, and implantations. Excluded are routine examinations (i.e., pap smears, cultures), venipunctures, parenteral therapy, injection of radiographic contrast media, and routine nursing procedures (i.e.: nasogastric tube insertion, Foley catheter insertion).
e. An operative or high-risk procedure report is written, typed, or dictated upon the completion of the operative or high-risk procedure and before the patient is transferred to the next level of care.
    - *Note1: The exception to this rule occurs when an operative or high-risk procedure progress note is written, typed, or dictated immediately after procedure and the full report can be written or dictated within twenty-four (24) hours.*
    - *Note 2: If the practitioner performing the operative or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written, typed, or dictated in the new unit or area of care.*
f. The operative report or other high-risk procedure report shall include:
    - The name of the practitioner who performed the procedure and the name(s) of involved assistants;
    - The name of the procedure(s) performed
    - A description of the procedure(s)
    - Procedure findings;
    - Estimated blood loss;
    - Specimen(s) removed;
    - Post-operative diagnosis.

6. Obstetrical Record:
    a. The obstetrical record shall include a complete prenatal record, including history of past pregnancies, laboratory data, past medical history, social history, and pertinent physical findings.
    b. The prenatal record shall be forwarded to the Hospital before the patient's admission.
    c. An interval admission note shall include pertinent additions and any subsequent changes to the H&P.
7. Discharge Summary:
    a. A discharge summary shall be written or dictated on all medical records of patients hospitalized greater than 48 hours.
    b. For patients hospitalized 48 hours or less, a final summary progress note shall suffice.
8. Medical Record Completion:
    a. The attending practitioner is responsible for the completion of the medical record. If the medical record is incomplete at the time of discharge, all essential documentation will be identified and made available to the practitioner for completion. A record will be considered delinquent when it has not been completed within 30 days of the patient's discharge. A practitioner who fails to complete his delinquent records shall not have clinical privileges, according to Ascension St. John Hospital Medical Staff Temporary Suspension of Admissions Privileges Policy.

b. The attending practitioner's responsibilities to complete medical records include the provision of a signed or cosigned: 1) History and Physical examination, 2) Operative and Invasive Procedure Note, 3) Consultation, 4) Discharge Summary.
c. For the purpose of enforcing medical record completion, justified reasons for delay may include, but not limited to the attending practitioner or any other individual contributing to the record is ill or otherwise unavailable for a period of time due to circumstances beyond his control.

9. Medical Records are the property of the Hospital and shall not be removed from the Hospital under any circumstances, except in accordance with a court order, subpoena, or statute. In the case of a readmission of a patient, all previous medical records shall be made available for the use of the attending practitioner.
10. The Hospital will provide appropriate access to electronic medical records, including password(s). The practitioner is responsible for preserving the privacy and authenticity of his/her password, and for following organizational requirements for periodic updating as required by public statute, regulation and/or corporate policy. Electronic signature is an appropriate method of authentication.
11. Access to all patient medical records shall be afforded to practitioners for bona fide study and research consistent with preserving the confidentiality of personal patient information. Subject to discretion of the President of the Hospital and/or CMO, former members of the Medical Staff may be permitted to access information from the medical records of their patients covering all periods during which they attended such patients at the Hospital.
12. Written consent of the patient is required as authority for release of medical information to persons not otherwise authorized to receive this information.
13. All documentation in the medical record shall be objective. Any inappropriate entries shall be referred to the practitioner's Department Chair/Section Chief.

ORDERS

1. Orders for medications and treatment shall be entered in the medical record and will be authenticated by the practitioner, resident, or non-physician practitioner responsible for the care of the patient or by a pharmacist (for **delegated medication management therapy**).
2. For departments still utilizing a written medical record, all orders for treatment shall be entered in the medical record in writing, legible, dated, timed, and authenticated by the practitioner, resident, non-physician practitioner responsible for care of the patient or by a pharmacist (for **delegated medication management therapy**).

NOTE: Consistent with State law, a. practitioner may delegate to a licensed or unlicensed individual (who is otherwise qualified by education, training, or experience) the performance of selected acts, tasks, or functions, where the acts, tasks, or functions fall within the scope of practice of the practitioner's profession and will be performed under the practitioner's supervision.

3. Telephone orders and/or verbal orders, given by a practitioner, must be in electronic or written format when provided to a:
    a. Nurse
    b. Resident
    c. Non-Physician Practitioner
    d. Pharmacist (for medication or therapeutic drug monitoring orders)

e. Registered Respiratory Therapist (for respiratory care orders)
f. Registered Dietician (for dietary and tube feeding orders)
g. Physical Therapist (for physical therapy orders)
h. Occupational Therapist (for occupational therapy orders)
i. Speech Therapist (for speech therapy orders)
j. Psychologist (for psychology testing)
k. Radiation Therapist/Dosimetrist (for radiation therapy)
l. Exercise Specialist (for cardiac rehabilitation)
m. Laboratory Technologist (for laboratory orders)
n. Radiologic Technologist (for radiology orders)
o. Infection Prevention & Control Practitioners (for isolation orders)
p. Health Unit Coordinators (for non- medication diagnostic and/or therapeutic orders)
q. Medical Assistant (in affiliated ambulatory care/physician practices who is certified and pharmacologically trained in an accredited medical assistant program or has a current national certification with the American Association of Medical Assistants).

4. Verbal orders may only be taken in an emergency situation or during sterile procedures where breaking aseptic technique would be impractical.
5. Telephone orders and/or verbal orders for controlled substances may only be given by a physician.
6. Telephone orders and/or verbal orders for medications (other than controlled substances) may be given by a physician, resident (under the supervision of a physician) or a non-physician practitioner (with delegated authority, according to delineation of privileges).
7. The practitioner, or designee, shall authenticate such Telephone Orders/Verbal Orders by next patient visit or within 48 hours.
8. For patients going to inpatient surgery, delivery, or moving into or out of specialty units (including the ICU) will have all previous orders cancelled and rewritten to confirm consistency with the care planned.

MEDICATIONS

1. The Medical Staff approves policies and procedures for medication administration, consistent with requirement s of Federal and State law and accepted standards of practices.
2. The Medical Staff will consult with nurses, pharmacists, quality associates, and others (as appropriate) in developing medication policies and procedures (examples include orders, order sets, protocols, and standing orders).
3. All medications administered to patients at the Hospital shall meet the standards of the United States Pharmacopoeia and/or be approved as a Hospital Formulary medication by the Pharmacy and Therapeutics Committee.
4. Medications under study for a bona fide clinical investigation shall be dispensed by the pharmacy following approval by the Hospital's Institutional Review Board (IRB) and need not be the Hospital Formulary. Such clinical investigation shall be subject to patient consent, IRB review, and in compliance with all appropriate regulatory agencies.
5. Use of proprietary medications shall be avoided. However, when ordered by the practitioner, and verified by the pharmacist, the proprietary medication may be prescribed.

6. In cases where the practitioner orders a medication by a trade name, the pharmacist will automatically dispense the medication by its generic name, unless the practitioner writes "Dispense as Written" (DAW).
7. The prescribing practitioner, resident, or non-physician practitioner will review the patient's current home medication regimen and reconcile the home medication list with the medications ordered on admission of the patient.
8. Suspected or confirmed adverse medication reactions should be documented in the patient's medical record and reported to the Pharmacy and Therapeutics Committee, via the electronic event reporting system.
9. Unless the practitioner specifies, a specific number of doses or days a medication is to be administered will be documented and enforced. Certain classes of medications will be discontinued according to the policy adopted by the Pharmacy and Therapeutics Committee, with the approval of MEC.

EMERGENCY SERVICES GENERAL RULES

1. Any individual who comes to the Hospital's Emergency Department (ED) 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 for care,* an appropriate Medical Screening Exam (MSE) to determine if the individual has an Emergency Medical Condition (EMC).

2. If the emergency physician requires and requests the services of an on-call physician to determine if an EMC exists or to stabilize a patient, the on-call physician is responsible to respond, examine and treat the patient, unless unavailable because of situations beyond his or her control. The on-call physician may not refuse to respond, examine and treat the patient based on a difference of opinion with the ED physician or the patient's ability to pay. If a particular specialty is not available, the hospital will follow the appropriate policies for back-up on-call physicians or appropriate EMTALA transfers or other policies that meet the needs of the patient presenting to the emergency department for treatment of an EMC.

