



# PROFESSIONAL STAFF BYLAWS

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**HURLEY MEDICAL CENTER**  
**PROFESSIONAL STAFF BYLAWS**

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## DEFINITIONS

**Allied Health Practitioner (AHP):** Physician Assistants, Nurse Practitioners, Certified Registered Nurse Anesthetists, Clinical Nurse Specialists, and Certified Nurse Midwives who participate in the management of patients under the supervision, direction or back-up of a Physician

**Board:** The Hurley Medical Center Board of Hospital Managers

**Collaborating Physician:** Any Physician that has agreed, through the process of signing a written agreement, to oversee the work of one or more Allied Health Practitioners.

**Dentist:** A duly licensed doctor of dental surgery

**Hurley Medical Center (Hurley):** A municipal hospital established through the City of Flint Charter, under the supervision and exclusive management of the Board of Hospital Managers

**Medical Center:** All locations licensed and accredited under Hurley Medical Center, including but not limited to the hospital, offices and clinics

**Medical Staff:** Dentists, Physicians, Podiatrists, and Psychologists who by license, training and privileges granted by Hurley Medical Center are able to practice independently and not under the supervision, direction or back-up of another licensed professional

**Moonlighters:** Practitioners enrolled in a graduate medical education program and engaged to provide medical services outside of the graduate medical education program.

**Physician:** A doctor of medicine or osteopathy

**Other Credentialed Staff:** Anyone other than Medical Staff, Allied Health Practitioners, and Moonlighters who require credentialing and/or privileging under these Bylaws

**Practitioner:** Any individual credentialed and granted privileges under these Bylaws

**Podiatrist:** A duly licensed doctor of podiatric medicine and surgery

**Professional Staff:** The governing organization of Members who are credentialed through Hurley Medical Center and appointed by the Board to perform the functions specified in Article II and elsewhere in these Bylaws.

**Psychologist:** A duly licensed doctoral-level psychologist (PsyD or PhD)

**ARTICLE I – NAME**

The name of this organization shall be the Professional Staff of Hurley Medical Center.

## **ARTICLE II – PURPOSE AND FUNCTIONS**

2.1. **PURPOSE.** The purpose of the Professional Staff shall be to govern, plan, conduct and coordinate the activities of Practitioners in order to carry out, in conformity with these Bylaws, the functions delegated to the Professional Staff by the Board.

2.2. **FUNCTIONS.** The functions of the Professional Staff shall be as follows:

- 2.2.1. To effectively review the professional practices of all Practitioners granted privileges at Hurley for the purpose of reducing morbidity and mortality and improving the care provided at all Hurley Medical Center locations. The review shall include the quality and necessity of the care provided and the preventability of complications and deaths. MCL 333.21513.
- 2.2.2. To determine the mechanism for establishing and enforcing criteria and standards for Professional Staff membership.
- 2.2.3. To assure the appropriate initial credentialing, delineation of clinical privileges, and ongoing evaluation, assessment and reappointment of all Practitioners through valid and reliable measurement systems based on objective and evidence-based criteria and make recommendations to the Board regarding same.
- 2.2.4. To provide a mechanism for oversight and accountability to the Board utilizing defined Professional Staff parameters for the quality and appropriateness of patient care, treatment and services, including but not limited to all professional and ethical conduct, teaching and research activities.
- 2.2.5. To direct Professional Staff organization activities, including Officer and Committee nominations, liaison with the Board, review and maintenance of licensure and accreditation activities, and the determination of rights and responsibilities of Professional Staff members, including but not limited to voting rights.
- 2.2.6. To lead or actively participate in the Hurley programs designed to improve the efficient and effective delivery of care, including but not limited to the quality, safety, utilization, infection control, drug usage, blood usage morbidity and mortality review, and the review of unexpected occurrences and outcomes.
- 2.2.7. To facilitate compliance with Michigan state law, The Joint Commission standards, and the Medicare Conditions of Participation and other applicable laws, regulations, rules and guidelines related to all matters, including but not limited to the supervision of Allied Health Practitioners.
- 2.2.8. To initiate and maintain the Professional Staff Bylaws in accordance with applicable laws, the Medicare Conditions of Participation, The Joint Commission standards, and enforce compliance with these Bylaws and Professional Staff policies and procedures.
- 2.2.9. To participate, upon request, in the Board's planning activities related to community health needs, Hurley policies, and the implications of external forces impacting healthcare.
- 2.2.10. To support education and maintenance of high educational standards through participation in the education and training of other professionals.

- 2.2.11. To carry out all phases of peer review, both alone and in conjunction with Hurley administrative personnel, in
  - 2.2.11.1. evaluating and making recommendations on the credentials and clinical privileges of all Practitioners seeking or holding such privileges at the Medical Center
  - 2.2.11.2. reviewing the quality of care provided to all patients setting standards for and reviewing the efficient and effective use of Hurley resources
  - 2.2.11.3. reducing the risk of medical liability by identifying adverse patient occurrences and other incidents or outcomes where corrective actions could eliminate or reduce the likelihood of recurrence
  - 2.2.11.4. investigating complaints and making recommendations to prevent recurrence
  - 2.2.11.5. generating objective performance improvement data that will be used in evaluating Practitioner performance
- 2.2.12. To promote an atmosphere conducive to healing, teaching, learning and research

**ARTICLE III – QUALIFICATIONS, RESPONSIBILITIES, TERM AND CATEGORIES**

- 3.1. Both Allied Health Practitioners and Medical Staff shall be eligible for membership on the Professional Staff of Hurley Medical Center, as further defined below. Moonlighters and Other Credentialed Staff shall not be granted membership in the Professional Staff of Hurley Medical Center and shall not be granted the same rights or given the same responsibilities as those who are granted membership in the Professional Staff. All Practitioners shall be considered part of the Hurley Medical Center Organized Health Care Arrangement (OHCA) as defined by the Health Insurance Portability and Accountability Act and approved by the Board.
- 3.2. Professional Staff Membership is a privilege, which shall be extended only to competent Allied Health Practitioners and Medical Staff who continuously meet the qualifications, standards and requirements as stated herein. Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of membership or clinical privileges.
- 3.3. Each Practitioner receiving privileges under these Bylaws shall be subject to these Bylaws, as well as subject to an initial and ongoing review of his or her professional and clinical competence. No Practitioner shall be entitled to membership or privileges merely by virtue of the fact that he or she 1) is duly licensed in the State of Michigan, 2) is an employee or contractor of Hurley Medical Center or any organization affiliated with Hurley Medical Center, 3) is a member of any professional organization, 4) holds certification by any professional Society or Board, or 5) had in the past, or presently has, such privileges at another hospital. Any Practitioner appointed to an administrative position in the institution is subject to the same expectations as all other applicants for membership and/or privileges.
- 3.4. The Professional Staff shall be responsible for the functions specified above, but shall not be responsible for ensuring compliance with any separate employment or contractual provisions between the individual Practitioner and Hurley Medical Center or organization affiliated with Hurley Medical Center. In the event of a conflict between these Bylaws (including all Professional Staff Policies, Procedures, Rules and Regulations) and the employment policies of Hurley Medical Center, these Bylaws shall prevail on matters of professional conduct, quality, competence and clinical privileges, and Hurley Medical Center employment policies shall prevail on all matters unrelated to professional conduct, quality, competence and clinical privileges.
- 3.5. Any Practitioner engaged by the Medical Center or organization affiliated with the Medical Center to provide patient care services pursuant to a contract shall only be allowed those clinical privileges granted in accordance with these Bylaws and other Professional Staff Policies, Procedures, Rules and Regulations.

### 3.6.QUALIFICATIONS FOR MEMBERSHIP

3.6.1. All Practitioners requesting Professional Staff Membership or clinical privileges shall be required to provide evidence of the following:

- 3.6.1.1. Licensure: Hold a current and valid Michigan professional and pharmacy license, if appropriate to the profession.
- 3.6.1.2. Except for Moonlighters and Other Credentialed Staff, provide evidence of board certification or board eligibility in accordance with the HMC Professional Staff Board Certification and Recertification policy.
- 3.6.1.3. Maintain professional liability insurance with liability limits no less than those established in the HMC Professional Staff Professional Liability Insurance policy.
- 3.6.1.4. Health Status: Be without a physical or mental condition, including alcohol or drug dependence, which would affect the Practitioner's ability to exercise the clinical privileges requested – unless an accommodation is requested and granted.
- 3.6.1.5. Timely and Accurate Completion of Medical Records: Complete all medical records in accordance with applicable policies and procedures.
- 3.6.1.6. Geographic Proximity: Demonstrate that he/she is located closely enough to the Medical Center to provide continuous care to patients and respond promptly to emergencies.
- 3.6.1.7. DEA: All new applicants and current Professional Staff members, must have/maintain a Federal DEA Certificate. This shall not apply to non-Forensic Pathologists, non-Interventional Radiologists, Psychologists, designated Other Credentialed Staff, and others if specified in a written department policy and approved by the Medical Executive Committee.
- 3.6.1.8. Background and Experience: Applicants must be able to document their background and experience and provide evidence, as may be modified from time to time by the Professional Staff, of current competence, adherence to the ethics of their profession, and their ability to work with others with sufficient adequacy to assure the Professional Staff and the Board .that any patient treated by them in the Medical Center will be given safe, efficient and high-quality of care.
- 3.6.1.9. Practice Agreement: Allied Health Practitioners required under Michigan state law to have a Collaborating Physician, and other Practitioners as specified by the HMC Professional Staff policy – Allied Health and Medical Staff Collaboration - must also provide evidence of a current, valid Practice Agreement, signed by one or more individual Physician member of the Professional Staff, in accordance with Professional Staff policy. It is the responsibility of the Practitioner needing the Practice Agreement to initiate and maintain the relationship with the Collaborating Physicians. An employment contract does not entitle any Practitioner to a Collaborating Physician or Practice Agreement.
- 3.6.1.10. Ongoing Monitoring: Each Practitioner agrees to be subject to the ongoing monitoring, including but not limited to OPPE and FPPE in accordance with established Professional Staff policy, of all Practitioners,



as established by the Medical Executive Committee and Board, and applied consistently in accordance with these Bylaws to all Practitioners.

- 3.6.1.11. Coverage: Medical Staff members of the Professional Staff must make appropriate arrangements for coverage of their patients in order to ensure continuous and ongoing availability for patient care needs.

3.7. RESPONSIBILITIES: All members of the Professional Staff, Moonlighters and Other Credentialed Staff agree/pledge to:

- 3.7.1. Provide continuous care to his or her patients in the Medical Center, within the generally recognized professional standards of quality, safety, efficiency and appropriateness.
- 3.7.2. Abide by the Bylaws, Policies and Procedures, and Rules and Regulations imposed by the Professional Staff or Board, as well as Hurley Medical Center Standard Practices/Policies and Procedures, Rules and Regulations, as applicable.
- 3.7.3. Carry out responsibilities, for which he or she is appointed or elected, to his or her department, committee or Hurley Medical Center.
- 3.7.4. Abide by the ethical principles of his or her profession.
- 3.7.5. Complete his or her medical records in a timely manner, as specified in the HMC Professional Staff Policy – Record Completion - for all patients cared for within the Medical Center, including but not limited to
  - 3.7.5.1. A medical history and physical examination be 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. The medical history and physical examination must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with Michigan law and HMC policy.
  - 3.7.5.2. An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with Michigan law and HMC policy.
- 3.7.6. Participate in Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) as part of the process of being granted and maintaining privileges.
- 3.7.7. Dues and assessments: Dues, assessments, application and reappointment fees in amounts and for purposes to be determined by the Professional Staff.
- 3.7.8. No Discrimination: Each Practitioner pledges that he or she will not discriminate on the basis of age, sex, race, political affiliation, disability as defined by the Americans With Disabilities Act, ethnic background, national origin, color or sexual orientation against other Practitioners , employees, contractors, volunteers

or any other individual working in, visiting, or receiving care at Hurley Medical Center.

- 3.7.9. Confidentiality of Information: Each Practitioner agrees to maintain as confidential all information and documents related to patients' condition or treatment, peer review, performance improvement and evaluation, risk management, utilization review, and other information related to the evaluation of the provision of healthcare and the business operations of the Medical Center. Failure to maintain the confidentiality of confidential information shall be grounds for immediate suspension and/or termination of membership and clinical privileges.

3.8. TERM OF MEMBERSHIP APPOINTMENT: All appointments/reappointments to the Professional Staff and/or granting of privileges to Moonlighters and Other Credentialed Staff shall be made by the Board and shall be for a term not to exceed twenty-four (24) months. For reappointments, the term commences on the first (1<sup>st</sup>) day of January and ends on the thirty-first (31<sup>st</sup>) day of December. Appointments in the Departments of Anesthesia, Emergency Medicine, Obstetrics & Gynecology, Pathology, Radiology, Radiation Oncology and Surgery will commence on the first (1<sup>st</sup>) day of January of odd numbered years and end on the thirty-first (31<sup>st</sup>) day of December of even-numbered years; appointments in the Departments of Medicine, Pediatrics, Psychiatry, and Psychology will commence on the first (1<sup>st</sup>) day of January of even numbered years and end on the thirty-first (31<sup>st</sup>) day of December of odd-numbered years.

- 3.8.1. Appointment, granting of clinical privileges and reappointment shall be in accordance with the procedure for appointment/reappointment, as specified in Article IV of these Bylaws.

### 3.9. CATEGORIES OF PRACTITIONERS.

#### 3.9.1. Provisional – Professional Staff Member

- 3.9.1.1. Upon initial appointment to the Professional Staff, all Practitioners will be placed into the Provisional Category. New Practitioners will only be advanced to any other staff category status following a recommendation by the Professional Staff Credentials Committee when the focused professional practice evaluation (FPPE) criteria has been met, as further described in the Professional Staff FPPE/OPPE Policy.
- 3.9.1.2. Practitioners in the Provisional Category shall be assigned to a clinical department, and shall be subject to the Bylaws, Rules and Regulations of the Professional Staff, and his or her department. Practitioners in the Provisional Category shall not be eligible to vote or hold office, but may be appointed to committees with vote.

