

# **MEDICAL STAFF**

# **BYLAWS**

**Revised 2011**

**University of Michigan  
Hospitals and Health Centers**

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## **DEFINITIONS**

“ABOG” shall mean the American Board of Obstetrics and Gynecology.

“ACGME” shall mean the Accreditation Council for Graduate Medical Education.

“ADA” shall mean the American Dental Association.

“Administration” means the executive and administrative organization of UMHHC.

“Admissions and Bed Coordination Center” (“ABCC”) means the Admission and Bed Coordination Center of UMHHC.

“Advanced Post-Graduate Trainee” (“APT”) means a qualified Physician, Dentist or Psychologist who is participating in advanced clinical education programs sponsored or otherwise approved by UMMS, but not approved by ACGME, and otherwise meets the requirements for designation as an APT as set forth in these Bylaws.

“Ambulatory Care Unit” (“ACU”) means each ambulatory care service and clinic of UMHHC.

“Applicant” means a Practitioner who applies for Membership on the Medical Staff.

“Board Certified” means that an Applicant or Member is certified as a specialist by a specialty board organization recognized by the American Board of Medical Specialties or international equivalent, the American Osteopathic Association’s Council for Graduate Medical Education, the Michigan Board of Dentistry and American Board of Maxillo-Facial Surgery or the American Board of Podiatric Surgery, as applicable.

“Board Qualified” means that an Applicant or Member has met the educational, post-graduate training and skill qualifications and is currently eligible to sit, within a specified amount of time, for the board certification examination of a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, American Dental Association or the American Podiatric Medical Association.

“Bylaws” means these bylaws of the Medical Staff.

“Chief Executive Officer” or “CEO” means the Director and Chief Executive Officer of UMHHC.

“Chief Medical Officer” or “CMO” means the individual appointed by the HHCEB and reporting to the CEO.

“Chief of Staff” or “COS” means the Medical Staff Member duly elected in accordance with these Bylaws to serve as the chief in the Office of Clinical Affairs of UMHHC.

“Clinical Information Decision Support Services” (“CIDSS”) means the support unit of the Office of Clinical Affairs.



“Clinical Program Trainee” (“CPT”) shall mean the traditional house officer enrolled in a program accredited by the ACGME or the ADA.

“C.S. Mott Children’s Hospital and Von Voigtlander Women’s Hospital Executive Committee” or “MCHVWHEC” means the executive committee of the C.S. Mott Children’s Hospital and Von Voigtlander Women’s Hospital.

“Data Bank” means the National Practitioner Data Bank.

“Dental School” means the University of Michigan School of Dentistry.

“Dentist” means a duly licensed dentist.

“Department” means the academic organizational structures of the University’s Medical School and Dental School.

“Department Chair” means the individual appointed by the Dean of the Medical School and approved by the Board of Regents to head a “Department” in the Medical School or Dental School.

“Executive Committee on Clinical Affairs” or “ECCA” means the executive committee of the Medical Staff.

“Executive Director” means the Executive Director of C.S. Mott Children’s Hospital and Von Voigtlander Women’s Hospital.

“Executive Medical Director” means the Executive Medical Director of the Faculty Group Practice.

“Executive Vice President for Medical Affairs” or “EVPMA” means the Executive Vice President for Medical Affairs of the University and CEO of the UMHS.

“Facility” means a health care facility or organization and includes the University, UMHHC, other hospitals, clinics, universities, health maintenance organizations, prudent purchaser organizations and independent practice associations.

“Faculty Group Practice” or “FGP” means the Faculty Group Practice of the University’s Medical School, which is the healthcare provider organization for the predominant number of Members with clinical privileges at UMHHC.

“FGP Board” means the governing board of the FGP.

“FGP Clinical Practice Committee” means that FGP committee established to optimize the clinical practice and operations involving the UMMS faculty in terms of safety, quality, satisfaction and financial performance.

“Focused Professional Practice Review” or “FPPE” means the period of special review applicable to Members and those granted clinical privileges as described in these Bylaws and associated Medical Staff policies.

“Graduate Medical Education Committee” or “GMEC” means the Graduate Medical Education Committee of the UMHHC.

“HHCEB Representatives” means two or more representatives of the Hospital and Health Centers Executive Board of UMHHC.

“Hospital and Health Centers Executive Board” or “HHCEB” means the Hospital and Health Centers Executive Board of UMHHC.

“House Officers Association” or “HOA” means the House Officers Association of UMHS.

“Medical School” or “UMMS” means the University of Michigan Medical School.

“Medical Staff” or “Staff” means the governing organization of Practitioners who are credentialed within UMHHC.

“Medical Staff Quality Committee” or “MSQC” means the quality committee of the Medical Staff.

“Medical Staff Services” or “MSS” means the support unit to the OCA that facilitates the processing of applications for appointment, reappointment, and clinical privileges.

“Medical Staff Year” means the fiscal year of UMHHC, July 1 through June 30.

“Member” means an appointed member of the Medical Staff.

“Office of Clinical Affairs” (“OCA”) means the administrative office of the COS and the Medical Staff.

“Official” means an officer, Department Chair, Service Chief, voting committee member of the ECCA or committee chair.

“Ongoing Professional Practice Evaluation” or “OPPE” means the process of continuous review of the practice of Members and others granted clinical privileges by the Medical Staff.

“Optometrist” means a duly licensed doctor of optometry.

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

“Past Chief of Staff” shall mean the individual who served as the COS immediately prior to the currently elected COS.

“Physician” means a physician duly licensed to practice medicine or osteopathic medicine and surgery.

“Physician Assistant” or “PA” shall mean an individual who is a graduate of a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessors and/or who is certified by the National Commission on Certification of Physician Assistants (NCCPA); and who is licensed, registered or certified to practice medicine with physician supervision.

“Podiatrist” means a duly licensed doctor of podiatric medicine and surgery.

“Practitioner” means a Physician, Dentist, Podiatrist, Psychologist or Optometrist.

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

“Professional Review Action” means an action taken in the process of a Professional Review or on account of Professional Review Information. Professional Review Actions include, but are not limited to: appointment, non-appointment, reappointment and non-reappointment to a medical staff or allied health staff of a Facility; corrective action proceedings or appeals in a Facility; preparation of reports upon conduct of an Applicant, Member or SPP’s activities in a Facility; and a recommendation or imposition of discipline or restrictions upon the professional activities of a Member, Trainee, or SPP.

“Professional Review Committee” means a committee convened to review the professional practice provided on behalf of UMHS for the purpose of reducing morbidity and mortality and improving care at UMHS.

“Professional Review Information” means records, data and knowledge developed or collected in connection with Professional Review, including, but not limited to, applications, reports, minutes, transcripts, recommendations and summaries respecting Professional Review.

“Psychologist” means a licensed clinical or educational psychologist.

“Regents” means that body which is the Board of Regents of the University of Michigan.

“Representative” means a person, committee, Medical Staff organization, board or entity which has the obligation to: conduct Professional Review; undertake Professional Review Actions; or collect, prepare, hold or disclose Professional Review information concerning an Applicant, Member or SPP.

“Rules and Regulations” means the Medical Staff Fair Hearing Plan, Medical Staff Rules and Committee Protocols and Additional Standing Committees containing additional provisions not described in these Bylaws and associated details governing the activities of Members, SPPs and Trainees.

“Scope of Service” means the specified range of services that may be provided under Member supervision within UMHHC, as determined through UMHHC administrative and/or Medical Staff credentialing mechanisms.

“Service” means a recognized specialty or specific practice area which can be formally designated as either a “Service” or a “Division;” “Departmental Services” means those Services which are within the scope of a Department.

“Service Chief” means the Member appointed to head a Service by the Department Chair, who may him/herself be the Department Chair, and as approved by the ECCA and the HHCEB.

“Special Notice” means formal notice given to an Applicant or Member (or if requested in writing, his/her agent or counsel) by or on behalf of a person acting on behalf of the University, UMHHC or the Medical Staff and sent by: registered mail; certified mail, return receipt requested; express mail service requiring a signed receipt; hand delivery directly to the Applicant or Member or a recognized assistant confirmed by affidavit of the delivering person; or other means designed to reasonably assure delivery and confirm receipt by the Applicant or Member of the item involved.

“Special Purpose Trainee” or “SPT” means, as further described in these Bylaws, qualified Physicians or Dentists who are currently enrolled in an accredited education program at an outside institution.

“Specified Professional Personnel” or “SPP” means those mid-level providers, which include physician assistants, certified registered nurse anesthetists, nurse midwives and nurse practitioners, who participate in the management of patients under the supervision, direction or back-up of a Member, consistent with the clinical privileges granted to the SPP.

“Trainee” means any Physician, Dentist or Psychologist assigned to a Service to train under the oversight of a Member, including CPTs, APTs, SPTs, and VPTs.

“UMHHC” means the University of Michigan Hospitals and Health Centers.

“UMHS” means an academic medical center composed of the Medical School, University of Michigan School of Nursing, FGP, UMHHC and affiliated organizations and units.

“University” means the University of Michigan, corporately the Regents of the University of Michigan, a constitutional corporation.

“Visiting Postgraduate Trainee” or “VPT” means a Physician, Dentist or Psychologist accepted by the course director to attend specific clinical training program in the UMHHC.

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

**ARTICLE I.**  
**MISSION, PURPOSES, SCOPE AND RELATIONSHIP TO FGP**

**1.1. MISSION**

The mission of the Medical Staff shall be to organizationally support the University's education and research in the health sciences and to maintain and improve the quality of the care within UMHHC.

**1.2. PURPOSES**

The purposes of the Medical Staff are:

- (a) To oversee the quality of professional services by all individuals with clinical privileges or a designated Scope of Service at UMHHC.
- (b) To provide a formalized organizational structure to facilitate the credentialing and review of the professional activities of Members and SPPs, and to make recommendations at the HHCEB on appointment and/or clinical privileges granted to such individuals.
- (c) To provide quality medical care for anyone admitted to or treated in any of the facilities or services of UMHHC.
- (d) To appropriately delineate, in conjunction with the HHCEB, the clinical privileges each Member may exercise through the continued review and evaluation.
- (e) To serve as a teaching resource for the schools, colleges and programs in the health sciences of the University and its affiliates in the teaching and training of health professionals and the establishment of rules and policies, in addition to these Bylaws, for Trainees.
- (f) To stimulate, promote and conduct research in human health, disease and delivery of medical care.
- (g) To cooperate with the various academic units of the University, affiliated hospitals and other health facilities and maintain educational standards at predoctoral and postdoctoral levels.
- (h) To initiate and maintain rules for governance of the Medical Staff and provide a means whereby issues and problems concerning the Medical Staff may be discussed and resolved.
- (i) To initiate, develop, review, approve, implement and enforce these Bylaws and associated Medical Staff rules, regulations and policies.

- (j) To collaborate with the HHCEB to enhance the quality and safety of patient care, treatment and services, as delegated to the HHCEB by the Regents.

### **1.3. SCOPE**

These Bylaws apply at all UMHHC facilities:

- (a) That are part of the UMHHC “campus” as that term is defined by federal law.
- (b) That are treated for reimbursement purposes as “provider-based”, where UMHHC is the “main provider.”

These Bylaws apply to Medical Staff Members, Trainees and SPPs who:

- (a) Practice their profession at UMHHC.
- (b) Practice at remote sites (including, but not limited to, unaffiliated hospitals, nursing homes, dialysis centers or professional practice) within the scope of their University employment, or otherwise as representatives of UMHS.

### **1.4. RELATIONSHIP TO FGP**

#### **1.4-1 Shared Responsibility for the Clinical Mission**

The FGP and Medical Staff share responsibility for advancing the clinical mission of UMHS and work collaboratively to pursue this objective. To facilitate coordination and avoid unnecessary duplication, the FGP Board and the ECCA each appoints one or more representatives of the other to actively participate in its meetings and those of its relevant committees, including, but not limited to, their respective nominating and bylaws committees.

#### **1.4-2 Delineation of Roles and Responsibilities**

- (a) Scope of Services
  - (i) Initial Development and Revisions. The FGP is initially responsible for determining the scope of services offered by the individual clinical Departments. Each Department, and each Service within a Department, is responsible for developing a standardized delineation of privileges document and subsequent appropriate revisions, which require approval by the FGP Board (with input from the FGP’s Clinical Practice Committee, as appropriate), and, prior to the exercise of such clinical privileges at UMHHC, recommendation by the

Credentialing and Privileging Committee and approval by ECCA. Approved delineations are made available on the OCA website.

- (ii) Quality Assurance. The Medical Staff, through the OCA and individual Departments and Services, is responsible for evaluating and assuring individual professional competence and conduct in the execution of clinical privileges.
- (b) Practice Standards
- (i) Development. The FGP, as a group, or through the Departments and Services, is responsible for developing, implementing and educating faculty and relevant staff concerning clinical practice guidelines and standards of conduct.
  - (ii) Measurement. Plans for measuring Medical Staff performance are developed by the Departments and Services and approved by the Medical Staff Quality Committee. Faculty performance is measured by the FGP and Departments and is included in annual performance evaluations and may be included in promotion materials for faculty. Department Chairs and Service Chiefs, through routine appointment, peer review (i.e. OPPE and FPPE evaluation), and reappointment activities, measure their Members' practice against those standards or receive relevant information and analysis from central units such as CIDSS. The FGP may develop standard institution-wide metrics for measuring performance where multiple Departments perform the same service or procedure.
  - (iii) Enforcement. Departures from established clinical practice standards are handled through the collegial intervention or corrective action processes described in these Bylaws. Information on alternatives to corrective action is provided in these Bylaws and in the Guidelines for Response to Medical Staff Concerns, which are jointly developed and modified from time to time by the Office of Faculty Affairs and OCA, and available on the OCA website.
  - (iv) Resolution of Interdepartmental Disputes. Resolution of interdepartmental disputes is addressed through collaborative action of the FGP and the Medical Staff. For example, questions of overlap of clinical services across Departments are addressed in accord with the "Clinical Services Overlap – Principles and Processes" document jointly developed by the



FGP and OCA and available on the OCA website. Disputes related to inpatient service failures are managed primarily by the COS and disputes related to ambulatory care service failures are managed primarily by the FGP, both in consultation with the relevant Departments and Services. To assure appropriate communication, the Executive Medical Director of the FGP is notified of resolution of inpatient Service disputes; and the COS is notified of resolution of ambulatory care service disputes.

(c) Resources

The FGP and Departments and Services are responsible for assuring the resources (for example, space, equipment, personnel) necessary to support any privileges requested are currently available, or will be available within a reasonable time after the individual receives privileges, but no more than six months. Certification of adequate support accompanies each requested amendment to a delineation of privileges form and each individual practitioner's application for the grant, renewal, or revision of clinical privileges.

(d) Professionalism and Ethics

The FGP and the OCA expect its members to uphold and be role models for the highest levels of professionalism and ethics. The UMMS Conflict of Interest Policy applies to all faculty members. Additionally, in view of the special relationship of healthcare providers to patients and their families, the FGP and the OCA expect sensitivity and disclosure of conflicts of interest, or its reasonable perception. No detailed set of rules can likely cover all potential conflicts of interest or legitimate perceptions. To maintain the public trust, and indeed to set a high standard for it, the FGP expects its members to understand and act according to its conflict of interest policies and the intent of those policies.

(e) Employment and Medical Staff Actions

Examples of permitted employment and medical staff actions, and the reporting implications of each, are described in the "Guidelines for Response to Medical Staff Concerns" available on the OCA Website.

**ARTICLE II.**  
**MEDICAL STAFF ADMINISTRATION AND OFFICIALS**

**2.1. CHIEF OF STAFF**

2.1-1 Nomination and Election

The Nominating and Bylaws Committee shall identify at least two candidates for the position of COS based on results of a nomination process conducted by the OCA with the cooperation of the CEO. The Medical Staff shall vote, by written or electronic ballot on the candidates. Rules for the election process shall be established by the ECCA. The result of the election shall be forwarded to the HHCEB for ratification.

2.1-2 Term of Appointment

The term of appointment shall be a three (3) year renewable term. The term of appointment shall begin on July 1 and terminate June 30, three (3) years hence.

2.1-3 Vacancy of Office

In the event of vacancy in the office of the COS for three (3) months or less, the COS will designate an Associate Chief of Staff to act as interim COS. In the event of a long-term (more than three (3) month) vacancy in the office of the COS, ECCA will appoint an ACOS to fill the position as interim COS, and may call an election to fill the vacancy pursuant to Section **Error! Reference source not found.** The ACOS acting as interim COS shall have the same authority as the COS, except that the ACOS shall not have the power to remove another ACOS.

2.1-4 Removal

The COS may be removed by action of two-thirds of the full voting membership of the Medical Staff or by unanimous (excluding the COS) vote of the entire membership of the HHCEB. The grounds for removal shall be one or more of the following:

- (a) Failure or inability to perform the duties of the office as delineated.
- (b) Any act, omission or circumstance which would justify corrective action, summary action or automatic action under these Bylaws.
- (c) Loss of qualifications necessary for the office.

2.1-5 Responsibilities

The COS shall:

- (a) Be responsible to the ECCA and the HHCEB for professional matters and to the CMO and HHCEB for UMHHC administrative affairs, including administrative systems designed to facilitate appropriate credentialing and privileging procedures and outcomes.
- (b) Devote such time to the OCA as is assigned by the HHCEB.
- (c) Be responsible for the enforcement of the Medical Staff Bylaws and Policies and shall have such other duties as assigned by the HHCEB through the CMO.
- (d) Represent Medical Staff interests through participation in strategic planning and operational decision-making forums, such as the Health System Clinical Quality Committee.
- (e) Perform other duties as deemed appropriate or assigned by the HHCEB.
- (f) Regularly consult with the CMO on UMHHC professional and administrative matters.
- (g) Provide Medical Staff leadership for patient safety and quality improvement and communicate with the CMO, FGP's Executive Medical Director and other senior UMHHC leaders as necessary to facilitate these efforts, including UMHHC Executive Director of Nursing.
- (h) Appoint chairs to all Medical Staff standing committees.
- (i) Promote collaborative practice and interdisciplinary, patient and family-centered care.
- (j) Participate, either personally or through a designee, as the representative of the Medical Staff, in all hearings pursuant to the Fair Hearing Plan.
- (k) Oversee any review of the necessity, appropriateness, or quality of health care services rendered to a person, or the qualifications, competence, or performance of a health care provider.

2.1-6 Membership

The COS shall serve as:

- (a) Chair of Medical Staff meetings.
- (b) Chair of the ECCA.

- (c) Member of the HHCEB and other UMHHC governance and administrative committees as appointed.
- (d) Ex officio member of all other Medical Staff committees except as otherwise indicated.

## **2.2. ASSOCIATE CHIEFS OF STAFF**

### **2.2-1 Appointment**

One or more ACOSs shall be appointed by the COS, subject to the approval of the ECCA and the HHCEB.

One ACOS, who practices all or part-time in the C.S. Mott Children's Hospital and Von Voigtlander Women's Hospital will be appointed by the COS. The ACOS cannot concurrently serve as Associate Chief Medical Officer of the C.S. Mott Children's Hospital and Von Voigtlander Women's Hospital.

### **2.2-2 Term of Appointment**

The term of appointment shall be three (3) years, with no limit upon reappointments.

### **2.2-3 Vacancy of Office**

In the event of vacancy, an interim appointment may be made by the COS until a successor is appointed by the regular means to fill the vacancy.

### **2.2-4 Responsibilities**

An ACOS:

- (a) Shall be responsible, administratively, to the COS.
- (b) Will have duties as assigned by the COS.
- (c) Shall act as the COS in the absence of the COS at the direction of the COS or the ECCA.

### **2.2-5 Removal**

An ACOS serves at the pleasure of the COS.

## **2.3. CHIEF MEDICAL OFFICER**

The CMO will develop the vision and strategy necessary to ensure that UMHS provides safe and high quality health care. In this capacity, the CMO will facilitate communication between the Medical Staff, the HHCEB and UMHS executive leadership. The CMO is

responsible for continuously educating clinicians, UMHS administration and the HHCEB about UMHS clinical quality performance, expectations and necessary revisions to practice and policy. The CMO will be appointed by the HHCEB following recommendation by the Executive Vice President of Medical Affairs. The CMO will meet the qualifications for Active Medical Staff membership, report to the CEO, and serve as a voting member of the HHCEB. As a leader of UMHS clinical quality and patient safety efforts, the CMO will co-chair the Health System Clinical Quality Committee with the CEO. He or she will integrate financial, strategic and quality planning, then monitor and implement appropriate interventions to ensure cost effective, quality patient outcomes. The CMO will coordinate the functioning of the Medical Staff and assist in the implementation and enforcement of the UMHS Medical Staff Bylaws, UMHS policies and rules and regulations of the Medical Staff. The CMO will work to facilitate and ensure a comprehensive approach to creating the ideal patient care experience and other related strategic initiatives.