3. Fulfillment of the Emergency Department on-call assignment is a requirement for Active Medical Staff membership.

    a. The on-call physician shall respond, examine, and treat the patient as requested by the ED physician.
    b. The on-call physician cannot consider the patient's financial circumstances, insurance or means of payment in the decision to respond to, treat or transfer the patient.
    c. The on-call physician shall respond, examine and treat the patient in ED promptly, and when requested must be physically present in the dedicated ED within 30 – 60 minutes from the time of the initial request, unless unavailable because of situations beyond his or her control.
    d. The on-call physician's responsibility to the dedicated ED is to assist in the medical screening exam (MSE), to assist in providing appropriate ongoing stabilization and treatment, and/or to assist in the appropriate transfer of the patient to an accepting facility, if necessary.
    e. Unless other arrangements are made, the on-call physician shall provide follow-up patient care throughout the episode of illness. The on-call physician may not condition

the first follow up office visit on advance payment or otherwise consider the patient's ability to pay.

f. Any violation of this policy by an on-call physician including failure to answer page in a timely manner should be reported to the on-call physician's Section Chief /Department Chair. The Section Chief/Department Chair will report to the CMO who will follow up with the Medical Staff President and Legal Services. Appropriate disciplinary action will be taken.

SPECIAL CARE UNITS

Patients shall be admitted to and discharged from the special care units in accordance with current policies of these units. Special care units include the MICU, SICU, CICU, PICU, and NICU.

SURGICAL SERVICES GENERAL RULES

1. The Department of Surgery shall recommend to and be empowered by the MEC to implement policy concerning care, treatment, services, scheduling, transport, and monitoring of patients in the pre-operative, peri-operative, and post-operative areas of the Hospital.
2. Surgical practitioners and proceduralists will be prepared to operate or perform invasive procedures at scheduled times in accordance with the Department of Surgery's Rules & Regulations.
3. The preoperative diagnosis and laboratory tests must be recorded on the patient's medical record prior to any surgical procedure.
4. Informed consent shall be obtained prior to the operative or invasive procedure and a consent form shall be signed, except in those situations where the patient's life is in jeopardy and suitable signatures cannot be immediately obtained from the guardian, parents, or next of kin (see CONSENT section of these Rules & Regulations or the SJP Consent for Treatment/Informed Consent Policy). These circumstances should be explained within the patient's medical record.
5. A History and Physical Examinations (H&P) must be completed as noted under the ***Ascension St. John Hospital Medical Staff Bylaws.***
6. The Anesthesiology Department shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.
7. The practitioner who is ultimately accountable for the surgery/invasive procedure (and who will be present when performed) is responsible for marking the operative/invasive procedure site (when indicated) before the operative/invasive procedure is performed, except in a life-threatening emergency. The physician practitioner may delegate the site marking to a resident or non-physician practitioner who is being supervised by the physician practitioner performing the operative/invasive procedure, who is familiar with the patient, and who will be present when the operative/invasive procedure is performed.
8. The practitioner(s), residents, and –non-physician practitioners who will be present when the operative/invasive procedure is performed will participate in the time-out, which is conducted immediately before starting the operative/invasive procedure.
9. Tissue specimens removed during the surgery/procedure and all foreign bodies needing identification shall be sent to Pathology, where a pathologist shall determine the extent of the examination necessary to arrive at a complete diagnosis. The pathologist's findings will be

documented in the patient's medical records and authenticated. All pathology specimens shall be the property of the Hospital and shall not be removed without the permission of the Department Chair of Pathology or designee.

COMMITTEES OF THE MEDICAL STAFF – OTHER STANDING COMMITTEES

Background: When the Ascension St. John Hospital Medical Staff Bylaws were amended in 2010, only two committees, (A.) Medical Executive Committee (MEC) and (B.) Credentials Committee, were listed as STANDING COMMITTEES within *Article X, COMMITTEES OF THE MEDICAL STAFF*. A third delineation entitled, (C.) OTHER STANDING COMMITTEES stated, "All other Standing Committees of the Medical Staff will be appointed by the Medical Staff President, approved by the MEC, and have its charter listed in the Ascension St. John Hospital Medical Staff's Rules & Regulations."

1. The Chairs and members of the Standing Committees of the Medical Staff shall be reviewed and approved by the Medical Staff President. All Standing Committees will have defined charters that outline the committee's focus, chair, purpose, composition, responsibilities, structure, and reporting. These charters will be approved by the MEC.

2. The Standing Committees shall be:

   A. ADULT PROFESSIONAL PRACTICE COMMITTEE
   B. BYLAWS COMMITTEE
   C. CANCER COMMITTEE
   D. COMMITTEE ON COMMITTEES
   E. CONTINUING MEDICAL EDUCATION (CME) COMMITTEE
   F. GRADUATE MEDICAL EDUCATION (GME) COMMITTEE
   G. INFECTION PREVENTION & CONTROL ADVISORY COMMITTEE
   H. MATERNAL CHILD PROFESSIONAL PRACTICE COMMITTEE
   I. MEDICAL STAFF AWARDS COMMITTEE
   J. MEDICAL STAFF FUND COMMITTEE
   K. MEDICAL STAFF PROFESSIONAL PRACTICE COMMITTEE
   (Medical Staff Peer Review Case Rating Consideration)
   L. MEDICAL STAFF RESEARCH COMMITTEE
   M. NOMINATING COMMITTEE
   N. PHARMACY & THERAPEUTICS COMMITTEE
   O. PHASE OF CARE MAJOR EVENT ANALYSIS COMMITTEE (POCMEA)
   P. TRAUMA PERFORMANCE IMPROVEMENT COMMITTEE
   Q. UTILIZATION REVIEW COMMITTEE

3. The Medical Staff President, CMO, and the President of the Hospital shall be *ex-officio* members of each committee.

4. The Medical Staff President may appoint Special Committees (ad hoc) as may be necessary to conduct specific business of the Medical Staff.

A. ADULT PROFESSIONAL PRACTICE COMMITTEE CHARTER

1. **Focus:** To improve quality of patient care and safety by identifying opportunities for improvement through peer review activities for the adult non-trauma patient population at Ascension St. John Hospital.
2. **Chair:** The Chair of the Adult Professional Practice Committee (APPC) will be appointed by the Medical Staff President and approved by the MEC. To be eligible for appointment as Chair, the individual must be a current voting member of the APPC and have served as a voting

member at some point in time for at least one year. The Chair will serve for a term of 2 years and may have an unlimited number of consecutive terms provided the chair is eligible to be a Professional Practice Committee member. The APPC chair may also have a Vice Chair to assist with Chair responsibilities, if needed.

3. **Purpose:** To provide a multi-specialty approach for the Medical Staff to evaluate practitioner performance through peer review.
4. **Composition:**
   a. The voting members will be appointed by the Medical Staff President based on the recommendations from the department chairs and the APPC Chair and approved by the MEC. Voting members will be appointed for a two-year term with opportunity for renewal. In the event that there is no other representative from a specialty available, the Section Chief will be the appointed representative. It is required that all members have access to and regularly check an Ascension email account.
   b. The APPC will be comprised of 23 voting members (inclusive of chair) who are active members of the medical staff from each of the following specialties: Internal Medicine/Medical Subspecialties to include expertise in the following areas: Adult Intensivist, Nephrology, Cardiology (2 members), Internal Medicine (2 members), Infectious Disease, and Neurology. Surgical specialties in the following areas: General Surgery (2 members), Gynecology, Urology, CV Surgery, Orthopedics, and Neurosurgery. Additional specialties: Emergency Medicine (2 members), Anesthesiology, Family Medicine, Radiology, and Pathology. One Non-Physician Practitioner (NPP) will also have voting rights.
   c. Other specialists may be asked to attend ad hoc at the request of the Committee Chair, Department Chair, or CMO.
   d. The CMO, the CNO or designee, the director of Quality Management and the quality support staff as determined by the Chair as well as one Registered Nurse actively employed at Ascension St. John Hospital are ex-officio members, without vote.
   e. Current department chairs are not eligible for APPC voting membership. Voting MEC members are eligible for APPC membership.
   f. 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.
5. **Responsibilities:**
   a. Evaluate practitioner performance and compliance with the Medical Staff Quality and Peer Review Indicators within its patient care scope via case review and determine if improvement opportunities exist utilizing Medical Executive Committee approved rating system:
      i. Standard of Care Met with Communication Concerns
      ii. Standard of Care Met with Documentation Concerns
      iii. Standard of Care Met with Opportunity for Improvement
      iv. Standard of Care Met with Trending
      v. Standard of Care Met-Appropriate
      vi. Standard of Care Met-Exemplary
      vii. Standard of Care Not Met-Minor Variance - (formerly Controversial)
      viii. Standard of Care Not Met-Major Variance - (formerly Inappropriate)
   b. Communicate case review ratings to individual practitioners and allow opportunity for reconsideration in accordance with the Medical Staff Peer Review Case Rating Reconsideration Policy. Copies of all correspondences sent to individual providers will be electronically shared with the applicable Department Chair in order to facilitate the

Ongoing Professional Practice Evaluation (OPPE) process and the Credentials Committee at the time of reappointment.