#### 3.9.2. Medical Staff Active With Vote (“MSAV”) – Professional Staff Member

- 3.9.2.1. The MSAV shall be those Medical Staff Members who regularly evaluate, treat, admit or refer to the Medical Center patients for admission, observation, ambulatory surgery or other intervention

- or diagnostic test (“Patient Contact”), have shown an active interest in the Medical Center and contributed to its progress.
- 3.9.2.2. For a Medical Staff Member to advance, change and/or maintain MSAV or MSWV status, he/she must demonstrate the following Patient Contacts:
- 3.9.2.2.1. Departments of Medicine, Surgery, and Obstetrics/Gynecology: must have demonstrated the following: twelve (12) inpatient consults, inpatient admissions, or inpatient/outpatient surgeries in the immediate twelve (12) month period.
  - 3.9.2.2.2. Department of Pediatrics: must have demonstrated a minimum of eight (8) Patient Contacts in the immediate twelve (12) month period.
  - 3.9.2.2.3. Department of Emergency Medicine: must have worked twelve (12) shifts in the immediate twelve (12) month period.
  - 3.9.2.2.4. All other Departments not specified above: must have a minimum of twelve (12) Patient Contacts per year.
  - 3.9.2.2.5. Individuals who are dual members of Departments (Medicine/Pediatrics) must have demonstrated activity of twelve (12) Patient Contacts, in the immediate twelve (12) month period.
- 3.9.2.3. Members who do not meet the patient contact requirement will have their status changed to the Courtesy Staff category.
- 3.9.2.4. In addition to the patient contacts noted above, it is expected that practitioners in the MSAV category will have, in the previous two (2) years, demonstrated professional behavior, good citizenship and stewardship at the Medical Center (participation in committee meetings, special projects of the Professional Staff and Medical Center, attendance at departmental and medical staff meetings, timely medical record completion, etc.), attended fifty percent (50%) of the regular general medical staff meetings, fifty percent (50%) of the departmental business meetings of the department(s) to which they are assigned and otherwise continue to meet qualifications for membership. Meeting attendance will be checked each July, reviewing attendance for the past twenty-four (24) months. Practitioners not meeting the attendance requirement shall automatically have his or her status changed to the MSWV category. Patient contacts will be checked at reappointment every two (2) years, counting patient contacts for the preceding twelve (12) month time period. Practitioners not meeting the patient contact requirement at the time of reappointment shall automatically have his or her status changed to the Courtesy Staff category. After six (6) months, the Practitioner may have his or status re-reviewed to determine if attendance and other requirements specified above have been sufficiently demonstrated to warrant Practitioner’s advancement back into the MSAV or MSWV category. It

- shall be the responsibility of the Practitioner to request the review and advancement.
- 3.9.2.5. Members of the MSAV shall be appointed to one or more departments, may hold office in accordance with Article VI of these Bylaws, and shall participate in other activities of the medical center.
  - 3.9.2.6. Unless otherwise specified in these Bylaws, or a written exception is granted by the Medical Executive Committee, MSAV status shall be required to become a member voting member of a Professional Staff Committee. MSAV Members should be accessible to the medical center within sixty (60) minutes when on call or with patients-care responsibilities.
  - 3.9.2.7. Chief of Staff, Vice Chief, Secretary, Members at Large, Department Chairs, and Professional Staff Standing Committee Chairs must be current MSAV Members.
- 3.9.3. Medical Staff Active Without Vote (“MSWV”) – Professional Staff Member
- 3.9.3.1. The MSWV shall consist of those Medical Staff members, eligible as herein provided, who wish to admit patients to the Medical Center, but who are not actively involved in Professional Staff affairs and are not major contributors to the fulfillment of Professional Staff functions due to practicing primarily at another hospital or in an office-based specialty, or do not meet criteria to become an MSAV Member, but who wish to remain affiliated with the Medical Center for consultation, call coverage, referral of patients, or other patient care purposes. The MSWV Member must meet the Patient Contact requirements specified in 3.9.2.2. The MSWV Member shall not be eligible to vote on general medical staff matters or hold office, but may serve on committees and may attend Professional Staff and department meetings.
  - 3.9.3.2. Practitioners demoted from MSAV to MSWV must wait six (6) months before requesting a reconsideration. Other requests for a change from MSWV to MSAV may be requested at any time but may only be granted subsequent to review of admission/consultation volume criteria, committee/meeting participation, and other criteria established by the Professional Staff.
- 3.9.4. Allied Health Practitioner – Professional Staff Member
- 3.9.4.1. Practitioners in the Allied Health category may care for patients and exercise clinical privileges in accordance with their license and scope of practice set forth by the State of Michigan and other parameters set forth by the Professional Staff in these Bylaws and other Professional Staff policies.
  - 3.9.4.2. Allied Health Practitioners may only practice when acting under a Collaborating Physician, with a written Practice Agreement, established in accordance with the Professional Staff Policy on Allied Health and Medical Staff Collaboration. Failure to maintain an active, current Practice Agreement will result in the Allied Health Practitioner’s automatic suspension of privileges and, if not rectified within sixty (60)

days, termination of membership and privileges, as specified in Section 4.8.6.

- 3.9.4.3. Allied Health Practitioners may only request and be considered for privileges that are consistent with those granted to the Allied Health Practitioner's Collaborating Physician. Allied Health Practitioners shall be eligible to vote on matters presented to the committees to which they are assigned, but unless otherwise specified, are not eligible for voting at their department and general staff meetings other than election of the Medical Executive Committee Allied Health Member at Large. Members of Professional Staff in the Allied Health Practitioner category shall not be eligible for nomination or election as Chief of Staff, Vice Chief of Staff, Secretary, Departmental Chair or Vice Chair.
  - 3.9.4.4. Allied Health Practitioners shall be eligible for nomination and election to an Allied Health Member at Large position. The Allied Health Member At Large position shall have a vote on the MEC.
  - 3.9.4.5. Unless granted a written exception in a department policy and approved by the Medical Executive Committee, Allied Health Practitioners shall not be privileged to admit patients under their name and must provide patient care under the direction of a Physician member of the Professional Staff.
  - 3.9.4.6. The extent to which Allied Health Practitioners may write orders and progress notes will be consistent with the duties and responsibilities described in their individual privileges and Practice Agreement, as well as any limitations set forth in these Bylaws, other Professional Staff policies and procedures, or the policies and procedures of the Allied Health Practitioner's department.
- 3.9.5. Courtesy – Professional Staff Member
- 3.9.5.1. The Courtesy Staff shall consist of those Practitioners, eligible as herein provided, who do not want privileges in the Medical Center but still desire Professional Staff membership to provide continuity of care to their patients or to satisfy a criterion of membership and access to in-network hospital services that may be required for participation in managed care organization panel(s).
  - 3.9.5.2. The Courtesy Staff category is a membership-only category with no clinical privileges, limited responsibilities and prerogatives. As Professional Staff members, the Courtesy Staff may be appointed to a specific department, accept committee appointments but shall not be privileged to admit or directly care for patients in the Medical Center, perform any procedures, hold office, or vote at departmental or staff levels. They shall be allowed to visit their patients in the medical center, review their patients' medical records, consult with staff caring for their patients, but are not permitted to write or give verbal or telephone orders, progress notes, or make other notations in the medical record. Courtesy Staff members must establish appropriate referral and coverage arrangements with an MSAV or MSWV staff member for the medical care of his/her patients that require medical center services or that patient(s) shall be admitted to staff and/or hospitalist service. Members in this

category must be fully credentialed in accordance with these Bylaws and other applicable Professional Staff policies.

3.9.5.3. Since no clinical privileges are granted, Courtesy Staff shall not be subject to the requirements for focused professional practice evaluation (FPPE) or ongoing professional practice evaluation (OPPE).

3.9.5.4. Courtesy Staff shall not be eligible to serve as a Collaborating Physician for Allied Health Practitioners.

### 3.9.6. Emeritus – Professional Staff Member

3.9.6.1. Emeritus staff membership may be granted to those Practitioners who request it and who have rendered long, useful, and honorable service to the profession and to Hurley Medical Center, who have retired from active practice and who maintain an interest in Hurley Medical Center therefore qualifying for distinction.

3.9.6.2. Professional Staff Members in the Emeritus category will not have any admitting or clinical privileges, nor can they be the Collaborating Physician to an Allied Health Professional.

### 3.9.7. Moonlighting (Not a member of the Professional Staff)

3.9.7.1. The Moonlighting Category is restricted to those Practitioners enrolled in a graduate medical education program and engaged to provide medical services outside of the graduate medical education program.

3.9.7.2. Appointment to this category shall only be considered when the applicant has received a written offer of Moonlighting employment or contract from the Hospital or a physician group with a current call contract with the Hospital.

3.9.7.3. Individuals designated within this category are not considered members of the Professional Staff, shall not be afforded the rights and responsibilities of Professional Staff membership, and shall only practice within the scope of service specifically approved for them by the Board of Managers. Appointment to this category is entirely discretionary and may be rescinded at any time by the Professional Staff and Board of Managers.

3.9.7.4. Individuals within the category shall not be subject to the Hearing and Appellate Review procedures prescribed for the members of the Professional Staff.

3.9.7.5. Qualifications for Moonlighting Status. In addition to the general qualifications specified above, individuals applying for privileges in this category must provide evidence of the following:

3.9.7.5.1. Obtain prior approval from his/her residency program and provide documentation of approval to the Medical Staff Office at the time the credentialing process begins.

3.9.7.5.2. Assure ongoing residency program approval, in accordance to residency program policies; and provide requisite documentation to the Medical Staff Office prior to the approval's expiration date.

3.9.7.6. Appointment shall automatically terminate upon the earlier of

3.9.7.6.1. the termination or expiration of the contract covering the Moonlighting employment, or

- 3.9.7.6.2. the completion of or exit from the hospital's graduate medical education program.
- 3.9.7.7. Regardless of the above, any appointment in this category shall be no longer than a term of up to two (2) years. While in this category, the Moonlighting Practitioner may not be appointed to the Professional Staff under a different category of membership. However, upon the Moonlighting Practitioner's termination of appointment in this category, the previously designated Moonlighting Practitioner shall be free to apply for membership and/or privileges in any medical staff category in which he or she is qualified.
- 3.9.7.8. Moonlighting Staff may NOT
  - 3.9.7.8.1. Admit patients to the hospital
  - 3.9.7.8.2. Participate in the Department's call schedule
  - 3.9.7.8.3. Vote or hold office
- 3.9.7.9. Obligations of Moonlighting Staff:
  - 3.9.7.9.1. Support the patient care mission of Hurley Medical Center by providing treatment for patients presenting to the facility seeking medical care regardless of the patient's ability to pay for such services
  - 3.9.7.9.2. Participate in the quality/safety/utilization review activities of Hurley Medical Center
  - 3.9.7.9.3. Other requirements for Practitioners set forth in these Bylaws and other applicable Professional Staff policies
- 3.9.8. Other Credentialed Staff (Not a member of the Professional Staff)
  - 3.9.8.1. The Other Credentialed Staff Category is restricted to those Practitioners who provide care to Medical Center patients, are not employed by the Medical Center, and do not qualify for the Medical Staff, Allied Health Practitioner, , or Moonlighting Category.
  - 3.9.8.2. Individuals designated within this category are subject to the credentialing, privileging, and ongoing monitoring described in these Bylaws and other Professional Staff policies, but are not considered members of the Professional Staff, shall not be afforded the rights and responsibilities of Professional Staff membership, and shall only practice within the scope of service specifically approved for them by the Board of Managers. Appointment to this category is entirely discretionary and may be rescinded at any time by the Professional Staff and Board.
  - 3.9.8.3. Practitioners within this category shall not be subject to the Hearing and Appellate Review procedures prescribed for the members of the Professional Staff.

**ARTICLE IV – CREDENTIALING, PRIVILEGING, APPOINTMENT AND REAPPOINTMENT**

- 4.1.GENERAL: Membership is a privilege that shall be limited to professional competent Practitioners who continuously meet the qualifications, requirements and responsibilities set forth in these Bylaws. All Practitioners requesting privileges must be credentialed and privileged through the process described in these bylaws before providing care, treatment or services at any Hurley Medical Center location. In addition, all Practitioners shall be subject to ongoing review in accordance with these bylaws and other approved Professional Staff policies and procedures, and shall be subject to a formal re-evaluation and reappointment no less than every twenty-four (24) months.
- 4.1.1. Any department may establish written standards, outlining the minimum requirements that must be met by an individual, before the individual may be eligible to receive an application. The minimum requirements must be in writing, approved by the Credentials Committee, Medical Executive Committee, and Board. The minimum requirements may only consider matters of professional qualifications and competence, and shall not discriminate pursuant to 3.7.8. In the event that a department established written criteria, the Medical Staff Office shall ensure that the minimum criteria have been met before providing a full application. Individuals not meeting the minimum written requirements established by the department shall not be eligible to apply and shall have no rights under these Bylaws.
- 4.1.2. Unless a written exception has been granted by the individual or group holding the contract, no application may be given to an individual if Hurley has contracted with an individual or group on an exclusive basis to provide the clinical services sought by the prospective applicant and the prospective applicant is not associated with the individual or group that is a party to the contract. Decisions to engage an individual or group to provide certain services on an exclusive basis shall be determined by the Board following input by the Medical Executive Committee.
- 4.1.3. Restriction on Application: An individual who has received a final adverse decision concerning appointment or reappointment shall not be eligible to reapply for appointment to the Professional Staff for a period of five (5) years. An individual who received a final adverse decision concerning one or more privileges may reapply at any time the Practitioner can demonstrate that the qualifications set forth by the Professional Staff can be met. An individual who has resigned or failed to apply for reappointment while under investigation or following an adverse recommendation by the Medical Executive Committee, shall not be eligible to reapply for appointment to the Professional Staff for a period of three (3) years unless the investigation later resulted in a determination that no adverse action would have been taken. Upon reapplication, the applicant shall submit, in addition to all of the other information required, specific information showing that the condition or basis for the earlier adverse decision, recommendation or resignation no longer exists.



- 4.2. APPLICATION FOR INITIAL APPOINTMENT AND/OR PRIVILEGES. A licensed Practitioner must have and maintain the following to apply for, receive and continue membership and/or privileges:
  - 4.2.1. Applicants must
    - 4.2.1.1. Document their experience and training
    - 4.2.1.2. Demonstrate their competence
    - 4.2.1.3. Demonstrate their ability to adhere to the ethics of their profession
    - 4.2.1.4. Demonstrate their ability to work well with others
  - 4.2.2. All applications for appointment to the Professional Staff and/or privileges shall be in writing, signed by the applicant, and submitted on a form as prescribed by the Medical Executive Committee and Board.
  - 4.2.3. Licensure. As specified in 3.6.1.1.
  - 4.2.4. DEA. As specified in 3.6.1.7.
  - 4.2.5. Insurance. As specified in 3.6.1.3.
  - 4.2.6. Education and Training.
    - 4.2.6.1. Graduate from an accredited school or program
    - 4.2.6.2. Satisfactorily complete graduate training programs and possess certification and/or qualification deemed necessary by the relevant department to safely and appropriately perform the privileges being requested.
    - 4.2.6.3. All Physicians have completed (or will complete within six (6) months a residency program approved by the Accreditation Council for Post Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA)
  - 4.2.7. Board Certification or Eligibility. As specified in 3.6.1.2.
  - 4.2.8. Application. Completed application and evidence supporting elements of the application
    - 4.2.8.1. medical training and post-graduate training, including the name of each institution, degrees granted, programs completed, dates attended, dates of graduation, names and contact information of program directors
    - 4.2.8.2. copies of all current and previous professional licenses and/or certificates, DEA certificate, and Michigan Controlled Substance Certificate
    - 4.2.8.3. copies of certificates for all specialty and sub-specialty board certification and, if applicable, recertification
    - 4.2.8.4. names and contact information of all professional liability carriers for the past ten (10) years, as well as claim history and experience
    - 4.2.8.5. location of office(s), names and addresses of other Practitioners with whom the applicant expects to have a coverage relationship with
    - 4.2.8.6. name of any other hospital(s) in which the applicant has privileges or did have privileges in the last ten (10) years
    - 4.2.8.7. signature by the applicant no greater than fifteen (15) days prior to submission (note that stamped signatures will not be accepted)
  - 4.2.9. Health Status. Information regarding health status, including medical, mental or physical conditions or use of substances that might limit the practitioner's ability to practice medicine with reasonable skill and safety.

