MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF MUNSON MEDICAL CENTER

CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in this Policy:

(1) "BOARD" means the Board of Trustees of Munson Medical Center.

(2) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(3) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(4) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(5) "DAYS" means calendar days.

(6) "DENTIST" means a Doctor of Dental Surgery ("D.D.S.") licensed by the State of Michigan or Doctor of Dental Medicine ("D.D.M."), licensed by the State of Michigan.

(7) "EX OFFICIO" means service as a standing or appointed member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

(8) "GOOD STANDING" means, at the time of assessment of standing, neither an individual's membership nor privileges are involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons.

(9) "HOSPITAL" means Munson Medical Center.

(10) "MEDICAL DIRECTOR" means a member who is assigned administrative duties and who also performs clinical services for which clinical privileges are required.

(11) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Executive Committee of the Medical Staff.

(12) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.

(13) "MEDICAL STAFF LEADER" means any Medical Staff Officer, department chair, section chief, and committee chair.

(14) "MEMBER" means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment by the Board.

(15) "MUNSON MEDICAL CENTER CHIEF MEDICAL OFFICER" ("MMC CMO") means the individual appointed by the CEO to act as the chief medical officer of the Hospital, in cooperation with the President of the Medical Staff.

(16) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, website, Hospital mail, hand delivery, or other electronic method.

(17) "ORAL SURGEON" means a dentist with advanced training qualifying him or her for board certification by the American Board of Oral and Maxillofacial Surgery.

(18) "ORGANIZED HEALTH CARE ARRANGEMENT" ("OHCA") means the term used by the HIPAA Privacy Rule which permits the Hospital and Medical Staff to use joint notice of privacy practices information when patients are admitted to the Hospital. Practically speaking, being part of an OHCA allows the members of the Medical Staff to rely upon the Hospital notice of privacy practices and therefore relieves Medical Staff members of their responsibility to provide a separate notice when members consult or otherwise treat Hospital inpatients.

(19) "PATIENT CONTACTS" includes any admission, evaluation, treatment, service, consultation, procedure, or response to emergency call performed in the Hospital or its outpatient facilities. It shall not include referrals for diagnostic or laboratory tests.

(20) "PERFORMANCE IMPROVEMENT PLAN" or "PIP" means a plan aimed at helping a member improve his or her clinical performance or professionalism when issues have been identified by the Medical Staff leaders. PIPs are voluntary in nature which means that no member is obligated to participate in such a plan if he or she disagrees with the basis for the plan.

(21) "PHYSICIAN" means an individual with an M.D. or D.O. degree who is licensed by the State of Michigan to practice medicine.

(22) "PODIATRIST" means a Doctor of Podiatric Medicine ("DPM") licensed by the State of Michigan with advanced training qualifying for board certification by the American Board of Podiatric Medicine.

(23) "PRESIDING OFFICER" means the individual who chairs a meeting of the Medical Staff, a department, a section, or a committee.

(24) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(25) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

(26) "TELEMEDICINE" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

(27) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B. DELEGATION OF FUNCTIONS

(1) When an administrative function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee is bound by all the terms, conditions, and requirements of this Policy. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, oral surgeons, and podiatrists must:*

(a) have a current, unrestricted license to practice in Michigan and have never had a license to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration;

(c) be located (office and/or residence) close enough to fulfill Hospital and Medical Staff responsibilities;

(d) have current, valid professional liability insurance coverage in a form and in amounts determined by the Board;

(e) have not been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(f) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(g) have not had Medical Staff appointment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have not resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

(i) have not been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

(j) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage (as determined by the applicable department and MEC) by another member of the Medical Staff;

(k) have or agree to make appropriate coverage arrangements (as determined by the applicable department and MEC) with other members of the Medical Staff for those times when the individual will be unavailable;

(l) demonstrate recent clinical activity in their primary area of practice during the last two years;

(m) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;

(n) if applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;

(o) document compliance with any health screening requirements (i.e., TB testing, mandatory flu vaccines, infectious agent exposures, and aging physician policy);

(p) have successfully completed:

(1) a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks clinical privileges;

(2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); or

(3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; and

(q) be certified in their primary area of practice by the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA), the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, or a certifying board acceptable to the MEC and the Board.