6. **Structure & Reporting:**
   a. The APPC will meet at least 9 times per year for purposes of making final determinations for individual case reviews a quorum will require the presence of 50% of the voting members at a regularly scheduled meeting. A majority will consist of a majority of voting members present.
   b. The Chair of APPC will report to the Medical Staff Professional Practice Committee (MSPPC) at least 4 times per year. No changes can be made to the APPC charter and policies without approval of the MSPPC and MEC.
   c. The minutes from the APPC are confidential and distributed to the MSPPC, MEC, and Risk Management for the purposes of identifying potentially compensable events, Quality/Safety risks and to identify opportunities improvements.

B. BYLAWS COMMITTEE

1. **Focus**: To ensure the Medical Staff Bylaws are relevant and reflect the current structure, standards of practice, and operations of the Medical Staff.
2. **Chair**: Appointed by the Medical Staff President.
3. **Purpose:** Serve as a group to review and make recommendations to update the Medical Staff Bylaws regarding necessary additions, amendments, and/or repeals.
4. **Composition:** At least three (3) members of the Medical Staff, the CMO (non-voting), and the Medical Staff President (or designee).
5. **Responsibilities:**
   a. Shall consider all proposed additions, amendments, and/or repeals of the Medical Staff Bylaws and consider strategies for necessary revisions.
   b. Shall make recommendations to the MEC regarding proposed additions, amendments, and/or repeals of the Medical Staff Bylaws.
   c. Minimally, will conduct a triennial review the Medical Staff Bylaws.
6. **Structure & Reporting:** To meet as necessary for the consideration of proposed additions, amendments, and/or repeals and submit recommendations to the MEC. In certain cases, committee business may be performed on an electronic platform (i.e., email). Will minimally meet on a triennial basis to conduct a review of the Medical Staff Bylaws and submit recommendations/minutes to the MEC.

C. CANCER COMMITTEE

1 **Focus**: High quality care for the Hospital's cancer patients.
2. **Chair:** Appointed by the Medical Staff President.
3. **Purpose:** To decrease the morbidity and mortality of patients with cancer.
4. **Composition:** The committee membership shall be multidisciplinary and consist of the following:
   a. Required physician members – At least one board certified physician from Surgery, Medical Oncology, Diagnostic Radiology, Radiation Oncology, Pathology, as well as a Cancer Liaison Physician who may be from one of the required specialties.
   b. A required member from each of the following areas: Administration, Certified Cancer Registrar, Oncology Nursing, Social Work, Quality, Rehabilitation, Clinical Research Representative, and Palliative Care Team Member.
   c. Additional members recommended, but not required, include Specialty Physicians representing key areas of cancer care, Dietician, Pharmacist, Pastoral Care, Psychiatrist

or Cancer Care trained mental health professional, American Cancer Society representative.

5. **Responsibilities:**
    a. To monitor and improve quality of care, ensuring that patients have access to the full scope of services required to diagnose, treat, rehabilitate, and support patients with cancer and their families, as well as provide prevention and early detection services to the community.
    b. To monitor, assess, and identify changes need to maintain compliance with the eligibility requirements of the American College of Surgeons Commission on Cancer Accreditation Program.
6. **Structure & Reporting:** Will meet quarterly and submit minutes to the MEC.

D. COMMITTEE ON COMMITTEES

1. **Focus**: Responsible for the ongoing assessment of the effectiveness of Medical Staff Committees.
2. **Chair**: Medical Staff President.
3. **Purpose:** To conduct an annual review of all Standing and Special Medical Staff Committees.
4. **Composition:** Medical Staff President, the Medical Staff President-Elect, the Medical Staff Past-President, and the CMO. May include not more than one additional member of the Active Staff.
5. **Responsibilities:**
    a. To recommend any additions, deletions, and/or consolidations of a Standing Committee of the Medical Staff to the MEC.
    b. To create, define, and/or appoint Special Committees of the Medical Staff.

6. Structure & Reporting: To meet as necessary, but minimally on an annual basis and submit recommendations to the MEC.

E. CONTINUING MEDICAL EDUCATION (CME) COMMITTEE:

1. **Focus**: Reviews continuing medical education (CME) activities, structure, and long-range planning.
2. **Chair**: A Vice-Chair shall be elected by the committee by a majority vote of the members. He/she will serve one (1) year as Vice-Chair and the following year as Chair. If the need arises, a Chair may be elected by majority vote of the committee to serve out an uncompleted year.
3. **Purpose:** The CME Committee will be structured in accordance with the Essentials for Continuing Medical Education of the Accreditation Committee for Continuing Medical Education.
4. **Composition:**
    a. Chair of the Department and/or department representatives in Departments of Family Medicine, Emergency Medicine, Internal Medicine, General Surgery, Obstetrics and Gynecology, Pathology, Pediatrics, and representatives from Anesthesiology and Radiology.
    b. CMO
    c. Director of Medical Education
    d. An Administrative Nursing Director
    e. Educational Coordinator, School of Medical Technology
    f. Educational Coordinator, School of Radiology Technology
    g. Director of Medical Library
    h. Director, Division of GME Biomedical Investigations & Educational Programs
    i. Manager of Medical Education
    j. CME Coordinator
5. **Responsibilities:**
    a. To grant category I credit, as delegated by the Accreditation Committee for Continuing Medical Education through the Michigan State Medical Society, to the Hospital's programs and to co-sponsor programs as indicated.

b. To annually survey all programs granted category credit and continue, change, or negate such approval.
c. To advise the Executive Director of CME, who is appointed by Administration, regarding all matters, including financial, pertaining to the Hospital's CME Programs.
d. To advise and assist in providing continual medical education programs and credit for the Nursing Department.

6. **Structure & Reporting:** To meet at least bi-monthly and submit minutes to MEC.

F. GRADUATE MEDICAL EDUCATION (GME) COMMITTEE:

1. **Focus**: Oversees the education, research, and patient care practices of the Hospital's residents and fellows.
2. **Chair**: Appointed by the Medical Staff President and will be a member of the MEC.
3. **Purpose:** To ensure that each residency and fellowship program provides quality educational experiences and meets the requirements set forth in the ACGME Special Requirements for each accredited program and non-ACGME accredited programs.
4. **Composition:**
   a. The Residency Program Directors of Family Medicine, General Surgery, Internal Medicine, Obstetrics & Gynecology, Pathology, Pediatrics, Emergency Medicine, Transitional Year, and Podiatric Surgery.
   b. One (1) resident representative from each residency program. The resident must be nominated and peer-selected.
   c. CMO.
   d. The Director of Medical Education.
   e. Two (2) members of the private Medical Staff selected by the Medical Staff President.
   f. The manager of Medical Education and the Graduate Medical Education Specialist.
   g. The Chairs of the departments of: Family Medicine, General Surgery, Internal Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Anesthesiology, Emergency Medicine, and Radiology.
   h. Residency Coordinators from each residency program are encouraged to attend, but it is not mandatory.
5. **Responsibilities:**
   a. To review, at least once a year, the reports of each departmental education committee, as outlined in the Hospital's Graduate Medical Education Manual of Policies and Procedures and make any recommendations for changes to the appropriate Department Chair, the Director of Medical Education, the Hospital's Administration and the MEC.
   b. To implement the educational program in graduate medical education as outlined in:
      i. The Hospital's Institutional Commitment to Graduate Medical Education.
      ii. The Hospital's Periodic Analysis of Residency Programs.
      iii. The Hospital's Graduate Medical Education Manual of Policies and Procedures.
   c. To refer to the MEC and the Hospital's Administration any matters requiring changes in the Graduate Medical Education or Student Programs and make recommendations regarding means to deal with such matters.
   d. To recommend to the MEC and the Hospital's Administration the allocation of resident physicians and other resources to each department as outlined in the Hospital's Educational Resources Plan.
6. **Structure & Reporting:** To meet monthly and submit minutes to MEC.