## **2.4. PEDIATRICIAN-IN-CHIEF OF THE C.S. MOTT CHILDREN’S HOSPITAL**

### **2.4-1 Appointment**

The Pediatrician-in-Chief of the C.S. Mott Children’s Hospital shall be, or be nominated by, the Chair of the Department of Pediatrics and Communicable Diseases, and endorsed by the Executive Director, the ECCA and the HHCEB.

### **2.4-2 Alternate**

The Pediatrician-in-Chief of C.S. Mott Children’s Hospitals shall designate a Member in the Department of Pediatrics to act as an alternate during absences or unavailability.

### **2.4-3 Term of Appointment**

The term of appointment shall be consistent with the term of the appointment of the Chair of Pediatrics.

### **2.4-4 Review of Position**

Input will be sought from the Executive Director with each appointment renewal.

### **2.4-5 Responsibilities**

The Pediatrician-in-Chief:

- (a) Shall be responsible for Medical Staff professional matters to the COS.

- (b) Shall provide advice to the Executive Director, particularly on planned or proposed operational decisions, which would have an impact on health care delivery at the C.S. Mott Children's Hospital.
- (c) Shall co-chair the MCHVWHEC.
- (d) Shall coordinate patient care activity and assist in maintaining the quality of patient care within the medical services of C.S. Mott Children's Hospital.
- (e) Shall serve as a liaison among the Medical Staff, nursing staff and administrative staff using the C.S. Mott Children's Hospital.
- (f) Shall represent the Medical Staff of C.S. Mott Children's Hospital in extramural matters.
- (g) May delegate duties of the office, as appropriate, to other Members using the C.S. Mott Children's Hospital.
- (h) Shall oversee, as appropriate, any review of the necessity, appropriateness, or quality of health care services rendered to a person, or the qualifications, competence, or performance of a health care provider.
- (i) Shall present an MCHVWHEC annual report to the ECCA.

2.4-6 Removal

The Pediatrician-in-Chief may be removed by action of the Dean and Executive Director. The grounds for removal shall be one or more of the following:

- (a) Failure or inability to perform the duties of the office as delineated.
- (b) Any act, omission or circumstance which would justify corrective action, summary action or automatic action under these Bylaws.
- (c) Loss of qualifications necessary for the office.

**2.5. SURGEON-IN-CHIEF OF THE C.S. MOTT CHILDREN'S HOSPITAL**

2.5-1 Appointment

The faculty members of the C.S. Mott Children's Hospital operating rooms will identify at least two (2), but no more than three (3), individuals to recommend to the Executive Director for the position. The Executive Director appoints the Surgeon-in-Chief from the list of recommendations. The ECCA and the HHCEB endorse the appointment. This process will be followed to fill vacancies in the

Surgeon-in-Chief role and also at least every six (6) years (following every two (2) completed terms of appointment by the same individual serving as Surgeon-in-Chief).

2.5-2 Alternate

The Surgeon-in-Chief of C.S. Mott Children's Hospital shall designate a surgical faculty who practices at C.S. Mott Children's Hospital to serve as Alternate Surgeon-in-Chief. He/she will act as the Surgeon-in-Chief in the event of the regular Surgeon-in-Chief's absence or unavailability.

2.5-3 Term of Appointment

The term of appointment shall be three (3) years and is renewable.

2.5-4 Review of Position

Every three (3) years or sooner at the discretion of the Executive Director, the performance of the currently serving Surgeon-in-Chief shall be reviewed by the Executive Director with input from the C.S. Mott Children's Hospital Operating Room Committee.

2.5-5 Responsibilities

The Surgeon-in-Chief of C.S. Mott Children's Hospital shall:

- (a) Review and evaluate professional matters relating to the surgical facilities, staffing and equipment in C.S. Mott Children's Hospital, in association/consultation with the CEO for general items, and to the Chairs of the several surgical Departments utilizing the C.S. Mott Children's Hospital.
- (b) Provide advice to the Executive Director, particularly on planned or proposed operational decisions which would have an impact on health care delivery within the operating rooms and other surgical facilities in the C.S. Mott Children's Hospital.
- (c) Serve as Chair and a voting member of the C.S. Mott Children's Hospital Operating Room, Post-Anesthesia and Recovery Room Committee.
- (d) Coordinate surgical activities and assist in maintaining the quality and efficiency of excellent patient care within the surgical services of the C.S. Mott Children's Hospital.

- (e) Serve as a liaison among the Medical Staff, nursing staff and administrative staff using the operating rooms in the C.S. Mott Children's Hospital.
- (f) Be responsible for Medical Staff professional matters to the COS.
- (g) Represent surgical Members at C.S. Mott Children's Hospital in extramural matters.
- (h) Confirm the efficient functioning of surgical facilities and develop new surgical programs in coordination with the Services, Departments and Administration.
- (i) Act, in keeping with institutional guidelines, to resolve immediate operational problems (such as scheduling conflicts) which occur in the operating rooms and other surgical facilities at C.S. Mott Children's Hospital.
- (j) Provide advice to the chair of the Departments using the operating rooms in the C.S. Mott Children's Hospital.
- (k) Serve on the UMHS Operating Room Executive Committee representing the Mott operating rooms.
- (l) Serve as co-chair of the MCHVWHEC.
- (m) Oversee compliance with policies and procedures related to the function of the operating rooms and other surgical facilities at C.S. Mott Children's Hospital.

#### 2.5-6 Removal

The Surgeon-in-Chief of C.S. Mott Children's Hospital may be removed by action of the Executive Director and the ECCA. The grounds for removal shall be one or more of the following:

- (a) Failure or inability to perform the duties of the office as delineated.
- (b) Any act, omission or circumstance which would justify corrective action, summary action or automatic action under these Bylaws.
- (c) Loss of qualifications necessary for the office.



## **2.6. OBSTETRICIAN/GYNECOLOGIST-IN-CHIEF OF VON VOIGTLANDER WOMEN'S HOSPITAL**

### **2.6-1 Appointment**

The Obstetrician/Gynecologist-in-Chief of the University of Michigan Von Voigtlander Women's Hospital shall be, or be nominated by, the Chair of the Department of Obstetrics and Gynecology and endorsed by the Executive Director, the ECCA and the HHCEB.

### **2.6-2 Alternate**

The Obstetrician/Gynecologist-in-Chief of Von Voigtlander Women's Hospital shall designate a faculty who practices at the University of Michigan Von Voigtlander Women's Hospital to act as an alternate in the Obstetrician/Gynecologist-in-Chief's absence or unavailability.

### **2.6-3 Term of Appointment**

The term of appointment shall be consistent with the term of the Chair of the Department of Obstetrics/Gynecology.

### **2.6-4 Review of Position**

Input will be sought from the Executive Director with each appointment renewal.

### **2.6-5 Responsibilities**

The Obstetrician/Gynecologist-in-Chief of the Von Voigtlander Women's Hospital:

- (a) Is responsible for professional matters relating to the obstetrics services and facilities for operational matters to the Executive Director and for departmental items to the Department of Obstetrics and Gynecology and the Von Voigtlander Women's Hospital.
- (b) Shall provide advice to the Executive Director, particularly on planned or proposed operational decisions which would have an impact on health care delivery within the Birth Center and Von Voigtlander Women's Hospital.
- (c) Shall serve as a member of the MCHVWHEC.
- (d) Shall coordinate obstetric activities and assist in maintaining the quality and efficiency of excellent patient care within the obstetric and

gynecologic Services of the Birth Center and Von Voigtlander Women's Hospital.

- (e) Shall serve as a liaison among the Medical Staff, nursing staff and administrative staff using Von Voigtlander Women's Hospital.
- (f) Shall represent Von Voigtlander Women's Hospital in extramural matters.
- (g) Shall be responsible for Medical Staff professional matters to the COS.
- (h) Shall confirm the efficient functioning of Von Voigtlander Women's Hospital facilities and develop new obstetric programs in coordination with the Services, Departments and Administration.
- (i) Shall act, in keeping with institutional guidelines, to resolve immediate operational problems which occur in the Von Voigtlander Women's Hospital or Birth Center.
- (j) Shall provide advice to the Chair of the Departments using the Von Voigtlander Women's Hospital and Birth Center.
- (k) Shall chair the UMHS Obstetrics and Gynecology Executive Committee.
- (l) Shall oversee, as appropriate, any review of the necessity, appropriateness, or quality of health care services rendered to a person, or the qualifications, competence, or performance of a health care provider.

## **2.7. OTHER MEDICAL-ADMINISTRATIVE OFFICIALS OF UMHHC**

### **2.7-1 Appointment**

The CEO or designee may appoint Members to perform specific medical-administrative functions in an official capacity (e.g., the Surgeon in Chief at University Hospital and C.S. Mott Children's Hospital). Any such appointment shall be endorsed by the applicable facilities executive committee or equivalent leadership group.

### **2.7-2 Term of Appointment**

The term of appointment shall be as provided in the position description prepared by the CEO, but in no event longer than three (3) years.

### 2.7-3 Responsibilities

- (a) The responsibilities of each such medical-administrative Official shall be described in a position description provided to the ECCA and the HHCEB at the time the appointment is endorsed or from time to time amended by the CEO in consultation with the ECCA.
- (b) Any such medical-administrative Official shall report primarily to the CEO, but if assigned matters relating to the delivery or quality of clinical services performed by Members, shall also report on such matters to the applicable Service Chief or Department Chair (if any) and the ECCA through the COS.

### 2.7-4 Removal

Any such medical-administrative Official may be removed by action of the CEO after consultation with the applicable facility's executive committee and the ECCA. The grounds for removal shall be one or more of the following:

- (a) Failure or inability to meaningfully or timely perform the duties of the office as delineated in the position description.
- (b) Inability to work cooperatively with Officials of the Medical Staff, Members, or UMHHC staff critical to the Official successfully achieving the goals of the position.
- (c) Any act, omission or circumstance which would justify corrective action, summary action or automatic action under these Bylaws.
- (d) Loss of qualifications necessary for the office.

### 2.7-5 Discontinuance of Position

After consultation with the affected medical-administrative Official, the ECCA and the HHCEB, the CEO may discontinue a medical-administrative Official position established under this section, on the basis that it is no longer necessary from the perspective of Administration or is not adequately funded under the UMHHC administrative budget.

## **2.8. DEPARTMENT CHAIR**

### 2.8-1 Designation

The Department Chair is the Chair of the corresponding Medical School or Dental School Department, with appropriate clinical experience and education and Board Certification (or equivalency).

2.8-2 Alternate

The Chair of a Department shall designate a Service Chief acceptable to the ECCA to act in the Chair's absence.

2.8-3 Responsibilities

The Department Chair:

- (a) Shall oversee all clinical, professional and administrative activities of the Services within the Department (this includes activities within both inpatient and ambulatory areas), including the following:
  - (i) Maintenance of quality control programs, as appropriate, as well as the continuous assessment of the quality of care, treatment and services.
  - (ii) Orientation and continuing education of all persons in the Department.
  - (iii) Development and implementation of policies and procedures that guide and support the provision of care, treatment and services.
- (b) Directly or through a designated Service Chief shall provide continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in a Department or Service.
- (c) Directly or through a designated Service Chief shall recommend the criteria for clinical privileges within the Department and communicate with the Service Chief on clinical privileges recommended for Members in each Service.
- (d) Directly or through a designated Service Chief shall facilitate the development of clinical privilege delineation documents and scope of service documents, as well as the qualifications and competence required of SPPs and other non-Member personnel who provide patient care, treatment and services.
- (e) Shall confirm that the quality and appropriateness of inpatient and ambulatory care provided within the Department's Services are consistent with and responsive to the UMHHC Quality Improvement Program.
- (f) Shall recommend a sufficient number of qualified and competent persons to provide care, treatment and services, and assess and recommend to the appropriate executive committee sources for needed

patient care, treatment and services not provided by the Department or UMHHC.

- (g) Shall be charged with integration of the Department into the primary functions of UMHHC and the coordination and integration of interdepartmental and intradepartmental services.
- (h) Shall recommend to the appropriate executive committee the space and other resources needed by the Department.
- (i) Shall ensure that Departmental goals and objectives are aligned with UMHHC goals and objectives.
- (j) Shall oversee, as appropriate, any review of the necessity, appropriateness, or quality of health care services rendered to a person, or the qualifications, competence, or performance of a health care provider.

#### 2.8-4 Removal

The Department Chair may be removed in accordance with University processes.

## **2.9. SERVICE CHIEF**

#### 2.9-1 Appointment

Each Service shall have a Service Chief appointed by the Department Chair in consultation with the COS. The nomination shall be accompanied by a recommendation of the ECCA before referral to the HHCEB for final action. A Department Chair may self nominate. In the circumstance of a Department Chair also being a Service Chief, the COS will be responsible for evaluation.

#### 2.9-2 Qualifications

- (a) A Doctor of Medicine/Osteopathy/Dentistry (DMD or DDS) is required.
- (b) Possession of a current license to practice medicine or dentistry in the State of Michigan is necessary.
- (c) Member in good standing on the Active Medical Staff is required.
- (d) Full-time faculty appointment in the Medical School or Dental School is required.
- (e) Appropriate clinical experience and education and Board Certification (or equivalency) is required.

- (f) Current, active clinical role in the Service is required.
- (g) Administrative leadership experience is desirable.

2.9-3 Term of Appointment

The term of appointment is one year, but the Service Chief shall serve until his/her successor is appointed. Reappointment is dependent on an annual performance review by the Department Chair or COS where applicable, and as recommended to the COS. There shall be no limitation as to the number of times a Service Chief may serve.

2.9-4 Removal

A Service Chief may be removed by action of the ECCA or the HHCEB, in consultation with the relevant Department Chair or COS, as applicable. The grounds for removal shall be one or more of the following:

- (a) Failure or inability to perform the duties of the office as delineated.
- (b) Any act, omission or circumstance which would justify corrective action, summary action or automatic action under these Bylaws.
- (c) Loss of qualifications necessary for the office.

2.9-5 Characteristics and Responsibilities

A Service Chief shall:

- (a) Demonstrate principled leadership, consistently focusing the Service and Department on institutional clinical goals, values and behaviors.
- (b) Establish, maintain and update, as clinical care evolves, a comprehensive, well documented clinical care peer review process within the Service, consistent with the Professional Practice Evaluation Policy.
- (c) Coordinate patient care, teaching, research and related activities within the Service in accordance with UMHS plans.
- (d) Critically evaluate quality related data received from MSS and other sources, and take action when appropriate to correct or prevent quality problems.
- (e) Oversee compliance of Members in the Service with licensure and Medical Staff requirements.

- (f) Provide leadership within the Service for a continuous quality improvement program and activities that incorporate UMHS quality priorities and goals, including the responsibility to:
  - (i) Identify key practice issues which impact patient safety, quality and cost.
  - (ii) Initiate actions to measure and improve clinical care within the Service.
  - (iii) Communicate priorities for improvement and cost efficiency to clinical staff, the Department Chair and UMHS.
  - (iv) Establish a peer review program and prepare and submit annual reports to the Medical Staff Quality Committee.
  - (v) Collaborate with other providers and Departments/Services to improve quality and safety of patient care and cost effectiveness.
- (g) Prepare for and participate in external regulatory and accreditation reviews and confirm that the Service meets external accreditation requirements.
- (h) Recommend appointment of individuals to the Medical Staff with the approval of the Department Chair.
  - (i) Delineate minimum privileging requirements including training, experience and demonstrated competency.
  - (ii) Recommend appropriate clinical privileges for Members of the Service. Privileges to provide specific patient care and treatment must be within well-defined limits, based on an individual's licensure, education, training, experience, competence, judgment and health status.
  - (iii) Review Members' clinical privileges and recommend necessary changes at the time of biennial reappointment or as needed.
- (i) Evaluate Members on the Service based on performance; provide documented feedback at the time of reappointment, consistent with the Professional Practice Evaluation Policy, or more often if needed, including continuing surveillance of licensure status.
- (j) Cultivate positive clinical relationships and referral patterns across internal and external boundaries.

- (k) Implement the policies and meet the requirements of the Medical Staff in all clinical matters including patient care, medical records, informed consent and consultations.
- (l) Advise the Department Chair, the Dean of the Medical School and the ECCA concerning the capability of the Service to provide education and training opportunities for medical students, CPTs and other health professionals.
- (m) Assume responsibility for the safe introduction of new or upgraded technologies (including the introduction of new “off-label” uses of drugs, devices or other technologies) through appropriate vetting, including possible referral to appropriate committees and/or the FGP for new privileges, and for notification and training of relevant staff and monitoring of outcomes.
- (n) Determine the qualifications and competence of SPPs within the Service.
- (o) Assist in the development of policies and procedures that guide and support the provision of care, treatment and services.
- (p) Assume responsibility for orientation and continuing education of all persons functioning in the Service and the establishment and communication of clear performance and compliance expectations.
- (q) Assess the minimum qualifications for any contracted service deemed necessary to meet a need of UMHHC and recommend to the relevant hospital authority both the qualifications and a monitoring plan for any contracted service necessary to provide oversight of the contracted service.
- (r) Assess and cooperate in evaluating and addressing any compliance concern related to the Service, including managing the timely implementation of any corrective action required by the Service.
- (s) Attend periodic Service Chief workshops.
- (t) Oversee, as appropriate, any review of the necessity, appropriateness, or quality of health care services rendered to a person, or the qualifications, competence, or performance of a health care provider.
- (u) Perform other duties as assigned.



## **2.10. FACILITY MEDICAL DIRECTOR**

A Facility Medical Director must:

- (a) For purposes of maintaining professional and ethical behavior and discipline of Members and others practicing at his/her assigned facility, perform the same functions, as a Service Chief for Members of a Service, at the Medical Center as provided in Section 2.8-4.
- (b) Report to the COS for Medical Staff issues and to ambulatory care directors or Service Chiefs for his/her other responsibilities.
- (c) Advise relevant Department Chairs and Service Chiefs of actions taken and other practice information concerning Members in their Departments and Services practicing at his/her assigned facilities.

These responsibilities shall be exercised under the oversight of the relevant Department Chairs, the COS and the ECCA and consistent with the procedures of these Bylaws and the Rules and Regulations, and also consistent with the FGP position description process for a medical director.

## **2.11. AMBULATORY CARE MEDICAL DIRECTOR**

Each Ambulatory Care Unit is led by a team that includes a medical director, a nurse manager/clinical lead and an administrative lead. Ambulatory care medical directors are appointed by the FGP and collaborate with the relevant Service Chief(s) to promote patient safety and quality improvement. With the concurrence of the relevant Department Chair and Service Chief, and after notification to the CMO and COS, an ambulatory care medical director may be delegated any of the authorities or responsibilities otherwise accorded to the Service Chief, including, for example, initiation of collegial intervention or corrective action as described in these Bylaws.

## **2.12. TEMPORARY DISQUALIFICATION OF OFFICIALS**

In the event that an Official is temporarily disqualified from serving in his/her capacity by reason of incapacity or lack of “good standing” (including the pendency of corrective action proceedings, suspension, consultation requirement or involuntary reduction in clinical privileges), (s)he shall be placed on a temporary leave of absence from his/her position as an Official while the incapacity or lack of good standing continues. While on leave of absence, his/her position shall not be deemed vacant. However, another qualified Member may be appointed temporarily to perform the duties of the Official. The Official on leave of absence may not assume any higher office by virtue of his/her position (e.g., ACOS may not ascend to COS even if the COS is no longer in office), and if his/her term expires while on leave of absence from office, (s)he may not be reelected or reappointed while still on leave of absence.

**ARTICLE III.  
MEDICAL STAFF MEMBERSHIP**

**3.1. MEMBERSHIP – A PRIVILEGE**

Membership is a privilege that shall be limited to professionally competent Practitioners who continuously meet the qualifications, requirements and responsibilities set forth in these Bylaws, including, if required for a Member’s Staff category, a faculty appointment in the Medical or Dental School.

**3.2. QUALIFICATIONS FOR MEMBERSHIP**

3.2-1 Documentation of Qualifications

A licensed Practitioner may apply for Membership. Applicants must document their experience and training and demonstrate their competence, adherence to the ethics of their profession, and ability to work with others with sufficient adequacy to assure that any patient treated by them will be given appropriate medical care. Documentation shall include peer recommendation. Further qualifications are contained later in Article III and in Articles IV and V of the Bylaws.