Those physician applicants who are not board certified at the time of application but who have recently completed their residency or fellowship training and are still within the initial board eligibility period, shall be eligible for Medical Staff appointment. However, to remain eligible, those applicants must achieve board certification in their primary area of practice within the initial board eligibility period as determined by their member board.

(r) maintain board certification in their primary area of practice on a continuous basis and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so. *

* The requirements pertaining to board certification are applicable to those individuals who apply for initial staff appointment after May 2004 and are not applicable to Medical Staff members who were appointed prior to that date. Those Medical Staff members shall be grandfathered and shall be governed by any board certification and residency training requirements that may have been in effect at the time of their initial appointments.2.A.2. Waiver of Threshold Eligibility Criteria:

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating **exceptional** circumstances (e.g., the individual is not board certified but has been granted an exception by applicable payors), and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(c) The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the State of Michigan or the National Practitioner Data Bank.

(e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

(f) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

(g) Except for those waivers granted on a time-limited basis, waivers do not need to be renewed and will remain in effect for the life of the member's appointment to the Medical Staff.

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

(a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;

(b) is or is not a member or employee of any particular physician group;

(c) is licensed to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Hospital; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

Neither the Hospital nor the Medical Staff shall discriminate in granting staff membership and/or clinical privileges on the basis of national origin, culture, race, gender, sexual orientation, gender identity, ethnic background, religion, or disability unrelated to the provision of patient care to the extent the individual is otherwise qualified.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment or reappointment, and as a condition of ongoing membership, every member specifically agrees to the following:

(a) to provide continuous and timely quality care to all patients for whom the individual has responsibility;

(b) to abide by all policies, the Code of Conduct Policy, and Rules and Regulations of the Hospital and the Bylaws and policies of the Medical Staff in force during the time the individual is appointed;

(c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as able/available;

(d) within the scope of his or her clinical privileges, provide consultations, care for unassigned patients, and emergency service call coverage, unless released by the department or section;

(e) to comply with clinical practice or evidence-based medicine protocols that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

(f) to comply with clinical practice or evidence-based medicine protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or to clearly document the clinical reasons for variance;

(g) to notify the Medical Staff Services Department, in writing, of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to:

- any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization,

- changes in professional liability insurance coverage,

- the filing of a professional liability lawsuit against the practitioner,

- changes in the practitioner's Medical Staff status (appointment and/or privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,

- knowledge of a criminal investigation involving the member, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,

- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,

- any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the practitioner health policy), and

- any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident will be reviewed by the President of the Medical Staff, the MMC CMO, and the chair of the Physician Well-Being Committee so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the Physician Well Being Committee/Impaired Practitioner Policy or this Credentials Policy.);

(h) to immediately submit to an appropriate evaluation in accordance with the Physician Well Being Committee/Impaired Practitioner Policy;

(i) to appear for personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(j) to maintain and monitor a Munson e-mail account, which will be the primary mechanism used to communicate all Medical Staff information to the member;

(k) to provide valid contact information in order to facilitate practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service information);

(l) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(m) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(n) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(o) to seek consultation whenever required or necessary;

(p) with respect to health care delivered in the Hospital, to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital and to utilize the electronic medical record as required;

(q) to cooperate with all utilization oversight activities;

(r) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;

(s) to perform all services and conduct himself/herself in a cooperative and professional manner;

(t) to comply with all applicable training and educational protocols that may be adopted by the MEC and the Board, including, but not limited to, those involving electronic medical records, CPOE, the privacy and security of protected health information, infection control, and patient safety;

(u) to promptly pay any applicable application fees and/or dues;

(v) to satisfy continuing medical education requirements; and

(w) that, if there is believed to be an intentional misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response that will be reviewed by the applicable department chair and/or section chief, who may refer the matter to the Credentials Committee for consideration, if needed. If this provision is triggered and an intentional misstatement or omission is determined by the Credentials Committee, the individual may not reapply to the Medical Staff for a period of at least two years.

2.B.2. Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and all application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 30 days after the individual has been notified of the need for new, additional, or clarifying information, the application shall be deemed to be withdrawn.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished,

withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request; and

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested.

(c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received in good faith and without malice by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials,

clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/ facility, and any licensure or regulatory matter.

(d) Authorization to Share Information within Munson Healthcare:

The individual specifically authorizes Munson Healthcare to share credentialing and peer review information pertaining to an individual's clinical competence and/or professional conduct among its affiliated entities. This information may be shared at initial appointment, reappointment, and/or any other time during the individual's appointment.