- 4.2.10. Delineation of Privileges form.
- 4.2.11. Personal References: the name of at least three (3) persons who have knowledge of the applicant's professional competence and ethical character. One of the three (3) individuals must be a peer individual who currently has membership on the Professional Staff.
- 4.2.12. Signed Practice Agreement if required under 3.6.1.9.
- 4.2.13. Department and Professional Staff Category

#### 4.3. EFFECT OF APPLICATION

- 4.3.1. The applicant must sign the application, submit the appropriate processing fee, and sign the Release from Liability and Release of Information form in order to be considered for Professional Staff Membership and/or privileges. In addition, by submitting the signed application, the applicant agrees to appear for interviews, as appropriate and requested, by the Chief of Staff, Department Chair, Section Chair, Credentials Committee, Medical Executive Committee, or Board.
- 4.3.2. The applicant shall release from any liability all individuals and organizations who are being requested to provide information, including otherwise privileged or confidential information, to Hurley Medical Center representatives in response to their inquiry regarding the applicant's professional competence, ethics, character, health, emotional stability, and other qualifications for staff appointment and clinical privileges.
- 4.3.3. The applicant shall releases from any liability all representatives of Hurley Medical Center, including its Professional Staff, for their acts performed in good faith and without malice in connection with the evaluation of the application and the applicant's credentials. Failure to execute such releases shall result in an application for appointment, reappointment, or clinical privileges being deemed voluntarily withdrawn. The terms "Medical Center" and "Professional Staff" as used in this paragraph is intended to include the Board of Managers, CEO, Chief of Staff, Chief Medical Officer, other officers of the Professional Staff, as well as their authorized representatives, agents and employees, and all members of Hurley Medical Center and the Professional Staff who have committee or other responsibility for collection and/or evaluating the applicant's credential's and/or acting upon the application.
- 4.3.4. The Medical Staff Office will complete the following:
  - 4.3.4.1. Criminal Background Check
  - 4.3.4.2. Excluded Provider Check
  - 4.3.4.3. National Practitioner Data Bank (NPDB) Check

#### 4.4. INITIAL APPOINTMENT & REAPPOINTMENT PROCESS

- 4.4.1. Applicant's Burden: The applicant shall have the burden of producing adequate information for a proper evaluation of his or her experience, training, health status, competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

- 4.4.2. Incomplete Application: No application shall be considered to be complete until it has been reviewed by the appropriate department chair, Credentials Committee, and Medical Executive Committee, and all have determined that no additional documentation or information is required to permit consideration of the application. Additional information or documentation may be requested by the department chair, Credentials Committee or Medical Executive Committee. If the applicant fails to submit the requested information or documentation within thirty (30) calendar days after being requested to do so, the application shall be deemed incomplete and automatically withdrawn.
- 4.4.3. Verification of Information: The Medical Staff Office will seek to verify the information provided by the applicant. The Medical Staff Office will validate information from the primary source, whenever possible. The Medical Staff Office will promptly notify the applicant of any problems in obtaining the information required, and it will then be the applicant's obligation to obtain the required information. The applicant shall ensure that the requested information is promptly submitted to the Medical Staff Office. Requested information will be due in the Medical Staff Office no greater than thirty (30) days from the date of the request or the application will be considered to have been withdrawn. When the collection and verification of the information is complete, the Medical Staff Office will submit the application and all supporting materials to the Chair of each Department in which the applicant seeks privileges. Once all the requested information has been provided, the application will be processed within 90 days.
- 4.4.4. Misrepresentation: Any misrepresentation of a material fact on the initial application, reappointment application, or at any time during the appointment or reappointment process shall result in an adverse recommendation regarding membership and/or privileges. Intentional misrepresentation of a non-material fact on the initial application, reappointment application, or at any time during the appointment or reappointment process may result in an adverse recommendation regarding membership and/or privileges.
- 4.4.5. Department and Section Action: Unless the Department Chair or Credentials Committee determines that it would not be in the best interest of the applicant and/or Hurley Medical Center for the Department Chair to provide the initial review, the Chair of each department in which the applicant seeks privileges shall review the application, request for privileges, and other supporting documentation. In the event either the Department Chair or Credentials Committee determines that it is not in the best interest of the applicant or Hurley Medical Center for the Department Chair to provide the initial review, then the application for membership shall first be reviewed by the Professional Staff Credentials Committee. The Professional Staff Credentials Committee or the Department Chair may interview the applicant, if appropriate. The Department Chair shall make a recommendation for appropriate clinical privileges based upon this review and/or interview, and the entire application shall be forwarded to the Professional Staff Credentials Committee. The Department Chair may include probationary conditions relating to privileges.

- 4.4.6. Credentials Committee Action: The Professional Staff Credentials Committee shall review the application and supporting documentation. If the Department Chair did not interview the applicant, or if the Credentials Committee identifies the need for additional information, the Credentials Committee may opt to require an interview. At the next regularly scheduled Professional Staff Credentials Committee meeting, the Professional Staff Credential's Committee shall prepare a written report of its recommendations for submission to the MEC. The Credentials Committee shall recommend that the applicant be either 1) deferred, 2) rejected, or 3) provisionally accepted. The Credentials Committee may include probationary conditions relating to privileges.
- 4.4.7. Medical Executive Committee Action: At its next regularly scheduled session, the MEC shall review and consider the recommendations of the Professional Staff Credentials Committee. The Medical Executive Committee shall recommend to the Board that the applicant be 1) deferred, 2) rejected, or 3) provisionally accepted. The Medical Executive Committee may include probationary conditions relating to privileges. The reason for the Medical Executive Committee recommendation will be stated.
  - 4.4.7.1. When a recommendation is made to defer action for further consideration or investigation, it must be followed up at the next regularly scheduled meeting by recommendation to accept or reject the applicant.
  - 4.4.7.2. When the recommendation of the Medical Executive Committee is favorable to the applicant, the Chief of Staff or designee shall promptly forward the recommendation, together with all supporting documentation, to the Board.
  - 4.4.7.3. When the recommendation of the Medical Executive Committee will be adverse to the applicant either in respect to appointment, or clinical privileges, the Chief of Staff shall promptly notify the Chief Executive Officer, if applicable, who will promptly notify the applicant of his or her appeal rights. No such recommendation will be forwarded to the Board until after the applicant has exercised or has deemed to have waived his or her rights to a Fair Hearing as provided in Article V of these Bylaws.
  - 4.4.7.4. If the applicant is provided a Fair Hearing in accordance with Article V, then the Medical Executive Committee shall reconsider the applicant after receiving and reviewing the report, recommendations and hearing record of the Hearing Committee.
    - 4.4.7.4.1. If the Medical Executive Committee's recommendation is favorable to the applicant, then the application shall continue to be processed in accordance with paragraph 4.4.7.2.
    - 4.4.7.4.2. If the Medical Executive Committee's recommendation will still be adverse to the applicant, the Chief of Staff shall promptly notify the Chief Executive Officer who shall forward such recommendation and documentation to the Board. However, the Board shall not take any action until the applicant has exercised or

deemed to have waived his or her right to an appellate review, as provided in Article V of these bylaws.

4.4.8. Board of Manager's Action:

- 4.4.8.1. At the next regularly scheduled meeting of the Board of Managers, the Board of Managers shall act on the application, considering the recommendation of the Medical Executive Committee and reviewing the application and supporting documents, as needed.
- 4.4.8.2. When the application has been acted upon favorably as outlined, the applicant will then be placed on the Provisional Staff for an initial period of one (1) year.
- 4.4.8.3. If the decision of the Board of Managers will be adverse to the applicant in respect to either appointment to the Professional Staff or clinical privileges, the CEO shall promptly notify the applicant of the decision by certified mail, return receipt requested. Such adverse decision shall not be finalized by the Board of Managers until the applicant has exercised or has been deemed to have waived the rights under the Professional Staff Bylaws or has exercised his or her rights in accordance with Article V.
- 4.4.8.4. Once the Hearing Committee has taken its action in accordance with Article V, or all the rights of the applicant described in these Professional Staff Bylaws have been exhausted or waived, the Board of Managers shall take its final action on the matter. The decision of the Board of Managers shall be final and conclusive.
- 4.4.8.5. Once the Board of Managers finalizes its decision, the Medical Staff Office shall notify the applicant on behalf of the CEO.

4.5. INITIAL CREDENTIALING AND PRIVILEGING UNDER SPECIAL CIRCUMSTANCES

- 4.5.1. Telemedicine: Telemedicine privileges may be granted by relying on a distant-site hospital or telemedicine entity's credentialing/privileging process only if granted in accordance with the requirements set forth in the Medicare Conditions of Participation and HMC Professional Staff Telemedicine Privileges policy. Both the Medical Executive Committee and Board must first agree that the specific privileges being considered are appropriately provided via telemedicine.
- 4.5.2. Expedited Credentialing: Practitioners may be considered and processed through expedited credentialing only in accordance with the HMC Professional Staff Expedited Credentialing and Privileging policy.
- 4.5.3. Temporary Privileges: Practitioners may be considered and processed with temporary privileges only in accordance with the HMC Professional Staff Temporary Privileges policy. Denial of a request for temporary privilege or natural termination of existing temporary privileges will not give rise to the Fair Hearing Plan. Formal denial of a request for appointment or privileges or termination of existing appointment or privileges will trigger the provisions of the Fair Hearing Plan.
- 4.5.4. Proctor Privileges: Practitioners may be considered for Proctor Only Privileges in accordance with the HMC Professional Staff Outside Proctoring Physician policy.

- 4.5.5. Disaster Emergency Privileges: Practitioners who do not have privileges granted under these bylaws may temporarily evaluate and treat patients in a disaster situation only when done in accordance with the HMC Professional Staff Policy –Disaster Privileges.

#### 4.6. ONGOING EXPECTATIONS

- 4.6.1. Provide high-quality, safe and efficient care
- 4.6.2. Participate, when requested by the Chief of Staff, in ongoing or special committee meetings.
- 4.6.3. Respond to requests for information and actively participate in the processing of the Practitioner’s initial application, ongoing review, special meetings, and reappointment process.
- 4.6.4. Complete all medical records in accordance with the HMC Professional Staff Medical Record Completion policy.
- 4.6.5. Actively participate in the ongoing and focused professional practice evaluation (OPPE/FPPE) in accordance with the HMC Professional Staff FPPE/OPPE policy and procedure, as well as the HMC Quality and Safety Plan, as amended from time to time by the Medical Executive Committee and Board.
- 4.6.6. Notify the Chief of Staff, or others, as appropriate, when required under 4.7.

#### 4.7. ONGOING REQUIREMENTS TO REPORT CHANGES

- 4.7.1. Practitioners shall be obligated to report immediately any of the following to the Medical Staff Office, Department Chair or Chief of Staff. It is the Practitioners responsibility to ensure that the information is received by the Medical Staff Office, Department Chair or Chief of Staff. Certain actions may result in the immediate relinquishment of privileges pursuant to Paragraph 4.8.
  - 4.7.1.1. felony or misdemeanor convictions or entering a guilty or nolo contendere plea to a felony or misdemeanor.
  - 4.7.1.2. any type of sanction, or are currently under investigation by any hospital or other professional healthcare organization;
  - 4.7.1.3. staff membership at any hospital or other professional healthcare organization was diminished, relinquished, suspended, or revoked, voluntarily or otherwise;
  - 4.7.1.4. suspension, debarment or investigation regarding eligibility to participate in the Medicare and/or Medicaid Program;
  - 4.7.1.5. clinical privileges at any hospital or other professional healthcare organization were diminished, relinquished, suspended, or revoked, voluntarily or otherwise in accordance with law;
  - 4.7.1.6. any relinquishment of licensure, registration, license to practice, DEA certificate, or controlled substance certificate in any state, district, or jurisdiction, voluntarily or otherwise.
  - 4.7.1.7. any previously successful, or are any pending challenges to any licensure, registration, license to practice, DEA certificate, or controlled substance certificate in any state, district, or jurisdiction, voluntarily or otherwise;

- 4.7.1.8. any investigations, suspensions, or revocations of licenses, registrations, licenses to practice, or controlled substance certificates in any state, district, or jurisdiction, voluntarily or otherwise;
- 4.7.1.9. any disciplinary action, such as imposition of consultation requirements, suspension or termination of staff membership, focus review or monitor of practice patterns by any hospital or other professional healthcare organization;
- 4.7.1.10. subjected to any corrective action by any hospital or professional Healthcare organization, such as restriction of admitting and/or clinical privileges, due to failure to complete medical records;
- 4.7.1.11. experienced any health problems (illness or disability) which caused them to be away from their practice for more than two (2) weeks or which rendered them unable to care for their patients;
- 4.7.1.12. received (in terms of professional liability actions) any Notice of Intent to sue; had any judgments rendered against them, including final judgments/settlements; and whether there are any cases pending;
- 4.7.1.13. change in the relationship between an Allied Health Practitioner and Collaborating Physician ;
- 4.7.2. Unless the action warrants the automatic relinquishment of privileges pursuant to Section 4.8., the information will be forwarded to the Department Chair and Professional Staff Credentials Committee.
- 4.7.3. The Professional Staff Credentials Committee shall make written recommendations to the MEC concerning the reported information If the recommendation is considered adverse to the Professional Staff Member, the recommendation will be handled in accordance with Article V.

4.8. AUTOMATIC RELINQUISHMENT OF PRIVILEGES. Unless a written Professional Staff or Department policy grants an exception to a category of Practitioners, a Practitioner's privileges shall be considered temporarily suspended and the action shall be without a right to hearing if any one or more of the following events listed in this section occurs. If the Practitioner disputes that these circumstances have occurred, the suspension will stand until the Medical Executive Committee determines whether it is applicable. If it is undisputed that the event or circumstances have occurred, then the Practitioner shall be required to appeal the action taken by the external agency or organization through the individual agency or organization taking the underlying action, not the HMC Professional Staff. The temporary suspension shall not be appealable through the HMC Professional Staff. If the Practitioner notified the Chief of Staff or Medical Staff Office of any of the following actions before the action went into effect, and the Practitioner is able to resolve the action with his or her license, exclusion, liability insurance, etc. and is fully reinstated, then the Chief of Staff may lift the temporary suspension and reinstate the Practitioner's privileges after confirming that the triggering circumstances have been rectified and the rectification occur no later than sixty (60) days after the initial suspension. If the Practitioner fails to notify Chief of Staff before the action goes into effect or if the resolution occurs greater than sixty (60) days after the suspension, the Practitioner shall automatically relinquish his/her HMC Professional Staff membership, if applicable, and the suspension of privileges shall

become a termination of privileges. If and when the underlying issue is resolved, the Practitioner shall be required to reapply for membership and privileges. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur.

4.8.1. Licensure:

- 4.8.1.1. Revocation or Suspension: Whenever a Practitioner's professional or pharmacy license, if applicable, authorizing him or her to practice in the state of Michigan, or exercise his or her privileges at Hurley Medical Center, is revoked, suspended, expired or voluntarily relinquished, the Practitioner will automatically relinquish his/her HMC Professional Staff privileges as of the date such action becomes effective.
- 4.8.1.2. Restriction or Limitation: Whenever a Practitioner's professional or pharmacy license authorizing him or her to practice in the state of Michigan, or exercise his or her privileges at Hurley Medical Center, is limited or restricted, any clinical privileges that the Practitioner has been granted that are within the scope of the limitation or restriction shall be automatically limited or restricted as of the date such action becomes effective. In addition, the Practitioner shall be required to notify the Medical Staff Office prior to the effective date of the limitation or restriction so that the Department Chair, Credentials Committee, Medical Executive Committee, and Board can determine whether additional action is warranted.
- 4.8.2. Exclusion from Medicare, Medicaid or other Federal Programs. Whenever a Practitioner is barred from participating in Medicare, Medicaid, or other federal programs, or chooses to not participate in Medicare and/or Medicaid, Professional Staff privileges shall be considered automatically relinquished as of the date such action becomes effective. In addition, any Practitioner listed on the U.S. 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.
- 4.8.3. DEA/Controlled Substances: Unless the Department establishes a written exception approved by the Medical Executive Committee, whenever a Practitioner's U.S. Drug Enforcement Agency (DEA) certificate is revoked, limited, expired, voluntarily relinquished, or suspended, the Practitioner will automatically relinquish his or her Professional Staff privileges the date the action becomes effective. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner must notify the Chief Medical Officer or Chief of Staff within two (2) business days.
- 4.8.4. Professional Liability Insurance: Failure of a Practitioner to maintain professional liability insurance in the amount required by the Professional Staff shall result in immediate relinquishment of Professional Staff privileges.
- 4.8.5. Board Certification: Failure of the Practitioner to maintain board certification or board eligibility in accordance with the HMC Professional Staff Board Certification policy.



- 4.8.6. Practice Agreement: Failure of an AHP to provide evidence of a current Practice Agreement with a Collaborating Physician as defined in the Professional Staff Policy – *Allied Health and Medical Staff Collaboration*.

#### 4.9. DELINEATION OF CLINICAL PRIVILEGES

- 4.9.1. Every Practitioner shall be granted specific clinical privileges and shall be entitled to exercise only those clinical privileges specifically granted to Practitioners by the Board of Managers.
- 4.9.2. Every initial and reappointment application must contain a request for specific clinical privileges. The evaluation of such requests shall be based on the applicant's education, training, experience, demonstrated current competence, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought. The applicant shall have the burden of establishing his or her qualifications and current competence in the clinical privileges that he or she requests.
- 4.9.3. Requests to add or remove clinical privileges during the appointment cycle must be in writing and state the specific privilege, relevant recent training and/or experience, or reason for relinquishment, as applicable.
- 4.9.4. Clinical privileges for dentists, psychologists, podiatrists and nurse midwives shall be as described in their individual department rules and regulations.

#### 4.10. REAPPOINTMENT

- 4.10.1. At the end of the Staff Term, as defined in 3.8. of the Bylaws, Staff members shall be required to reapply for renewal of their staff membership and clinical privileges.
- 4.10.2. Approximately one hundred and twenty (120) days prior to the expiration date of a Practitioner's term of appointment or privileges, the "Application for Reappointment to the Professional Staff" will be mailed by the Medical Staff Office to all members whose appointment is scheduled to expire. The Practitioner is expected to return the reappointment application to the Medical Staff Office within thirty days. Failure to return the reappointment application within the timeframes specified may result in a lapse in membership and/or privileges.
- 4.10.3. The reappointment application shall be in writing and contain detailed information in support of any changes requested by the Practitioner.
- 4.10.4. If the Practitioner's level of clinical activity at HMC is not sufficient to permit the Professional Staff and Board to evaluate the Practitioner's competence to exercise the clinical privileges requested, then the Practitioner will have the burden of providing sufficient evidence of clinical performance at other facilities that may be required by the Professional Staff.
- 4.10.5. Staff members who fail to apply for reappointment to the staff within the timeframes specified shall be considered to have resigned and in so doing will waive the right of hearing and appeal as outlined in the Fair Hearing Plan.