G. INFECTION PREVENTION & CONTROL ADVISORY COMMITTEE

1. **Focus:** Represents the decision-making authority for the Infection Prevention & Control Program.

2. Chair: Medical Staff physician, elected by the committee, preferably an infectious disease specialist.

3. Purpose: Will provide the authority and primary forum where the annual Infection Prevention & Control Plan and goals will be finalized and where strategies for goal attainment and evaluation will be determined.

4. Composition:

a. Chair (physician)

b. Administration

c. Medical staff appointees/consultants

d. Infection prevention & Control staff

e. Nursing

f. Standing members or consultants from specific departments/services when issues or problems are identified

g. Health department representatives as needed when investigating a problem or developing a program

5. Responsibilities:

a. Determine the annual plan for the IPCP; evaluate IPCP effectiveness according to the Annual Plan.

b. Annually determine the type and scope of surveillance activities and general methodology (Surveillance Plan).

c. Review and revise healthcare-associated infection definitions when needed.

d. Review healthcare-associated infection surveillance data summaries, antibiotic susceptibility trends, special surveillance studies, and make recommendations on prevention/ control interventions to appropriate Committees, Improvement and Shared Governance Councils and department managers with the support and approval of the MEC.

e. Review published authoritative guidelines and requirements regarding infection prevention and control and incorporates into SJH & MC policy and procedure.

f. Review clinical infection prevention and control issues when identified or submitted by the Hospital's administration, Hospital committees, the quality improvement program or departments.

g. Review environmental infection prevention and control issues when identified or submitted by Hospital administration, Hospital committees, the quality improvement program or departments.

h. Make recommendations to appropriate managers/administrators after clinical and environmental issues are reviewed; assist managers/administrators to facilitate change as needed using continuous quality improvement (CQI) methods when possible.

i. Review Occupational Health reports, issues, trends and makes recommendations as needed.

j. Review public health-reported infectious disease frequencies.

k. Review and make recommendations when necessary as to the content of new associate orientation and staff education programs with infection prevention and control content.

l. Review antibiotic usage issues as appropriate.

m. Review Safety Committee proceedings for issues/topics with infection prevention and control significance and upon request for review, comment, and recommendations.

All review activities and recommendations should be documented in committee minutes. Assigned responsibility for acting on recommendations should be documented and follow-up and status reported in subsequent minutes.

6. Structure & Reporting: The minutes from the Infection Prevention & Control Advisory Committee are confidential and distributed to:

a. Medical Executive Committee (MEC)

b. Standing members and liaisons of the Infection Prevention & Control Advisory Committee

c. Risk Management

d. Chair, Environmental of Care Committee

e. President of the Hospital (through the MEC)

f. Chief Medical Officer

g. Chief Nursing Officer

h. Director, Surgical Services

i. Additional persons as determined by the committee and issues discussed at the meeting.

H. MATERNAL CHILD PROFESSIONAL PRACTICE COMMITTEE

1. Focus: To improve quality of patient care and safety by identifying opportunities for improvement through peer review activities for the obstetric and pediatric non-trauma patient population at Ascension St. John Hospital.

2. Chair: The Chair of the Maternal Child Professional Practice Committee (MCPPC) will be appointed by the Medical Staff President and approved by the Medical Executive Committee (MEC). To be eligible for appointment as Chair, the individual must be a current voting member of the MCPPC and have served as a voting member at some point in time for at least one year. The Chair will serve for a term of 2 years and may have an unlimited number of consecutive terms provided the chair is eligible to be a Professional Practice Committee member. The MCPPC chair may also have a Vice Chair to assist with Chair responsibilities, if needed.

3. Purpose: To provide a multi-specialty approach for the Medical Staff to evaluate practitioner performance through peer review.

4. Composition:

a. The voting members will be appointed by the Medical Staff President based on the recommendations from the department chairs and the MCPPC Chair and approved by the MEC. Voting members will be appointed for a two-year term with opportunity for renewal. In the event that there is no other representative from a specialty available, the Section Chief will be the appointed representative. It is required that all members have access to and regularly check an Ascension email account.

b. The MCPPC will be comprised of 14 voting members (inclusive of chair) who are active members of the medical staff from each of the following specialties: General Pediatrics, Neonatology, Pediatric Intensivist, Family Medicine, Pediatric General Surgery, General

Obstetrics, Maternal Fetal Medicine, Emergency Medicine, Anesthesiology, Radiology, Pathology. One Non-Physician Practitioner (NPP) will also have voting rights.

c. Other specialists may be asked to attend ad hoc at the request of the Committee Chair, Department Chair, or CMO.

d. The CMO, the CNO or designee, the director of Quality Management and the quality support staff as determined by the Chair as well as one Registered Nurse actively employed at Ascension St. John Hospital are ex-officio members, without vote.

e. Current department chairs are not eligible for MCPPC voting membership. Voting MEC members are eligible for MCPPC membership.

f. 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.

5. Responsibilities:

a. Evaluate practitioner performance and compliance with the Medical Staff Quality and Peer Review Indicators within its patient care scope via case review and determine if improvement opportunities exist utilizing Medical Executive Committee approved rating system

i. Standard of Care Met with Communication Concerns
ii. Standard of Care Met with Documentation Concerns
iii. Standard of Care Met with Opportunity for Improvement
iv. Standard of Care Met with Trending
v. Standard of Care Met-Appropriate
vi. Standard of Care Met-Exemplary
vii. Standard of Care Not Met-Minor Variance - (formerly Controversial)
viii. Standard of Care Not Met-Major Variance - (formerly Inappropriate)

b. Communicate case review ratings to individual practitioners and allow opportunity for reconsideration in accordance with the Medical Staff Peer Review Case Rating Reconsideration Policy. Copies of all correspondences sent to individual providers will be electronically shared with the applicable Department Chair in order to facilitate the Ongoing Professional Practice Evaluation (OPPE) process and the Credentials Committee at the time of reappointment.

6. Structure & Reporting:

a. The MCPPC will meet at least 9 times per year. For purposes of making final determinations for individual case reviews a quorum will require the presence of 50% of the voting members at a regularly scheduled meeting. A majority will consist of a majority of voting members present. b. The Chair of MCPPC will report to the Medical Staff Professional Practice Committee (MSPPC) at least 4 times per year. No changes can be made to the APPC charter and policies without approval of the MSPPC and MEC.

b. The minutes from the MCPPC are confidential and distributed to the MSPPC, MEC, and Risk Management for the purposes of identifying potentially compensable events, Quality/Safety risks and to identify opportunities improvements.

I. MEDICAL STAFF AWARDS COMMITTEE

1. Focus: To seek, nominate, and select qualified members of the Hospital's Medical Staff for the following: Wall of Honor Award, Distinguished Physician Award, and Research Faculty Recognition Award, according to defined criteria.

2. **Committee Chair:** Medical Staff President
3. **Purpose:** With the strong belief that it is in the best interest of Hospital's Medical Staff to provide members with special recognition for remarkable contributions and achievements.
4. **Composition:** Each Medical Staff Department Chair nominates one (1) senior department member who will sit on the Medical Staff Awards Committee. A member of the Hospital's Medical Affairs department will serve as committee secretary and will organize meetings, prepare meeting minutes and receive nominees.
5. **Responsibilities:** Award nominees are submitted to the Medical Staff Awards Committee, by the Department Chair, on or before March 31st, the year the award is presented. Department Chairs will provide the documentation to support the decision and ensure eligibility.
6. **Structure & Reporting:** The Medical Staff Awards Committee shall meet annually in April to review the award nominees and select the best nominee for each established Medical Staff Award, which will then be submitted to the Medical Executive Committee for approval. The awards will be presented before the general medical staff.
7. **Awards:**
   a. **The Wall of Honor Award:**
      i. No limit to the number of awardees.
      ii. Nominated by the members of each Medical Staff Department and approved by the Medical Staff Awards Committee.
      iii. Presented every year.
      iv. Awardee may only receive this award once.
      v. Must have been an Active Medical Staff member for a minimum of twenty (20) years.
      vi. Consideration Criteria (may include one or more of the following):
         a. A distinguished, retired senior physician leader at the Hospital.
         b. Had contributed significantly to the growth of the Hospital.
         c. Had contributed significantly to residents' education.
         d. Had been instrumental in bringing state of the art services and technology to the Hospital.
         e. Had contributed significantly to placing the Hospital "on the map" as a leader in health care providers.
         f. Had contributed to scholarly activities.
         g. Had served in a leadership position with local or national societies, representing the Hospital.
   b. **Distinguished Physician Recognition Award:**
      i. Presented to one (1) awardee.
      ii. Nominated by the members of each Medical Staff Department and approved by the Medical Staff Awards Committee.
      iii. Presented every year.
      iv. Awardee may only receive this award once.
      v. Must be a member of the Active Medical Staff for a minimum of fifteen (15) years (may or may not currently be an Active Medical Staff member).
      vi. Consideration Criteria (may include one or more of the following):
         a. Has loyalty to the Hospital.
         b. Has dedicated > 75% of time to the Hospital.
         c. Contributed significantly to residents' training.