(e) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in the Medical Staff Bylaws are the sole and exclusive administrative remedy with respect to any professional review action taken by the Hospital.

(f) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(1) whether or not appointment or clinical privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about their tenure as a member of the Medical Staff.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) Applications for appointment shall be in writing and shall be on forms approved by the MEC and Credentials Committee.

(b) Upon receipt of a CV, an individual seeking initial appointment will be sent (i) a letter that outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, (ii) any applicable eligibility criteria for the clinical privileges being sought, and (iii) the application form.

(c) Applications may be provided to residents or fellows a year in advance pending the successful completion of their training. Such applications may be processed, but final action on the applications shall not become effective until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical Staff Services Department within 30 days after receipt. The application must be accompanied by the application fee.

(b) As a preliminary step, the application shall be reviewed by the Medical Staff Services Department to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in the Medical Staff Bylaws.

(c) The Medical Staff Services Department shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

3.A.3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from peer references (from the same discipline where practicable) and from other available sources, including the

applicant's past or current department chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chair, the section chief, the Credentials Committee, a Credentials Committee representative, the MEC, the President of the Medical Staff, the MMC CMO, and/or the CEO.

3.A.4. Department Chair and/or Section Chief Procedure:

(a) The Medical Staff Services Department shall transmit the complete application and all supporting materials to the chair of each department and/or the chief of each section in which the applicant seeks clinical privileges. The department chair and/or section chief shall verify eligibility and prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested on a form provided by the Medical Staff Services Department.

(b) The department chair and/or section chief shall be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

3.A.5. Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the report prepared by the relevant department chair and/or section chief and shall make a recommendation.

(b) The Credentials Committee may use the expertise of the department chair, the section chief, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. In addition, any practitioner who is 70 years of age or older and who applies for clinical privileges (or for renewal of clinical privileges) shall be required to undergo an examination as outlined in applicable policy. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than the term described in 3.A.9.in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 8.A.1(a) of the Medical Staff Bylaws, such conditions do not entitle an individual to request the procedural rights set forth in Article 8 of the Bylaws.

3.A.6. MEC Recommendation:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall:

(1) adopt the findings and recommendation of the Credentials Committee, as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board.

(c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with the Medical Staff Bylaws, the MEC shall forward its recommendation to the President of the Medical Staff, who shall promptly send special notice to the applicant. The President of the Medical Staff shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

(a) Expedited Board Process. The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for information at its next meeting.

(b) Full Board Process. When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the President of the Medical Staff. If the Board's determination remains unfavorable to the applicant, the President of the Medical Staff shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 90 business days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.A.9. Duration of Appointment:

All initial appointments and any other initial grants of clinical privileges pursuant to this Policy shall be for a duration of not more than three years.

3.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence and professionalism. The FPPE process for these situations is outlined in the relevant Medical Staff policy.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

(b) For privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

(c) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).

(d) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.

(e) The clinical privileges recommended to the Board shall be based upon consideration of the following factors:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of other qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(f) Core privileges, special privileges, privilege delineations, and/or the criteria for the same will be developed by the relevant section chief and/or department chair and shall be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendation to the MEC, which will review the matter and forward its recommendation to the Board for final action.

(g) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.

(h) The report of the chair of the clinical department (or section chief) in which privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications and Waivers:

(a) Scope. This Section applies to all requests from a Medical Staff member for modification of clinical privileges during the term of appointment (increases and relinquishments), resignation from the Medical Staff, and waivers related to eligibility criteria for privileges or the scope of those privileges.

(b) Submitting a Request. Requests for privilege modifications, waivers, and resignations must be submitted in writing or electronically to the Medical Staff Services Department.

(c) Increased Privileges.

(1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

(2) If the individual is eligible, the application will be processed in the same manner as an application for initial clinical privileges.

(d) Waivers.

(1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the process set forth in this paragraph shall apply.