- 4.10.6. October 1<sup>st</sup> of the reappointing year shall be considered the deadline for receipt of all requested information from the applicant. After this date, there will be no further attempts to collect this information from the applicant by the Medical Staff Office.
- 4.10.7. Verification and Compilation: The Medical Staff Office shall compile and verify the additional information made available on each reappointment application form. Information subject to change (licensure, professional liability insurance, etc.) shall be revalidated.
- 4.10.8. Information gathered in accordance with the FPPE/OPPE policy or other established Professional Staff or HMC Committees, including but not limited to the following sources, if available, shall be considered.
  - 4.10.8.1. Performance Improvement Committees
  - 4.10.8.2. Peer Review Committee
  - 4.10.8.3. Hospital acquired conditions
  - 4.10.8.4. Blood Utilization Review
  - 4.10.8.5. Drug Utilization Review
  - 4.10.8.6. Medical Records Review
  - 4.10.8.7. Utilization Review
  - 4.10.8.8. Patient Clinical Information System Usage
  - 4.10.8.9. National Practitioner Data Bank
  - 4.10.8.10. Professional license verification
  - 4.10.8.11. Any other source that will assist in completing a profile of the staff member's hospital practice, including a profile of procedures performed, and current competence for the privileges requested.
  - 4.10.8.12. Patient satisfaction and patient complaint data
  - 4.10.8.13. Malpractice claims
- 4.10.9. Once all of the information is gathered, the application for reappointment shall be handled in accordance with the steps outlined under 4.4. Any recommendations considered adverse to a Professional Staff Member shall be handled in accordance with Article V.
- 4.11. CONTINUING EDUCATION
  - 4.11.1. Upon request, all Practitioners at Hurley Medical Center shall be required to show evidence of having attained continuing education in approved programs each calendar year upon request, and designate that they are in pursuit of credits, in accordance with State licensure requirements.
  - 4.11.2. All staff members are required to maintain continuing education credits that relate in part to: patient care, medical/clinical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and/or systems based practice.

## **ARTICLE V – DISCIPLINE OR CORRECTIVE ACTION, HEARING AND APPEAL**

The Professional Staff encourages the use of progressive steps by Professional Staff leaders (the Chief of Staff, Department Chairs, Professional Staff Committee Chairs, etc.) beginning with collegial and educational efforts, to address questions related to a Practitioner's clinical practice, professional conduct, or privileges. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve identified concerns.

5.1. DISCIPLINE OR CORRECTIVE ACTION: Whenever the professional or clinical conduct or competence of any Practitioner, is considered to be beneath the standards of the Professional Staff, are considered to be disruptive to the operations of the Medical Center, or include any of the actions specified below, corrective action may be requested by: 1) any Officer of the Professional Staff, 2) the chairperson of any clinical department, 3) the chairperson of any standing committee of the Professional Staff, if on behalf of the committee, 4) the President & CEO of the Medical Center, 5) the Chief Medical Officer, or 6) by the Board of Hospital Managers. All requests for corrective action shall be in writing and shall be supported by reference to the specific activities or conduct that constitute the grounds for requesting the corrective action. The request may be triggered by a single incident or may be based on an accumulation of incidences or complaints. All requests for discipline or corrective action shall be forwarded to the Chief of Staff's through the Medical Staff Office. .

5.1.1. The professional or clinical conduct of any Practitioner, including but not limited to all complaints related to patient care

5.1.2. The care and treatment of a patient or patients or the management of a case by any Practitioner

5.1.3. Violation by any Practitioner of applicable ethical standards, state licensing or scope of practice laws, these Bylaws, or any Professional Staff or Department policy, including but not limited to the Professional Staff Code of Conduct Policy (Standard Practice 0175).

5.1.4. Behavior or conduct on the part of the Practitioner that is considered lower than the standards of the Professional Staff and Medical Center or disruptive to the orderly and efficient operation of the Medical Center or the Professional Staff, including the inability of the Practitioner to work harmoniously with others.

5.1.5. Violation of any state or federal statute or regulation which governs or prescribes behavior for the practice of medicine or ethical practice.

5.1.6. Any act or omission which in any way threatens the quality or safety of patient care.

5.2. PROCEDURE FOR INITIATING DISCIPLINE OR CORRECTIVE ACTION

5.2.1. All requests for corrective action shall be in writing, refer to any witnesses, incident reports, medical records, or other documentation, and be submitted to the Chief of Staff for review by the Medical Executive Committee. The individual or committee submitting the request for corrective action may recommend a specific corrective action or may ask

- that the Medical Executive Committee propose the corrective action. A copy shall be given to the Practitioner by special notice.
- 5.2.2. Whenever the appropriate corrective action could entail a modification, reduction, suspension or limitation of clinical privileges or Professional Staff membership, and the request came from an individual rather than from a standing committee of the professional staff, the Medical Executive Committee shall first forward such request for corrective action to the Chair of the Department in which the Practitioner has privileges. Upon receipt of such request, the Chair of the Department shall immediately appoint an ad hoc committee to investigate the matter. In the event that the matter involves the Chair of a Department, the Chief of Staff shall initiate the Department Ad Hoc Committee Review as referenced in Section 5.2.3.
  - 5.2.3. Department Ad Hoc Committee Review. Within twenty-one (21) days of the Department's receipt of the request for corrective action, the Ad Hoc Committee review shall occur and it shall make a report of its investigation to the Medical Executive Committee. Prior to making the report, the Practitioner against whom corrective action has been requested shall have an opportunity for an interview with the Ad Hoc Committee. At such time, he/she shall be informed as to the nature of the concerns and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be considered preliminary in nature, and none of the provisions of the Fair Hearing Plan shall apply. The Practitioner's legal counsel shall not be permitted to attend. A record of this interview shall be made by the Department Ad Hoc Committee and included in its report to the Medical Executive Committee. Failure of the Practitioner to appear before the Ad Hoc Committee pursuant to its invitation shall constitute a waiver of the Practitioner's opportunity to appear.
  - 5.2.4. Medical Executive Committee Review. The Medical Executive Committee shall undertake appropriate consideration of the request received from either a standing committee of the medical staff or the Ad Hoc Committee of the Practitioner's department. If the appropriate corrective action could involve a reduction, suspension or limitation of clinical privileges or Professional Staff membership, the affected Practitioners may be permitted to make an appearance before the Medical Executive Committee prior to its decision. The Chief of Staff shall determine, in his or her sole discretion, whether the nature of the complaint warrants an appearance before the Medical Executive Committee. The appearance shall not constitute a Hearing, shall be considered preliminary in nature and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. The Practitioner's legal counsel shall not be permitted to attend. If an appearance is requested and made, the Medical Executive Committee shall make a record of such appearance. Failure of the Practitioner to appear before the Medical Executive Committee pursuant to its invitation shall constitute a waiver of the Practitioner's opportunity to appear.
  - 5.2.5. The action of the Medical Executive Committee on a recommendation for corrective action may be to accept, reject, modify, or such other action as

the Medical Executive Committee deems appropriate. A record of any and all such actions shall be made in the minutes of the MEC meeting.

- 5.2.6. If the MEC recommends reduction, suspension, revocation or limitation of clinical privileges, or suspension from the Professional Staff, or any other recommendation considered adverse to the Practitioner, the affected Practitioner shall be entitled to procedural rights provided under the Fair Hearing and Appeal sections of these Bylaws. A notice of recommendation shall be provided to the affected Practitioner immediately following the MEC's meeting, outlining the following:
  - 5.2.6.1. statement of proposed action
  - 5.2.6.2. brief statement of facts, findings on which the action is recommended
  - 5.2.6.3. recommendations the Practitioner must fulfill, if applicable
  - 5.2.6.4. any requirements of compliance, if applicable
  - 5.2.6.5. statement of Fair Hearing and Appeal rights and process
  - 5.2.6.6. statement that the Practitioner must notify the President/CEO, in writing, within 30 days of receipt of the notice of recommendation of his/her desire for a Fair Hearing.
- 5.2.7. All notices to staff members whose privileges are affected shall be sent Certified Mail, Return Receipt Requested or personal service. Records reflecting the date of service shall be maintained.

### 5.3. SUMMARY SUSPENSION:

- 5.3.1. In urgent situations, when the conduct of a Practitioner creates a reasonable possibility of injury or damage to any patient, employee or person present in the Medical Center, at least two of the following individuals must concur in the decision to summarily suspend any or all of the clinical privileges of a Practitioner. At least one of the two must be the Chief of Staff (or designee) or Department Chair:
  - 5.3.1.1. Chief of Staff (or in his/her absence, the Vice Chief of Staff),
  - 5.3.1.2. Department Chair of the Practitioner's clinical department,
  - 5.3.1.3. President & CEO,
  - 5.3.1.4. Chief Medical Officer
- 5.3.2. This summary suspension shall become effective immediately. The Practitioner shall be notified as soon as reasonably possible, and such notice shall contain a general statement regarding the reasons for the summary suspension and advise the Practitioner of his/her hearing rights under this Article.
- 5.3.3. The Chief of Staff, Vice Chief of Staff, Department Chair or Chief Medical Officer shall make necessary arrangements to provide for proper and necessary patient care during the period of suspension. The suspended Practitioner is expected to confer with the staff member who has been designated to replace him or her as considered necessary for the safeguard of the Practitioner's patients.
- 5.3.4. Any Practitioner whose privileges have been summarily suspended shall be entitled to either:

- 5.3.4.1. Request an expedited Department Ad Hoc Committee Review in accordance with 5.2.4. if the summary suspension was not an act of a standing Professional Staff Committee,
- 5.3.4.2. Waive the expedited Department Ad Hoc Committee review, if applicable, and proceed immediately to a review by the Medical Executive Committee; or
- 5.3.4.3. Escalate to a Fair Hearing in accordance with Section 5.6.
- 5.3.5. The Practitioner shall have five (5) business days to make his/her request. Failure to make a request will result in the summary suspension being reviewed at the next regularly scheduled Medical Executive Committee.
- 5.3.6. Because the Practitioner's privileges have already been suspended, the expedited Department Ad Hoc Committee meeting shall occur within ten (10) business days of the request, if applicable, and the MEC shall convene to discuss the matter within ten (10) business days following the report of the Department Ad Hoc Committee or summary suspension. As in Section 5.2.5., the Practitioner may be invited to attend the MEC meeting to provide any information necessary and pertinent to the deliberation of the MEC in the instance of the summary suspension. If, at the time of the MEC meeting (special or regular), the MEC's recommendation to the Board will be to continue the summary suspension, or some other corrective action considered adverse to the Practitioner, the Practitioner shall be entitled to request an appeal, as provided in the Fair Hearing Plan. The MEC's recommendation will not be forwarded to the Board until such time the Practitioner has exhausted or waived his or her right to a Fair Hearing. A notice of recommendation shall be provided to the affected practitioner outlining the same items as specified in 5.2.6.
- 5.3.7. The terms of the summary suspension, as recommended by the MEC, shall remain in effect pending a final decision by the Board.
- 5.3.8. All notices to staff members whose privileges are affected shall be sent Certified Mail, Return Receipt Requested or personal service. Records reflecting the date of service shall be maintained.

5.4. AUTOMATIC SUSPENSION: A temporary automatic suspension, in the form of withdrawal of a Practitioner's right to exercise clinical privileges previously granted, shall be imposed for any of the reasons specified in Section 4.8.

5.5. ACTIONS FOR WHICH NO HEARING IS REQUIRED:

- 5.5.1. In the event any Practitioner is summarily suspended for
  - 5.5.1.1. failure to maintain appropriate malpractice insurance,
  - 5.5.1.2. failure to maintain a current, active, unrestricted appropriate State license,
  - 5.5.1.3. exclusion from participation in Medicare or Medicaid, or
  - 5.5.1.4. failure to maintain a current, active DEA certification (if required for the Practitioner's specialty),
  - 5.5.1.5. Opt-out of Medicare or Medicaid
- 5.5.2. The Practitioner shall be notified of the suspension and the basis for the suspension by regular and certified mail, and given sixty (60) calendar

days to produce clear and convincing evidence that the facts relied on in taking the summary action are not correct. If the Hospital does not receive such evidence from the member within sixty (60) calendar days, the individual shall be deemed to no longer be qualified for Professional Staff membership and/or clinical privileges, and the Practitioner's Professional Staff membership and clinical privileges shall automatically terminate, in which event the practitioner shall not be entitled to a hearing as set forth elsewhere in these Bylaws.

- 5.5.3. No Practitioner shall be entitled to a hearing as a result of any action which is recommended or taken which is not reportable to the state or the National Practitioner Data Bank, including, but not limited to, the following:
  - 5.5.3.1. Letters of warning, reprimand, or admonition;
  - 5.5.3.2. Imposition of monitoring, proctoring, review or consultation requirements;
  - 5.5.3.3. Requiring provision of information or documents, such as office records, or notice of events or actions;
  - 5.5.3.4. Imposition of educational or training requirements;
  - 5.5.3.5. Placement on probationary or other conditional status;
  - 5.5.3.6. Appointment or reappointment for less than two (2) years;
  - 5.5.3.7. Failure to place a practitioner on any on-call or interpretation roster, or removal of any practitioner from any such roster;
  - 5.5.3.8. Continuation of provisional appointment;
  - 5.5.3.9. Refusal of the Board of Managers to grant a request for a waiver or extension of time regarding the Board certification requirements set forth in the Professional Staff Board Certification policy;
  - 5.5.3.10. Termination of Professional Staff membership and/or Practitioner's clinical privileges as a result of matters which are not related to the Practitioner's professional qualifications, competence or conduct such as:
    - 5.5.3.10.1. failure to pay dues or assessments,
    - 5.5.3.10.2. failure to meet any objective requirement if imposed on all Practitioners in a designated Department, Category or with a specific privilege that specifies a certain number of procedures be performed to maintain or demonstrate clinical competence, or
    - 5.5.3.10.3. the Hospital, through a resolution by the Board, elects to enter into an exclusive contract for the provision of certain services.
    - 5.5.3.10.4. The Hospital, through a resolution by the Board, elects to no longer perform the procedure or treatment in the Medical Center
- 5.5.4. If any action is taken which does not entitle the Practitioner to a hearing, the Practitioner shall be offered the opportunity to submit a written statement or any information which the practitioner wishes to be included in the Practitioner's credentialing file along with the documentation regarding the action taken.

## 5.6. FAIR HEARING:

- 5.6.1. Notice of Adverse Recommendation: When a Practitioner receives a Notice of Recommendation that, if ultimately ratified by the Board of Hospital Managers, will adversely affect his or her appointment to, or status as, a member of the

Professional Staff, or his or her exercise of clinical privileges, he or she shall be notified within seven (7) days of his/her right to request a Fair Hearing as defined in this Section 5.6. Such Notice of Recommendation shall state:

- 5.6.1.1. That professional review action that has been proposed to be taken against the Practitioner.
- 5.6.1.2. The reasons for the proposed action.
- 5.6.1.3. That the Practitioner has the right to request a hearing.
- 5.6.1.4. That the Practitioner has thirty (30) days from the date of notice sent to request a hearing
- 5.6.1.5. A summary of rights at the hearing:
  - 5.6.1.5.1. right to representation (by attorney or otherwise)
  - 5.6.1.5.2. right to have a record made of the proceedings and receive a copy upon payment of reasonable charges
  - 5.6.1.5.3. right to call, examine and cross-examine witnesses – live and through deposition hearing
  - 5.6.1.5.4. testimony is limited to a maximum of eight (8) hours unless more live testimony is deemed essential to a meaningful hearing, at the sole discretion of the hearing officer; however, deposition testimony, relevant to the subject matter of the hearing, may be taken and submitted to the hearing panel
  - 5.6.1.5.5. right to present relevant evidence, whether admissible in court or not
  - 5.6.1.5.6. right to submit a written statement at the close of the hearing
  - 5.6.1.5.7. right to receive the written recommendations of the hearing panel or officer including the basis for recommendation
- 5.6.1.6. That if the recommendation of the Medical Executive Committee following such Hearing is still adverse to the affected Practitioner, he or she then shall be entitled to an appeal of any procedural matters (see Section 5.7. – Appellate Review) before the Board of Managers makes a final decision on the matter.
- 5.6.1.7. The Notice of Adverse Recommendation shall be served by Certified Mail, Return Receipt Requested, or personal service. Records reflecting the date of service shall be maintained.
- 5.6.2. Response to Notice of Adverse Recommendation: In the event such Practitioner desires a Hearing, the Practitioner shall notify the President & CEO of his or her desire for a Hearing, in writing, within thirty (30) days of receipt of the Notice of Recommendation.
- 5.6.3. Scheduling of Hearing: Upon receipt of notice of request for Hearing, the Chief of Staff or designee shall arrange for such Hearing. Unless an expedited Hearing is requested, the Hearing shall occur no later than thirty (30) calendar days from the date the Practitioner’s request is received by the President & CEO, and the Practitioner will be notified of the date no less than ten (10) days before the hearing.