d. Involved in the scholarly activity.
e. Served on the Hospital/Medical Staff Committees.
f. Is active or had served on local or national professional societies**.**

c. Research Faculty Recognition Award:

i. Presented to at least one (1) awardee.
ii. Nominated by the members of each Medical Staff Section/Department or Program Director and approved by the Medical Staff Awards Committee.
iii. Presented every year.
iv. Awardees may receive this award multiple times.
v. Must be a member of the Active Medical Staff (no minimum of years of active service required).
vi. Consideration Criteria (may include one or more of the following, points will be awarded by the Committee for each of the following activities):
    a) Worked a minimum of two (2) years in research activities.
    b) Be a presenting or senior author on a minimum of one (1) poster or oral presentation at a local, regional, state, or national meeting.
    c) Within the past two years, has at least one (1) article accepted or published in a peer reviewed journal or as a book chapter.
    d) Has served as a manuscript reviewer in a peer reviewed journal.
    e) Participates in the scholarly activity and research activity for publications, involving the respective department. Has served as a mentor to residents or fellows on research projects, as evidenced by inclusion as a co-investigator or co-author on protocols, manuscripts or abstracts (local or national).

J. MEDICAL STAFF FUND COMMITTEE

1. **Focus:** To fulfill its legal and moral obligations to ensure the financial health and effectiveness of the Medical Staff of St. John Hospital & Medical Center funds.
2. **Chair:** The Secretary-Treasurer of the Medical Staff
3. **Purpose:** Will conduct its due diligence function related to assuring fiscal health and effectiveness of the Medical Staff of St. John Hospital & Medical Center's funds.
4. **Composition:** The Medical Staff Fund Committee shall consist of the officers of the Medical Staff.
5. **Responsibilities:**
    a. To collect, hold, disburse and account for the Medical Staff of St. John Hospital &Medical Center fund.
    b. Prepare an annual budget of the Medical Staff of St. John Hospital & Medical Center fund and submit it to the MEC.
    c. To recommend to the MEC the amounts to be assessed as dues for the Medical Staff of St. John Hospital & Medical Center fund.
    d. To determine what amounts shall be expended from the fund.
    e. To submit annually, through its Chair, a written report to the MEC and Medical Staff of receipts and disbursements, assets, and liabilities.
7. **Structure & Reporting**: To meet at least annually and submit minutes to the MEC.

K. MEDICAL STAFF PROFESSIONAL PRACTICE COMMITTEE

1. **Focus:** To improve quality of patient care and safety by identifying opportunities for improvement through oversight of peer review activities for the Medical Staff at Ascension St. John Hospital and to ensure optimum patient care by promoting a safe, cooperative, and professional healthcare environment, and to prevent or eliminate Medical Staff conduct that is unacceptable and/or disruptive.

2. **Chair:** The Medical Staff President Elect will chair the MSPPC during his/her term as President Elect.

3. **Purpose:** To provide a centralized, multi-specialty approach for the Medical Staff to evaluate practitioner performance on an individual and aggregate level through oversight of the peer review committees of the Medical Staff. In addition, to conduct peer review of events involving Medical Staff performance and unacceptable/disruptive behaviors and make the final determination as to whether the event is "Valid, Invalid, or Indeterminate". Unacceptable/Disruptive Behavior is defined as the following: Disrupts hospital/health system operations; Affects the ability of others to do their jobs; Creates a hostile work environment for Ascension St. John Hospital and/or Ascension associates or members of the Medical Staff; Interferes with an individual's ability to practice competently; Adversely affects the community's confidence in Ascension St. John Hospital/Ascension's ability to provide quality of patient care.

4. **Composition:**
   a. The MSPPC will be comprised of eighteen (18) voting members (inclusive of MSPPC Chair) who are active members of the medical staff defined by the individual holding the following positions: the ten (10) Department Chairs (Medicine, Family Medicine, Surgery, Pediatrics, Obstetrics/Gynecology, Emergency Medicine, Anesthesiology, Psychiatry, Radiology and Pathology); the Adult Professional Practice Committee Chair and Vice Chair; the Maternal Child Professional Practice Committee Chair or designee; the Trauma Performance Improvement Committee Chair or designee, the Phase of Care Major Event Analysis Committee Chair or designee; the President of the Medical Staff and the Director of Graduate Medical Education. Practitioners from other specialties may be invited to the MSPPC meeting as needed.

   b. Voting members will be appointed for an indefinite term as long as they hold the positions described above.

   c. The CMO, CNO, director of Quality Management and quality support staff as determined by the Chair are ex-officio members without vote.

5. **Responsibilities:**
   a. Make recommendations to the MEC for practitioner relevant performance measures and targets for Medical Staff Quality and Peer Review Indicators.

   b. Evaluate practitioner performance and compliance with these indicators through oversight of the Medical Staff peer review committees and through review of aggregate data and trends.

   c. Assure accountability for the development of quality improvement plans identified through peer review activities.

   d. In accordance with the Medical Staff Peer Review Case Rating Reconsideration policy, perform peer review of cases and evaluate practitioner performance and compliance with the

Medical Staff Quality and Peer Review Indicators and determine if improvement opportunities exist utilizing Medical Executive Committee approved rating system

1. For clinical quality events:
    I. Standard of Care Met with Communication Concerns
    II. Standard of Care Met with Documentation Concerns
    III. Standard of Care Met with Opportunity for Improvement
    IV. Standard of Care Met with Trending
    V. Standard of Care Met-Appropriate
    VI. Standard of Care Met-Exemplary
    VII. Standard of Care Not Met-Minor Variance
    VIII. Standard of Care Not Met-Major Variance
2. For medical staff conduct events:
    I. Valid
    II. Invalid
    III. Indeterminate
    IV. Initiates the applicable step process as outlined in the Medical Staff Accountability Policy for all events determined to be Valid or Indeterminate (see Medical Staff Accountability Policy for further details).

e. Communicate final case review ratings to individual practitioners. Copies of all correspondences sent to individual providers will be electronically shared with the applicable Department Chair in order to facilitate the Ongoing Professional Practice Evaluation (OPPE) process and the Credentials Committee at the time of reappointment.

6. Structure & Reporting:

a. The MSPPC will meet at least 4 times per year. For purposes of making final determinations or recommendations for individual case ratings or improvement opportunities based on aggregate data a quorum will require the presence of 50% of the voting members at a regularly scheduled meeting. A majority will require a ⅔ vote of members present.

b. Minutes from the MSPPC are confidential and will be forwarded to the MEC. The Chair of MSPPC will report to the MEC at least 4 times per year.

MEDICAL STAFF PEER REVIEW CASE RATING CONSIDERATION

1. Purpose: The process whereby an individual practitioner may provide additional information and request reconsideration of a final peer review case rating determination made by a peer review committee of the Medical Staff at Ascension St. John Hospital (ASJH).