(i) Formal Request: The individual must forward a written or electronic request to the Medical Staff Services Department which must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

(ii) On-Call Obligations: By applying for a waiver related to limiting the scope of core privileges, the individual nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other physicians on the Medical Staff in assessing and stabilizing patients who require services within that specialty, if this call responsibility is required by the Medical Staff leadership after review of the specific circumstances involved. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual shall work cooperatively with the other physicians in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

(iii) Review Process: A request for a waiver shall be submitted to the applicable department chair and/or section chief for consideration. In reviewing the request for a waiver, the department chair and/or

section chief shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from other members of the Medical Staff. The department chair and/or section chief's recommendation will be forwarded to the MEC, which shall review the recommendation and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation. Any request for a waiver that cannot be resolved by the department chair and/or section chief will be referred to the MEC for review.

(e) Relinquishment and Resignation of Privileges.

(1) Relinquishment of Individual Privileges. A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

(2) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual:

(i) has completed all medical records;

(ii) will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and

(iii) has completed scheduled emergency service call or has arranged for appropriate coverage to satisfy this responsibility.

After consulting with the department chair and/or section chief, the President of the Medical Staff will act on the resignation request and report the matter to the MEC.

(f) Factors for Consideration. The Medical Staff Leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to privileges:

(1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;

(2) whether sufficient notice has been given to provide a smooth transition of patient care services;

(3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed upon the individual;

(4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them;

(5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;

(6) any perceived inequities in modifications or waivers being provided to some, but not others;

(7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

(8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(g) Effective Date. If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.

(h) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

4.A.3. Clinical Privileges for New Procedures:

Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure shall be reviewed in accordance with the Medical Staff's new technology policy.

4.A.4. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

(c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

(1) the appropriate education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;

(5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

(6) the impact, if any, on emergency call responsibilities.

(e) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

4.A.5. Clinical Privileges for Dentists and Non-MD/DO Oral Surgeons:

(a) For any uncomplicated patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists and non-MD/DO oral surgeons may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient that is outside of their scope of practice.

(b) For any complicated patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician before dental surgery may be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The dentist or non-MD/DO oral surgeon shall be responsible for the oral surgery care of the patient, including the complete history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and non-MD/DO oral surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.6. Clinical Privileges for Podiatrists:

(a) For any uncomplicated patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient that is outside of their scope of practice.

(b) For any complicated patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician before podiatric surgery shall be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The podiatrist shall be responsible for the podiatric care of the patient, including the complete podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are

within the scope of their license and consistent with relevant Hospital policies and rules and regulations.

4.A.7. Physicians in Training:

(a) Physicians in training programs (i.e., residency or fellowship) shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital and the MEC or their designee(s). The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in the training program.

(b) A physician in training at the fellowship level may request clinical privileges in an area for which he or she has already completed residency training as a Licensed Independent Practitioner if he or she can demonstrate that all necessary eligibility criteria as set forth in this Policy have been met. Requests for privileges shall be reviewed in accordance with the initial credentialing process outlined in this Policy and, if granted, shall be subject to all relevant oversight provisions, including ongoing and focused professional practice evaluation. Physicians in training at the fellowship level may not be granted clinical privileges in the specialty area in which they are currently in training as part of their training program.

4.A.8. Telemedicine Privileges:

(a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.

(b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the CEO or MMC CMO in consultation with the President of the Medical Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the

distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in Michigan (or meets the alternative licensing requirements applicable to telemedicine providers in both the state where the individual is located and Michigan) and has current professional liability coverage;

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(vi) any other attestations or information required by the agreement or requested by the Hospital.

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(c) Telemedicine privileges, if granted, shall be for a period of not more than three years.

(d) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners, or staff, will be shared with the hospital or entity providing telemedicine services.

(e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CEO, upon recommendation of the President of the Medical Staff, under the following conditions:

(1) the applicant has submitted a complete application, along with the application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the application is pending review by the MEC and/or the Board, following a favorable recommendation by the Credentials Committee, after considering the evaluation of the department chair; and

(5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive days.

(b) Locum Tenens. The CEO, following a favorable recommendation by the Credentials Committee and after considering the evaluation by the applicable department chair, may grant temporary privileges (both admitting and treatment) to an individual serving as a locum tenens for a member of the Medical Staff who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

(1) the applicant has submitted an appropriate application, along with the application fee;

(2) the applicant meets the relevant threshold eligibility criteria outlined in Section 2.A.1 of this Policy;

(3) the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least

the previous two years), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(4) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(5) the applicant has received a favorable recommendation from the Credentials Committee Chair, after considering the evaluation of the department chair;

(6) the applicant will meet the applicable responsibilities outlined in Section 2.B.1 of this Policy and be subject to any focused professional practice requirements established by the Hospital; and

(7) the individual may exercise locum tenens privileges for a maximum of 120 days. Should further coverage assistance be required, the CEO may grant up to two additional terms of 120 days, following a favorable recommendation by the department chair and the Chair of the Credentials Committee.