- 5.6.3.1. The President & CEO shall ensure that the Practitioner is timely notified.
  - 5.6.3.2. The Notice of Hearing shall state in concise language the acts or omissions with which the Practitioner is charged, a list of specific or representative medical records being questioned, and/or the reason or subject matter that was considered in making the adverse recommendation, preliminary decision or summary suspension. The Notice of Hearing will also include a list of witnesses expected to testify on behalf of the recommending body and the names of the Professional Staff Members of the Hearing Panel, and shall be served by certified mail, return receipt requested, or personal service. Additional witnesses may be added to the witness list by either party, provided that the other party receives written notice at least forty-eight (48) hours prior to the Hearing.
  - 5.6.3.3. In the event that the Practitioner's clinical privileges have been summarily suspended in accordance with Section 5.3. of these Bylaws, he or she shall be entitled to an expedited Hearing. If requested, the expedited Hearing shall occur within fourteen (14) days. A Practitioner may waive rights to an expedited Hearing in favor of a regular Hearing.
- 5.6.4. Composition of Hearing Panel
- 5.6.4.1. If the Practitioner is a Medical Staff Member, Moonlighter or Other Credentialed Staff, r, such Hearing shall be conducted by a Hearing Committee of not less than three (3) Medical Staff Members on the Professional Staff. If the Hearing involves a member of the Allied Health Staff, then one (1) of the three (1) Professional Staff Members on the panel shall be an Allied Health Member. All three (3) Members shall be appointed by the Chief of Staff in consultation with the Medical Executive Committee and subject to the approval of the President & CEO of the Medical Center. There also may be appointed one or more alternate members of the Hearing Panel. Any member of the Hearing Panel, including any alternate, who participates in the entire hearing or reviews the transcripts of any portions of the hearing for which the Panel member is not in personal attendance, may be permitted to participate in the deliberations and to vote on the recommendations of the Hearing Panel. One of the Members shall be designated by the Chief of Staff as the Chair. The Chief of Staff may appoint a Hearing Officer to preside over the Hearing and be an advisor the Hearing Panel. The Hearing Officer shall not vote. No Member who actively participated in the consideration of the adverse recommendation or summary suspension shall be appointed as a Member of the Hearing Panel. In addition, no Member who is in direct economic competition with the affected Practitioner shall be appointed to serve on the Hearing Panel.
  - 5.6.4.2. The Practitioner shall be notified of the prospective members of the Hearing Panel makeup at least seven (7) days prior to the Hearing. If the Practitioner has any reason to challenge any Member of the Hearing Panel

for bias, prejudice, or being in direct economic competition, such specific challenge and the particular facts supporting the allegation shall be stated in writing to the Chief of Staff within seven (7) days of the Practitioner's receipt of notice of the Members assigned to the Hearing Panel. The Chief of Staff and Medical Center President & CEO shall consider the request and, considering such objections, decide in their discretion whether to appoint a replacement Member, if appropriate.

5.6.5. Hearing Rights. At the Hearing, each Party shall be entitled to the following rights:

- 5.6.5.1. Right to representation (by attorney or otherwise)
- 5.6.5.2. Right to have a record made of the proceedings and receive a copy upon payment of reasonable charges
- 5.6.5.3. Right to call, examine and cross-examine witnesses (Live hearing testimony is limited to a maximum of eight (8) hours unless more live testimony is deemed essential to a meaningful hearing, at the sole discretion of the Hearing Officer; however, deposition testimony, relevant to the subject matter of the hearing, may be taken and submitted to the hearing panel)
- 5.6.5.4. Right to challenge a witness or rebut evidence
- 5.6.5.5. Right to submit a written statement at the close of the hearing
- 5.6.5.6. Write to submit written memoranda objecting to any proceedings

5.6.6. Conduct of Hearing

- 5.6.6.1. If requested, the Hearing Officer shall preside at such hearing and shall determine the order or procedure and shall assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. The Hearing Officer shall determine the relevance of evidence for purposes of its admissibility. If a Hearing Officer has not been designated, then the Hearing Chair shall serve in this capacity. The Hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or representation of evidence. The Members of the Hearing Panel shall be present when the Hearing takes place and no Member may vote by proxy.
- 5.6.6.2. An accurate record of the Hearing shall be kept. The mechanism shall be established by the Hearing Panel Chair or Officer and may be accomplished by use of a court reporter, electronic or video recording, or detailed transcription. If a record keeping method other than a court reporter is used, the Practitioner must agree, in writing, to the method of record keeping before the Hearing commences. Hurley Medical Center shall bear the cost of the court reporter.
- 5.6.6.3. The personal presence of the Practitioner for whom the Hearing has been scheduled is required throughout the Hearing. A Practitioner who fails without good cause to appear personally and proceed at such Hearing shall be deemed to have waived his or her rights to a Fair Hearing or Appeal and to have accepted the adverse recommendation, preliminary decision.

- 5.6.6.4. Postponement of the Hearing beyond the time set forth in the Bylaws shall be made only with the approval of the Hearing Panel and upon a showing of good cause. Granting of such postponement shall be at the sole discretion of the Hearing Panel.
- 5.6.6.5. The Practitioner shall be entitled to be accompanied by and/or represented by an attorney or other advisor at his or her expense. The Medical Executive Committee may be represented by legal counsel.
- 5.6.6.6. The Hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make the evidence inadmissible over objections in civil or criminal action. Both parties shall, prior to or during the Hearing, be entitled to submit memoranda concerning any issue or procedure or fact, and such memoranda shall become a part of the Hearing record.
- 5.6.6.7. The body which initiated the corrective action, through a representative, shall present the facts in support of such adverse recommendation or summary suspension and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation, preliminary decision or summary suspension, but the affected Practitioner shall thereafter be responsible for supporting his or her challenge by showing, by clear and convincing evidence, that the charges or grounds involve lack of any factual basis or that such basis or that the conclusions drawn or any action based thereon is either arbitrary, unreasonable, or capricious.  
It shall not be a defense to any action proposed by the Medical Executive Committee or the Board of Managers that different action may have been taken in the past with regard to any other Practitioner.
- 5.6.6.8. If the Practitioner chooses not to testify on his or her own behalf, he or she may still be called and examined as if under cross-examination. Oral evidence shall be taken only on oath or affirmation.
- 5.6.6.9. The Hearing Panel may, without special notice, recess the Hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the Hearing Panel's determination to conclude the presentation of further oral and written evidence, the Hearing shall be closed. At the close of the Hearing, either party may submit a written statement for consideration by the Hearing Committee. The written statement must be submitted to the Hearing Committee Chair or Officer no greater than twenty-four (24) hours after the conclusion of the Hearing.
- 5.6.6.10. The Hearing Panel may deliberate outside the presence of the parties who participated in the Hearing. The Hearing Panel shall complete its written

recommendation no later than fifteen (15) business days following the conclusion of the Hearing.

- 5.6.6.11. Decision by Hearing Committee: The Hearing Panel Officer or Hearing Panel Chair shall ensure that the affected Practitioner, Medical Executive Committee and President & CEO receive the written recommendation(s) of the Hearing Panel. The Hearing Panel Recommendation will include a statement of the basis for the recommendation and the supporting facts. The Recommendation may recommend confirmation, modification, or rejection of the original adverse recommendation, summary suspension, or preliminary decision. If the Recommendation is adverse to the Practitioner, the Practitioner will receive notice that he/she will have ten (10) days to request an Appellate Review by the Board of Managers. Such notice will advise Practitioner that failure to timely request Appellate Review by the Board of Managers shall constitute a waiver if his/her right to same and that the Board of Managers will proceed to a final decision on the matter based on the recommendations, determination and information available.
- 5.6.6.12. Hearing Record. A written record of the Hearing must be of sufficient accuracy to permit an informed and valid judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter.

#### 5.7. APPELLATE REVIEW:

- 5.7.1. Request for Appellate Review: A Practitioner shall have ten (10) days following his receipt of a Hearing Recommendation to file a written request to the President and CEO for an Appellate Review. Such request shall be deemed to have been delivered to the HMC President & CEO or designee when received in person. Such request should specify whether the Appellate Review will be held only on the record on which the adverse determination is based, or if the Practitioner is requesting the opportunity to present an oral argument. Oral argument shall only be granted at the sole discretion of the Board Chair.
- 5.7.2. Waiver for Failure to Request: A Practitioner who fails to request an Appellate Review within the time and in the manner specified above waives any right to such review and the Board of Managers shall proceed in making its final decision based on the information available to them.
- 5.7.3. Notice of Time and Place of Appellate Review: Upon receipt of a timely request for Appellate Review, the President & CEO shall deliver such request to the Chairman of the Board of Managers. The Board shall promptly schedule and arrange for an Appellate Review which shall be not more than thirty (30) days from the receipt of the request. However, if the Practitioner is already under suspension then such review shall be held as soon as arrangements for it can reasonably be made. The President & CEO shall ensure that the Practitioner is notified of the day and time for such review, including whether the Practitioner will be able to present an oral argument, if requested.

- 5.7.4. The Practitioner shall have access to the Hearing record and other written documentation, if any, of the Hearing Panel. The Practitioner shall submit a written statement detailing the findings of fact or procedural matters with which he or she disagrees. The Practitioner's reasons for such disagreement on factual or procedural matters must be specified. The written statement may cover any procedural matters raised at any step in the procedure to which the appeal is related and Practitioner's legal counsel may assist in its preparation or the statement, if requested by the Practitioner. Such written statement shall be submitted to the Review Body, defined below, through the President & CEO no less than five (5) business days prior to the scheduled Appellate Review. The Board Chair may, in his or her sole discretion, share the written statement with the Medical Executive Committee, Hearing Panel or other appropriate individual or committee to request a statement in reply.
- 5.7.5. Appellate Review Body. The Board Chair shall appoint three (3) members of the Board to serve as the Appellate Review Body ("Review Body"). One of its members shall be designated by the Board Chair as the chairperson. The Board Chair may not be a part of the Review Body.
- 5.7.6. Appellate Review Procedure
- 5.7.6.1. Nature of the Proceedings: The proceedings by the Review Body shall be in the nature of an appellate review based upon the record of the hearing before the Hearing Panel, the Hearing Panel's report, and any post-hearing written statements submitted by the Practitioner or others in reply to the statement submitted by the Practitioner.
- 5.7.6.2. Presiding Officer: The individual designated as the Review Body Chair shall be the presiding officer. He or she shall determine the order of procedure during the review, make all required rulings, and maintain quorum.
- 5.7.6.3. Oral Statement: The Review Body Chair, in its sole discretion, may allow the parties or their representatives to appear personally and make oral statements in favor of their positions. Any party or representative so appearing shall be required to answer questions put to him or her by any member Review Body.
- 5.7.6.4. Consideration of New or Additional Matters: New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record shall be introduced at the appellate review only under unusual circumstances. The Review Body, in its sole discretion, shall determine whether such matters or evidence shall be considered or accepted.
- 5.7.6.5. Powers: The Review Body shall have all power granted to the Hearing Committee and such additional powers as are reasonable and appropriate to the discharge of its responsibilities.
- 5.7.6.6. Recesses and Adjournment: The Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the

conclusion of oral statements, if allowed, the appellate review shall be closed. The Review Body shall then, at a time convenient to it, conduct its deliberation outside the presence of the parties.

- 5.7.6.7. Action Taken: No greater than five (5) days after the conclusion of the Appellate Review, the Review Body will make its written recommendation to the full Board of Managers regarding whether any procedural deficiencies were identified. If the Appellate Review Body determines that no procedural deficiencies were identified, then the matter and recommendation from the Hearing Panel will be forwarded to the full Board for review and consideration. If the Appellate Review Body identified actual or potential procedural deficiencies, it will document those deficiencies and its recommendations to correct. It shall be the responsibility of the Chief of Staff to ensure that the Practitioner receives a Fair Hearing and that the matter is remanded to correct the procedural deficiencies. The Chief of Staff has the authority to remand the matter back to the original body recommending the corrective action, to the Medical Executive Committee, to the Hearing Panel, or engage a new Hearing Panel in accordance with the expectations set forth above. The Chief of Staff will ensure that all procedural deficiencies have been corrected before the final recommendation is presented to the full Board for consideration.

#### 5.8. FINAL DECISION BY THE BOARD OF MANAGERS:

- 5.8.1. Within thirty (30) days after the conclusion of the Appellate Review, or waiver of Appellate Review by Practitioner, the Board shall render its final decision on the matter in writing and the President & CEO shall notify the Practitioner and Medical Executive Committee of its final decision. If the decision is in accord with the Medical Executive Committee's last recommendation in the matter, if any, it shall be immediately effective and final. If the Board's action has the effect of changing the Medical Executive Committee's last such recommendation, the Board shall refer the matter to the next Joint Conference Committee which shall conduct its review based upon the documented records.
- 5.8.2. Joint Conference Committee: Within fifteen (15) days of its receipt of a matter referred to it by the Board pursuant to the fair hearing and appeal process, the Joint Conference Committee shall conduct its review based upon the documented records.
- 5.8.3. The President & CEO, Chief of Staff, and HMC General Counsel shall determine whether the Practitioner will be invited to address the Joint Conference Committee. Once the Joint Conference Committee has been given the opportunity to hear both recommendations, it shall make a written recommendation back to the Board of Managers. The Board shall then make its decision and the decision shall become final.
- 5.8.4. The Board shall cause a copy of their official action, which shall include its decision and the basis for it, to be served on the Practitioner, in writing, by Certified Mail, Return Receipt Requested, or by personal service.

## 5.9. OTHER

- 5.9.1. Report to Applicable External Authorities: Reports of disciplinary actions will be reported to the appropriate authorities upon completion or waiver of the Fair Hearing and Appellate Review procedures. The Chief of Staff shall work with the Chief Medical Officer, Medical Staff Office and Hurley Medical Center General Counsel to ensure that all reporting obligations, including but not limited to state licensing and the National Practitioner Data Bank, are met.
- 5.9.2. Nothing in the above shall preclude the Medical Executive Committee or Hospital Board of Managers from remanding the case back to an individual or committee previously involved in the investigation or recommendation for corrective action for further consideration prior to making its decision.
- 5.9.3. Payment of Attorney Fees: If any Practitioner who is the subject of an adverse recommendation or action in connection with the Practitioner's Professional Staff membership or clinical privileges initiates a suit against any entity or person who is in any way involved in any peer review, credentialing, recredentialing, corrective action, or other action, recommendation or decision, the Practitioner filing the suit shall be required to pay all costs and expenses incurred by each individual defendant in defending the suit, including reasonable attorney fees, unless the practitioner substantially prevails against the individual defendant.

**ARTICLE VI – ELECTED POSITIONS: OFFICERS, MEC MEMBER-AT-LARGE, DEPARTMENT CHAIR AND VICE CHAIR, SECTION HEAD**

6.1. GENERAL INFORMATION

- 6.1.1. Officers: The Officers of the Professional Staff shall be the Chief of Staff, Vice Chief of Staff, and Secretary.
- 6.1.2. Members-at-Large: Five (5) individuals shall be elected in accordance with the guidelines specified below, three (3) to represent the Medical Staff on the Medical Executive Committee and two (2) to represent the Allied Health Staff on the Medical Executive Committee regarding issues of interest or concern.
- 6.1.3. Department Chair and Vice Chair, Section Head: Each Department listed in Article VII shall elect a Department Chair and Department Vice Chair in accordance with this Article VI. Sections may, but are not required to, elect a Section Head if it is determined that the Section is substantially separate such that a Section Head is necessary to promote consistent, efficient, effective, high-quality and safe care.