2. Policy:

a. **Scope:** All practitioners granted privileges at ASJH who are subject to Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation (see Focused Professional Practice Evaluation Policy and Ongoing Professional Practice Evaluation Policy).

b. **Process:**

i. After a member of the medical staff receives a final case review rating correspondence, the individual has the opportunity to submit additional information to the appropriate peer review committee for review and reconsideration.

ii. Additional information must be received in writing within fourteen (14) days of receipt of the final case rating letter. If additional information is received after the fourteen (14) day period, it will be at the discretion of the committee chair as to whether or not this information will be considered. Correspondences should be sent via one of the following methods:

    a) Via email to PeerReview@ascension.org
    b) Via U.S. Mail to:
    Ascension St. John Hospital, Quality Department
    Mack Office Building
    19251 Mack Avenue, Suite 400
    Grosse Pointe Woods, MI 48236

iii. The involved practitioner may present to the peer review committee, at the discretion of the committee chair. This type of request must be made in writing and must be submitted within the fourteen (14) day period described above. Any literature review or other supporting documentation that is felt relevant must be provided at that time. The involved practitioner will be required to sign a confidentiality statement. The committee will first be allowed to review the additional information; the involved practitioner will be given 10 -15 minutes to present additional information and will then be excused. The committee will then deliberate. If the committee has additional questions that need to be answered, the involved practitioner will be notified in writing.

iv. Following review, the peer review committee will issue a final quality level determination via encrypted email directly to involved practitioner.

v. If the involved practitioner is still in disagreement with the determination, he/she may submit a request for final reconsideration to the Medical Staff Professional Practice Committee. This request must be received in writing within fourteen (14) days of receipt of the final case rating letter. If additional information is received after the fourteen (14) day period, it will be at the discretion of the committee chair as to whether or not this information will be considered.

vi. The process outlined in item iii. above will be followed for practitioners wishing to present to the MSPPC.

vii. The MSPPC will make a final determination that will be made a permanent part of the practitioner's quality file.

viii. Individual Department Chairs cannot change the final case rating, nor can they insist on further reconsideration. The Department Chair will be given the opportunity to document their findings, if different from those of the peer review committee, in the involved practitioner's quality file.

L. MEDICAL STAFF RESEARCH COMMITTEE

1. **Focus**: Responsible for Faculty, Non-GME Research
2. **Committee Chair**: Appointed by the Medical Staff President and reviewed on a biennial basis.
3. **Purpose**: Develops, reviews, and implement plans to promote clinical research within the Hospital.
4. **Composition**: Department Chair and/or department representatives in addition to administrative, medical education, research and IRB representatives
5. **Responsibilities**:

a. Coordinate and facilitate research activities
b. Periodically review the goals of research in the institution; identify the issues and the needs to support that research
c. Develop an annual report on research; work on venues to keep medical staff informed
d. Establish mechanisms for sharing information about research processes and results
e. Recognize and reward persons involved in research
f. Provide resources and support for those interested in conducting research
g. Identify areas for research collaboration among departments and other institutions, including translational research
h. Develop agreements for all research areas for the costs of common services needed by research
i. Develop sources of funding for research efforts including philanthropic contributions
j. Educate the membership on what research is and how to carry it out.

6. **Structure& Reporting**: To meet at least quarterly and submit minutes to the MEC.

M. NOMINATING COMMITTEE

1. **Focus**: To seek and nominate qualified candidates for election of the Medical Staff Officers, and Undesignated MEC positions.
2. **Committee Chair**: Appointed by the Medical Staff President.
3. **Purpose**: With the belief that it is in the best interest of the Medical Staff to obtain highly qualified candidates who are members of the Active Staff, in good standing, and actively involved in patient care in the Hospital.
4. **Composition:** Each Medical Staff Department nominates one (1) department member who will sit on the Nominating Committee
5. **Responsibilities**: The Nominating Committee shall meet annually before the March General Medical Staff Meeting to develop a ballot of Medical Staff Officers and MEC members.
6. **Structure & Reporting**: Will submit the ballot of nominations to the Chief Medical Officer who will present the nominations at the March Medical Staff Meeting as set forth in Article IX of Medical Staff Bylaws.

N. PHARMACY AND THERAPEUTICS COMMITTEE

1. **Focus**: All matters pertaining to the therapeutic use of pharmacological agents employed within the Hospital, including policy development, communication & education, and formulary management.
2. **Committee Chair**: Medical Staff member appointed by the Medical Staff President.
3. **Purpose**: The Pharmacy and Therapeutics Committee reviews new and existing pharmacological agents and selects those to be included in the Hospital's formulary based on safety, cost–effectiveness, and efficacy.
4. **Composition:** Members of the Medical Staff with one as Chair of the Committee, Director of Pharmacy who shall function as the secretary, the Chief Nursing Officer or a designee, representatives from Pharmacy Service (medical safety, drug information, clinical practice, operations), clinical dietician and other nursing representatives.
5. **Responsibilities**:
    a. Review, analyzes, and evaluates the use and administration of all pharmacological agents employed within the Hospital.
    b. To formulate and recommend policy to the MEC as to the evaluation, selection, administration, dispensing, and monitoring of pharmacological agents.
    c. Ensures mechanisms are in place to communicate with nursing, and other involved healthcare associates related to the dispensing of pharmacological agents.

d. Recommends or assists with the formulation of educational programs designed to meet the needs of the Medical Staff, nursing, and other involved healthcare associates on matters related to pharmacological agents and their use.
e. Develops, organizes, and administers a formulary system to optimize patient care by ensuring access to clinically appropriate, safe, and cost-effective pharmacological agents.
f. To work in concert with the Institutional Review Committee to review and recommend approval or disapproval of all research project protocols and clinical investigations. Once approved, the investigation will be followed by the Pharmacy and Therapeutics Committee to assure adherence to the approved plan.

6. **Structure & Reporting**: To meet at least semi-annually and submit minutes to the MEC.

O. PHASE OF CARE MAJOR EVENT ANALYSIS COMMITTEE (POCMEA)

1. **Focus:** To improve quality of care and safety of patients by identifying opportunities for improvement through peer review activities for the Percutaneous Coronary Intervention (PCI) patient population at Ascension St. John Hospital.
2. **Chair:** The Chair of the Phase of Care Major Event Analysis Committee (POCMEA) will be appointed by the Medical Staff President and approved by the Medical Executive Committee (MEC). To be eligible for appointment as Chair, the individual must be a current voting member of the POCMEA committee and have served as a voting member at some point in time for at least one year. The Chair will serve for a term of 2 years and may have an unlimited number of consecutive terms provided the Chair is eligible to be a Professional Practice Committee member. The POCMEA committee Chair may also have a Vice Chair to assist with Chair responsibilities, if needed.
3. **Purpose:** To provide a multi-specialty approach for the Medical Staff to evaluate practitioner performance through peer review.
4. **Composition:**
    a. The voting members will be appointed by the Medical Staff President based on the recommendations from the department chairs and the POCMEA Chair and approved by the MEC. Voting members will be appointed for a two-year term with the opportunity for renewal.
    b. The committee consists of 21 multidisciplinary members which represent the following disciplines: Interventional Cardiology physicians, Non-Interventional Cardiology physicians, Electrophysiology physicians, Cardiac Catheterization Lab administration and nursing, Cardiology Unit nursing, Mechanical Support Team, Cardiac Fellows, Anesthesiology, Nurse Practitioners, Pharmacy, and Quality.
    c. Other specialists may be asked to attend ad hoc at the request of the Committee Chair, Department Chair, or CMO.
    d. The CMO, the director of Quality Management and the Quality support staff as determined by the Chair are ex-officio members, without vote.
    e. 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.
5. **Responsibilities:**
    a. Evaluate practitioner performance and compliance with the Medical Staff Quality and Peer Review Indicators within its patient care scope via case review and determine if improvement opportunities exist utilizing Medical Executive Committee approved rating system.
        i. Standard of Care Met with Communication Concerns

ii. Standard of Care Met with Documentation Concerns
iii. Standard of Care Met with Opportunity for Improvement
iv. Standard of Care Met with Trending
v. Standard of Care Met - Appropriate
vi. Standard of Care Met - Exemplary
vii. Standard of Care Not Met - Minor Variance
viii. Standard of Care Not Met - Major Variance

b. Communicate case review ratings to individual practitioners and allow opportunity for reconsideration in accordance with the Medical Staff Peer Review Case Rating Reconsideration Policy. Copies of all correspondences sent to individual providers will be electronically shared with the applicable Department Chair in order to facilitate the Ongoing Professional Practice Evaluation (OPPE) process and the Credentials Committee at the time of reappointment.