3.2-2 Practice Elsewhere Not Basis for Membership

Practitioners shall not be entitled to Membership or to exercise clinical privileges within UMHHC merely by virtue of the fact that they are duly licensed to practice in this or any other state, or that they are members of any professional organization, or that they had in the past, or presently have, such privileges at another hospital.

3.2-3 Non-Discrimination

Appointments and clinical privileges shall not be denied on any basis that violates applicable law or University policy.

**3.3. BASIC REQUIREMENTS AND RESPONSIBILITIES FOR THOSE SEEKING OR HOLDING MEDICAL STAFF MEMBERSHIP**

To be a Member and hold clinical privileges, an Applicant must personally establish and thereafter, if appointed, a Member must continue to fulfill the following basic requirements and responsibilities:

3.3-1 Licensure

Each Member and Applicant shall secure and maintain Michigan licensure, in good standing, to practice his or her profession, except in the case of visiting

Members or Applicants or those individuals granted disaster privileges consistent with the Michigan Public Health Code and these Bylaws.

### 3.3-2 Education, Training and Certification

Each Member and Applicant shall:

- (a) Graduate from a professional school or program generally recognized for its quality of education, per the Medical Staff appointment policy.
- (b) Satisfactorily complete graduate training programs and possess any certification or qualification deemed necessary by the relevant Department and the ECCA to safely and appropriately perform the clinical privileges requested.
- (c) Participate and satisfactorily complete continuing education programs and activities which relate to his/her delineated clinical privileges.
- (d) Maintain full academic appointment in good standing with the University and compliance with all academic appointment requirements, if performing in an academic role.
- (e) Be Board Certified or Board Qualified by an appropriate specialty board where required by the Department. Applicants must be Board Certified or Board Qualified for the primary specialty and/or subspecialty applicable to his or her practice if required by the Department in which (s)he expects to exercise clinical privileges. A Member must be Board Qualified or Board Certified in accordance with the specific (or stated) requirements of the specialty, and in compliance with specific Department criteria for delineation of privileges applicable to that Member. If an Applicant does not meet the Board Certification requirement and there are extraordinary reasons to support the application, the Department Chair must send a written request to the Credentialing and Privileging Committee requesting a waiver prior to that committee's review of the Applicant's initial appointment file. Following review by the Credentialing and Privileging Committee, a recommendation will be forwarded to the ECCA, who will make the final decision regarding approval or denial of the waiver. Reappointment is contingent upon Board Certification as outlined in the Medical Staff Policy.

### 3.3-3 Professionalism

Each Applicant and Member shall:

- (a) Adhere to the ethics of his/her profession, consistent with the UMHC mission and philosophy, and maintenance of good personal and

professional reputation regardless of profession, including compliance with any reporting obligations established by Michigan law relating to reportable conduct and misconduct by a licensed health care provider, which in all cases shall also be reported to the COS.

- (b) Cooperate with other Members, SPPs, support staff, Administration and the HHCEB, consistent with institutional policies regarding communications among persons working within UMHHC and the Code of Conduct.
- (c) Comply with applicable federal, state and local law; the Bylaws, the Rules and Regulations, Department and Service Rules; and all policies applicable to Members.
- (d) Discharge Medical Staff and institutional functions for which (s)he is responsible by appointment, election or otherwise, including committee service.
- (e) Prepare and complete, in a timely manner, medical and other records required for patients for which (s)he provides care, consistent with these Bylaws, the Rules and Regulations, and institutional policy.
- (f) Respect privacy, security and confidentiality of patient, Medical Staff, and institutional information, and adherence to institutional policies, except as otherwise required by law or authorized by UMHHC.

#### 3.3-4 Physical and Mental Capacity to Practice

Each Applicant and Member shall demonstrate the physical and mental capacity and freedom from chemical dependency, to permit the safe exercise of privileges. In this respect, the HHCEB may, at the time of initial application, reappointment or during any interim period, condition the exercise of privileges upon the Applicant or Member undergoing a physical and/or mental health examination conducted by one or more health care professionals selected in accordance with these Bylaws and established institutional policies.

#### 3.3-5 Quality and Safety of Care

Each Applicant or Member shall:

- (a) Provide for professional and medically necessary care directly and through those supervised at a recognized level of quality and efficiency and within the scope of his/her clinical privileges.
- (b) Comply with minimum activity requirements within UMHHC (patient care and/or meeting attendance) established by the HHCEB and the ECCA after considering Department Chair, Service Chief and, if

appropriate, ACU Medical Director input, to assure awareness of current UMHHC procedures and, if holding clinical privileges, an opportunity to observe his/her professional conduct and practice for quality improvement and risk management purposes.

- (c) Meaningfully participate in UMHHC's programs for quality assurance, utilization review, risk management and promotion of patient and staff safety and support activities designed to address issues identified by these programs.
- (d) Meaningfully participate, as requested, in UMHHC's Professional Review activities, including fulfilling assigned monitoring activities.
- (e) Meaningfully participate, as requested, in providing inpatient consultations, Department of Emergency Medicine consultations for those patients potentially requiring admission and inpatient attending coverage for those patients who are not under the ongoing care of a Member, according to on-call coverage mechanisms, Medical Staff, Department, and Service policies.
- (f) Personally provide or arrange for another Medical Staff Member to provide care on a continuous basis for his/her patients. The arrangement could occur through on-call physicians.
- (g) Demonstrate the ability to effectively understand and communicate in the English language sufficient for patients, colleagues, Members, SPPs, Trainees, medical students and hospital staff to understand his/her spoken words (or equivalent if medically speech impaired) and for his/her medical records to be reasonably understood by others.

### 3.3-6 Business and Reporting

Each Applicant or Member shall:

- (a) Refrain from use of the UMHHC name or other service marks of the UMHS or the Medical Staff in any commercial message, advertisement or other writing for the purpose of promoting his/her services, or any entities of which (s)he is owner, partner, shareholder or employee, without the advance written authorization of the CEO and COS, and others as may be required by University policy.
- (b) Secure, maintain, and upon request, provide evidence of professional liability insurance of a kind, type and limits prescribed by the HHCEB. This requirement does not apply to Members who do not hold clinical privileges, or Applicants who are not requesting clinical privileges or those who are employees of the University.

- (c) Immediately report to the Service Chief and MSS relevant facts and documents: regarding the institution of disciplinary proceedings or taking of action by any health facility (including HMOs), professional society or licensing authority of any state or nation; limitation, suspension, revocation or resignation of clinical privileges at any health facility; censure, reprimand, suspension, restriction, probation or limitation of professional licensure by the licensing authority of any state or nation; or censure of any kind by any professional organization.
- (d) Immediately report to the Service Chief and MSS relevant facts and documents regarding the loss of, suspension of, or other action taken by any state or federal government concerning: the authority to prescribe or administer controlled substances; the filing of notice of exclusion or debarment from any state or federal health care program, including Medicare and Medicaid.
- (e) Immediately report to the Service Chief and MSS the facts and circumstances of: any judgment or settlement arising from professional practice in civil cases; any current formal criminal charges (e.g., indictment); and any conviction of a felony or any other crime growing out of professional practice.
- (f) Immediately report to the Service Chief and MSS if (s)he contracts a contagious disease which is reportable to public health authorities under law and which could endanger the health of the patients, the Member or Applicant, or others working with him/her if he/she practiced within UMHHC.
- (g) Comply with other institutional policies and procedures on required reporting, including disclosure of and participation in outside activities.

### **3.4. INSTITUTIONAL FOCUSED CONSIDERATIONS FOR APPOINTMENTS**

Appointments and grants of clinical privileges shall also take into account the present and future needs of UMHHC and the community it serves, including the following:

- (a) Consistency with the University's academic mission and goals.
- (b) Delivering quality of care in a cost-effective manner, taking into account the limited resources of UMHHC.
- (c) Having adequate facilities and supportive services within UMHHC for the Applicant or Member and his/her patients.
- (d) Needing the professional skills of the Applicant or Member for UMHHC's delivery of care to its patients.

- (e) Absence of pre-existing, available and sufficient services or capabilities within UMHHC which are redundant to the services offered by the Applicant or Member.
- (f) Meeting UMHHC's contractual obligations.
- (g) Consistency with organizational plans.

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

### **3.5. SPECIAL RESPONSIBILITY REGARDING THE APPLICATION AND REAPPOINTMENT PROCESS – TIMELY ACTION AND MATERIAL INACCURACIES OR OMISSIONS**

Applicants and Members shall be required to produce timely and adequate information in the application and reappointment processes for proper evaluation of his/her experience, background, training, demonstrated ability, and physical and mental health status, as well as resolving any doubts about these or any other qualifications. This responsibility includes obtaining meaningful and timely responses to UMHHC reference requests from persons the UMHHC deems appropriate. The Applicant or Member shall further have the responsibility of completing any application or reappointment form in a full, complete and intellectually honest manner and to update any information which changes while the application is pending. In this respect and with regard to the reporting requirements of this Article, if the Applicant or Member has any doubt as to whether disclosure of any information is required during the application or reappointment process, (s)he shall disclose the information with an explanation of his/her uncertainty as to whether the information is required or not.

### **3.6. CONDITIONS AND DURATION OF APPOINTMENT**

#### **3.6-1 Acknowledgement**

Acceptance of Membership shall constitute acknowledgement that (s)he has received and reviewed the Bylaws and the Rules and Regulations of the Medical Staff, and is specifically aware that (s)he shall be bound by the terms thereof.

#### **3.6-2 Code of Conduct**

Acceptance of membership on the Medical Staff shall constitute acceptance of the Code of Conduct.

#### **3.6-3 Clinical Privileges**

Appointment to the Medical Staff shall confer only such clinical privileges as have been granted pursuant to Article VII.

3.6-4 Term

The term of appointment shall be for a maximum period of two years or less, as determined by the reappointment schedule or the ECCA and the HHCEB appointment documentation. As more fully provided in Section 4.5-4, Members in the Active, Courtesy and Affiliate Staff categories shall serve as initial provisional appointment of no less than twelve (12) months or more than two (2) years, which will expire no later than the biennial Medical Staff review for his/her Department.

3.6-5 Testing

Acceptance of membership on the Medical Staff authorizes UMHHC to conduct drug and alcohol screens and a health assessment on a Member at any time during the normal pursuit of duties when requested by the Member's Department Chair or Service Chief, or the COS.



**ARTICLE IV.  
CATEGORIES AND DESIGNATIONS OF THE MEDICAL STAFF AND TRAINEES**

**4.1. THE MEDICAL STAFF CATEGORIES AND TITLES OF MEDICAL STAFF AND TRAINEES**

The Medical Staff shall consist of Active, Courtesy, Honorary, and Affiliate Staff Members. In conjunction with the Medical Staff, Visiting Staff, CPTs and designated other Trainees shall also practice within UMHHC. Each such individual category shall be designated by one of the following titles:

<u>Medical Staff</u>	<u>School Title/Track</u>
Active	Instructional Track Faculty Clinical Track Faculty Research Track Faculty Lecturers Clinical Associate
Courtesy	Adjunct Faculty Adjunct Clinical Associate
Affiliate	N/A
Honorary	Emeritus Faculty
Visiting	Visiting Faculty

<u>Medical School Track</u>	<u>School Titles</u>
Instructional Track	Instructor, Assistant Professor, Associate Professor, Professor
Clinical Track	Clinical Instructor, Clinical Assistant Professor, Clinical Associate Professor, Clinical Professor
Adjunct Instructional Track	Adjunct Instructor, Adjunct Assistant Professor, Adjunct Associate Professor, Adjunct Professor
Adjunct Clinical Track	Adjunct Clinical Instructor, Adjunct Clinical Assistant Professor, Adjunct Clinical Associate Professor, Adjunct Clinical Professor
Visiting Faculty	Visiting Lecturer, Visiting Instructor, Visiting Assistant Professor, Visiting Associate Professor, Visiting Professor
Other Medical School Titles	Lecturer, Clinical Lecturer, Clinical Associate, Adjunct Clinical Associate

**4.2. THE ACTIVE STAFF**

The Active Staff shall consist of Practitioners who meet the basic qualifications, requirements and responsibilities of Membership, and have an Instructional Track, Clinical Track, Research Track, Lecturer, or Clinical Associate appointment in the Medical or Dental School, who are involved in the diagnosis of patient illnesses and their

treatment, and who assume all the functions and responsibilities of membership of the Active Staff. Members of the Active Staff shall be appointed to a specific Service. Only Members of the Active Staff shall be eligible to vote on matters brought before the Medical Staff, and to hold office. They shall serve on Medical Staff committees in accordance with established committee composition as described in these Bylaws and act in accordance with these Bylaws.

### **4.3. THE COURTESY STAFF**

#### **4.3-1 Appointment Criteria**

The Courtesy Staff shall consist of those Practitioners who meet the basic qualifications, requirements, and responsibilities of Membership, and hold an Adjunct Faculty or Adjunct Clinical Associate appointment in the Medical or Dental School. Any specified clinical privileges that are required for Courtesy Staff shall be accompanied by a supporting letter from the appointing Clinical Chair, and endorsed by the Dean of the Medical or Dental School (or designee) indicating that these specified privileges are essential to the discharge of the academic mission. The Courtesy Staff are involved in the diagnosis of patient illnesses and their treatment and assume all the functions and responsibilities of Membership, including where appropriate, emergency service care and consultation assignments, within the scope of delineated clinical privileges. Members of the Courtesy Staff shall be appointed to a specific Service. They may attend Medical Staff meetings but may not vote. They shall be eligible for full committee membership but may not chair the committee. They shall participate in Medical Staff conferences, seminars, and teaching programs.

#### **4.3-2 Scope of Appointment and Privileges**

The extent of clinical privileges and responsibilities in the UMHHC shall be matters of written recommendation initiated by their Service Chief (and, where applicable, Facility or Ambulatory Care Medical Director), endorsed by the Department Chair and Dean (or designee) of the Medical or Dental School, referred to the Credentialing and Privileging Committee, endorsed by the ECCA and forwarded for approval to the HHCEB. Clinical privileges for the Courtesy Staff shall not include the admission of patients to UMHHC facilities unless specifically proposed by the appropriate Department Chair and Dean of the Medical School (or designee) in a separate written communication. Such exceptions must be identified and approved annually by the ECCA and the HHCEB.

#### **4.3-3 Appointment Term**

Courtesy Staff shall be appointed for up to two (2) years and shall be subject to all the Rules and policies of UMHHC.

#### **4.4. THE AFFILIATE STAFF**

##### **4.4-1 Appointment Criteria**

The Affiliate Staff shall consist of Practitioners who meet the basic qualifications, requirements and responsibilities of Membership, and:

- (a) Provide evidence of active, capable practice of their profession at UMHHC or other facilities with a recognized quality improvement program.
- (b) Do not hold an academic appointment with the University.
- (c) Have been granted clinical privileges to practice at UMHHC on a site-specific basis.
- (d) Will practice in a manner which supports the University's and UMHHC's academic mission.

##### **4.4-2 Review of Academic and Institutional Criteria**

Fulfillment of the University's and UMHHC's academic mission is a paramount consideration for all Medical Staff processes. For this reason, the policy determinations as to whether this Affiliate category is appropriate for use at specific UMHHC sites is consistent with that academic mission shall be made jointly by the ECCA and the Medical School Executive Committee.

##### **4.4-3 Scope of Appointment and Privileges**

Affiliate Staff may diagnose and treat patients within the scope, and at the location specified for exercise, of their clinical privileges. They may also be required to assume emergency service care assignments at those UMHHC facilities where they are entitled to practice. Affiliate Staff may attend Medical Staff meetings but may not vote. Affiliate Staff may not hold elected office on the Medical Staff or assume academic responsibility for CPTs. They may serve on, but not chair, committees and may attend conferences and seminars.

##### **4.4-4 Appointment Term**

Affiliate Staff may be appointed for up to two (2) Medical Staff Years after successfully completing a Provisional Status period.

## 4.5. PROVISIONAL STATUS

### 4.5-1 Applicability

Members who are initially appointed to the Active, Courtesy, and Affiliate Staff categories shall serve a Provisional Status period of no less than one year. During this period they shall be designated “Provisional-” based on the request in their application and the actions of the ECCA and the HHCEB.

### 4.5-2 Responsibilities

- (a) Continuously meet the basic requirements for Membership set forth in Section 3.3.
- (b) Meet all other qualifications, and fulfill the other responsibilities of a Member in the Medical Staff category being sought (i.e., Active, Courtesy or Affiliate).
- (c) Meet or exceed minimum activity requirements which may be set by the Service Chief, the Department Chair, the ECCA or the COS to assure sufficient opportunity to observe the Member’s skill, ability and judgment.

### 4.5-3 Prerogatives

- (a) Exercise the clinical privileges granted consistent with the special requirements described below.
- (b) Participate, but not vote, in Medical Staff functions.

### 4.5-4 Special Requirements

- (a) Special Review. Each Practitioner shall be subject to FPPE during the period (s)he is on Provisional Status. The details of how that scope and duration of that review is determined shall be consistent with Medical Staff policy.
- (b) Lack of Activity While on Provisional Status. If at any time in the first twelve (12) months after a Member on Provisional Status is eligible to begin practice, a Service Chief (including for this purpose a Facility or Ambulatory Care Medical Director) determines that a Member has had insufficient activity at UMHHC or other practice settings upon which to base a meaningful evaluation of the Member’s ability, the Service Chief may require that the Member develop, in cooperation with the Service Chief or designee, a plan for increasing clinical activity, including extending the FPPE period of monitoring. If the Member shall substantially fail to comply with such a plan, the ECCA, may withdraw

the Membership and clinical privileges of such Member because of insufficient activity of the Member, upon which to base an evaluation of the Member's ability. If such withdrawal is not related to the qualifications or ability of the Member on Provisional Status, it shall not constitute a disciplinary action, but rather a resignation. Any Practitioner who has resigned his/her Membership and clinical privileges in accordance with this section may reapply for Membership only when the Practitioner can demonstrate that (s)he will have sufficient clinical activity upon which an adequate evaluation of his/her ability may be conducted.

- (c) Failure to Qualify for Advancement. The failure of a Member to qualify for removal of Provisional Status within two (2) years after initial appointment to the Medical Staff shall result in non-renewal of appointment and clinical privileges at the time of reappointment review.

#### **4.6. THE HONORARY STAFF**

The Honorary Staff shall consist of Practitioners honored by emeritus titles in the University of Michigan Medical or Dental School, and/or those who have retired from active hospital practice as Active Staff Members. Appointment requires a supporting letter from the appointing Department Chair, endorsed by the Dean of the Medical or Dental School, or his or her designee granting an Emeritus Faculty appointment. Honorary Staff may serve on standing Medical Staff committees. They may attend all Medical Staff meetings, but may not vote. Qualified individuals may, under circumstances prescribed by the Service Chief, endorsed by the Department Chair, and approved by HHCEB, admit and/or care for UMHHC patients if granted clinical privileges to do so; however, Honorary Staff who request and are granted clinical privileges are expected to meet all of the qualifications required of Members, and will be subject to all applicable Medical Staff and institutional policies.

#### **4.7. THE VISITING STAFF**

The Visiting Staff shall consist of Practitioners whose employment responsibilities lie with another institution of higher education or who are appointed to temporarily supplement the clinical instructional staff. These individuals shall have a faculty appointment in the Medical or Dental School as a visiting professor, visiting associate professor, visiting assistant professor, visiting instructor or visiting lecturer. Appointment requires a supporting letter from the appointing Department Chair, endorsed by the Dean of the Medical or Dental School (or his or her designee). Visiting Staff are not Members and may not serve on standing Medical Staff committees. They may attend all Medical Staff meetings, but without voting privileges. Visiting Staff may be, if consistent with policies, approved by the ECCA to admit and/or care for UMHHC patients if granted clinical privileges to do so.

**4.8. TRAINEES**

Consistent with UMHS’s academic and clinical missions, licensed physicians, dentists and psychologists enrolled in medical school or dental school training programs may be granted permission to practice within the scope of their respective programs at UMHS, consistent with job descriptions developed by the respective program directors, approved by the GMEC, and communicated as approved or amended to MSS. Each job description must include information about the scope of services performed and level of supervision required by Trainees at each stage in their training.

Trainees are not Members. Their academic and employment or affiliation status at UMHS are not governed by these Bylaws, but instead by the documents or processes described in Table 4.8 below.