6.2. QUALIFICATIONS

- 6.2.1. Officers & Members At-Large:  
Only members of the Professional Staff in the MSAV category and who are Board Certified within their specialty are eligible to hold office or serve as Officers or MEC Member A-Large, and must maintain Board Certification throughout the duration of their term.
- 6.2.2. Allied Health Members At-Large: : No special qualifications required
- 6.2.3. Department Chair & Vice Chair:  
Only members of the Professional Medical Staff in the MSAV category and who are board certified within their specialty are eligible to serve as Chair or Vice-Chair, maintaining board certification throughout their term. Department Chair's and Vice-Chair's for the departments of Anesthesia, Pathology, Radiology and Emergency Medicine may be appointed by the Professional Corporation, if specified in the exclusive contract to provide those services.
- 6.2.4. Section Heads:  
Only members of the Professional Medical Staff in the MSAV category and who are board certified/eligible within their specialty are eligible to hold office as section head. Section Heads must maintain board certification throughout the duration of their term. Unless otherwise approved by MEC, section heads can only be elected by members of their own section. Voting members of the section are not required to have MSAV status.

6.3. METHOD OF ELECTION:

- 6.3.1. Officers and MEC At-Large Members
  - 6.3.1.1. A nominating committee composed of five (5) MSAV members and two (2) Allied Health members shall be selected by the MEC. The members of the Nominating Committee shall not be members of the MEC. The nominating committee shall select nominees for



the offices of Chief of Staff, Vice Chief of Staff, Secretary, three (3) Medical Staff Members at Large, and two (2) Allied Health Staff Members at Large to the MEC. The nominating committee shall determine a candidate's willingness to have his or her name placed in nomination, and verify his or her eligibility for the office. The nominating committee shall present its proposed slate of candidates to the General Staff at the May meeting in even-numbered years.

- 6.3.1.2. Additional nominations for any of the offices may be made from the floor at the May meeting of the General Staff. Nominations shall be closed at the conclusion of the May meeting. Any candidate whose name is placed in nomination from the floor must be present to accept or reject such nomination. The Medical Staff Office will confirm eligibility and those nominees eligible to fill the specified position will be listed on the ballot to be voted upon at the December Regular Meeting of the General Staff.
- 6.3.1.3. Individuals accepting a nomination must notify the Medical Staff Office by November 15 in the event that they are no longer willing to be considered a candidate. In the event that one or more nominees notifies the Medical Staff Office that they are no longer willing to be considered, the Medical Executive Committee will be asked to consider reopening the nominations.
- 6.3.1.4. Ballots shall be mailed at least fifteen (15) days prior to the December meeting of the General Staff.
- 6.3.1.5. In the event there is an unscheduled need to fill a vacancy and a decision is made by the MEC to mail ballots to eligible voters rather than calling a Special Meeting, the ballots will be mailed to eligible voters who will be notified that the votes will be tallied fifteen (15) days from the date of the mailing.
- 6.3.1.6. The individual(s) receiving the highest number of votes in each category shall become the Officer or MEC Member-at-Large. In the event of a tie, a new vote will occur, but only covering the position that resulted in a tie.
- 6.3.2. Departmental Chairs, Vice Chairs, and Section Heads: Not earlier than September 1 and not later than November 30 of odd-numbered years, each Department shall elect a Chair and Vice Chair of their respective department and Section shall elect a Section Head, if applicable. Nominations may be made from the floor at the September or October Department meeting, or submitted in writing no later than seven (7) days prior to the September or October Department meeting, and vote shall be by ballot at the November Department meeting. In the event a Departmental Meeting is not held in November, ballots will be mailed by the Medical Staff Office on or around November 10, to be returned to the Medical Staff Office on or around November 30. Ballots received after this date and/or time shall be considered null and void. In the event a Department fails to elect a Department Chair or Vice Chair, or a designated Section fails to elect a Section Head, by the December MEC meeting, it shall become the prerogative of the MEC to designate a Department Chair, Vice Chair, or Section Head.

6.4. TERM OF OFFICE. The Chief of Staff, Vice Chief of Staff, Secretary, Department Chair, Department Vice Chair, Section Head, three (3) Medical Staff Members at Large and two (2) Allied Health Members at Large to the MEC shall hold office during the next two (2) calendar years or until a successor is elected, whichever is later, should they resign or otherwise leave office. The following positions shall be limited to a total of four (4) full or partial terms (consecutive or non-consecutive).

6.4.1. Chief of Staff,

6.4.2. Vice Chief of Staff,

6.4.3. Secretary,

6.4.4. Three (3) MEC Medical Staff Members at Large, and

6.4.5. Two (2) Allied Health MEC Members at Large

6.5. REMOVAL OF OFFICERS, MEC At-Large Members, Chairs, Vice Chairs, or Section Heads

6.5.1. Officer or MEC At-Large Member: A petition for recall may be initiated by a majority vote of the Medical Executive Committee or twenty-five (25) percent of the MSAV Staff who feel that an Officer or Member-At-Large is not performing his or her duties in the prescribed manner. Such petition shall be signed and presented to the Chief of Staff (or, in the event the petition is regarding the Chief of Staff, the petition should be given to the Vice Chief of Staff) who shall call a Special Meeting of the Professional Staff within fifteen (15) days. The charges against the Officer or Member-at-Large shall be summarized at such meeting and mailed to the individuals authorized to vote on the election of the Officer or Member-at-Large with a ballot to vote for or against recall. The ballot shall be returned to the medical center by Certified Mail within ten (10) calendar days. Recall shall occur if the majority of the individuals eligible to vote has voted in favor of the recall.

6.5.2. Departmental Chair, Vice Chair, or Section Head: In the event a Department Chair, Vice Chair or Section Head fails to fulfill his or her duties, a petition for recall may be initiated by a majority vote of the Medical Executive Committee (see Section 7.3.5) or a majority of the MSAV represented by the party to be recalled. Consideration to a recall shall be given in the event the Department Chair holds less than the required meetings and/or fails to attend 50% or more of MEC meetings. Such petition shall be signed and presented to the Chief of Staff who shall call a Special Meeting of the MSAV represented by the party to be recalled. The charges against the party to be recalled shall be summarized at such meeting and mailed to the individuals authorized to vote on the election of the position in question, with a ballot to vote for or against recall. The ballot shall be returned to the medical center by Certified Mail within ten (10) calendar days. Recall shall occur if the majority of the individuals eligible to vote has voted in favor of the recall.

6.5.3. Vacancies in the office of Chief of Staff shall be filled by the Vice Chief assuming the role for the duration of the term. Vacancies in the

Department Chair position shall be filled by the Vice Chair assuming the role for the duration of the term.

- 6.5.4. Vacancies in the office of Vice Chief of Staff, Secretary, MEC Member-at-Large, Department Vice Chair or Section Head shall be filled in accordance with Section 6.3.

## 6.6. DUTIES

### 6.6.1. Chief of Staff

- 6.6.1.1. To call, preside at, and be responsible for the agenda for all meetings of the Professional Staff;
- 6.6.1.2. Serve as Chair of the MEC;
- 6.6.1.3. Serve as an ex-officio member of all other Professional Staff committees;
- 6.6.1.4. Be responsible for enforcement of the Professional Staff Bylaws, Rules and Regulations;
- 6.6.1.5. Appoint members annually to all standing and special committees, except the MEC, or other committees whose membership is specified by these Bylaws;
- 6.6.1.6. Represent the views, policies, needs and grievances of the Professional Staff to the Board of Hospital Managers and to the Medical Center President/CEO;
- 6.6.1.7. Represent the policies of the Board of Hospital Managers to the Professional Staff and report to the governing body on the maintenance of quality and patient safety with respect to the Professional Staff's delegated responsibility to provide medical care;
- 6.6.1.8. Represent the Professional Staff in its external professional and public relations;
- 6.6.1.9. Be responsible for assuring that the Professional Staff is aware of, and strives to meet, all requirements and standards of accrediting bodies and agencies;
- 6.6.1.10. Is responsible for all performance improvement/quality of care and patient safety activities.
- 6.6.1.11. Perform any of the duties of any department chair, section chair, or chair of any Professional Staff committee, if such individual is unavailable or otherwise fails to perform their necessary duties

### 6.6.2. Vice Chief of Staff

- 6.6.2.1. assume all the duties in the absence of the Chief of Staff
- 6.6.2.2. automatically succeed the Chief of Staff, if or when the Chief of Staff fails to serve for any reason

### 6.6.3. Secretary

- 6.6.3.1. shall keep accurate and complete minutes of all staff meetings,
- 6.6.3.2. call meetings on order of the Chief of Staff,
- 6.6.3.3. attend to all correspondence, and
- 6.6.3.4. perform such other duties, which ordinarily pertain to his or her office.

- 6.6.3.5. where there are funds to be accounted for, he or she shall also act as Treasurer.
- 6.6.4. Members at Large
  - 6.6.4.1. Participate as a member of the MEC through attendance at monthly meetings and special meetings as scheduled or requested.
  - 6.6.4.2. Represent the general membership on issues of interest or concern, particularly those that arise outside of the standing committee structure.
  - 6.6.4.3. Listen to membership and communicate their issues, needs and interests to the MEC.
  - 6.6.4.4. Identify potential problems and opportunities.
  - 6.6.4.5. Work effectively with MEC, Administration and Board of Hospital Managers in the mission, vision, goals, and values of the organization.
- 6.6.5. Departmental Chair: Be responsible to the Chief of Staff, through the MEC, for the functioning of the department and shall have general supervision over the clinical work falling within his or her department.
  - 6.6.5.1. shall serve as a member of the MEC and be responsible for:
  - 6.6.5.2. all clinically related activities within their department;
  - 6.6.5.3. all administratively related activities within their department, unless otherwise provided for by the medical center;
  - 6.6.5.4. continuing surveillance of the professional performance of all individuals in their department who have delineated clinical privileges;
  - 6.6.5.5. recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided within their department;
  - 6.6.5.6. development and implementation of policies and procedures that guide and support the provision of services within their department;
  - 6.6.5.7. assessing and recommending to the relevant medical center authority off-site sources for needed patient care services not provided by the department or the organization;
  - 6.6.5.8. integration of the department or service into the primary function of the organization;
  - 6.6.5.9. coordination and integration of interdepartmental and intradepartmental services;
  - 6.6.5.10. recommendation for a sufficient number of qualified and competent persons to provide care or service;
  - 6.6.5.11. determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care services;
  - 6.6.5.12. continuous assessment and improvement of the quality of care and services provided;
  - 6.6.5.13. maintenance of quality control programs, as appropriate;

- 6.6.5.14. orientation and continuing education of all persons in the department or service;
  - 6.6.5.15. recommendations for space and other resources needed by the department or service;
  - 6.6.5.16. implementing, within their department, actions recommended by the MEC;
  - 6.6.5.17. initiating corrective action, investigating clinical performance and ordering required consultations as may be appropriate/necessary;
  - 6.6.5.18. enforcement of the Professional Staff Bylaws, Policies and Procedures, and Rules and Regulations within their department;
  - 6.6.5.19. recommendations concerning initial appointment and classification, reappointment, delineation of privileges or corrective action to the MEC and to the Board of Hospital Managers;
  - 6.6.5.20. participating in budget planning and all other reasonable duties requested by the MEC, President and Chief Executive Officer, or the Board of Hospital Managers.
- 6.6.6. Department Vice Chair:
- 6.6.6.1. shall have the duties and responsibilities of the Chair in his or her absence, and shall automatically succeed the Chair if and when he/she fails to serve or is unable to serve for any reason.
  - 6.6.6.2. perform such other duties as may be requested by the Chair;
- 6.6.7. A Section Head shall:
- 6.6.7.1. be responsible for the general supervision of the clinical work within the area;
  - 6.6.7.2. assist in quality management, performance improvement, patient safety within the area;
  - 6.6.7.3. participate in the review of clinical privileges within the area and make recommendations with respect to clinical privileges to the department;
  - 6.6.7.4. organize meetings with other staff members assigned to his/her area, as may be needed, and report to the department when appropriate;
  - 6.6.7.5. be responsible for teaching, education, and research within his or her area.

6.7. USE OF TITLE. All Practitioners that are given a title as part of his/her role on the Hurley Medical Center Professional Staff shall only use that title when fulfilling the functions specific to the designated role or in communications representing Hurley Medical Center. This includes but is not limited to use of the title on his/her own personal email, office website, non-HMC business cards or letterhead, social media, etc. without the written permission of the CEO, General Counsel, or Chief Medical Officer. Practitioners that are also a full-time employee of Hurley Medical Center or one of its affiliates may use their title as they deem appropriate, always taking into consideration the mission, vision and values of Hurley Medical Center and the message being conveyed when using the title.

6.8. PROFESSIONAL STAFF LEADERSHIP ROLE. No Practitioner in an elected position on the HMC Professional Staff may serve as a department chair, Medical Executive Committee member, Board member, or employee of another hospital in the region.

## **ARTICLE VII – ORGANIZED DEPARTMENTS AND SECTIONS**

7.1. **DIVISION OF SERVICES:** To promote efficiency and coordination among the various branches and specialties, the services shall be divided into the Departments and Sections as specified in the Professional Staff Policy – Organization of Departments and Sections.

### 7.2. ORGANIZATION OF DEPARTMENTS

- 7.2.1. Each Department shall be made up of a group of Practitioners in the same/similar specialty. Core Departments shall be Medicine, Pediatrics, Surgery, Emergency Medicine, Pathology, Radiology, OB/GYN and Anesthesiology. Core Departments are those minimally necessary for the basic operation of an inpatient hospital.
- 7.2.2. Departments shall be created and may be consolidated or dissolved by the MEC upon approval by the Board of Managers as set forth below:
- 7.2.3. The following factors will be considered in determining whether a clinical department should be created:
  - 7.2.3.1. It has a sufficient number of Professional Staff Members to enable the department to accomplish the functions set forth in these bylaws
  - 7.2.3.2. Its specialty area is a key part of the services provided by Hurley Medical Center such that the Medical Executive Committee rather than an individual department should provide direct oversight.
  - 7.2.3.3. Because of the nature of the specialty, the Professional Staff Members in the Section have been routinely meeting, for at least the last twelve (12) months, to review, revise and change the provision of care by the Section as a whole (i.e. has routine meetings, has PI initiatives, etc.) and the actions have been documented in section minutes and/or policies and procedures.
  - 7.2.3.4. A majority of the MSAV members of the proposed department vote in favor of the creation of a new department
  - 7.2.3.5. The voting Professional Staff members of the proposed department have offered a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions;
  - 7.2.3.6. It has been determined by the Professional Staff leadership, Chief Medical Officer, Chief of Staff and CEO that there is a clinical and administrative need for a new department.
- 7.2.4. The following factors shall be considered in determining whether the dissolution of a clinical department is warranted:
  - 7.2.4.1. there is no longer an adequate number of members of the Medical Staff in the clinical department to enable it to accomplish the functions set forth in the Bylaws and related policies;
  - 7.2.4.2. there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department;

- 7.2.4.3. the department fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements including minutes of those meetings;
  - 7.2.4.4. no qualified individual is willing to serve as chair of the department; or
  - 7.2.4.5. a majority of the voting members of the department vote for its dissolution.
- 7.2.5. If the Department has a performance improvement (PI) committee, the Chair of the Committee shall be appointed by the Department Chair.
- 7.2.6. Departmental business meetings where peer review activities are conducted as part of the peer review functions and activities of the Medical Staff shall be privileged and protected by MCLA 330.1143a, 331.531, 331.533, 333.20175(8), 333.21513 and 333.21515. Provisions of the Health Care Quality Improvement Act of 1986 and the Patient Safety and Quality Improvement Act of 2005 shall apply to Departmental meetings, as applicable.