6. Structure & Reporting:

a. The POCMEA committee will meet monthly to review all PCI cases falling into the following categories: Mortality, Stroke, Emergent or Salvage CABG, Emergent or Salvage Repeat Target Vessel Revascularization and reserve the right to add or delete categories as deemed necessary by the voting members of the committee. If none of the reviewable events have been identified within a reviewable time period prior to the meeting, the meeting will be canceled. If a majority of physician members are not available for the scheduled meeting date, the meeting will be rescheduled. For purposes of making final determinations for individual case reviews a quorum will require the presence of 50% of the voting members at a regularly scheduled meeting. A majority will consist of a majority of voting members present. The Chair of the POCMEA committee will report to the Medical Staff Professional Practice Committee (MSPPC) at least 4 times per year. No changes can be made to the POCMEA charter and policies without approval of the MSPPC and MEC.

b. The minutes of the POCMEA committee are confidential and distributed to the MSPPC, MEC, and Risk Management for the purposes of identifying potentially compensable events, Quality/Safety risks and to Identify opportunities for improvement**.**

P. TRAUMA PERFORMANCE IMPROVEMENT COMMITTEE

1. **Focus:** To improve quality of patient care and safety by identifying opportunities for improvement through peer review activities for the adult and pediatric trauma patient population at Ascension St. John Hospital.
2. **Chair:** The Chair of the Trauma Performance Improvement Committee (TPIC) will be the Trauma Medical Director (TMD). To be eligible for appointment as Chair, the individual must be a fellowship trained board-certified surgical intensivist who serves under contract through Ascension St. John Hospital. The Chair will serve for a term commensurate with hospital contract and may have an unlimited number of consecutive terms, provided the chair remains in good standing and remains a member of Trauma/Surgical Critical Care Division in the Department of Surgery. The TPIC Chair may also have a Vice Chair to assist with Chair responsibilities, if needed.
3. **Purpose:** To provide a multi-specialty approach for the senior trauma attending staff and departmental liaisons to evaluate practitioner performance through peer review**.**

4. **Composition:**
    a. The voting members will be appointed by the Trauma Medical Director and approved by the Medical Executive Committee; trauma senior attending staff surgeons/APP taking trauma call and departmental liaisons from, Anesthesia, Surgical Critical Care Services, Emergency Department, Neurosurgery, Orthopedics, and Pediatric Surgery. It is required that all members have access to and regularly check an Ascension email account.
    b. Other specialists may be asked to attend ad hoc at the request of the Trauma Medical Director.
    c. Ex-officio members without voting privileges include Trauma Program Manager, Adult Trauma Coordinator, Pediatric Trauma Coordinator, PI Coordinator, Administrative Assistant and designee from quality management.
    d. Voting members may serve terms commensurate with participation as senior staff on the Surgical Critical Care Services or the duration of appointment as trauma liaisons from multi-specialty services.
5. **Responsibilities:**
    a. Evaluate practitioner performance and compliance with the Medical Staff Quality and Peer Review Indicators within its patient care scope via and determine if improvement opportunities exist utilizing Medical Executive Committee approved rating system:
        i. Standard of Care Met with Communication Concerns
        ii. Standard of Care Met with Documentation Concerns
        iii. Standard of Care Met with Opportunity for Improvement
        iv. Standard of Care Met with Trending
        v. Standard of Care Met-Appropriate
        vi. Standard of Care Met-Exemplary
        vii. Standard of Care Not Met-Minor Variance
        viii. Standard of Care Not Met-Major Variance
    b. All mortalities will also be classified using the American College of Surgeons definitions listed below:
        i. Mortality without opportunity for improvement
        ii. Mortality with opportunity for improvement
        iii. Unanticipated mortality with opportunity for improvement
    c. Communicate case reviews to individual practitioners and allow opportunity for reconsideration in accordance with the Medical Staff Peer Review Case Rating Reconsideration Policy. Final case review/loop closure will be sent to individual providers, documented in Trauma Performance Improvement Committee minutes and presented at the MSPPC where the Departmental Chairs may utilize Trauma Performance Improvement Committee minutes to facilitate the Ongoing Professional Practice Evaluation (OPPE) process and the Credentials Committee at the time of reappointment.
6. **Structure & Reporting:**
    a. The TPIC will meet 12 times per year in accordance with the American College of Surgeons (ACS) verification guidelines. All members will be required to achieve 50% attendance of regularly scheduled meetings for purposes of making final determinations for individual case reviews. A quorum will require the presence of 50% of the voting members at a regularly scheduled meeting. A majority will consist of a majority of voting members present.

b. The Chair of TPIC will report to the Medical Staff Professional Practice Committee (MSPPC) at least 4 times per year. No changes can be made to the TPIC charter and policies without approval of the MSPPC and MEC.
c. The minutes from the TPIC are confidential and distributed to the MSPPC, MEC, and Risk Management for the purposes of identifying potentially litigious events, Quality/Safety risks and to identify opportunities improvements.

Q. UTILIZATION REVIEW COMMITTEE

1. **Focus**: To ensure and support effective utilization of healthcare resources.
2. **Committee Chair**: The Chief Medical Officer (CMO) and Chief Financial Officer (CFO) will appoint the Chair of the UR Committee. The Chair will be a physician knowledgeable in quality assurance and utilization review
3. **Purpose**: To develop, promote and maintain those aspects of high-quality patient care that are related to effective utilization of the Hospital's facilities and services on a level consistent with local, state and national standards.
4. **Composition**: The Committee shall be composed of two or more physicians. The non-physician Committee members include representatives from Care Management, Nursing, Quality Improvement and ad hoc members as deemed by the Committee.
5. **Responsibilities:** Include, but are not limited to the following:
    a. Review of diagnosis related groupers (DRGs), length of stay (LOS) and readmission data.
    b. Review of Physician Advisor activity
    c. Monitor Utilization Management activities and make recommendations, as necessary.
    d. Share information regarding Utilization Management activities with other Medical Staff committees, as necessary.
    e. Review results from external monitoring agencies, i.e.; audit results, and recommend changes to continuously improve our internal program.
    f. Review medical necessity of professional services including imaging, drugs and procedures.
    g. Establish mechanisms to monitor implementation of correct action and to determine its effectiveness.
    h. No member of the Committee or anyone involved in Utilization Management activities can review a case in which he/she is professionally involved as the provider of service. This includes consultations. No physician or non-physician member of the Committee shall review the Hospital services for which he/she has a direct financial interest.
6. **Structure & Reporting:** The Committee shall meet at least biannually, and the minutes will be sent to the MEC.

TEACHING PATIENTS

All patients shall be teaching cases with the exception of those patients who object, or whose practitioner objects to them being used for this purpose. In the event of such objection, the attending practitioner shall so indicate by placing an order in the patient's medical record. When residents are assigned to care for patients, their care is supervised by the attending practitioner or consulting practitioner on whose service they are assigned. The method of supervision is determined by the respective department. In all cases the supervising practitioner should be notified for all new admissions and for all significant

changes in the patient's condition. Either resident staff or supervisory staff may write orders on these patients.

GRADUATE MEDICAL EDUCATION

The Medical Staff Members at the Hospital will provide supervision for residents and medical students according to their level of education, ability, and experience as structured in each department's Education Manual and in each rotation's goals and objectives. For residents, the supervision provided by the Medical Staff will comply with the Accreditation Council for Graduate Medical Education's requirements on progressive patient responsibility and the Council on Podiatric Medical Education requirements for approval of residencies and podiatry medicine and surgery, as found in each department's Education Manual and in each rotation's goals and objectives.

DUES

All categories of the Medical Staff may be subjected to a medical staff dues assessment on an annual basis. The amount shall be proposed by the Medical Staff Funds Committee and would require approval by the MEC. Dues will be paid to **The Medical Staff of St. John Hospital & Medical Center Corporation.**

1. Dues shall become payable in January of each year by electronic notification and shall be deemed delinquent after June 30th . Notices shall be sent out at intervals on behalf of the Secretary-Treasurer of the Medical Staff.
    - A $100.00 late fee shall be assessed to delinquent dues not paid by July 1st.
2. A final electronic notification will be sent to the practitioner, indicating that failure to pay dues by October 31st shall be considered a "voluntary resignation" from the Medical Staff.
3. In cases of hardship, the Medical Staff President may waive or reduce dues upon written request by the practitioner. If a practitioner takes a leave of absence, the Medical Staff President may waive or reduce the dues for the term of the leave of absence, upon written request by the practitioner.
4. All newly appointed Non-Physician Practitioners will be assessed a one-time fee of $150.00 to compensate for required Focused Professional Practice Evaluation activities.
5. 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 Credentials Committee. The non-disclosure fee will be collected as part of the Medical Staff Funds.