Trainees’ clinical activities and professional conduct are governed by these Bylaws. Accordingly, violation of any of the requirements of these Bylaws may result in collegial intervention and/or corrective action, including as described in Article VIII, in addition to any disciplinary action that may be imposed in connection with their academic and employment or affiliation status.

**Table 4.8: Trainees and Governing Documents**

Trainee Category	Governing Document(s)
Clinical Program Trainee (House Officer)	House Officers Association Collective Bargaining Agreement  ACGME, ABOG or ADA Common Program Requirements
Advanced Post-Graduate Trainee	Offer Letter/Employment Agreement
Special Purpose Trainee	Affiliation Agreement
Visiting Post-Graduate Trainee	Offer Letter/Employment Agreement/Clinical Trial Agreement

4.8-1 Clinical Program Trainees

- (a) CPTs are qualified physicians and dentists who:
  - (i) Are enrolled in good standing in educational programs (e.g., residencies or fellowships) sponsored or otherwise approved by the Medical or Dental School, as applicable, and accredited by ACGME, ABOG or ADA (see below for Trainees enrolled in other programs).
  - (ii) Are members of the HOA.

- (iii) Meet the basic qualifications, requirements and responsibilities associated with participation in their training programs at their respective levels.
  - (iv) Are actively involved, with appropriate direction and supervision, in the prevention, diagnosis or treatment of patient injury and illness, or in related research.
- (b) Designation of an individual as a CPT requires recommendation of the Department Chair in consultation with the applicable program director and Service Chief, concurrence of the Graduate Medical Education Office, Credentialing and Privileging Committee and approval of the ECCA and HHCEB.
  - (c) CPTs may attend Medical Staff meetings but may not vote. They are eligible to vote on Medical Staff committees as described in these Bylaws. CPTs are expected to attend and participate in staff conferences, seminars, and teaching programs. Their employment status and related rights and responsibilities are set forth in the contract between the University and the House Officers Association.

#### 4.8-2 Advanced Postgraduate Trainees

- (a) APTs are qualified physicians, dentists and psychologists who:
  - (i) Are not CPTs.
  - (ii) Are participating in advanced clinical education programs sponsored or otherwise approved by the UMMS, but not accredited by ACGME.
  - (iii) Meet the basic qualifications, requirements and responsibilities of Membership.
  - (iv) Are actively involved, with appropriate direction and supervision, in the prevention, diagnosis or treatment of patient injury and illness, or in related research.
- (b) APTs are appointed to one or more specific Services. Appointment of an APT requires recommendation of the Department Chair in consultation with the applicable Service Chief, concurrence of the Graduate Medical Education Office, and approval of the Credentialing and Privileging Committee, the ECCA and the HHCEB.
- (c) APTs may attend Medical Staff meetings but may not vote. They are eligible for non-voting membership on Medical Staff committees and may attend and participate in staff conferences, seminars and teaching

programs. Their employment status is set forth in offer letters or employment agreements approved by the GMEC or the Office of Faculty Affairs.

#### 4.8-3 Special Purpose Trainees

- (a) SPTs are qualified physicians or dentists who are:
  - (i) Currently enrolled in good standing in an education program at an outside institution (the Sponsoring Institution) accredited by ACGME, ABOG or ADA for which a temporary educational rotation on a Service within UMHS of less than one year has been arranged with the Sponsoring Institution under an appropriately executed affiliation agreement.
  - (ii) Are actively involved, with appropriate direction and supervision, in the prevention, diagnosis or treatment of patient injury and illness or in related research.
- (b) Appointment of an SPT is to a specific Service and requires recommendation of the Department Chair in consultation with the applicable Program Director and Service Chief, concurrence of the Graduate Medical Education Office and approval of the Credentialing and Privileging Committee, the ECCA and HHCEB.
- (c) SPTs may not attend Medical Staff meetings, nor are they eligible for membership on Medical Staff committees. They are expected to attend and participate in staff conferences, seminars, and teaching programs in connection with their rotations. Their affiliation status and related rights and responsibilities are set forth in a contract between the University of Michigan and the Sponsoring Institution. SPTs are not eligible for membership in the House Officers Association.

#### 4.8-4 Limited Clinical Privileges for Trainees

The ECCA may determine that there are circumstances where CPTs, APTs, and SPTs may be granted clinical privileges, in accordance with these Bylaws.

### **4.9. VISITING POST GRADUATE TRAINEE**

#### 4.9-1 Applicants

Individuals may apply for VPT status to learn a specific defined patient care technique under the direction of one of the Services at UMHHC. Individuals applying for VPT status shall be licensed to practice medicine, dentistry or psychology in one of the United States and shall have been accepted by the course director to attend a specific clinical training program in the UMHHC.



4.9-2 Limitations On Scope

VPTs shall not: maintain an office nor designate an independent site to meet and examine patients, do any patient billing, perform any independent patient care, perform any independent patient workups, take calls, write orders, write on nor sign any patient medical record.

4.9-3 Status

The VPT will receive instruction from one of the Services under the oversight of a Member. VPTs will not be required to have a Michigan license, pursuant to Michigan law. VPT status does not confer independent clinical privileges nor appointment to the Medical Staff. These Bylaws, the Rules and Regulations, and other applicable UMHS and UMHHC policies shall govern the activities and conduct of VPTs.

**ARTICLE V.  
PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT**

**5.1. APPLICATION FOR APPOINTMENT OR REAPPOINTMENT**

5.1-1 Form

All applications for appointment or reappointment to the Medical Staff shall be completed, shall be signed by the Applicant/Member, as applicable, and shall be submitted on forms approved by the ECCA.

5.1-2 Burden Upon Applicant or Member

Consistent with Section 3.5, the Applicant/Member shall have the burden of producing adequate information for a proper evaluation of competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications, including the reporting of impending, past, or present liability actions.

5.1-3 Obligations of Applicant or Member

By applying for appointment to the Medical Staff, each Applicant/Member signifies willingness to appear for interviews in regard to the application. The Applicant/Member authorizes the UMHHC to consult with members of the medical staffs of other hospitals with which the Applicant/Member has been associated and with others who may have information bearing on the competence, character and ethical qualification. Furthermore, the Applicant/Member consents to the UMHHC's inspection of all records and documents that may be material to an evaluation of the professional qualifications and competence to carry out the clinical privileges requested by the Applicant/Member, as well as the moral and ethical qualifications for Membership to become a member of the Medical Staff. The applicant also releases from any liability all representatives of the UMHHC and its Medical Staff for their acts performed in good faith and without malice concerning the Applicant or Member's competence, ethics, character and other qualifications for Medical Staff appointment and clinical privileges, including otherwise privileged or confidential information, to the fullest extent permitted by law. In addition, for Practitioners who are to be employed by UMHS, any contract for employment is contingent upon successful completion of the credentialing process and the receipt of clinical privileges.

5.1-4 Acceptance of Testing

By applying for and accepting appointment to the Medical Staff, the Applicant/Member acknowledges the provisions in these Bylaws related to testing and health assessment, as described in Section 3.6-5.

### 5.1-5 Applicant and Member Review

The submission of an application for appointment/reappointment by an Applicant/Member indicates that the Applicant/Member has been given access to and read the Bylaws, Rules and Regulations and has been given access to other policies of the Medical Staff, and that s/he agrees to be bound by the terms thereof if granted Membership and/or clinical privileges.

## 5.2. **APPOINTMENT PROCESS**

### 5.2-1 Pre ECCA Review

After review and recommendation is made by the Department Chair and the Service Chief (if applicable), the Department Chair shall forward to the Credentialing and Privileging Committee the completed application, appropriate references and other pertinent material and recommendations regarding the clinical privileges the Applicant is requesting. The Credentialing and Privileging Committee shall review the evidence of the character, physical and mental competence, professional competence, qualifications, and ethical standing of the Applicant, obtaining additional information, if necessary, from references, other Members of the Service to which the applicant wishes to be appointed, and from other hospitals where (s)he has previously held staff membership. Within sixty (60) days after information on the application has been verified, the Credentialing and Privileging Committee shall report to the ECCA the results of its review of the application, with a recommendation that the application be accepted, rejected, or deferred for further action, and if acceptance is recommended, the clinical privileges recommended.

### 5.2-2 ECCA Review

At its next regular meeting after receipt of the application and the report and recommendation of the Credentialing and Privileging Committee, the ECCA shall determine whether to recommend to the HHCEB that the Applicant be appointed or rejected for Membership, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

### 5.2-3 Deferral by the ECCA

When the recommendation of the ECCA is to defer, the application for further consideration, it must be followed up within sixty (60) days with a subsequent recommendation for specified clinical privileges, or for a recommended denial of Membership.

5.2-4 Favorable Recommendation by the ECCA

When the recommendation of the ECCA is favorable to the applicant, the COS shall promptly forward it, together with all supporting documentation, to the HHCEB.

5.2-5 Unfavorable Recommendation

When the recommendation to the ECCA is unfavorable to the Applicant, either in respect to appointment or clinical privileges, the COS shall promptly so notify the Applicant by Special Notice. No such unfavorable recommendation need be forwarded to the HHCEB until after the Applicant has exercised or has been deemed to have waived the right to a review as provided in these Bylaws.

5.2-6 ECCA Consideration After Review

If, after the ECCA has considered any review, including any report and recommendation of the hearing committee and the hearing record, the ECCA's reconsidered recommendation is favorable to the Applicant, it shall be processed in accordance with Section 5.2-4. If such recommendation continues to be unfavorable, the COS shall promptly so notify the Applicant by Special Notice. The COS shall also forward such recommendation and documentation to the HHCEB, but the HHCEB shall not take any action thereon until after the applicant has exercised or has been deemed to have waived any opportunity for an appellate review as provided in these Bylaws. If appellate review is applicable and is exercised, the HHCEB shall make its final decision on appellate review.

5.2-7 Favorable HHCEB Action

After receipt of a favorable recommendation, the HHCEB or a subset of two (2) HHCEB Representatives shall act in the matter. Favorable action by the HHCEB Representatives on the appointment and extension of clinical privileges shall be considered conditional. The HHCEB Representatives' action shall become the final action of the HHCEB if not rescinded by the HHCEB at its next scheduled meeting after receiving notice of the HHCEB Representatives' action. If the HHCEB should rescind notice of the HHCEB Representatives, the conditional membership and clinical privileges shall be immediately prospectively terminated. The rescission shall be considered and processed in the same manner as an unfavorable decision by HHCEB following a favorable ECCA recommendation, as provided in Section 5.2-8.

5.2-8 Unfavorable HHCEB Action

If, after a favorable ECCA recommendation, the HHCEB's decision is unfavorable to the Applicant in respect to either appointment or clinical privileges, the COS shall promptly notify the Applicant of such decision by

Special Notice, and such decision shall be held in abeyance until the Applicant has exercised or has been deemed to have waived the rights under these Bylaws and the Rules and Regulations and until there has been compliance with Section 5.2-10. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

5.2-9 HHCEB Action – Deferral

Upon receipt of a recommendation, the HHCEB may defer final determination by referring the matter back for further reconsideration. Any such referral back shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the HHCEB shall be made, and may include a directive that further review be conducted to clarify issues which are in doubt. At its next regular meeting after receipt of such subsequent recommendation, and new evidence in the matter, if any, the HHCEB shall make a decision either to recommend acceptance or rejection of the application for Membership. All decisions to appoint shall include a delineation of the clinical privileges which the Applicant may exercise.

5.2-10 Resolution of HHCEB Differences with the ECCA

Whenever the HHCEB decision would be contrary to the recommendation of the ECCA, the HHCEB shall return the application to the ECCA stating reason for denial. The recommendation is then to be reconsidered by the ECCA and referred back to the HHCEB with recommendation before final decision is made by the HHCEB. Either the HHCEB or the ECCA may request a joint meeting review and potentially resolve continuing differences.

5.2-11 Final HHCEB Action

At its next regular meeting after a favorable recommendation or any opportunity of the Applicant for review under these Bylaws and the Rules and Regulations have been exhausted or waived, and other issues have been resolved, the HHCEB, or its duly-authorized committee, shall act in the manner. The HHCEB decision shall be final.

5.2-12 Report to Regents and Others

Notices of any final decision by the HHCEB shall be sent to the Regents, the ECCA, and the Applicant.

**5.3. REAPPOINTMENT PROCESS**

5.3-1 Process in General

The processing of reappointment will begin only when the Member has fully completed and submitted to the MSS office authorized reappointment forms

with necessary supporting information. Thereafter, the process for reappointment shall generally follow the same conditions and procedures as provided for appointment, except as modified below.

5.3-2 Basis for Reappointment

Each recommendation concerning the reappointment of a Member and the clinical privileges to be granted upon reappointment shall be based upon such Members': professional competence; physical and mental competence and clinical judgment in the treatment of patients; ethics and conduct; attendance at Medical Staff meetings and participation in Staff affairs; compliance with the Medical Staff Bylaws, Rules and Policies; cooperation with UMHHC personnel; use of the UMHHC facilities for patients; relations with other Members; general attitude toward patients, the UMHHC and the public; cooperation with academic goals; and timely reporting of impending, past, or present liability and licensure actions; if seeking reappointment in the Active, Courtesy, Visiting or Honorary Staff categories, having current faculty appointment and recommendation from the Dean of the Medical School, and the other qualifications stated in Article III; and if an Affiliate Staff Member, the special requirements of Sections 4.4-1 and 4.4-2.

The above qualifications are documented by the Department Chair and Service Chief and reported to the Credentialing and Privileging Committee in a form approved by the ECCA.

5.3-3 Credentialing and Privileging Committee Recommendation

In sufficient time for the ECCA to make a recommendation on reappointment, the Credentialing and Privileging Committee shall review all pertinent information available on each Member scheduled for reappointment consideration, and shall transmit its recommendations to the ECCA. Where non-reappointment or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

5.3-4 ECCA Recommendation and HHCEB Action

- (a) At least thirty (30) days prior to the last scheduled meeting of the HHCEB before expiration of a Member's appointment, the ECCA shall make written recommendations to the HHCEB through the COS, concerning the reappointment, non-reappointment and/or clinical privileges of each Member.
- (b) A formal recommendation shall also be delivered to designated HHCEB Representatives, if so provided in a policy approved by the HHCEB. As provided in Section 5.2-7 with initial appointments, the HHCEB Representatives' favorable action shall be considered the action by the

HHCEB unless the HHCEB, at its next meeting following notice of action of the HHCEB Representatives elects to rescind that action. If rescinded, the HHCEB shall act in the manner consistent with Section 5.2.

- (c) Where non-reappointment or a change in clinical privileges is recommended by the ECCA, the reasons for such recommendations shall be stated and documented.
- (d) When a Member is not to be reappointed, such Member shall be notified by the COS at least thirty (30) days before termination of the Member's appointment and, if applicable, contract; however, the notice period may be shorter if the termination is at the request of or for the benefit of the Member or is to implement corrective action.

#### 5.3-5 Leave of Absence

A Member may request a Medical Staff leave of absence as provided herein. The grant or denial of any such leave has no bearing on the grant or denial of an employment-related leave of absence by a Department or Division. Likewise, the grant or denial of an employment-related leave has no bearing on a request for a Medical Staff leave of absence.

- (a) A Member may request a Medical Staff leave of absence by submitting a written request to the Service Chief with notice to the Chair of the Credentialing and Privileging Committee. The request must state the proposed beginning and ending dates of the leave, which will not exceed one (1) year, along with the reasons for the leave.
- (b) The Service Chief will determine whether a request for a leave of absence will be granted. The granting of a leave of absence or reinstatement, as appropriate, may be conditioned upon the Member's completion of all medical records. The granting of a leave of absence shall have no impact on any evaluation, investigation, professional review or corrective actions pending for the Member.
- (c) During a leave of absence, the Member will not exercise any clinical privileges. In addition, the Member will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations).
- (d) At least thirty (30) days prior to termination of the leave of absence, the Member may request reinstatement of his/her privileges by submitting a written request to the Service Chief that contains a written summary of his/her relevant clinical activities during the leave of absence.

- (e) Requests for reinstatement will then be reviewed by the relevant Service Chief, Department Chair and the Chair of the Credentialing and Privileging Committee. If all these individuals make a favorable recommendation on reinstatement, the Member may immediately resume clinical practice. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentialing and Privileging Committee for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the Member will be entitled to request a hearing and appeal as provided in the Fair Hearing Plan.
- (f) If the leave of absence was for health reasons, the request for reinstatement shall be accompanied by a report from the Member's treating physician indicating that the Member is physically and mentally capable of returning to a hospital practice and safely exercising the clinical privileges requested.
- (g) Absences of more than six (6) months will result in automatic FPPE. Absences of longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the CEO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of UMHS.
- (h) If a Member's current appointment period is due to expire during the leave, and the Member does not timely submit a complete reappointment application, then the Member's appointment and clinical privileges will lapse at the end of the appointment period, and the Member will be required to proceed through the new appointment process. No patient care activities may occur after the expiration date, or prior to the Member's new appointment date (if applicable).
- (i) Members must report to the Service Chief any time they are away from Medical Staff and/or patient care responsibilities for longer than thirty (30) consecutive days and the reason for such absence if related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Failure to comply with this requirement may result in corrective action. In the event of a thirty (30)-day or greater absence, the Service Chief, in consultation with the COS, may trigger an automatic leave of absence.
- (j) Leaves of absence are matters of courtesy, not of right. If it is determined that a Member has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing or appeal.



**ARTICLE VI.  
SPECIFIED PROFESSIONAL PERSONNEL**

**6.1. PREROGATIVES**

SPPs are not eligible for Medical Staff Membership, but participate directly in the management of patients under the supervision, direction or back-up of a Physician Member. They are assigned to an appropriate Service and carry out their activities subject to the policies and procedures of the Service, and consistent with the clinical privileges granted, including FPPE and OPPE.

Although not Members, the administrative guidelines or policies, drafted with Service Chief input, shall set forth the criteria for clinical privileges for each type of SPP. Such criteria shall include the following:

- (a) They exercise judgment within their areas of competence, provided that a physician Member shall have the ultimate responsibility for patient care or in the case of nurse midwives, provide back-up in complex pregnancy situations.
- (b) They participate directly in the management of patients under the supervision, direction or back-up of a Physician Member.
- (c) They record reports and progress notes in patients' records and write orders to the extent established for them by the Medical Staff.
- (d) They perform services in conformity with the applicable provisions of these Bylaws and appropriate state law.
- (e) The physician Member immediately responsible for the direction and supervision of the SPP shall have the authority to initiate disciplinary action of the SPP for legitimate reasons and with the concurrence of the appropriate Service Chief or UMHHC administrative department head, in accordance with the procedures set forth in this Section.
- (f) How the participation of the SPP will support the academic and research mission of UMHHC.

**6.2. PROCEDURE FOR GRANTING CLINICAL PRIVILEGES**

The designation of individuals eligible to apply for clinical privileges as an SPP, and the corresponding procedures and protocols, as well as terms and conditions for each type of SPP, shall be designated by the HHCEB based on the recommendations of the relevant Service, the Credentialing and Privileging Committee, and the ECCA. SPPs applying for initial and renewed clinical privileges shall be processed in a manner parallel to the process described herein for appointment and reappointment to the Medical Staff, provided, however, that the rights of SPPs with respect to actions taken are as provided below.

### **6.3. HEARING PROCEDURES APPLICABLE TO SPPs**

SPP's privileges are subject to suspension, restriction or termination consistent with the process described in Article VIII and the SPP's hearing and appellate rights are set forth in this section. A limited fair hearing process with respect to termination, suspension, denial or reduction of clinical privileges for SPPs will be provided in the form of a conference with the Service Chief and the SPP's responsible Member, with the inclusion of other SPPs or Members as appropriate. The Service Chief will provide the affected SPP written notice of the date, time, and place of the conference, along with the basis for the privilege action. The SPP has the right to appear at the conference and present evidence regarding the privilege action. Within a reasonable time after adjournment of the conference, the Service Chief will issue a written decision indicating whether it agrees with the privilege action. If the decision is in disagreement with the privilege action, the matter will be referred to the ECCA for its consideration and recommendation. If the decision is in agreement with the privilege action, the SPP may appeal the decision to the COS who shall have the authority to decide the status of the SPP's privileges. The COS or the ECCA may afford SPP's additional hearing rights, but such additional rights are not required.