### 7.3. DEPARTMENT MEETINGS

- 7.3.1. Each department shall conduct regularly scheduled business meetings to address departmental activities. The date, time, location and frequency of the meetings may be determined by each individual department; however, there shall be no less than six (6) meetings per calendar year.
- 7.3.2. The departmental business meeting will be conducted by the Chair of the department. In his or her absence, the meeting will be conducted by the Vice Chair of the department, or his or her designee.
- 7.3.3. The departmental business meeting agenda may include, but is not limited to:
- 7.3.3.1. complaints/requests from department members and others;
  - 7.3.3.2. patient care issues;
  - 7.3.3.3. requests for new equipment or new procedures;
  - 7.3.3.4. review of reports from quality assurance, utilization review, nursing, or other ancillary services;
  - 7.3.3.5. MEC recommendations for educational program;
  - 7.3.3.6. any other issues that may affect or be of interest to the department.
- 7.3.4. Minutes from each departmental business meeting will be submitted to the Medical Staff Office prior to the next MEC meeting. Formal actions taken by the department are forwarded to the MEC for their approval.
- 7.3.5. MEC may, by a majority vote, initiate the recall of a Department Chair who fails to hold regular department meetings, attend MEC or otherwise fulfill the expectations set forth in the duties of Department Chair described above. See Section 6.5.2. In the event a Department Chair is removed in accordance with this section, the Department Chair will be replaced with the Vice Chair or, if no Vice Chair, in accordance with Section 6.3.2.
- 7.3.6. Departmental business meetings where peer review activities are conducted as part of the peer review functions and activities of the Professional Staff shall be privileged and protected by MCLA 330.1143a,



333.531, 331.533, 333.20175, 333.21513. Provisions of the Health Care Quality Improvement Act and Patient Safety Act of 2007 shall apply to Departmental meetings as applicable.

## **ARTICLE VIII – COMMITTEES**

### **8.1. GENERAL**

- 8.1.1. Committees shall be standing and special. Standing committees shall include but not be limited to: Bylaw Committee, Cancer Committee, Credentials Committee, Medical Executive Committee, Infection Control Committee, Medical Record Committee, Operating Room Committee, Pharmacy and Therapeutics Committee, and the Peer Review Committee.
- 8.1.2. Unless otherwise specified, the membership and Chairs of all Professional Staff committees shall be appointed by the Chief of Staff. Each Committee shall submit its minutes to the Medical Executive Committee no later than thirty (30) days after approval.

### **8.2. MEDICAL EXECUTIVE COMMITTEE (MEC)**

#### **8.2.1. Membership:**

- 8.2.1.1. Chief of Staff, who shall serve as Chair
- 8.2.1.2. Vice Chief of Staff
- 8.2.1.3. Secretary
- 8.2.1.4. All Department Chairs
- 8.2.1.5. Three (3) MSAV Members-at-Large
- 8.2.1.6. Two (2) Allied Health Members-at-Large
- 8.2.1.7. Chair of the GMEC
- 8.2.1.8. Chief Medical Officer
- 8.2.1.9. One (1) Resident, appointed by his peers, without vote

#### **8.2.2. Duties:**

- 8.2.2.1. Leads the Professional Staff in fulfilling the purpose and functions set forth in Article II of these Bylaws
- 8.2.2.2. seeks out the views of the Professional Staff on all issues including those relating to quality and safety and accurately conveys those views to the Board of Managers.
- 8.2.2.3. coordinate the activities and general policies of the various departments and to act on behalf of the Professional Staff, subject to such limitations as may be imposed by the staff;
- 8.2.2.4. implement policies of the Professional Staff not otherwise the responsibility of the departments;
- 8.2.2.5. receive and act upon reports and recommendations from Professional Staff committees and Departments;
- 8.2.2.6. fulfill the accountability of the Professional Staff to the governing body for the medical care provided to patients in the medical center;

- 8.2.2.7. ensure that the Professional Staff is kept informed of all issues pertaining to accreditation, licensure and certification of the medical center;
- 8.2.2.8. make recommendations to the governing body regarding:
  - 8.2.2.8.1. medical staff structure
  - 8.2.2.8.2. mechanism used to review credentials and delineate individual clinical privileges
  - 8.2.2.8.3. recommendations of individuals for Medical or Allied Health staff membership, assignment to departments, and for delineated clinical privileges for each eligible individual
  - 8.2.2.8.4. participation of the medical staff in organization performance improvement and patient safety activities;
  - 8.2.2.8.5. mechanism by which Professional Staff Membership and Practitioner privileges may be terminated;
  - 8.2.2.8.6. mechanism for fair-hearing procedures
- 8.2.2.9. take steps to ensure professional behavior, ethical conduct and competent clinical performance on the part of the members of the staff, including the initiation of corrective or review measures;
- 8.2.2.10. report the activities of the MEC to the General Staff at each of its meetings.
- 8.2.3. Meeting Frequency: The MEC should meet at least ten (10) times per year (preferably monthly) and maintain a permanent record of its proceedings and actions. Meetings typically occur in person but may occur electronically from time to time, as necessary to conduct the business of the committee. Activities of the Professional Staff shall be reviewed at subsequent General Staff meetings.
- 8.2.4. Other:
  - 8.2.4.1. The Medical Executive Committee is empowered to represent and act for the Professional Staff subject to such limitations as may be imposed by these Bylaws. The Professional Staff has delegated to the Medical Executive Committee the authority to adopt, on behalf of the voting members of the Professional Staff, any Professional Staff Policies & Procedures to address the details for describing, implementing, enforcing or otherwise operationalizing the provisions contained within these Bylaws.
  - 8.2.4.2. The MEC, as representatives of the Professional Staff will make its best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Medical Center, and the members of the Professional Staff. When the Medical Executive Committee plans to act or is considering acting in a manner contrary to the wishes of the voting members of the Professional Staff, the voting members of the Professional Staff shall present their recommendations to the MEC in a written petition signed by at least ten percent (10%) of the voting members of the Professional Staff, with two specific Professional Staff Members identified to serve as the Professional Staff's representatives on the matter. The Vice Chief of Staff and Secretary shall meet with the two

representatives and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the issue shall be presented to the Joint Conference Committee for additional discussion. If resolution is not achieved through the Joint Conference Committee, then either the Chief of Staff, the representatives of the Professional Staff, or the Board Chair may request additional conflict resolution processes, which may include mediation.

- 8.2.4.3. In the event a Department Chair is unable to attend an MEC meeting, the Vice-Chair of the Department or designee shall be his or her representative with the full rights of the MEC member. In order to conduct business at the MEC, a simple majority (50% +1) of voting members must be present.

### 8.3. BYLAW COMMITTEE

#### 8.3.1. Membership:

- 8.3.1.1. Immediate Past Chief of Staff who will act as Chair
- 8.3.1.2. Chief of Staff
- 8.3.1.3. Chief Medical Officer
- 8.3.1.4. Chief Medical Information Officer
- 8.3.1.5. VP & General Counsel
- 8.3.1.6. Five (5) MSAV members to include both faculty and community physicians, appointed by the Chief of Staff
- 8.3.1.7. Two (2) Allied Health Practitioners, appointed by the Chief of Staff

#### 8.3.2. Duties: The purpose of the Bylaws Committee is to review the Professional Staff Bylaws, to recommend revisions based on regulatory requirements or changes recommended by Medical Staff Committees, or to change Hurley's current practice with respect to Medical Staff organization and functions. The committee shall:

- 8.3.2.1. Perform regular review of the Bylaws
- 8.3.2.2. Submit proposed amendments to the Medical Executive Committee for review and approval
- 8.3.2.3. Prepare correspondence to the MSAV regarding proposed revisions for review, note, and approval

#### 8.3.3. Meeting Frequency: The committee will meet annually, but may meet more frequently or be canceled as determined by the Medical Executive Committee

### 8.4. CANCER COMMITTEE

#### 8.4.1. Membership shall consist of representatives from all specialties involved in the care of the cancer patients within the limits of those disciplines available to the institution. These shall include, but not be limited to representatives from:

- 8.4.1.1. Medical Oncology
- 8.4.1.2. Diagnostic Radiology
- 8.4.1.3. Radiation Oncology
- 8.4.1.4. Pathology
- 8.4.1.5. Surgery

- 8.4.1.6. Hurley Medical Center Cancer Liaison Physician Representative to the American College of Surgeons Commission on Cancer
- 8.4.1.7. Other non-voting members as deemed appropriate by the Committee in order to fulfill its Duties.
- 8.4.2. Duties:
  - 8.4.2.1. plan, initiate, stimulate and assess the results of oncology-related activities at Hurley Medical Center
  - 8.4.2.2. ensure that patients have access to consultative services in all disciplines;
  - 8.4.2.3. be responsible for assuring that educational programs, conferences and clinical activities cover the entire spectrum of oncology care;
  - 8.4.2.4. perform an audit role regarding patient care, either directly or by review of audit data supplied by other committees;
  - 8.4.2.5. actively supervise the cancer registry for quality control of abstracting, staging and reporting.
  - 8.4.2.6. report results of reports and assessments to the MEC and the Board at least annually.
- 8.4.3. Meeting Frequency: At least quarterly as an entity separate from conferences or tumor boards and document its activities and attendance.

## 8.5. CREDENTIALS COMMITTEE

- 8.5.1. Membership: Minimum of five (5) Members of the Professional Staff and (two) Members of the Allied Health staff, selected so as to ensure representation from the major specialties and the entire staff.
- 8.5.2. Duties:
  - 8.5.2.1. Review the credentials of applicants whose application is deemed complete by the Medical Staff Office and recommend actions on appointment, reappointment, and/or clinical privilege requests by applicants, Members and other Practitioners with the endorsement of the relevant Department Chairs.
  - 8.5.2.2. Prepare a summary report of each meeting listing each individual recommended or denied for appointment, reappointment or clinical privilege
  - 8.5.2.3. Ensure each Department and/or Section maintains an up-to-date delineation of privilege form
  - 8.5.2.4. Facilitate the Medical Center's compliance with accreditation requirements related to credentialing and privileging
  - 8.5.2.5. Make recommendations on Bylaw changes, policies and procedures for the efficient and effective operation of the credentialing and privileging processes
  - 8.5.2.6. Attend at least 50% of the scheduled Credentials Committee meetings annually. Individuals who do not meet this expectation may be replaced at the discretion of the Chief of Staff.
- 8.5.3. Meeting Frequency: At least ten (10) times per year. Meetings typically occur in person but may occur electronically from time to time, as necessary to conduct the business of the committee.

## 8.6. GRADUATE MEDICAL EDUCATION COMMITTEE (GMEC)

### 8.6.1. Membership:

- 8.6.1.1. Chief of Staff, who shall sit without vote
  - 8.6.1.2. Graduate Medical Education Program Directors for:
    - 8.6.1.2.1. Emergency Medicine/Pediatric Emergency Medicine Fellowship
    - 8.6.1.2.2. Internal Medicine
    - 8.6.1.2.3. Obstetrics & Gynecology
    - 8.6.1.2.4. Pediatric Dentistry
    - 8.6.1.2.5. Pediatrics
    - 8.6.1.2.6. Combined Internal Medicine/Pediatrics
    - 8.6.1.2.7. Transitional Year
    - 8.6.1.2.8. Pediatric Psychology Fellowship
    - 8.6.1.2.9. Rehabilitation Psychology Fellowship
  - 8.6.1.3. Three (3) additional representatives of the Professional Staff, appointed by the Chief of Staff
  - 8.6.1.4. One (1) representative from Michigan State University College of Human Medicine
  - 8.6.1.5. One (1) Director of Research or designee
  - 8.6.1.6. Residents:
    - 8.6.1.6.1. President, Housestaff Association or designee
    - 8.6.1.6.2. Chair, Resident Well-Being Committee or designee
    - 8.6.1.6.3. Two peer-selected residents-at-large
  - 8.6.1.7. Vice President/Chief Medical Officer
  - 8.6.1.8. Academic Officer/Designated Institutional Official
  - 8.6.1.9. Resident Well-Being Community Faculty Advisor
  - 8.6.1.10. Quality and Patient Safety Director
  - 8.6.1.11. Other: Selected experts may be called upon when needed.
- 8.6.2. Duties: Oversee the graduate medical education program, including but not limited to monitoring, advising and implementing policies regarding the quality of education and work environment
- 8.6.3. Meeting frequency: The Committee shall meet on a monthly basis, a minimum of eight (8) times per year, and must have a quorum of ten (10) members to conduct official business. The chair may call special meetings with whatever frequency is necessary and whenever appropriate. The Chair and Vice Chair shall be a Hurley Medical Center based Program Director of an ACGME (Accreditation Council for Graduate Medical Education) accredited program, elected in the same fashion as a Department Chair.

## 8.7. INFECTION CONTROL COMMITTEE (ICC)

### 8.7.1. Membership:

- 8.7.1.1. Infectious Disease Specialty Physicians [minimum of three (3)]
- 8.7.1.2. at least one (1) representative from each of the clinical departments
  - 8.7.1.2.1. Nursing service
  - 8.7.1.2.2. Pathology
  - 8.7.1.2.3. Administration

- 8.7.1.2.4. Resident nominated by the Committee Chair in conjunction with the appropriate Program Director
- 8.7.1.2.5. other appropriate medical center services such as, but not limited to OR, Sterile Services, Ambulatory Care areas, Respiratory Therapy
- 8.7.2. Duties: The ICC shall be responsible for the surveillance of inadvertent medical center infection potential, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the medical center's activities.

#### 8.8. JOINT CONFERENCE COMMITTEE

- 8.8.1. Membership: Representatives of the Professional Staff as specified by the Bylaws of the Governing Body. Representatives from the Board of Hospital Managers, as specified in the Bylaws of the Governing Body.
- 8.8.2. Duties: The Joint Conference Committee shall be a medico-administrative liaison committee and the official point of contact between the Professional Staff, the Board of Hospital Managers, and the Medical Center President. Committee meetings may be called by the Chief of Staff, Board of Hospital Managers, or the Medical Center President.

#### 8.9. MEDICAL RECORD COMMITTEE

- 8.9.1. Membership:
  - 8.9.1.1. three (3) members of the MSAV (at minimum)
  - 8.9.1.2. one (1) member of the Allied Health Staff
  - 8.9.1.3. (1) representative each from the Health Information Management (HIM) Department and either Risk Management or Legal Services
  - 8.9.1.4. Two (2) Resident designated by the Committee Chair
- 8.9.2. Duties:
  - 8.9.2.1. Provide recommendations regarding the accuracy, availability and integrity of the legal health record
  - 8.9.2.2. review records to assure that they contain sufficient information to justify the diagnosis and to assure that the record meets documentation standards of patient care.
  - 8.9.2.3. conduct and review records of discharged patients to determine the promptness, pertinence, adequacy and completeness thereof.
  - 8.9.2.4. maintain oversight of the quality of the organization's medical record documentation by:
    - 8.9.2.5. Establishing focused reviews if needed
    - 8.9.2.6. Analyzing data, and taking action as appropriate
    - 8.9.2.7. Review of the monthly delinquent record statistics and taking action as needed
  - 8.9.2.8. Other duties as relate to the documentation, and use of medical records
- 8.9.3. Meeting Frequency: Ad Hoc

## 8.10. MEDICAL STAFF EDUCATION COMMITTEE (MSEC)

### 8.10.1. Membership:

- 8.10.1.1. Chair (Appointed by the Chief of Staff)
- 8.10.1.2. Chief of Staff
- 8.10.1.3. Chief Medical Officer and/or designee
- 8.10.1.4. Manager of CME and/or Academic Officer
- 8.10.1.5. Three (3) Professional Staff members
- 8.10.1.6. Chair, GMEC, or the committee's designee
- 8.10.1.7. Manager of Medical Library
- 8.10.1.8. Manager of Research
- 8.10.1.9. Allied Health Practitioner Representative
- 8.10.1.10. Coordinator of Continuing Medical Education (Non-Voting Member)
- 8.10.1.11. Additional committee members may be recommended to the committee by the Chair and appointed by the Chief of Staff, as deemed necessary and appropriate to carry out functions of the MSEC to meet its responsibilities or accreditation requirements.