DEPARTMENT/SECTION RULES & REGULATIONS

The various Medical Staff Department/Sections shall establish individual Rules & Regulations as are necessary for the proper functioning of the Department/Section. These Department/Section Rules & Regulations (amendments and/or repeals thereto) will be submitted to the MEC every three (3) years for review and recommendation and then further submitted to the BOT for approval. It is incumbent upon each practitioner treating patients within the individual Department/Section to be acquainted with these Department/Section Rules & Regulations.

INCONSISTENCIES BETWEEN MEDICAL STAFF RULES & REGULATIONS AND DEPARTMENT/SECTION RULES & REGULATIONS

In the event an inconsistency exists between Ascension St. John Hospital Medical Staff Rules & Regulations and the Department or Section Rules & Regulations, the Ascension St. John Hospital Medical Staff Rules & Regulations will govern.

AMENDMENT OF THE RULES & REGULATIONS

The Medical Staff shall develop, amend, and revise its own Rules & Regulations. Amendments, additions, and repeals of the Rules & Regulations may be proposed by the MEC or by any active member of the Medical Staff.

Any request for amendment, addition, or repeal of the Rules & Regulations will be submitted to the CMO, who will in turn submit the request to the Medical Staff President. The Medical Staff President will appoint a Special (ad hoc) Committee/Chair for recommendation(s). The Rules & Regulations recommendation(s) will be presented to the MEC for approval. After approval by the MEC, the Rules & Regulations recommendation(s) will go to the BOT for final approval.

ADOPTION OF THE RULES & REGULATIONS

The Ascension St. John Hospital Medical Staff Rules & Regulations shall be adopted when reviewed and supported by the MEC and approved by the BOT. The Medical Staff Rules & Regulations shall be reviewed at least every three years. Neither the Medical Staff nor the BOT may unilaterally amend the Medical Staff Rules & Regulations or policies of the Medical Staff.

CONFIDENTIALITY, IMMUNITY, AND RELEASES

1. Definitions: For the purposes of these Rules & Regulations, the following definitions shall apply:

    a. The term "information" means documentation of proceedings, minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures, whether in written or oral form.

    b. The term "malice" means the dissemination of a falsehood: (i) with knowledge it was false, or (ii) with a reckless disregard for whether it was true or false.

    c. The term "representative" means the Board, and any trustee, director, member or committee thereof; Medical Staff President, medical staff 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.

    d. The term "other parties" means any entity other than a representative of the Hospital and the Medical Staff providing information to a representative of the Hospital or the Medical Staff and includes both individuals and organizations.

2. By applying for or exercising clinical privileges or providing specified patient care services within the Hospital, a Medical Staff Member:

a. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing on his or her professional ability and qualifications;

b. Agrees to be bound by the provisions of these Rules & Regulations and to waive all legal claims against any representative who acts in accordance with the provisions of this section of these Rules & Regulations; and

3. No representative of the Hospital or the Medical Staff shall be liable to a Medical Staff Member for damages or other relief for any action taken or statement or recommendation made within the scope of his or her duties as a representative, if he or she acts in good faith and without malice.

4. No representative of the Hospital or Medical Staff and no other party shall be liable to a Medical Staff Member for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning a Medical Staff Member who is or has been an applicant to or Member of the Medical Staff or did or does exercise clinical privileges or provides specified services at the Hospital, provided that such representative or other party acts in good faith and without malice.

5. The confidentially and immunity provided by this section of these Rules & Regulations shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's or any other health care facility or organization's activities including, but not limited to: patient care audits; medical care evaluations; utilization reviews; independent "outside" peer review evaluations; and other hospital, department or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct. These are confidential professional/peer review and quality assurance documents of the Hospital and protected from disclosure pursuant to the provisions of state and federal laws.

6. The information referred to in this section of these Rules & Regulations may relate to a Medical Staff Member's professional qualification, clinical ability, judgment, character, professional ethics, health status, or any other matter that might directly or indirectly affect patient care.

7. Each Medical Staff Member shall, upon request of the Hospital, execute general and specific releases in accordance with the tenor and import of this section of these Rules & Regulations in favor of the individuals and organizations specified in the confidentially and immunity provided by this section of these Rules & Regulations. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this section.

8. Provisions in these Rules & Regulations and in application forms relating to consents, authorizations, releases, rights, privileges, confidentiality of information and immunities from liability shall be in addition to the protection provided in this confidentially and immunity section provided by these Rules & Regulations and by law and not in limitation thereof.

AMENDMENT DATES

04/l8/2001 Quality
04/23/2002 Orders/Duty Assignments
09/16/2002 Medical Records
04/16/2003 Medical Records/Medical Staff
10/27/2004 Quality Committee of the Board of Trustees
10/05/2009 SJH&MC Board of Trustees (upon merger of the SJNSH and the SJH&MC medical staffs)
11/24/2009 SJH&MC Board of Trustees (Dues and Medical Clearance language)
03/24/2012 East Region Quality Committee Board of Trustees (Committee Language)
04/24/2012 East Region Quality Committee Board of Trustees (Cancer Committee)
04/22/2013 East Region Quality Committee of the Board of Trustees (Triennial Review & Revise)
02/25/2014 East Region Quality Committee of the Board of Trustees (Emergency Services General Rules)
04/22/2014 East Region Quality Committee of the Board of Trustees (Admission – see patient no later than 24 hours)
10/28/2014 East Region Quality Committee of the Board of Trustees (Confidentiality, Immunity and Releases)
01/27/2015 East Region Quality Committee of the Board of Trustees (NPP, Orders-IP&C for Isolation)
03/23/2016 Joint Conference Committee of the Board of Trustees (Board Governance, event reporting, Nominating Committee, new Medical Staff fund name)
04/27/2016 Joint Conference Committee of the Board of Trustees (OR/High Risk Procedure Note)
07/26/2016 Joint Conference Committee of the Board of Trustees (Medical Staff Awards Committee)
11/23/2016 Joint Conference Committee of the Board of Trustees (H&Ps, Operative Note/High Risk Procedure Note)
02/22/2017 Joint Conference Committee (JCC)of the Board of Trustees (BOT) (Orders and Medications)
02/28/2018 JCC of the BOT (Medical Staff Awards Committee, Nominated by:)
04/11/2018 Medical Executive Committee (adding "senior" department member who will sit on the Medical Staff Awards Committee)
05/23/2018 JCC of the BOT (adding "senior" department member under Medical Staff Awards Committee and admit orders within 6 hours)
06/27/2018 Executive Committee of the BOT (remove Family History from the H&P shall minimally include)
09/01/2018 Amended (Naming Convention Change to Ascension St. John Hospital; previously considered by the JCC on 03/23/2018)
11/20/2018 Executive Committee of the BOT (added "pertinent" and "which is clinically appropriate, and symptom directed" to physical exam, regarding H&P)
11/28/2018 JCC of BOT ratified adding added "pertinent" and "which is clinically appropriate, and symptom directed" to physical exam, regarding H&P
01/31/2019 Medical Executive Committee Vote (added clarification of NPP progress note co-signature and P&T frequency of meeting)
02/13/2019 Medical Executive Committee (Clarified Nominating Committee Focus)
09/11/2019 Medical Executive Committee (Clarified "President", updated Informed Consent Language, amend MS Awards Committee presentations)
02/11/2020 Medical Executive Committee (One-time assessment of $150.00 fee for Newly Appointed NPPs, effective June 1, 2020)
03/11/2020 Medical Executive Committee (Delete the Minimally Invasive Surgery Committee)
06/24/2020 JCC of BOT (Added APPC, MCPPC, MSPPC, Medical Staff Conduct Committee and Medical Staff Peer Review Case Rating Consideration)
05/12/2021 Medical Executive Committee (refer to Medical Staff Bylaws for H&P process and components, TPIC); Approved by JCC on 05/26/2021.
12/29/2021 PEER REVIEW CASE RATING CONSIDERATION - "involved practitioner" and encrypted email notification. Approved by JCC.
10/12/2022 Medical Executive Committee (Added Surgical Admission), MI Market Board of Trustees (BOT) 11/01/2022
09/01/2023 Board of Trustees (Changed language under "DUES" (dates, amount of late fee, and written to electronic).
08/01/2024 Board of Trustees (Added $100 non-disclosure fee, Medical Staff Professional Practice Committee Charter, Phase of Care Major Event Analysis (POCMEA) Committee Chair and removed Medical Staff Conduct Committee).