**ARTICLE VII.  
CLINICAL PRIVILEGES**

**7.1. CLINICAL PRIVILEGES**

7.1-1 Clinical Privileges Required

Every Member and SPP practicing within UMHHC shall be entitled to exercise only those clinical privileges specifically granted to the Member or SPP by the HHCEB except as provided in Sections 7.2 and 7.3.

7.1-2 Requests

Every application or reapplication for clinical privileges must contain a written request for the specific clinical privileges desired, and the facilities where those clinical privileges are sought, by the applicant. The burden of establishing qualifications and competency in the clinical privileges requested rests with the applicant. Every initial application for Membership and for reappointment, and every SPP application for clinical privileges, must contain a written request for the specific clinical privileges desired, and, if applicable, the facilities where those clinical privileges are sought. Application for clinical privileges or changes therein, shall originate and be: signed by the applicant; reviewed, completed and signed by the relevant Service Chief and Facility or Ambulatory Care Medical Director, if applicable; approved by the appropriate Department Chair; endorsed by the Credentialing and Privileging Committee and the ECCA; and finally approved by the HHCEB. An application by a Service Chief must be endorsed by his or her Department Chair; and application by a Department Chair must be endorsed by the relevant Service Chief and Executive Medical Director of the FGP. Requirements for education, training, monitored performance, etc. shall be on the ECCA-approved delineation of privileges forms.

7.1-3 New Procedures and Techniques

Requests for clinical privileges to perform either a significant procedure not currently being performed at UMHHC or a new technique for an existing procedure (new procedure) will not be processed until, consistent with the shared responsibilities described in Article I: (1) the FGP has determined that the procedure should be offered by UMHHC; and (2) criteria to be eligible to request those clinical privileges have been established. In such a case, the FGP will make a preliminary recommendation as to whether the new procedure should be offered. Factors that may be considered include, but are not limited to (1) whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients; (2) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and (3) whether UMHS has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new

procedure. If it is recommended that the new procedure be offered, the FGP will conduct an assessment and consult with internal and/or external experts to develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure; (2) the Departments or Services that should be permitted to offer the new procedure; and (3) the extent of monitoring and supervision that should occur if the privileges are granted. The FGP may also develop criteria and/or indications for when the new procedure is appropriate. The FGP will forward its recommendations to the Credentialing and Privileging Committee and to the ECCA, which will review the matter and forward its recommendations to the HHCEB for final action.

#### 7.1-4 Ongoing and Focused Practice Evaluation

All clinical privileges are subject to ongoing evaluation by the appropriate Department(s) and Service(s) as provided in the Professional Practice Evaluation policy. OPPE and FPPE are elements of peer or professional practice review and protected by the confidentiality policies described in the Bylaws and Rules and Regulations. OPPE may include direct observation of care and review of the records which document the evaluation of the Member or SPP's participation in the delivery of medical care. OPPE indicators are reported to and approved by the MSQC.

Each Member or SPP afforded clinical privileges at UMHHC and Provisional Status shall complete such focused-monitoring period (also known as FPPE) as may be required by the Service. Monitoring shall be in accordance with standards set forth in the Professional Practice Evaluation Policy. Monitoring may be altered only if the applicant is a Trainee (within two (2) years) of residency or fellowship, or had been a Member of the Medical Staff within the last two (2) years. A Member on Provisional Status shall remain subject to completion of monitoring. Documentation attesting to completion of monitoring shall be signed by the monitor or Service Chief, along with an evaluation of performance, and a statement as to whether the Member meets all of the qualifications. Medical Staff Members who change Medical Staff classification to one of greater clinical responsibility, or Members or SPPs who are granted additional privileges shall also complete a period of monitoring as assigned by the Service Chief and approved by the Credentialing and Privileging Committee. Monitoring shall be performed by a Member in good standing of the Medical Staff with privileges in the specialty area being monitored. The Service Chief shall establish the plan for FPPE, which is subject to approval by the Credentialing and Privileging Committee.

#### 7.1-5 Dentists, Podiatrists and Oral Surgeons

Clinical privileges granted to Dentists, Podiatrists and Oral Surgeons shall be based on their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each Dentist, Podiatrist or Oral

Surgeon may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by Dentists, Podiatrists and Oral Surgeons who are not also Physicians shall be under the overall supervision of the Chair of a Department and a Service Chief designated by the ECCA in the same degree as other surgical services within a Department or Service. Surgery off the main campus at licensed UMHHC facilities shall also be subject to oversight by the appropriate ACU Medical Director. All dental and podiatric patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A Physician Member shall be consulted for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

7.1-6 Psychologists

Clinical privileges granted to Psychologists shall be based on their training, experience and demonstrated competence and judgment. In outpatient settings, they may diagnose and treat a patient's psychological illness. They will ensure that their patients receive referral to appropriate medical care. Psychologists may not admit patients to UMHHC hospital facilities. However, in inpatient settings, they may diagnose and treat the patient's psychological illness as a part of the comprehensive care offered by their program. Psychologists may provide consultation within their area of expertise on the care of patients within the UMHHC. They may receive consultation from other Members concerning their patient's care, with the collaboration of a physician on their Service. Psychologists will not prescribe drugs, perform surgical procedures, or otherwise practice outside the area of their expertise. They shall practice under the overall supervision of a Department Chair and Service Chief designated by the ECCA.

7.1-7 Optometrists

Clinical privileges granted to Optometrists shall be based on their training, experience, and demonstrated competence and judgment. Optometrists generally may conduct eye examinations, evaluate the need for vision correction and prescribe such correction, as appropriate, and screen for certain eye conditions. Optometrists will ensure that patients receive referrals to appropriate medical care as necessary. Optometrists may not admit patients to UMHHC hospital facilities, or practice outside of their area of expertise or their scope of practice permitted by law. Optometrists shall practice under the overall supervision of a Department Chair and Service Chief designated by the ECCA.

## 7.2. TEMPORARY PRIVILEGES

### 7.2-1 Granting of Temporary Privileges

Temporary clinical privileges may be granted with the written concurrence of the appropriate Service Chief and of the COS, only when there is an important clinical need, and when, at the start of an academic year, an Applicant who completed his or her academic training program after the date of any postgraduate verification forms necessary for appointment has submitted a complete application that otherwise raises no concerns and that is simply awaiting HHCEB action. A Practitioner is not eligible for temporary privileges under this section if (s)he has ever been subject to (i) involuntary limitation, reduction, restriction, suspension, or termination of Medical Staff membership or clinical privileges at any organization; (ii) professional licensure sanctions; or (iii) sanctions in connection with his or her most recent training program.

An Applicant seeking temporary privileges must be interviewed by the Service Chief, Department Chair and/or COS (in person or by telephone) and submit adequate evidence of his/her identity and qualifications, which at a minimum shall include a copy of his/her driver's license with photo, a copy of current medical license, a copy of his/her authority to prescribe restricted drugs, and a favorable reference from a chief executive officer, chief of staff or medical staff department head of a reputable healthcare facility where (s)he holds clinical privileges concerning his/her capabilities and other criteria specified in administrative guidelines. Administrative guidelines may also specify what information shall be obtained from primary sources. Before temporary clinical privileges are granted, the Practitioner must acknowledge in writing that (s)he has read those sections of the Bylaws, Rules and Regulations and policies, which would govern his/her temporary activities within UMHHC facilities.

### 7.2-2 Exercise of Temporary Privileges

In exercising such clinical privileges, the Applicant shall act under the supervision of the Service Chief to whom the Applicant is assigned.

### 7.2-3 Limitations

Temporary clinical privileges may be granted for not more than two (2) periods of thirty (30) days or less, each by joint action of the COS and either the Department Chair or Service Chief. Special requirements of supervision and reporting may be imposed by the Service Chief concerning any Practitioner granted temporary clinical privileges.

#### 7.2-4 Termination Procedure

Any two (2) of the COS, Department Chair or Service Chief jointly, may at any time, terminate a Practitioner's temporary clinical privileges effective as of the discharge from the UMHHC of Practitioner's patient(s) then under the Practitioner's care without statement of cause or reason. However, where it is determined that the life or health of one or more patients would be endangered by continued management and/or treatment by the Practitioner, any person entitled to impose Summary Action pursuant to these Bylaws may immediately terminate temporary clinical privileges. In addition, temporary clinical privileges may also be immediately terminated by the COS upon notice to the Practitioner for any failure by the Practitioner to comply with such special conditions or limitations or any other reason giving rise to doubts about the Practitioner's patient care, integrity or ethics which would more effectively be assessed through a full application process. Upon termination, the appropriate Service Chief or, in the absence of the Service Chief, the COS, shall assign a Member to assume responsibility for the care of such terminated Practitioner's patient(s) until they are discharged from the UMHHC hospitals. The wishes of the patient(s) shall be considered where feasible in selection of a substitute Member.

### **7.3. SPECIAL EMERGENCY AND DISASTER PRIVILEGES FOR MEMBERS**

In the case of emergency, any Member, to the degree permitted by the Member's license and regardless of Service or Medical Staff status, shall be permitted to do, and assisted in doing, everything possible to save the life of a patient, using every facility necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such Member must request the additional clinical privileges, if any, necessary to continue to treat the patient. In the event such clinical privileges are denied or the Member does not desire to request clinical privileges, the patient shall be assigned by the COS to an appropriate member of the Medical Staff. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and that any delay in administering treatment would add to that danger. The provisions this Section shall be supplemented by policies of UMHHC.

### **7.4. SPECIAL EMERGENCY AND DISASTER PRIVILEGES FOR NON-MEMBERS**

In the case of emergency or disaster where the Emergency Management Plan has been officially activated, and UMHHC may potentially be unable to handle immediate patient care needs, any Practitioner or SPP who is not currently a participating provider for UMHHC, and who volunteers to provide clinical services to patients during said emergency or disaster, shall be processed according to the Policy and Procedure for Temporary Emergency Privileges During Activation of UMHHC Emergency Management Plan.

**ARTICLE VIII.**  
**PERFORMANCE IMPROVEMENT AND CORRECTIVE ACTION**

The Medical Staff encourages the use of progressive steps by Medical Staff leaders (the COS, ACOS, Department Chairs, or Service Chiefs), beginning with collegial and educational efforts, to address questions relating to a Member's clinical practice or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the Member to resolve identified concerns. The indications for performance improvement and actions described in this Article apply to Trainees and SPPs to the extent applicable to their positions. However, hearing rights for SPPs with regard to actions related to the exercise of clinical privileges are limited to those procedures described in Section 6.3.

**8.1. SPECIAL PROFESSIONAL REVIEW AT DEPARTMENT OR SERVICE LEVEL**

A collegial and confidential review, study or investigation of the practice of one or more Members, SPPs or Trainees, or the use of a particular medication or procedure, may be initiated on a Department or Service basis for the purpose of formulating policy or resolving concerns regarding patient care, cooperation, and collegiality among the Medical Staff and System Staff, or the reputation of UMHC, the University and/or the Medical Staff. Examples of events triggering review under this section include, but are not limited to: one or more unanticipated patient deaths or major injuries; recurrent unexpected patient morbidity; events for which a claim or licensure report is threatened by patient; or circumstances where state reporting by colleagues may be legally required. The details of such processes shall be set forth in the Fair Hearing Plan.

Collegial intervention efforts are encouraged, but are not mandatory, and are within the discretion of the responsible Medical Staff leaders. When pursued, the Medical Staff leaders determine whether it is appropriate to include documentation of collegial intervention efforts in a Member's confidential peer review files. If documentation is included, the Member is furnished with the opportunity to review the allegations and respond in writing. The response, if any, is maintained in the file along with the original documentation. Professional Review Committees meet from time to time to facilitate inquiries, investigations, collegial intervention and corrective action activities.

**8.2. ROUTINE CORRECTIVE ACTION**

8.2-1 Criteria for Initiation

The COS, any ACOS, any Department Chair, any Service Chief, or the CEO may initiate requests for corrective action for, but not limited to, the following grounds:

- (a) The activities or professional conduct of any Member with clinical privileges are or are reasonably probable of being:
  - (i) Detrimental to patient safety.



- (ii) Detrimental to effective delivery of patient care.
- (iii) Disruptive to UMHHC operations.
- (b) Unethical conduct.
- (c) Institution of formal charges for, or conviction of, a felony or any other crime involving or affecting professional practice.
- (d) Incompetency (to include mental, judgment and physical).
- (e) Unauthorized disclosure of confidential University, UMHHC, Medical Staff, patient, Professional Review, or designated confidential business, information.
- (f) Violation of these Bylaws or the Rules or Medical Staff or UMHHC policies (including, but not limited to, falsification of application or credential documents).
- (g) Failure to discharge the responsibilities of Membership.
- (h) Illegal personal conduct which impairs the ability of the Member to effectively practice within UMHHC or has a reasonable likelihood of damaging the reputation of UMHHC or the University.
- (i) Non-compliance with a plan of correction or memorandum of understanding agreed upon by the Member and Medical Staff leadership or UMHHC.
- (j) Any conduct which forms the basis of summary action as described under Section 8.3 or automatic action under Section 8.4.
- (k) Institution of administrative proceedings which could lead to the Member being suspended or excluded from the Medicare or Medicaid programs.
- (l) A finding by any local, state or national professional organization that a Member committed unethical acts.
- (m) A finding by any professional licensing board that a Member violated licensing statutes or rules.

#### 8.2-2 Contact

If a member or UMHHC employee observes or is aware of behavior that corrective action of a Member may be warranted, that person should contact the Service Chief, Department Chair and/or the OCA.

### 8.2-3 Requests and Notices

All requests for routine corrective action, in accordance with Section 8.2-1, shall be in writing, submitted to the ECCA and supported by reference to a description or examples of the specific activities or conduct which constitute the grounds for the request. The ECCA referrals of matters subject to summary action for concurrent or alternative processing as routine corrective action shall also be recorded in writing and shall briefly summarize the ECCA's reasons for making the referral (e.g., “summary action alone does not address long-term concerns”). The COS and CEO shall be kept fully informed of all action taken in conjunction therewith which they are not personally managing. The affected Member shall also be advised that corrective action is under consideration.

### 8.2-4 Investigation When Appropriate and Report

The ECCA may designate a person or an ad hoc committee to investigate, if an investigation is deemed necessary and appropriate. When so designated, the investigator (person or committee) shall promptly investigate the matter and generally within forty-five (45) business days after the receipt of the designation, forward a written report of the investigation to the ECCA. If the corrective action request was preceded by an evaluation, a report of that evaluation or other peer review activity may be used in lieu of a subsequent investigation.

### 8.2-5 Interview of Subject Member

At any point after a corrective action request is made, the ECCA, a Department Chair, a Service Chief, or an investigator (person or committee) may, upon request, have the opportunity to interview the Member subject to the corrective action request.

### 8.2-6 ECCA Action

Promptly following receipt of the request, or if an investigation is requested, promptly following receipt of the investigation report, the ECCA shall take action. Action taken by the ECCA may include without limitation:

- (a) Rejecting the request for corrective action with or without a warning letter or admonition;
- (b) Recommending to the HHCEB requirements of consultation, other than administrative consultations (as specified in Section 8.5-4) or consultation required for Provisional Status Members;
- (c) Issuing a letter of reprimand;
- (d) Imposing a probation without limitation of clinical privileges;

- (e) Recommending to the HHCEB reduction, suspension or revocation of clinical privileges;
- (f) Recommending to the HHCEB reduction of category or limitation of any prerogatives directly related to patient care;
- (g) Recommending suspension or revocation of Membership; and
- (h) Recommending to the HHCEB that other action be taken.

8.2-7 Exercise or Waiver of Procedural Rights

Any recommendation or action taken pursuant to (b) through (h) of Section 8.2-6 (but not Sections 8.3, 8.4 or 8.5) will ordinarily be held in abeyance for a period of thirty (30) days or the timely and effective exercise of procedural rights applicable to the action, whichever is longer. However, during such period, other actions including those described in Sections 8.3, 8.4 or 8.5 may still be taken, if appropriate. The ECCA may, based on the outcome of any hearing, revise its action or recommendation. Failure of the subject Member to timely request and pursue exercise of procedural rights shall constitute acquiescence to an adverse action or recommendation as provided in the Fair Hearing Plan.

8.2-8 Report to HHCEB and HHCEB Action

All ECCA actions and recommendations regarding a corrective action request shall be reported promptly to the HHCEB. A rejection of a request for corrective action or the taking of actions specified in Section 8.2-6(c) and (d) shall not be final until affirmatively approved by the HHCEB. If not approved by the HHCEB, the HHCEB may, after due consultation with the ECCA, take any other action specified in Section 8.2-6. As to any corrective action taken or recommended by the ECCA for which the Member has timely and effectively pursued a hearing, if applicable, the HHCEB action will await the outcome or waiver of the Member's appeal. As to any corrective action taken or recommended by the ECCA for which the Member is not entitled to or has waived a formal hearing, the HHCEB may expressly affirm, or after consultation with the ECCA, reject (or rescind) such action or recommendation with such special directives to the CEO and/or the ECCA as it deems appropriate. Silence or non-action by the HHCEB for sixty (60) days after receipt of notice of the ECCA corrective action, without the pendency of hearing or appeal proceedings, shall constitute the HHCEB's implied approval of same.

### 8.3. SUMMARY ACTION

#### 8.3-1 Criteria and Initiation

The COS or CEO acting in combination with the relevant Department Chair or Service Chief, or the ECCA or the HHCEB acting alone, will have the authority to summarily suspend or place conditions upon the exercise of all or any portion of the Privileges of a Member whenever:

- (a) The Member's temporary or permanent mental or physical state is such that one or more patients under his/her care would be subject to imminent danger to their health as a result of his/her action or inaction if (s)he is permitted to continue exercise privileges.
- (b) There is substantial evidence that the Member has committed acts of an illegal or unethical nature while in the UMHHC or in another health care setting which are of such gravity that, if proven, would justify revocation or permanent suspension of Medical Staff Membership, privileges, professional licensure or prescribing authority.
- (c) There is substantial evidence of a gross dereliction of duty which relates to the assurance of a patient's well-being, or in the management of a patient, which, in the judgment of those having the authority to summarily act, indicates one or more patients under the present and/or future care of the Member involved would be subject to imminent danger to their health, if (s)he is permitted to continue to exercise privileges. (A pattern of unusually high frequencies of unexpected deaths or morbidity shall constitute sufficient ground to invoke this provision.)
- (d) There is substantial evidence of an act, omission or pattern by the Member which has the potential of materially damaging UMHHC's licensure status or ability to effectively function as a provider of services.
- (e) Non-compliance with an agreement between a Member and the ECCA or UMHHC, where the Agreement either specifies non-compliance will result in suspension or the acts of non-compliance will place patient, staff or Member welfare at significant risk.

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

### 8.3-2 ECCA Action

At an ECCA meeting held no later than twelve (12) days following such summary action, the ECCA shall review and consider the action to be taken. The ECCA shall have the right, but not the obligation, to require the presence of the affected Member for the ECCA interview and ascertainment of his/her position on the summary action. The ECCA, in consultation with the CEO, may impose a modification, continuation or termination of the terms of the summary action. The ECCA may also make a referral of the matter for routine corrective action, as an alternative or concurrently. If an ECCA decision is other than to rescind the action in total within fourteen (14) days of imposition, the subject Member may make a request to pursue the procedures applicable in the Fair Hearing Plan. If the ECCA should rescind the summary action, but refer the matter for routine corrective action as an alternative, any request for the procedures of the Fair Hearing Plan shall be pursued in accordance with these Bylaws only after the ECCA has taken action. In the event that the ECCA should recommend routine corrective action concurrent with summary action for the same Member, then any review procedures for both actions shall be consolidated in accordance with the provisions of the Fair Hearing Plan.

### 8.3-3 Responsibilities

The medical coverage for the inpatients in the UMHHC of the Member subject to summary action shall be selected by the Service Chief of the Service to which said Member is assigned. As much as possible, the wishes of the respective patient(s) shall be considered in the selection.

## **8.4. AUTOMATIC ACTION**

Automatic action occurs in response to determinations by external agencies or authorities that by definition implicate the affected Member's basic qualifications to practice at UMHS. Automatic action may trigger additional internal inquiry or investigation, or such inquiry or investigation may, at the discretion of the relevant Medical Staff leaders, be delayed pending resolution of the external proceedings. The affect of automatic action on a Member is not subject to hearing or appeal and reinstatement following the end of the disqualifying event is considered a reapplication, unless determined otherwise by the ECCA.