### 8.10.2. Duties:

- 8.10.2.1. Oversee all Professional Staff Continuing Medical Education and Institute for Continuing Medical Education sponsored by Hurley Medical Center
- 8.10.2.2. Establish a written statement of Hurley Medical Center's Continuing Education mission;
- 8.10.2.3. Identify and analyze the Professional Staff's continuing medical education needs in an ongoing fashion;
- 8.10.2.4. Monitor the objectives, design, and implementation of all educational offerings;
- 8.10.2.5. Evaluate the effectiveness of all continuing medical education programs, thereby facilitating future educational planning (see Accreditation Manual of ACCME [Accreditation Council for Continuing Medical Education]); and
- 8.10.2.6. Ensure compliance with the Michigan State Medical Society Accreditation Council for Continuing Medical Education (ACCME).

### 8.10.3. Meeting Frequency: Quarterly

- 8.10.4. Other: It is expected that committee members will attend at least 50% of the scheduled MSEC meetings annually. Individuals who do not meet this expectation will be considered to have voluntarily resigned and may be replaced at the discretion of the Chief of Staff.

## 8.11. OPERATING ROOM COMMITTEE

### 8.11.1. Membership:

- 8.11.1.1. Chair or designee for Department of Anesthesia
- 8.11.1.2. Chair or designee for Department of Surgery
- 8.11.1.3. Two (2) Physician members from the Department of Surgery
- 8.11.1.4. Chair or designee for Department of Obstetrics & Gynecology

- 8.11.1.5. Managers of the following:
  - 8.11.1.5.1. OR
  - 8.11.1.5.2. CRNA Anesthesia Services
  - 8.11.1.5.3. Ambulatory Surgery Unit
  - 8.11.1.5.4. Sterile Processing
- 8.11.1.6. Vice President responsible for surgical services
- 8.11.2. Duties:
  - 8.11.2.1. oversight for establishing, reviewing and enforcing policies which govern the operating room, recovery room (PACU), pre-op holding, ambulatory surgery and all anesthetizing and procedural areas
  - 8.11.2.2. sterile processing
  - 8.11.2.3. instrument selection and recommendations for purchase
  - 8.11.2.4. surgical patient flow
  - 8.11.2.5. scheduling/boarding/recovery
- 8.11.3. Meeting Frequency: Six (6) times per year

## 8.12. PHARMACY AND THERAPEUTICS COMMITTEE (P&T)

- 8.12.1. Membership:
  - 8.12.1.1. representatives from the Professional Staff
  - 8.12.1.2. at least one (1) member from:
    - 8.12.1.2.1. Pharmacy
    - 8.12.1.2.2. Nursing service
    - 8.12.1.2.3. Administration
    - 8.12.1.2.4. Resident appointed by the Committee Chair in conjunction with appropriate Program Director
- 8.12.2. Duties: The responsibilities of this committee shall include the development and surveillance of all drug utilization policies and practices within the medical center in order to assure appropriate clinical results and a minimum potential for hazard to ensure patient safety. Responsibilities also include participation and oversight in compliance with licensure, accrediting and certifying standards, rules and regulations. The Committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs and drug safety in the medical center. Pharmacy and Therapeutics Committee activities shall be reported to the MEC. Policies and practices reflecting the above responsibilities shall be recommended to the MEC for action and recommendation to the Governing Board.
- 8.12.3. Meeting Frequency: At least six (6) times per year

## 8.13. PROFESSIONAL CONDUCT COMMITTEE

- 8.13.1. Membership: shall consist of five MSAV members, appointed by the Chief of Staff. Department Chairs shall not be eligible for membership. All members shall be voting members of the committee unless the matter being discussed poses a potential conflict with a member. In the event of a potential conflict, the Chief



of Staff will appoint an alternate member. Other guests or consultants may be invited or queried as needed to provide additional input. The Chief of Staff, Chief Medical Officer and Vice President and General Counsel shall serve in an advisory capacity only.

8.13.2. Duties:

- 8.13.2.1. Review matters referred to the Committee by the Chief of Staff, Department Chair, Administration, standing Professional Staff Committee, or other involving allegations of inappropriate Practitioner behavior or conduct, including but not limited to violations of the Professional Staff Code of Conduct, issues involving behavioral health, or allegations of impairment.
  - 8.13.2.2. Recommend and oversee compliance with the Professional Staff Code of Conduct
  - 8.13.2.3. ;
  - 8.13.2.4. When appropriate, refer Practitioners for education, therapy, proctoring, participation in the Michigan Health Professional Recovery Program, mentoring or other intervention to assist the Practitioner or Resident in returning to full function;
  - 8.13.2.5. Make recommendations to the Medical Executive Committee, when appropriate, to limit privileges or scope of practice until such time Practitioner can demonstrate compliance with the expectations set forth by the Professional Staff.
  - 8.13.2.6. When appropriate, monitor the Practitioner to assist in preventing recurrence.
- 8.13.3. Meeting Frequency: As needed based on a referral to review a matter of concern or specific incident.

8.14. PEER REVIEW COMMITTEE (PRC)

8.14.1. Membership:

- 8.14.1.1. The Clinical Directors from Departments designated by the Chief Medical Officer. Note: Medical groups contracted with Hurley Medical Center (Anesthesia, Emergency Medicine, Pathology and Radiology) will appoint a member of their respective department to serve in the role as clinical director. In an effort to avoid potential conflict, the Clinical Director shall not be the same as the Department Chair.
- 8.14.1.2. The Chief of Staff
- 8.14.1.3. The Chief Medical Officer
- 8.14.1.4. The Director of Quality & Patient Safety

8.14.2. Duties:

- 8.14.2.1. Promoting the ongoing assessment, measurement and improvement of patient care, including but not limited to the necessity, appropriateness, or quality of healthcare rendered to patients of Hurley Medical Center, as well as the qualifications, competence, or performance of its health care providers.
- 8.14.2.2. Review of all cases referred for peer review of a Practitioner with privileges

- 8.14.2.3. Timely communication with Department Chairs, Vice Chairs, and Section Heads, as appropriate
- 8.14.3. Frequency: At least ten (10) time per year
- 8.14.4. Other: All information communicated to or collected by or for the PRC, as well as all records of the proceedings, or the reports, findings, and conclusions of the PRC, shall be afforded the full protections of state and federal law.

## **ARTICLE IX – MEETINGS**

### **9.1. REGULAR/ANNUAL**

- 9.1.1. Two (2) regular meetings of the Professional Staff shall be held each calendar year. One (1) meeting shall be held in May, the other in December. The agenda of these meetings shall include a report from the MEC on the activities of the MEC and the medical work in the medical center, reports from administration, any other business deemed necessary and important by the Chief of Staff.
- 9.1.2. The December meeting shall be designated the Annual Meeting. At this meeting retiring officers, standing, and special committees shall make such reports as may be desirable and deemed necessary/appropriate by the Chief of Staff.

### **9.2. SPECIAL**

- 9.2.1. Special meetings may be called at any time by the Chief of Staff by request of the Board, or by request of the MEC. Special meetings may also be called upon receipt of a petition signed by at least ten (10) MSAV Members or 10% of the Professional Staff. Within fifteen (15) days after receipt of the request by the Medical Staff Office Coordinator, or designee and Chief of Staff, arrangements will be made for such meeting. No business, other than that which is stated in the notice of the meeting, will be conducted at any special meeting.
- 9.2.2. Notice of a special meeting shall be provided either electronically, by facsimile or USPS to all members of the Professional Staff not less than ten (10) days in advance of the date of the special meeting, with postings outside the Medical Staff Office, Medical Staff Lounge and Surgical Lounge.

### **9.3. QUORUM**

- 9.3.1. Twenty percent (20%) of the total MSAV membership shall constitute a quorum.

### **9.4. AGENDA**

- 9.4.1. Regular Meeting:
  - 9.4.1.1. Call to order
  - 9.4.1.2. Review activities of the MEC since the last meeting
  - 9.4.1.3. Report from the Chief of Staff
  - 9.4.1.4. Report of the Chief Medical Officer
  - 9.4.1.5. Report from Medical Center President/CEO
  - 9.4.1.6. Old business
  - 9.4.1.7. New business
  - 9.4.1.8. Report of the Chief Medical Officer
  - 9.4.1.9. Adjournment
- 9.4.2. Special Meeting:
  - 9.4.2.1. Reading of notice calling the meeting
  - 9.4.2.2. Transaction of business for which the meeting was called

9.4.2.3. Adjournment

9.5. **MINUTES:** Minutes of regular and special meetings of the Professional Staff and its departments and committees shall include a record of attendance of members and vote taken. Minutes shall be maintained for all Professional Staff meetings.

## **ARTICLE X - RULES AND REGULATIONS, POLICIES AND PROCEDURES**

- 10.1. The Medical Executive Committee shall have the power to adopt such policies and procedures as may be necessary to facilitate compliance with these Bylaws and applicable state and federal law, rules, regulations, accreditation standards, licensure requirements, etc., as may be advisable for the proper conduct of the work of the Professional Staff and the various departments and committees described herein, subject to the approval of the Hurley Medical Center Board of Managers. The Medical Executive Committee shall have the power to modify, amend, or repeal any policy at any meeting of the Medical Executive Committee and such change shall become effective when approved by the Hurley Medical Center Board of Managers. The Medical Executive Committee shall not have the authority to amend these bylaws or take any action that would conflict with these Bylaws, without following the requirements set forth in Article XI – Bylaw Amendments. The Professional Staff will be notified by the MEC of any policy adoption or change made by the Medical Executive Committee.
- 10.2. Proposed policies and procedures impacting the Professional Staff may be originated or amended by the Medical Executive Committee, any Department or Committee of the Professional Staff, or by a petition signed by 25% of the MSAV.
- 10.3. In addition, the Professional Staff may recommend amendments to any policies directly to the Board of Managers by submitting a petition signed by 25% of the MSAV. On presentation of such petition, the Bylaw Amendment and Conflict Resolution process of Article XI shall be followed.

## **ARTICLE XI – BYLAW AMENDMENTS & CONFLICT RESOLUTION**

- 11.1. **RESPONSIBILITY AND AUTHORITY.** The Professional Staff has the responsibility and authority to formulate and recommend to the Board of Managers and, once approved, adopt and implement the Professional Staff Bylaws. Such responsibility and authority will be exercised in good faith and in a reasonable, timely and responsible manner reflecting the interest in providing high-quality and safe patient care, Practitioner engagement, and maintaining a collaborative relationship between the Professional Staff, Board of Managers, Administration and the community served by Hurley Medical Center.
- 11.2. **AUTHORITY TO REQUEST CHANGES.** Any of the following may request a change to the Bylaws. All requests will be submitted to the Bylaws Committee for review before being presented to the Medical Executive Committee.
- 11.2.1. Professional Staff Department or Committee
  - 11.2.2. Medical Executive Committee
  - 11.2.3. Board of Managers
  - 11.2.4. Bylaw Committee
  - 11.2.5. Petition signed by 25% or more members of the MSAV.
- 11.3. **BYLAW COMMITTEE:** All proposed amendments shall be reviewed by the Bylaws Committee, which shall report out the proposed changes to the Medical Executive Committee. The report shall include a recommendation to approve or disapprove a proposed amendment. It may also suggest changes to a proposed amendment.
- 11.4. **MEDICAL EXECUTIVE COMMITTEE:** The Medical Executive Committee will consider the proposed changes and will either:
- 11.4.1. return the proposed amendment to the Bylaws Committee for further consideration, if appropriate;
  - 11.4.2. deny the proposed amendment; or
  - 11.4.3. approve the proposed amendment and pose the proposed amendment to all MSAV members in accordance with 11.5
  - 11.4.4. If the proposed change is for correction only (clarification, reorganization, renumbering, or to correct grammatical, spelling or punctuation errors), the Chief of Staff shall have the authority to adopt the correction without presentation to the Medical Executive Committee or MSAV. If the proposed amendment is for compliance with state or federal law, or The Joint Commission Accreditation standards or the Medicare Conditions of Participation, the Medical Executive Committee shall have the authority to adopt the changes without presentation to or approval by the MSAV members. Such amendments shall be effective when approved by the Board. All other amendments must be presented to the Medical Executive Committee and posed to the MSAV in accordance with these Bylaws before any changes may be presented to and considered by the Board.

- 11.4.5. Note: if the proposed changes to the Bylaws are initially recommended by a petition put forth by the Professional Staff in accordance with Section 11.2.5., and the Bylaws Committee or Medical Executive Committee proposes additional changes or denies the request, the original request from the petition will be presented at the Regular or Special meeting in which the Professional Staff will deliberate and vote on the proposed changes.
- 11.5. ACTION BY THE MSAV:
  - 11.5.1. All proposed amendments approved by the Medical Executive Committee or recommended by a petition put forth by the Professional Staff in accordance with Section 11.2.5, shall be subject to approval by majority vote of the MSAV before being submitted to the Board. The Medical Executive Committee shall determine the method in which the proposed amendments will be presented to the MSAV and shall be one of the following:
    - 11.5.1.1. At the next Regular Meeting of the Professional Staff
    - 11.5.1.2. At a Special Meeting of the Professional Staff, called at least fifteen (15) days in advance of the Special Meeting
    - 11.5.1.3. Submitted for approval to all MSAV via written or electronic ballot
  - 11.5.2. Regardless of how the Bylaw revisions are presented, the proposed Bylaw revision(s) will be sent to the Professional Staff Members a minimum of ten (10) days in advance of the Regular Meeting, Special Meeting, or return of the mailed ballot. Only Professional Staff Members eligible to vote at the time of the mailing shall receive a ballot.
  - 11.5.3. Approval of the proposed amendment shall require an affirmative vote of two thirds (2/3) of the Professional Staff eligible to vote
    - 11.5.3.1. that are present at the Regular or Special Meeting or
    - 11.5.3.2. that returned a mailed ballot if a Regular or Special Meeting is not held
    - 11.5.3.3. In the event that the ballots are submitted for approval via written or electronic ballot, only those ballots received twenty-one (21) days from submission shall be considered.
- 11.6. ACTION BY THE BOARD OF MANAGERS: Once approved by the Professional Staff, proposed amendments will be sent to the Board of Managers for approval. If the Professional Staff proposed changes directly to the Board of Managers, it will communicate the proposed amendment to the Medical Executive Committee before final action is taken and conflicts will be handled in accordance with Paragraph 11.7.
- 11.7. CONFLICT RESOLUTION. Conflict Resolution for Bylaw changes that are recommended by the MSAV members and denied by the Board,
  - 11.7.1. The Board shall provide a detailed response specifying the reason for the denial.
  - 11.7.2. The Medical Executive Committee shall have the option of requesting that the Bylaws Committee review the reason for the denial, the original intent of the change and recommend language to the bylaws or policies that is agreeable to both the

Professional Staff and the Board. The Bylaws Committee shall submit its recommendation to a special Joint Conference Committee. The Joint Conference Committee shall review the language proposed by the Bylaws Committee. The Joint Conference Committee Members shall vote on the matter in accordance with the HMC Bylaws. All MSAV members shall have the opportunity to participate in the discussion but shall not vote on any matters presented.

11.7.3.

11.7.4. At any point in the process, the Medical Executive Committee or Board of Managers shall each have the right to recommend using an outside facilitator to assist in addressing the differences. The ultimate decision on the use of a facilitator shall be the responsibility of the Board of Managers.

11.8. **EFFECTIVE DATE:** The amendments shall be effective when approved by the Board of Hospital Managers. Proposed Bylaws may also originate by the Board of Hospital Managers. These bylaws may not be unilaterally changed by the Board of Hospital Managers or the Professional Staff without approval from the other body.

11.9. Any proposed changes to the Professional Staff Bylaws, Rules and Regulations, and/or Policies and Procedures will be communicated in writing to the Professional Staff members, and other individuals who have delineated membership or privileges following the process indicated above.

11.10. **LIMITED AUTHORITY TO WAIVE REQUIREMENTS.** Notwithstanding all of the above, the Board may, after considering the recommendations of the Medical Executive Committee and any appropriate department chairs, waive any of the requirements for Professional Staff Membership and clinical privileges established pursuant to these Bylaws and other policies and procedures of the Professional Staff or any department or section for good cause shown if the Board determines that such waiver is necessary to meet the needs of the Hospital and community it serves. However, the refusal of the Board to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

## **ARTICLE XII - REVIEW OF BYLAWS**

These Bylaws shall be reviewed no less than biennially and earlier as may be necessary to determine compliance with current regulatory, accrediting, licensure and certification standards.

## **ARTICLE XIII - RULES FOR PROCEDURE**

In all matters of procedure not otherwise provided for, Robert's Rules of Order shall be the recognized parliamentary authority.