### 8.4-1 Loss of License or Serious Crime

A Member whose license authorizing him/her to practice in this State is revoked or suspended or who is convicted of a crime involving medical practice or hospital facilities or of any felony, or who becomes temporarily or permanently excluded, suspended, sanctioned or otherwise ineligible to fully participate in Medicaid, Medicare or other governmental healthcare program, shall immediately and automatically be suspended from practicing in the UMHHC.

Such action shall not be exclusive of any other corrective action that may be imposed.

8.4-2 Termination of Faculty Appointment

The termination of a faculty appointment by the University of a Member in a Medical Staff category, that requires faculty appointment, automatically terminates the appointment to the Medical Staff and clinical privileges of a Member.

8.4-3 Suspension of Faculty Appointment

The total suspension or partial suspension of the clinical practice aspect of a Member's faculty appointment, or Medical School title, automatically results in suspension of all clinical privileges at UMHHC of the Member which are directly within the scope of the University faculty suspension.

**8.5. ADMINISTRATIVE ACTION**

8.5-1 Circumstances

Administrative action which suspends a Member's appointment and clinical privileges shall be automatically imposed for any reasons enumerated in Section 8.4 and under this Section 8.5. Administrative action, under the provisions of this Section, may not constitute a reportable Medical Staff action in accordance with state and federal reporting requirements, as it is considered to be a non-disciplinary and non-professional review action for purposes of those reporting requirements.

8.5-2 Prescribing Authority

A Member with clinical privileges whose authority to prescribe and administer is revoked or suspended shall immediately and automatically be divested of his/her right to prescribe medications covered by such authority. After such administrative action, the ECCA at its next regularly scheduled meeting shall review and consider the facts under which the authority was revoked or suspended. The ECCA may then take corrective action as is appropriate to the facts disclosed in its review and report the action taken to HHCEB.

8.5-3 Medical Records

If, after a warning of delinquency from the Compliance Office or the COS, a Member fails to complete medical records in a timely fashion, clinical privileges shall be withheld until all the delinquent records have been completed. Failure to complete the medical records within thirty (30) days from the date that clinical privileges were first withheld or in a shorter time specified by the ECCA, will be

deemed a resignation of Membership and all clinical privileges for a Member or if applicable, resignation as a Trainee.

Unless the ECCA or HHCEB find after informal review the records were not delinquent or, if delinquent, were timely completed, Membership and clinical privileges resigned, in this manner may be reinstated by the COS or the CEO, in consultation with the other, only upon complete correction of all delinquencies, credible assurances by the Member that there will be no further medical record violations, and a determination by either the COS or CEO that such reinstatement will serve the best interests of the patients and the UMHHC. Otherwise, Membership and clinical privileges of a former Member after a resignation in this manner may be obtained by the Member only by new initial application for which all expenses of processing are paid by the Applicant.

Review and any reinstatement of resignation of Trainee status on the Medical Staff shall be in accordance with grievance procedures established in Section 4.8

With respect to any Member who fails to complete medical records resulting in resignation of clinical privileges or status as a Trainee, the COS and the OCA may decline to provide a recommendation or information regarding the delinquent Member or Trainee to third parties.

#### 8.5-4 Administrative Consultations

The CEO, COS or Department Chair or Service Chief may initiate an administrative consultation requirement as to a particular patient, certain particular patients, or all patients of a Member when it is determined that the interests of the UMHHC or the welfare of a patient or patients of a Member require such action. Such consultation requirement may include proctoring, co-management or other conditions or limitations upon the practice. Initiation of an administrative consultation should be preceded by the concurrence of the CEO or COS or Department Chair or Service Chief. Where obtaining such prior concurrence is not possible due to the matter requiring that immediate action be taken, concurrence should be obtained as soon as reasonably possible thereafter. The consultation requirement imposed may stay in effect, without institution of corrective action for thirty (30) days, or if corrective action proceedings are in process, for the duration of those proceedings. Imposition of an administrative consultation requirement, in accordance with this provision, shall be communicated to the affected Member immediately by written notification. The result of the administrative consultation shall be reported back to the COS, Department Chair, Service Chief and CEO. This information will be conveyed to the ECCA at its next regularly scheduled meeting for determination of an appropriate course of action, which may include corrective action pursuant to Section 8.2.

#### 8.5-5 Professional Liability Insurance

In the event that a Member who is required to maintain his/her own insurance coverage fails to:

- (a) Maintain in force professional liability insurance in prescribed amounts or maintain other proof of financial responsibility.
- (b) Report any change in the status of his/her professional liability insurance to the CEO within seven (7) days subsequent to the change; the clinical privileges of the Member shall be withheld until the requirement is met. While clinical privileges are withheld, the Member may not see, treat, consult with respect to, or admit a patient at UMHHC facilities. Clinical privileges, which are withheld for failure to comply with the financial responsibility requirement, shall continue to be withheld until the requirement is satisfied. Continued failure to be in compliance may result in corrective action pursuant to Section 8.2. and/or non-reappointment.

#### 8.5-6 Technical Non-Compliance with Bylaws, Rules or Other UMHHC Policies

In the event a Member is found to have violated a provision of the Bylaws, Rules, or policy (written or unwritten) which does not directly or immediately involve patient well-being, the CEO or COS, after consultation with the ECCA or the HHCEB, is empowered to issue a letter to the Member giving notice of non-compliance and advising the Member of the importance of future compliance. The Member involved shall be required, within thirty (30) days after receipt of such notice, to acknowledge in writing its receipt, and to pledge (s)he will thereafter comply with the policy involved, and provide any mitigating factors (s)he feels are warranted. A copy of such Notice of Non-Compliance and the Member's response shall be placed in the file with respect to the Member. Such notice may be considered, for two (2) reappointment periods after issuance, in any corrective action proceedings involving the Member. If no further Notices of Non-Compliance are issued within two (2) reappointment cycles for similar infractions, it will, at the request of the Member, be permanently expunged from his/her Medical Staff review file.

#### 8.5-7 Failure to Comply with Special Attendance Requirement

A Member who fails to attend a specially required meeting of the Medical Staff, a Department, Service, or committee without advance permission by the chair of the body involved, after having been given written notice of a special requirement to attend such meeting shall, upon written notice by the COS, have all clinical privileges withheld until the matter is resolved by the ECCA review.



8.5-8 Partial Suspension of Faculty Appointment or Clinical Privileges in Another Practice Setting Potentially Impacting Clinical Practice

In the event that the faculty appointment of a Member is partially suspended, but the suspension does not specifically encompass practice at UMHHC, or clinical privileges in another practice setting are suspended, the COS may, if (s)he determines that clinical practice and/or grounds for corrective action at UMHHC may be implicated, direct that all or part of the Member's clinical privileges be withheld until the matter can be reviewed at the next meeting of the ECCA or sooner by a designee of the ECCA.

8.5-9 Licensure Probation

When a Member is placed on probation by State licensure authorities, such Member's voting and office holding prerogatives are suspended effective upon and for at least the term of the probation.

8.5-10 Continuing Medical Education Requirements

Failure to complete sufficient number and type of continuing education credits to meet minimum Michigan licensure requirements shall be grounds for the COS to withhold clinical privileges until those requirements are met regardless of whether or not the Member's license is suspended. Continued or repeated failure to meet either of these requirements shall be grounds for denying reappointment.

8.5-11 Disruptive or Impaired Practitioner

A Member who meets the criteria for a "Disruptive Practitioner" or "Impaired Practitioner" under Medical Staff or UMHHC policy shall be required to proceed through the process specified in such policy. However, nothing therein shall limit the availability of corrective or summary action where the frequency or nature of the acts or omissions in question are deemed to require it.

**8.6. ALTERNATIVE ACTION**

If at any time during an inquiry, review, investigation, or other proceeding, information demonstrates that the subject of the proceeding may be caused by an impairment to the Member's physical or mental health, the Member will be referred for evaluation and potential treatment as provided in the Practitioner Impairment Policy 04-06-046. Alternative Action is not exclusive of other corrective action proceedings which may, at the discretion of the applicable Medical Staff leaders and ECCA and HHCEB, or in response to a Member's refusal to cooperate, be pursued concurrent with or in lieu of Alternative Action.

#### 8.6-1 Alternative Action Defined

Alternative Action is an alternative and cooperative non-disciplinary means of remedying a problem of a Member for which corrective action or other traditional means of behavioral modification are either not feasible or not as appropriate. Alternative Action requires the consent of the subject Member and is in lieu of formal hearing opportunities.

#### 8.6-2 Basis for Alternative Action

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

#### 8.6-3 Procedures

The ECCA shall establish the procedures for Alternative Action on a case by case basis consistent with applicable policies as determined by ECCA. Participation in an Alternative Action is dependent on the voluntary participation by the Member, or SPP or Trainee as applicable, so no actions taken and agreed to are subject to a hearing or appellate review.

#### 8.6-4 Education

The COS will establish an educational process in which any such policies and the Alternative Action process is explained and presentations are made to the Medical Staff and UMHHC staff concerning health, recognition of impairment, and the availability of rehabilitation for Members.

### **8.7. PRECAUTIONARY SUSPENSION OR RESTRICTION**

#### 8.7-1 Grounds, Timing, and Implications

- (a) Whenever, in their sole discretion, failure to take such action may result in (i) imminent danger to the health and/or safety of any individual *or* (ii) may interfere with the orderly operation of UMHS, any two (2) individuals, which shall include, the COS, or designee, and a Department Chair, or designee, or a Service Chief, or ECCA may as a precautionary measure, suspend or restrict all or any portion of a Member's clinical privileges; and afford the Member an opportunity to

voluntarily refrain from exercising privileges pending an inquiry or investigation.

- (b) A precautionary suspension or restriction becomes effective immediately upon imposition, and is reported in writing to the Member's Department Chair and to the COS (who in turn reports it to ECCA without identifying the affected Member, if feasible). The precautionary suspension and will remain in effect unless it is modified by the person who initiated it or by ECCA, but in no event longer than fourteen (14) days.
- (c) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete Professional Review Action. It is not final and is not disciplinary. Rather, it facilitates preliminary review and inquiry, and shall be removed or converted to summary action pending any resulting investigation within fourteen (14) days.
- (d) The Member is provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within three (3) days of the imposition of a precautionary suspension.
- (e) ECCA Procedure
  - (i) ECCA reviews the facts supporting the precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed fourteen (14) days. Prior to, or as part of this review, the Member may be given an opportunity to meet with ECCA. If the Member wishes to be accompanied to the meeting by legal counsel, the Member must so notify ECCA prior to the meeting. At that time, the Member may propose methods, other than precautionary suspension or restriction, to address any identified concerns.
  - (ii) After considering the facts supporting the suspension or restriction and the Member's response, if any, ECCA will determine whether it is necessary to commence an investigation and, if so, whether the precautionary suspension or restriction should be continued, modified, or terminated pending completion of the investigation (and subsequent hearing, if applicable). Alternatively, ECCA may determine there is sufficient information to support closing the matter or recommending summary action or routine corrective action.

8.7-2 Hearings

There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction. Provided, however, that ECCA may afford hearing and appellate rights as it determines.

8.7-3 Continuity of Care

The suspended Member's Service Chief must promptly assign another Member with appropriate privileges responsibility to care for the suspended Member's patients. The assignment is effective until the patients all are discharged or the suspension is withdrawn. The wishes of the patient will be considered in the selection of a covering Member.

**ARTICLE IX.  
HEARING AND APPELLATE REVIEW**

**9.1. HEARINGS AND APPELLATE REVIEW**

In the event a Member or Applicant believes him/herself aggrieved by a recommendation or action of the ECCA or the HHCEB, (s)he may be entitled to pursue review as provided in, and in the manner provided by, these Bylaws and the Fair Hearing Plan. Review under the Fair Hearing Plan is limited to those types of actions identified in the Fair Hearing Plan.

**9.2. TERMINATION OF CONTRACT**

If so specified in a written contract, the appointment and/or clinical privileges of a Member held in accordance with such a contract will be terminated automatically in the event of expiration (without renewal) or termination of the contract, without regard to the professional competence of the Member.

**ARTICLE X.**  
**COMMUNICATION AND RESOLUTION OF DIFFERENCES**

In the event that the ECCA or the Medical Staff as a whole have concerns regarding policies affecting patient care services, including these Bylaws, associated policies, and/or the Rules and Regulations, either may request and obtain, an opportunity for three or less of its representatives to meet with an equal number of representatives of the HHCEB. The results of that meeting (or series of meetings) shall be reported to the full membership of the bodies which participated. In the event of such patient care concerns among the Medical Staff and Administration, either the CEO or COS may request and timely obtain a meeting among themselves and other interested persons from the Medical Staff or Administration. The facts and results of any such meeting shall be reported to the ECCA and the HHCEB.

**ARTICLE XI.  
REPRESENTATIVE OF MEDICAL STAFF ON HHCEB**

**11.1. REPRESENTATIVES OF MEDICAL STAFF ON HHCEB**

If permitted by the HHCEB bylaws, two (2) Medical Staff representatives shall serve on the HHCEB in addition to the COS.

**11.2. ELECTION OF MEDICAL STAFF CANDIDATES**

Election of Medical Staff candidates to the HHCEB shall be by mail or electronic ballot of the Medical Staff from a list of nominees of the ECCA or write-in nominees.

For each vacancy the COS shall submit the names of the two (2) candidates who received the most votes to the CEO for recommendation to the HHCEB.

**11.3. APPOINTMENT OF MEDICAL STAFF REPRESENTATIVES TO THE HHCEB**

Appointment(s) shall be made by the Regents in accordance with the HHCEB bylaws.

**11.4. TERM OF OFFICE**

Representatives on the HHCEB shall serve four (4) year terms, so staggered as to provide one replacement each two (2) years.

**11.5. VACANCIES**

In the event a vacancy occurs during the term of a representative on the HHCEB, the unexpired term shall be filled as outlined under Section 11.2 of this Article XI.

**11.6. MEMBERSHIP ON EXECUTIVE COMMITTEE ON CLINICAL AFFAIRS**

Representatives of the Medical Staff on the HHCEB shall be members ex officio of the ECCA with voting rights specified in Bylaws governing the ECCA.

**ARTICLE XII.**  
**ORGANIZATIONAL UNITS OF THE MEDICAL STAFF**

**12.1. GENERAL PURPOSE AND DUTIES OF SERVICES AND COMMITTEES**

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

- (a) Review of professional practices at UMHHC in an effort to reduce morbidity and mortality.
- (b) Review of professional practices in an effort to improve the care and treatment provided patients in the hospital facilities, which shall include monitoring UMHHC and Medical Staff policies and procedures, requirements for alternate coverage and consultations, and recommending methods of enforcement and changes when appropriate.
- (c) Review of the safety, quality and necessity of care provided patients in the UMHHC hospitals.
- (d) Review of preventability of complications and deaths occurring in the UMHHC hospitals.
- (e) Directing, ordering and requiring the collection of records, data and knowledge in furtherance of its duties.
- (f) Submission of reports to the ECCA concerning:
  - (1) Findings of the committee's review and evaluation activities, actions taken thereon, and the results of such action.
  - (2) Recommendations for maintaining and improving the quality of care provided in the UMHHC hospitals.
  - (3) Such other matters as may be requested from time to time by the ECCA.

All data, knowledge and records of these Services and committees shall and must be kept in a confidential manner and shall not be subject to being subpoenaed or produced in legal proceedings consistent with the provisions of Michigan and federal law .



## 12.2. DEPARTMENTS AND SERVICES

### 12.2-1 Department and Services

The Medical Staff delivers health care services through clinical Departments and Services. Departments are organized by the Medical School and their Chairs appointed by the Medical School to reduce morbidity and mortality at UMHHC and otherwise promote patient safety and quality improvement. Departments and Services at UMHHC include the following:

- (a) Anesthesiology: Adult, Pediatric, Pain Management.
- (b) Dentistry.
- (c) Dermatology.
- (d) Emergency Medicine: Adult, Pediatric.
- (e) Family Medicine.
- (f) Internal Medicine: Allergy, Cardiovascular Medicine, Metabolism, Endocrinology & Diabetes, Gastroenterology, General Medicine, Geriatric Medicine, Hematology/Oncology, Infectious Diseases, Medical Genetics, Nephrology, Pulmonology, Rheumatology.
- (g) Neurology.
- (h) Neurosurgery.
- (i) Pathology; Clinical, Anatomical.
- (j) Pediatrics & Communicable Diseases; Cardiology, Child Behavioral Health Service, Critical Care Medicine, Endocrinology, Gastroenterology, General Pediatrics, Genetics, Hematology/Oncology, Infectious Diseases, Neonatology, Nephrology, Neurology, Pulmonary, Rheumatology.
- (k) Physical Medicine and Rehabilitation.
- (l) Psychiatry: Adult, Child & Adolescent.
- (m) Radiation Oncology.
- (n) Radiology: Adult, Child, Nuclear Medicine.
- (o) Obstetrics/Gynecology.
- (p) Ophthalmology.

- (q) Orthopedics: General Surgery, Trauma, Pediatric, Adult Joint Reconstructions, Sports Medicine.
- (r) Otolaryngology.
- (s) Surgery: Critical Care/Trauma/Burn, Cardiac, General, Maxillofacial, Pediatric, Plastic, Thoracic, Vascular.
- (t) Urology.

12.2-2 Criteria for a Service

- (a) A Service consists of Members who confine their activities to a nationally defined field of medical practice or specialization.
- (b) A Service must meet the criteria for qualification to conduct a recognized graduate training program for Practitioners.
- (c) Within a Service there must be defined responsibility for patient care.

12.2-3 Establishment or Dissolution of a Service

- (a) Services in place at the time these Bylaws are adopted shall remain in place until and unless dissolved as provided in (c) below.
- (b) To establish a Service, a group of Members (two or more), must submit documentation demonstrating that a proposed Service meets the criteria of Section 12.2-2 and secure the endorsement of the relevant Department Chair, the Dean of the Medical or Dental School, as applicable, and the request, accompanied by the required documentation and endorsements, must then be submitted to the ECCA for review and recommendation, and then to the HHCEB for final action.
- (c) Existing Services may be reorganized or eliminated by the HHCEB, after receiving input from the CMO, the ECCA and the affected Department(s) and Service(s). No Service may be unilaterally created, reorganized or eliminated by a Department or Service.

## 12.3. COMMITTEES

### 12.3-1 Role of Committees

- (a) A committee is appointed to perform duties and functions, which cannot be achieved effectively through normal medical or administrative staff action.
- (b) The use of a committee to perform a given function within the Medical Staff will be authorized by the ECCA only after clearly showing that its use affords a more effective, expeditious or economical means of accomplishing the objective. Use of a committee is considered effective for fact-finding, research, special studies, audit, review, inspection and survey activities. It is used as a complement to Medical Staff or administrative staff actions, not as a substitute.

### 12.3-2 Types and Categories of Committees

The Medical Staff recognizes two types of committees, either of which can be a Professional Review Committee:

- (a) Standing – established for an indefinite period of time; subject to annual review.
- (b) Ad hoc – established to perform a specific task, including investigations and special reviews, in a given period of time, usually six (6) months or less.

### 12.3-3 Establishment, Appointment and Tenure of Committees and their Membership

- (a) The ECCA must approve the establishment of all Medical Staff committees, both standing and ad hoc, the purposes for which they are established, and their duties.
- (b) Standing and ad hoc committees are advisory to the ECCA.
- (c) The COS shall, except as specifically provided in these Bylaws or the Rules and Regulations, designate the chair of Medical Staff committees.  
.
- (d) Members of committees will be appointed by the committee chair, with the approval of the ECCA, except for those committees with membership criteria otherwise specified by these Bylaws, the Rules and Regulations or the policies of the Medical Staff, UMHHC or UMHS.
- (e) Each committee shall prepare minutes or a report of its meetings which shall be signed by its chair or designee.

- (f) The Committee chair shall be responsible for recording attendance and reporting to the COS on positive contributions or poor attendance by individual committee members.

## **12.4. PROFESSIONAL REVIEW COMMITTEES**

### 12.4-1 Functions

Functions of Professional Review Committees may include, but are not limited to, review of qualifications of Applicants, Members and SPPs, the quality and medical necessity of care provided, and the preventability of complications and deaths. Examples of Professional Review Committees at UMHS include, but are not limited to, the ECCA, the Credentialing and Privileging Committee, the Medical Liability Review Committee, the Medical Staff Quality Committee, the Peer Review Advisory Committee and various institution and Department-level peer review and quality improvement committees.

### 12.4-2 Confidentiality

Michigan law protects against disclosure of the records, data and knowledge collected for or by individuals or committees assigned a quality or professional review function for hospitals and other health care organizations, including UMHS. All records, data or knowledge created or maintained by, at the direction of, or otherwise on behalf of a Professional Review Committee are confidential and not discoverable and shall be used only for Professional Review Committee purposes at UMHS. The documents are protected from disclosure under federal and state laws and institutional policies.

### 12.4-3 Breach of Confidentiality

Effective professional review, the consideration of the qualifications of Applicants to and Members of the Medical Staff and of SPP applying for or exercising clinical privileges, and the evaluation and improvement of the quality of care rendered by UMHS must be based on free and candid discussions. The exchange or release of confidential quality and/or peer review information must be in compliance with applicable laws, regulations and institutional policies. Any breach of confidentiality of the records, discussions or deliberations of Professional Review Committees is considered outside appropriate standards of conduct for this Medical Staff, disruptive to the operations of UMHS and detrimental to quality patient care, treatment and services. Any such breach of confidentiality is grounds for corrective action.

## **12.5. EXECUTIVE COMMITTEE ON CLINICAL AFFAIRS**

### 12.5-1 Function

The ECCA has the primary authority for activities related to self governance of the Medical Staff and for performance improvement of the professional services provided by Members and other health professionals privileged through the Medical Staff process, and acts on behalf of the Medical Staff between meetings.

### 12.5-2 Composition

ECCA is comprised of the following voting and non-voting Members:

- (a) 17 Voting Members
  - (i) Chair: COS, ex officio.
  - (ii) Vice Chairs: all ACOS, ex officio, sharing a single vote.
  - (iii) 2 ECCA representatives to the HHCEB, selected by the process described below.
  - (iv) 1 CPT (selected by the HOA and approved by the ECCA).
  - (v) 12 Members at large, selected by the process described below (no more than 5 may hold the title of Department Chair or Service Chief at any given time).
- (b) Non-Voting Members
  - (i) CEO, ex officio (or designee).
  - (ii) Any Medical Staff officers, ex officio.
  - (iii) UMMS Dean, ex officio (or Physician designee).
  - (iv) Executive Medical Director of the FGP, ex officio.
  - (v) Assistant Dean for Graduate Medical Education, ex officio.
  - (vi) Chair, MCHVWHEC, ex officio.
  - (vii) Chair, CVC Steering Committee, ex officio.
  - (viii) Medical Director, Comprehensive Cancer Center, ex officio.
  - (ix) Chair, FGP Clinical Practice Committee, ex officio.

- (x) Chief Nursing Officer, ex officio.
- (xi) Chief Medical Information Officer, ex officio.
- (xii) CMO, ex officio.
- (xiii) Chief PA, ex officio.
- (xiv) Chair, Credentialing and Privileging Committee, ex officio.

Additional guests may be invited on a standing basis or to individual meetings at the discretion of the COS. The COS may, at any time, call the voting Members and other UMHS faculty, staff or advisors s/he deems appropriate, into executive session to discuss matters of particular sensitivity, such as, but not limited to, recommendations for corrective action. The CEO (or designee) and the Medical School Dean (or designee) shall be invited to attend any executive session convened to discuss a recommendation for corrective action.

12.5-3 Selection, Removal and Interim Appointments

(a) HHCEB Representatives

Each of the two (2) HHCEB representatives is selected through the procedures described below.

(b) CPT Representatives

The HOA recommends at least one (1), but not more than two (2), CPTs (who may be the HOA President) to serve on the ECCA. Final selection is accomplished by the procedures described below. The elected CPT serves a one year term with eligibility for re-election for up to one additional term.

(c) At-Large Members

At-large Members are selected by a cohort according to the procedures described below. The cohorts are designed to promote diversity of Membership and broad representation across specialties. Each cohort may select two or three representatives as specified in this Section. No single Department may be represented by more than one (1) at-large Member.

Table 12.5-3(c): ECCA At-Large Membership Cohorts

Cohort	Number of ECCA Representatives
Hospital-Based Departments: Anesthesiology, Emergency	3

Medicine, Pathology, Radiation Oncology, Radiology	(No more than 2 from any 1 Department)
Medical Departments (Excluding Internal Medicine): Dentistry, Dermatology, Neurology, Pediatrics (Excluding General Pediatrics), PM&R, Psychiatry	3 (No more than 2 from any 1 Department)
Internal Medicine (Non-Primary Care)	2
Primary Care Departments (Excluding Non-Primary Care Internal Medicine): Family Medicine, General Medicine, OB/GYN, General Pediatrics	2 (No more than 1 from any Department)
Surgical Departments: Neurosurgery, Ophthalmology, Orthopedics, Otolaryngology, Surgery, Urology	2 (No more than 1 from any Department)

(d) Election Procedures

Regular terms for elected Medical Staff leadership positions begin on July 1 and end on June 30 of the appropriate year. The frequency of elections and rotation arrangements are summarized in Table 12.5-3(d)

Table 12.5-3(d): Election Procedures

Position	Term Time	Details
COS	3 years	No term limits; no rotations.
HHCEB	4 years	Terms are staggered so that a new election is held every 2 years for the alternate representative.
At-Large ECCA Members	3 years	Term limit: One 3-year term, after which rotation off as a voting Member is mandatory for at least 2 years. At-large Members are divided into 5 cohorts of 2 or 3 Members each. In 2011, 3 new at-large Members will be added to the ECCA (increased to 12 from the previous 9), with terms expiring in 2012, 2013, and 2014.

(e) Removal

- (i) Any elected Medical Staff leader will be removed from office automatically in the event of a termination, suspension, or restriction of employment at UMHS or Medical Staff membership, or loss of other minimum qualifications for office. In addition, a Medical Staff leader may be removed by a two-thirds vote of the Active Medical Staff, by the unanimous vote of the ECCA (excluding the vote of the leader, or at the direction of the HHCEB for inability or failure to perform the duties of the position held.
  - (ii) At least ten (10) days before initiation of any removal action, the individual must be given written notice of the date of the meeting at which action will be taken. The individual will be afforded an opportunity to address the Medical Staff or the ECCA, as appropriate, prior to a vote on removal.
- (f) Interim Appointments
- (i) In the event of a vacancy in the voting Member's position, interim representatives will be appointed as follows:
    - [a] An HHCEB representative will be replaced with an Active Medical Staff Member selected by the COS, in consultation with the Executive Medical Director of the FGP.
    - [b] A CPT representative will be replaced with a CPT selected by the HOA President.
    - [c] An at-large representative will be replaced by the Department Chair applicable to the outgoing Member, subject to the approval of the COS.
  - (ii) Within thirty (30) days after a vacancy occurs in an elected position, ECCA will vote to fill the position until the next annual election, at which point the vacancy will be filled through regular election procedures.

12.5-4 Charge

- (a) The ECCA shall be advisory to the COS, the CMO and the CEO. It will serve as the executive body of the Medical Staff and will have the authority to act for it on all matters except those which require specification by the entire Medical Staff, as provided in the Bylaws, or reserved to the HHCEB or Regents.



- (b) The ECCA shall consider all matters, which pertain to patient care and the professional conduct and activity of Members.
- (c) The ECCA shall receive and act upon reports and recommendations of the committees of the Medical Staff.
- (d) The ECCA shall implement policies of the Medical Staff not otherwise the responsibility of the Services and programs.
- (e) The ECCA shall have authority, delegated by the Medical Staff and HHCEB, to amend and addend the Rules and Regulations and the Medical Staff policies as provided in Article XIX.
- (f) The ECCA shall have authority, delegated by HHCEB, to approve and amend (1) the application and evaluation forms for appointment and reappointment to the Medical Staff; and (2) the application forms for clinical privileges.
- (g) The ECCA shall provide liaison between the Medical Staff and the CEO and the COS and the HHCEB.
- (h) The ECCA shall recommend action to the CMO and the CEO on matters of medico-administrative nature.
- (i) The ECCA shall serve in the capacity of an accreditation committee, and will keep the Medical Staff informed concerning the accreditation status of UMHHC and the factors influencing that status.
- (j) The ECCA shall review the reports of the Credentialing and Privileging Committee and make recommendations to the HHCEB, as well as the assignment of Trainees and SPPs to the various programs and Services, and the delineation of clinical privileges or Scope of Service.
- (k) The ECCA shall take all responsible steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted.
- (l) The ECCA shall recommend policies and programs for the delivery of institutional services for patient care with the concurrence of the Medical Staff.
- (m) The ECCA shall review, evaluate and recommend to the CMO and the CEO the allocation of resources affecting the priorities for patient care and programs.

- (n) The ECCA shall adopt and maintain rules and policies for the governance of the Medical Staff, subject to the acceptance of the Staff as provided in these Bylaws.
- (o) The ECCA shall make recommendations when necessary to the HHCEB regarding the following:
  - (i) Medical Staff structure changes;
  - (ii) The methodology for reviewing credentials and recommending clinical privileges;
  - (iii) The Medical Staff role in patient safety and quality improvement;
  - (iv) The mechanism for termination of Membership; and/or
  - (v) The hearing process applied to disciplinary actions and terminations.

#### 12.5-5 Meetings and Records

The ECCA shall meet at least monthly and at other times as called by the COS and will maintain a permanent record of its proceedings and actions.

### **12.6. CREDENTIALING AND PRIVILEGING COMMITTEE**

#### 12.6-1 Composition

The Credentialing and Privileging Committee includes at least five (5) members selected by the COS: a chair, who is an Active Member of the Medical Staff; an at-large member of the Medical Staff; a CPT; an advanced practice nurse; and a physicians' assistant. The Committee is staffed by MSS, with oversight from the OCA.

#### 12.6-2 Charge

- (a) Reviews the credentials of Applicants whose application is deemed complete by MSS and recommends action on appointment, reappointment, and/or clinical privileges requests made by Applicants, Members and SPPs with the endorsement of the relevant Department Chairs and Service Chiefs, as well as Trainees whose application has been recommended for approval by the GMEC.
- (b) Prepares a summary report for each ECCA meeting listing each individual recommended for appointment, reappointment, or any change in clinical privileges.

- (c) Assures Departments and Services maintain up-to-date privilege delineation documents.
- (d) Facilitates UMHS compliance with applicable laws, regulations, accreditation requirements and delegated credentialing agreements related to credentialing and privileging.
- (e) Recommends amendments to these Bylaws and the Rules and Regulations, and other applicable policies, as necessary for the efficient operation of the credentialing and privileging process.
- (f) Take action on recommendations of the GMEC with regard to Trainees, and makes recommendations to the ECCA regarding their respective Trainee appointment.

### 12.6-3 Meetings and Records

The Credentialing and Privileging Committee meets at least monthly on a schedule determined by its chair and posted on the OCA website. Meetings typically occur in person but may occur electronically from time to time, as necessary to conduct the business of the committee. Committee recommendations are forwarded to the ECCA based on a majority vote of those present. MSS is responsible for documenting the agenda and minutes for all meetings to assure compliance with applicable laws, regulations, and accreditation standards.

## **12.7. MEDICAL LIABILITY REVIEW COMMITTEE**

The Medical Liability Review Committee is comprised of an experienced, multi-disciplinary group of caregivers and administrators and reviews medical issues in cases of unanticipated outcomes that have been identified as potential or asserted claims. Cases that have been thoroughly investigated and subject to expert reviews are presented for robust peer review, discussion and analysis, providing direction for claims management, further quality and safety improvements, more focused peer review and educational opportunities. The committee is a vital component of UMHS' integrated corporate quality and safety system and claims management program.

### 12.7-1 Composition

The Medical Liability Review committee is chaired by the CMO, with the COS or an ACOS serving as vice chair. The composition of the committee is left to the discretion of the chair, with advice from the Chief Risk Officer, but includes at a minimum, the following representation;

- (a) Chief Risk Officer.
- (b) 1 Senior Hospital Administrator.

- (c) 1 Senior Medical School Administrator.
- (d) 1 Senior Nursing Administrator.
- (e) Executive Director.
- (f) 3 Representatives from Internal Medicine.
  - (i) 1 General Hospital Based Representative.
  - (ii) 1 General Ambulatory Based Representative.
  - (iii) 1 Specialty Procedural Based Representative.
- (g) 3 Representatives from Surgical Specialties.
  - (i) 1 Adult General Surgery Representative.
  - (ii) 1 Pediatrics General Surgery Representative.
  - (iii) 1 Adult Surgical Specialty Representative.
- (h) 2 Representatives from OB/GYN.
- (i) 2 Representatives from General Pediatrics.
  - (i) 1 General Pediatric Representative.
  - (ii) 1 Subspecialty Pediatric Representative.
- (j) 2 Representatives from Emergency Medicine.
- (k) 1 Representative from Radiology.
- (l) 1 Representative from Anesthesiology.
- (m) 1 Patient Safety Manager, OCA.
- (n) Ad hoc members, as appropriate for individual cases or issues.

The committee is staffed by the Risk Management office and supported by an attorney from the Health System Legal Office who shall serve as counsel to the committee.

#### 12.7-2 Charge

- (a) As a component of an integrated quality/safety/peer review and claims management system, reviews unanticipated clinical outcomes that

resulted in patient harm and provides direction to the Claims Management Committee, OGC and Risk Management.

- (b) Assists the Office of the General Counsel, UMHS Quality Improvement, UMHHC Administration, Service Chiefs, risk management, clinical leadership and committees by identifying opportunities for improvement in clinical care, peer review and educational needs expressly for the purposes of reducing morbidity and mortality within UMHHC and improving the delivery of clinical care and enhancing patient safety.
- (c) Identifies institutional systems, procedures, trends, individuals and practice patterns that may affect patient safety, clinical quality and medical liability for referral to appropriate responsible parties and committees.
- (d) Recommends interventions, follow-up and provides direction to responsible administrators, leadership, committees and other based on its analysis of medical injuries, medical care, trends, clinical patterns and unanticipated clinical outcomes in the cases considered.

#### 12.7-3 Meetings and Records

The Medical Liability Review Committee meets at least monthly on a schedule determined by its chair. Meetings occur only in person. Risk Management is responsible for agendas, case investigations and presentations, communication of committee findings to appropriate individuals and committees and preparation of minutes. Based on a majority vote of those present, the committee's recommendations are forwarded to the appropriate individuals and committees, including the Claims Management Committee, the Medical Staff Quality Committee and/or the UMHS Clinical Quality Committee.

### **12.8. MEDICAL STAFF QUALITY COMMITTEE**

The MSQC provides a multi-disciplinary forum for development and implementation of local Department and Service and facility-based peer review policies, procedures, programs and initiatives for the purpose of improving patient care and reducing morbidity and mortality within UMHHC. MSQC assures that local peer review programs, including, but not limited to, policies and procedures for OPPE and FPPE are developed, implemented and enforced.

#### 12.8-1 Composition

- (a) 3 Representatives from Internal Medicine.
  - (i) 1 General Hospital Based Representative.
  - (ii) 1 General Ambulatory Based Representative.

- (iii) 1 Specialty Procedural Based Representative.
- (b) 3 Representatives from Surgical Specialties.
  - (i) 1 Adult General Surgery Representative.
  - (ii) 1 Pediatrics General Surgery Representative.
  - (iii) 1 Adult Surgical Specialty Representative.
- (c) 1 Representative from OB/GYN.
- (d) 2 Representatives from General Pediatrics.
  - (i) 1 General Pediatric Representative.
  - (ii) 1 Subspecialty Pediatric Representative.
- (e) 1 Representative from Emergency Medicine.
- (f) 1 Representative from Radiology.
- (g) 1 Representative from Anesthesiology.
- (h) Chair, Data Analysis Council.
- (i) Chair, Credentialing and Privileging Committee.
- (j) Director, MSS (nonvoting).
- (k) Chief Risk Officer.
- (l) Administrative Director, OCA (nonvoting).
- (m) Project Manager, OCA (nonvoting).
- (n) 1 SPP Representative.

12.8-2 Charge

- (a) Develop policies and standards for review.
- (b) Provides assistance to Departments and Services in developing, evaluating and selecting measures of individual and aggregate Medical Staff performance.
- (c) Provides assistance to Departments and Services in developing local Medical Staff peer review programs.

- (d) Reviews and approves local peer review programs, including policies for OPPE and FPPE.
- (e) Assures Departments and Services implement their peer review programs.
- (f) Performs, as a committee of the whole or through the members of an ad hoc peer review committee, individual case peer review at the request of ECCA, the COS, the Chief Risk Officer or any Department Chair or Service Chief.

#### 12.8-3 Meetings and Records

MSQC meets at least quarterly, or more often at the call of its chair. Meetings occur only in person. The OCA is responsible for documenting the agendas and minutes of all MSQC meetings to assure compliance with applicable laws, regulations and accreditation standards.

### **12.9. PROFESSIONAL REVIEW ADVISORY COMMITTEE**

The Professional Review Advisory Committee meets from time to time to facilitate inquiries, investigations, collegial intervention and corrective action activities.

#### 12.9-1 Composition

The Professional Review Advisory Committee consists of the following ex officio and other members including:

- (a) COS or designee.
- (b) Administrative Director, OCA (staff).
- (c) Associate Dean for Faculty Affairs.
- (d) Department Chair (for the applicable Department).
- (e) Service Chief (for the applicable Service).
- (f) A nonvoting medical staff advocate, which the subject would be informed in advance that he or she would be welcome to bring in a support capacity.

#### 12.9-2 Charge

- (a) Coordinates the Medical Staff and employment activities of UMHS to assure that complaints or concerns involving Members are investigated and addressed in the appropriate forum.

- (b) At the request of the COS, identifies individuals with the requisite knowledge and expertise to serve on ad hoc peer review committees to promote a professional and fair process when collegial intervention or corrective action may be contemplated.
- (c) Collaborates on activities and initiatives designed to assure compliance with applicable laws, regulations and accreditation standards related to peer review and corrective action proceedings and mandated reporting.

#### 12.9-3 Meetings and Records

The Professional Review Advisory Committee meets on an ad hoc basis. Meetings occur only in person. The OCA is responsible for documenting, as necessary, the committee's meetings and activities.

### **12.10. OTHER MEDICAL STAFF COMMITTEES**

The ECCA, in coordination with the HHCEB, shall establish standing committees, arrange Member participation in UMHHC committees, or otherwise establish other procedures, for the general standing committees listed below. The details of the charge, composition and meeting and record requirements for such committees are included in the Rules and Regulations:

- (a) Adult Ethics Committee.
- (b) Cardiopulmonary Resuscitation Committee.
- (c) Cerebral Death Determination Committee.
- (d) Computer Information Management Operations Committee.
- (e) Critical Care Steering Committee.
- (f) Disaster Committee.
- (g) EHR Standards Committee.
- (h) Infection Control Committee.
- (i) Nominating and Bylaws Committee.
- (j) Operating Room Policy Committee.
- (k) Pain Committee.
- (l) Patient Safety Committee.
- (m) Pediatric Ethics Committee.



- (n) Pharmacy and Therapeutics Committee.
- (o) Practitioner Wellness
- (p) Sedation Analgesia Committee.
- (q) Transfusion Committee

The authority and responsibilities, including meetings and reporting of standing committees performing any of these review functions, shall be set forth in the Rules and Regulations. The continuing need for standing committees so established shall be reviewed periodically, but at least biennially.

#### **12.11. RECORD MAINTENANCE AND ACCESSIBILITY**

Committees are encouraged to maintain websites containing information on the committee's charge and membership. Except as otherwise provided, Services and Medical Staff committees must record and maintain minutes of their meetings and make reports and recommendations to the ECCA. Committee and Service members shall have access to the minutes of the body of which they are members. Members of the Active category shall have access to all minutes which do not involve confidential information; what constitutes confidential, Professional Review Information for this purpose shall be determined by either the CEO or COS in his/her discretion, after mutual consultation.

#### **12.12. UMHHC AND UMHS COMMITTEES**

The Medical Staff shall routinely participate in UMHHC and UMHS committees, which affect the discharge of Medical Staff responsibilities. The COS shall appoint the Medical Staff representatives to such committees, who are not designated by some other mechanism.

**ARTICLE XIII.  
MEDICAL STAFF MEETINGS**

**13.1. REGULAR MEETINGS OF THE MEDICAL STAFF**

Meetings of the Medical Staff will ordinarily be held at a time and place of, and in conjunction with, scheduled meetings of the Medical School faculty, at least once a year. The agenda for regular Medical Staff meetings will be distributed in advance.

**13.2. THE ANNUAL MEETING OF THE MEDICAL STAFF**

One meeting of the Medical Staff will be designated the annual meeting.

**13.3. SPECIAL MEETINGS OF THE MEDICAL STAFF**

The COS or the ECCA may call a special meeting of the Medical Staff at any time. The COS shall call a special meeting within fourteen (14) days after the receipt of a written request for same signed by not less than fifty (50) Medical Staff members and stating the purpose for such meeting. The ECCA shall designate the time and place of any special meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

**13.4. QUORUM**

Fifty (50) voting Members of the Medical Staff shall constitute a quorum at any regular or special meeting.

**ARTICLE XIV.  
SERVICE MEETINGS**

**14.1. PERIODIC MEETINGS**

Services will periodically meet independently or participate as a Service in other organization (e.g., a Department) meetings to address administrative matters affecting the Service and conduct preferred review.

**14.2. SPECIAL OR EMERGENCY MEETINGS**

A special meeting of any Service may be called by or at the request of the Department Chair or Service Chief. There shall be no specified number of days required for advance notice of special or emergency meetings.

**14.3. NOTICE OF MEETINGS**

Where a formal action will be taken, written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of a Service not less than five (5) days before the time of such meeting, by the person or persons calling the meeting. Otherwise, notice shall be given in the time and manner specified by the Service Chief or COS. The attendance of a member at a meeting shall constitute a waiver of notice of such a meeting.

**14.4. QUORUM**

Each Service shall set its quorum requirements, which shall be subject to approval by the COS.

**14.5. MANNER OF ACTION**

The action of a majority of the voting Members present at a meeting at which a quorum is present shall be the action of a Service. Action may be taken without a meeting by unanimous consent in writing signed by each Member entitled to vote.

**14.6. RECORD OF PROCEEDINGS**

Services shall prepare such minutes or reports as may be required by the COS or the ECCA.

**14.7. ATTENDANCE REQUIREMENTS**

Each Member of the Active Staff shall meet attendance requirements controlled by the Service or the ECCA.

**ARTICLE XV.  
COMMITTEE MEETINGS**

**15.1. REGULAR AND SPECIAL MEETINGS**

Unless otherwise provided, meetings shall be on call of the committee's chair.

**15.2. QUORUM**

A quorum for the transaction of business at any meeting of any Medical Staff committee shall be fifty percent (50%) of the voting members of that committee.

**15.3. MANNER OF ACTION**

The action of a majority of voting committee members present at a meeting at which a quorum is present shall be the action of the committee. Action may be taken without a meeting by notice of the contemplated action to each committee member and the consent, confirmed either in writing or electronically, of at least seventy-five percent (75%) of the committee members entitled to vote.

**15.4. RIGHTS OF EX OFFICIO MEMBERS**

Persons serving under these Bylaws as ex officio members of a committee shall have all the rights and privileges of regular members except they shall not vote, unless otherwise stated, or be counted in determining the existence of a quorum.

**15.5. MINUTES/MEETING SUMMARIES**

Minutes/meeting summaries of each meeting shall be prepared and shall include a record of the attendance of committee members and the vote taken on each matter. A copy of the minutes/meeting summary shall be available to the OCA.

**ARTICLE XVI.  
CONFIDENTIALITY, IMMUNITY, AND RELEASES**

**16.1. AUTHORIZATIONS AND CONDITIONS**

By applying for or exercising clinical privileges within UMHHC, an Applicant, Member, Trainee or SPP:

- (a) Authorizes Representatives of UMHHC and the Medical Staff to solicit, provide and act upon Professional Review Information.
- (b) Agrees to be bound by the provisions of these Bylaws and to waive and release all legal claims against any Representative who acts in accordance with the provisions of these Bylaws to the fullest extent permitted by law.
- (c) Acknowledges that the provisions of these Bylaws are express conditions to his/her application for, or acceptance of, Membership, clinical privileges or provision of specified patient services at UMHHC or on behalf of UMHS.

**16.2. CONFIDENTIALITY OF PROFESSIONAL REVIEW INFORMATION**

Professional Review Information regarding an Applicant, Member, Trainee or SPP held by UMHHC or Health System shall, to the fullest extent permitted by law, be confidential and not discoverable. Such Professional Review Information shall not be disclosed to anyone other than a Representative or Facility which is conducting Professional Review involving that individual Applicant, Member, Trainee or SPP or, as required by law, to a governmental agency. Professional Review Information concerning an Applicant, Member, Trainee or SPP shall not be part of a patient's medical record nor routinely the UMHHC's general business records. The HHCEB, the ECCA, the COS, a Department Chair, and the CEO (including his/her designee) shall each have the authority to enforce this section.

**16.3. IMMUNITY FROM LIABILITY**

16.3-1 Good Faith Immunity

Any Representative who acts in good faith in discharging duties, functions or responsibilities in accordance with these Bylaws on behalf of UMHHC shall be indemnified by UMHHC and, to the fullest extent permitted by law, be immune from liability to a Member, Applicant, Trainee or SPP for taking action in a Professional Review Committee or providing or disclosing information for such purposes.

16.3-2 Immunity for Communication to Governmental Agencies or Compliance with Law or Court Procedures

Neither a Representative of UMHHC nor UMHHC itself shall have any liability, in damages or otherwise, to an Applicant, Member, Trainee or SPP for any information communicated to a governmental agency under the assumption or belief that the Representative or UMHHC had a legal, ethical or moral obligation to do so. Moreover, neither a Representative affiliated with the UMHHC, nor the UMHHC itself, shall have any liability to an Applicant, Member, Trainee or SPP or communication of any information in accordance with a court order and/or court subpoena, or in accordance with the directive, in any form, of a governmental agency. The provisions of this Section, however, do not waive confidentiality rights of the UMHHC or its Representatives under Section 16.2.

#### **16.4. WAIVER OF PRIVILEGE**

Any Applicant, Member, Trainee or SPP who makes any claim or brings any internal or external administrative proceeding or legal action (collectively a “Claim or Action”) against the Regents, UMHHC, a Facility or a Representative for a Professional Review Action or disclosure of Professional Review Information, shall, by initiating such Claim or Action, waive any confidentiality privilege (s)he may have respecting Professional Review Information concerning him/her in the Claim or Action.

Any Applicant, Member, Trainee or SPP who discloses or whose agents or legal representatives disclose Professional Review Information to third parties shall, by virtue of such disclosure, thereby waives any confidentiality privilege(s) (s)he may have related to the professional matter.

Any waiver made pursuant to this Section 16.4 shall be deemed to permit UMHHC Representatives to make further disclosures concerning the Professional Review Action or Professional Review Information in response to the Applicant, Member, Trainee or SPP’s (or his/her agents’ or representatives’) disclosure.

#### **16.5. RELEASES AND AUTHORIZATIONS**

Each Applicant, Member, Trainee or SPP shall, to facilitate Professional Review and Professional Review Actions, execute written releases and/or authorizations consistent with this Article upon request of UMHCC or a UMHCC Representative. However, execution of a release or authorization is not a prerequisite to the effectiveness of this Article.

#### **16.6. CUMULATIVE EFFECT**

Provisions in these Bylaws, in the Rules and Regulations, and in application forms relating to authorizations, confidentiality of information, and immunities from liability, shall be in addition to other protections provided by law and not in limitation of such legal protections.

**ARTICLE XVII.  
MISCELLANEOUS PROVISIONS**

**17.1. TIME LIMITS**

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

**17.2. INTERNAL REPORTING**

Any action taken concerning Membership or clinical privileges, including at time of appointment, reappointment, or corrective or other action, shall be reported if not already known, to the COS, CEO, HHCEB Chair, and on a need-to-know basis, to other Members and UMHHC Staff (e.g., reduction in surgical privileges would have to be reported to the operating room supervisor). Any HHCEB action which would result in denial appointment, denial of reappointment, or substantially reducing clinical privileges shall be reported to the Regents.

**17.3. NOTICES AND OTHER COMMUNICATIONS**

Except as otherwise provided (e.g., Special Notices for hearings) notices and other communications pursuant to these Bylaws and the Rules and Regulations may be communicated by any reasonable method which will fairly give notice and a timely opportunity to access and review the matter so communicated. Such methods include U.S. Mail, private mail (e.g., Federal Express), hand delivery, Member boxes, and to any person who has an electronic mail address (personal or a designee like an assistant), electronic mail. The ECCA may also authorize electronic voting procedures.

**17.4. PERFORMANCE OF HISTORY AND PHYSICAL EXAMINATIONS**

Generally, a history and physical examination must be completed and documented in the medical record no more than thirty (30) days before or twenty-four (24) hours after admission or registration of each patient, but prior to surgery or a procedure requiring anesthesia services. When the history and physical examination is completed within the thirty (30) days prior to admission or registration, an examination of the patient must be documented in the medical record within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Notwithstanding the foregoing, the specific timelines for completion of the history and physical examination for circumstances involving inpatients, outpatients and various procedures is set forth in the Rules and Regulations.

**ARTICLE XVIII.  
INTERPRETATION, REVIEW, AND AMENDMENT**

**18.1. INTERPRETATION**

These Bylaws, policies, rules and appendices shall be interpreted in a manner consistent with applicable law. In the event the provisions of these Bylaws, policies, rules or appendices promulgated hereunder shall not be in conformance with Michigan or federal law, they shall be deemed automatically amended to comply with such law. As soon thereafter as may be practicable, such change shall be made in writing in the Bylaws, rules, or policies. A finding that any article, section or subsection is legally invalid shall not invalidate the effectiveness of all other portions of the Bylaws, policies, rules or appendices that are consistent with law. Nothing contained in these Bylaws or the Rules and Regulations, shall in any manner restrict or limit the authority of the HHCEB or the Regents to exercise its respective responsibilities as the governing bodies of the UMHC and the University under applicable law.

**18.2. MEDICAL STAFF RESPONSIBILITIES FOR BYLAWS**

The Medical Staff is responsible for developing, reviewing as needed and proposing amendments thereto, and recommending approval to the HHCEB, Bylaws, policies and amendments thereto, which shall be effective when approved by the HHCEB. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner.

**18.3. ECCA REVIEW OF BYLAWS AND AMENDMENTS**

All proposed amendments to the Bylaws, policies and amendments, whether originated by the ECCA, another standing committee or by a Member in the Active Staff category, must be submitted to the ECCA for review and discussion and an ECCA vote, before action is taken by the Active Staff Members as a whole.

**18.4. AMENDMENT PROCEDURE FOR BYLAWS**

18.4-1 Formal Amendment of Bylaws

Any proposal to amend the Bylaws shall be submitted to the Medical Staff's Nominating and Bylaws Committee. The Nominating and Bylaws Committee may recommend adoption, adoption with modification or refusal of the amendment. If approved, the amendment is presented to ECCA for preliminary consideration. The ECCA may agree or decline to submit the proposal for a vote by all Active Staff Members.

If ECCA agrees, the proposal must be distributed in writing or electronically to all Active Staff Members at least fourteen (14) days prior to an ECCA vote and approved by the Medical Staff. For such approval, each Member in the Active category of the Medical Staff will be eligible to vote on the proposed



amendment via printed/ or electronic ballot. An affirmative vote may be cast by either marking the Ballot “yes”; by an electronic vote of “yes” or by discarding the paper ballot if a printed ballot is used; or by not voting if an electronic ballot system is used. A negative vote shall be affirmatively cast by marking printed ballot or indicating a “no” electronic vote and returning to it to the OCA or by voting “no” on the electronic ballot. An amendment will be deemed approved by the Medical Staff providing that seventy-five percent (75%) of Members in the Active Staff category have voted “yes.” The amendment shall become effective upon ratification by the HHCEB.

18.4-2 ECCA Technical Amendment of Bylaws

The ECCA may adopt such amendments to the Bylaws as are, in the ECCA’s judgment, technical or legal modifications or clarification; reorganization or renumbering or those needed due to punctuation, spelling or other errors of grammar or expression. Such amendments need not be approved by the entire HHCEB, but shall be approved by the CEO.

18.4-3 Modification by Formal Agreement of Medical Staff and HHCEB

The provisions of the Bylaws may be modified or superseded by an agreement or policy adopted by the Medical Staff and approved by the HHCEB in a manner which meets the voting requirements of an amendment to these Bylaws under Section 18.4-1.

18.4-4 Emergency Action

In the event there is a bona fide need for immediate action by the Medical Staff, any procedural rule or requirement in these Bylaws or the Rules and Regulations (e.g., a meeting notice requirement) may be modified by joint written action of the CEO, the COS, and authorized representative of the HHCEB, subject to prompt submission thereafter to the ECCA and the Medical Staff of a proposed amendment to the provision so modified on an emergency basis.

18.4-5 HHCEB Action

In the event that the Medical Staff shall fail to exercise its responsibility and authority as required by Section 18.2, and this inaction puts UMHHC’s accreditation, licensure, payment or legal status at risk, after written notice from the HHCEB to such effect, including a period of sixty (60) days for response and a joint conference, the HHCEB may resort to its own initiative in formulating or amending the Bylaws. In such event, Medical Staff recommendations and views shall be carefully considered by the HHCEB during its deliberations and in its actions.

## **18.5. NOTICE TO MEMBERS**

When Bylaws, appendices, rules or policy provisions are adopted, materially amended or repealed, notice of the action and copies of any materially changed provisions shall be made available to all Members.

**ARTICLE XIX.**  
**RULES AND REGULATIONS AND MEDICAL STAFF POLICIES**

**19.1. MEDICAL STAFF RULES AND REGULATIONS**

The Medical Staff shall adopt Rules and Regulations consisting of such rules, protocols and selected policies as may be necessary for the proper conduct of the work of the Medical Staff.

19.1-1 Rules and Regulations

The Rules and Regulations shall consist of the Fair Hearing Plan, Rules and Committee Protocols which set forth detailed procedures for exercise of governance responsibilities, including, but not limited to, the Medical Staff rules, the process for conducting hearings and any appellate review and the protocol for establishing the name, appointment process for and charge of Medical Staff committees.

19.1-2 Rules and Regulations Amendment

The Rules and Regulations may be amended or added to by the ECCA, provided, however, that notice shall be given to Members prior to the amendment or addition becoming effective. In cases where an urgent amendment or addition to the Rules and Regulations may be necessary to comply with law or regulation, the ECCA may approve such an amendment or addition without providing notice to the Medical Staff, provided, however, the Medical Staff has the opportunity for retrospective review of the amendment. Any such amendment or addition is final upon approval of the HHCEB.

**19.2. MEDICAL STAFF POLICIES**

The Medical Staff shall from time to time issue policies. Policies are statements of principle that shall guide the Medical Staff on matters of moral, legal, or academic concern. While violations of a policy may form the basis for corrective action, policies shall not either increase or limit procedural process protections in the Bylaws or Rules and Regulations.

Medical Staff policies may be amended by the ECCA, provided that notice of such amendment is provided to the Medical Staff following adoption. Such amendment or adoption is final upon approval of the HHCEB. All policies shall be published (on paper and/or electronically) for the Medical Staff when issued and posted to the MSS Policy website. However, if in the judgment of the ECCA or the HHCEB, a policy is of a governance nature or a policy specifies a manner of personal conduct expected of Members in the nature of a Rule, it shall be made part of the Rules and Regulations.

### **19.3. ADMINISTRATIVE GUIDELINES OR PROCEDURES**

Administrative guidelines or procedures are issued to guide Medical Staff leadership and supporting staff in the implementation of the Bylaws and Rules and Regulations. They shall be entirely interpretive, advisory and procedural in nature and shall not set forth substantive requirements for Members generally. Administrative guidelines or procedures may be adopted by the COS, the ECCA or the HHCEB with notice to others. Administrative guidelines or procedures shall be issued to those persons who are expected to use them.

### **19.4. SERVICE RULES**

Each Service may adopt such rules and policies subject to the ECCA approval as may apply strictly to the administration of its own activities. Joint Service rules may be proposed for the ECCA's approval by two or more Services when activities of those Services overlap or consistent rules would otherwise be desirable.

### **19.5. BYLAWS GOVERN**

No rules, appendices, policies, or administrative guidelines that conflict with these Bylaws shall be adopted.

**ARTICLE XX.  
CONFLICT OF INTEREST**

**20.1. MANAGEMENT OF CONFLICTS OF INTEREST**

Free flow of communication and sound decision making requires Members and UMHHC employees who serve as Medical Staff officers or committee members or staff to disclose any duality of interest on matters under consideration by them in those capacities and, where personal economic interest could influence fair decision making concerning fellow Members and Applicants, or UMHHC related-business issues, to refrain from voting in such matters.

**20.2. GOOD FAITH**

Members, UMHHC employees, and independent contractors involved in Medical Staff decision making roles or processes, all exercise the utmost good faith in all transactions touching upon their respective duties on behalf of the Medical Staff and the UMHHC. The use of position, or knowledge gained there from, in such a way that a conflict may arise between his/her interest and the interest of the Medical Staff as a whole, the UMHHC, or other Members, including improper personal gain, shall not be permitted. Moreover, acceptance of gifts, favors, hospitality or consulting fees which may influence decisions or actions affecting the best interest of Medical Staff, UMHHC, the Health System, or UMHHC patients may constitute a potential or actual conflict of interest.

**20.3. DISCLOSURE OF ACTUAL OR POTENTIAL CONFLICTS**

Each Member or UMHHC employee holding a Medical Staff or Department officer position or serving on a committee (as member or staff) should be alert for potential or actual conflicts of interest and should express any concern or possible conflict prior to discussion of the matter. All potential or actual conflicts of interest should be identified and explained to the body, committee, or person taking action on the matter. Any person having a potential or actual conflict of interest on a matter should not otherwise use his/her personal influence to affect a decision on the matter. Where such a potential or actual conflict exists the minutes or other record of a meeting should reflect that a disclosure of the potential or actual conflict of interest was made along with an explanation of same, and except as hereinafter provided, that the person having the potential or that the person abstained from voting or taking action. Persons having a potential or actual conflict of interest shall be excused from deliberations and any action regarding the matter except where such person is permitted to remain during deliberation and/or vote as specifically provided below.

**20.4. LIMITED PARTICIPATION UPON DISCLOSURE**

The foregoing requirements should not be construed to prevent any such person from disclosing any reason known by him/her why a contract, transaction or other matter is not in the best interests of the Medical Staff, UMHHC, or UMHS. Upon proper identification

and explanation of potential or actual conflict of interest, such person may answer pertinent questions stating his/her position on the issue especially where such person possesses relevant special knowledge, education, or training and where permitted by affirmative majority vote of the remaining members of a body or committee, or where action is to be taken by another person, the permission of such other person. All decisions to merit participation by a person with a potential or actual conflict of interest shall be evaluated in accordance with the following sections of this policy.

#### **20.5. DETERMINATION OF NONEXISTENCE OR WAIVER OF CONFLICT**

Potential or actual conflicts involving an action or decision should be evaluated by the body, committee, or person (other than the person having a potential or actual conflict of interest). Where it is determined a conflict of interest exists but is minor, irrelevant, or the best interests of the Medical Staff, UMHHC, UMHS, and patients are not at risk based upon a weighing of the advantages and disadvantages accompanying the conflict, the body, committee, or person (other than the person having a potential or actual conflict of interest) may resolve and conclude a conflict does not exist. Upon such a finding, the individual whose potential conflict of interest or actual conflict of interest was under consideration, shall be permitted to freely participate and vote or take action on the matter, as appropriate. A finding that a conflict does not exist or is waived, should be reflected in the pertinent body's minutes and/or records. Where there are conflict of interest questions involving the chairperson of any body, the question will be resolved pursuant to the foregoing. In such cases, the vice-chair or in his/her absence, the senior member of the body shall serve as chair during the review and settlement of conflict question.

#### **20.6. OTHER POLICIES**

This policy should be read consistent with any other UMHHC, UMHS, Medical School or Medical Staff confidentiality and conflict of interest policies. However, in the event another more specific policy covering similar subject matter is more restrictive and protective against conflicts, that policy's more restrictive requirements shall supersede.

**Revisions to the Medical Staff Bylaws were:**

Amended and Approved by The University of Michigan Michigan Medicine Executive Committee on Clinical Affairs:	12/13/2016
Amended and Approved by The University of Michigan Hospitals and Health Centers Bylaws Committee:	6/3/2004
Approved by the Medical Staff of The University of Michigan Hospitals and Health Centers:	10/14/2004
Approved by The University of Michigan Hospitals and Health Centers Executive Committee on Clinical Affairs:	10/12/2004 (Pending Medical Staff Approval 10/14/2004)
Approved by The University of Michigan Hospitals and Health Centers Executive Board	10/25/2004
Approved by The Regents of the University of Michigan	11/18/2004