(c) Visiting. Temporary privileges may also be granted in other limited situations by the CEO, upon recommendation of the applicable department chair, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:

(1) the care of a specific patient;

(2) when a proctoring or consulting physician is needed, but is otherwise unavailable; or

(3) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing and applicable clinical privileges at primary practice facility(s)), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, from a criminal background check, and from OIG queries. The grant of clinical privileges in these situations will not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the department chair and the CEO.

(d) Automatic Expiration. All grants of temporary privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken by the relevant department chair, the Chair of the Credentials Committee, and the CEO to renew such temporary privileges.

(e) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

(f) FPPE. Individuals who are granted temporary privileges will be subject to the Medical Staff policy regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Withdrawal of Temporary Clinical Privileges:

(a) The CEO may withdraw temporary admitting privileges at any time, after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, the department chair, the section chief, and/or the MMC CMO. Clinical privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the department chair, the President of the Medical Staff, the MMC CMO, or the CEO may immediately withdraw all temporary privileges. The department chair or the President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient shall be assigned by the department chair or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO, the MMC CMO, or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (i) current hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation,

mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.

(2) To the extent that:

(a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or

(b) the Board by resolution limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized practitioners are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

(3) Prior to the Hospital signing any exclusive contract in a new specialty area and/or passing any Board resolution described in paragraph (2) in a specialty service and/or specialty area that has not previously been subject to such a contract or resolution, the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by the President of the Medical Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution, and provide a report of its findings and recommendations to the Board within 30 days of the Board's request. As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Hospital administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff members who may be a party to the arrangement, are not relevant and shall neither be disclosed to the MEC nor discussed as part of the MEC's review.

(4) After receiving the MEC's report, the Board shall make a preliminary determination on whether or not to proceed with the exclusive contract or Board resolution. If the Board makes a preliminary determination to pursue an

arrangement that would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures (Note: if more than one member in a relevant specialty area will be affected by the determination of the Board, the following procedures will be coordinated to address all requested meetings in a combined and consolidated manner):

(a) The affected member shall be given notice of the proposed arrangement and the right to request to meet with the Board (or a committee designated by the Board) to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective. Any such meeting must be requested by the affected member within 30 days of the notice. Once requested, the meeting will be held on a date and time that is mutually agreeable to the Board and the affected member.

(b) At the meeting, the affected member shall be entitled to present any information that he or she deems relevant to the Board's final decision to enter into the exclusive contract or enact the resolution.

(c) If, following this meeting, the Board determines to enter into the exclusive contract or enact the Board resolution, the affected member shall be notified that he or she will be ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. The affected member's ineligibility will begin on a date specified by the Board, but no sooner than 180 days after the date of the notice.

(d) The affected member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 8 of the Medical Staff Bylaws.

(e) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the Michigan Board of Medicine or to the National Practitioner Data Bank.

(5) The ability to practice at the Hospital is contingent upon continued appointment and is also constrained by the extent of an individual's clinical privileges. An individual's right to use the Hospital's facilities is automatically terminated if his or her appointment expires or is terminated. Similarly, no individual under contract may exceed the limit of his or her clinical privileges, notwithstanding the terms of the contract. An exclusive contract may provide for automatic termination of an individual's appointment and clinical privileges in the event that the contract is terminated or the individual's affiliation with the contract group terminates, with no entitlement to a hearing or appeal.

(6) Except as provided in paragraph (1), in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

(a) completed all medical records and be current at time of reappointment;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in Section 2.A.1 of this Policy;

(e) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of their confidential quality profile from their primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further; and

(f) paid any reappointment processing fees and dues.

5.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the Bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;

(b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, timely and completeness of medical record documentation, cooperation with case management, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of the Medical Staff's performance improvement and professional practice evaluation activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(d) any focused professional practice evaluations;

(e) verified complaints received from patients, families, and/or staff; and

(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Services Department within 30 days.

(b) Failure to return a completed application within 30 days may result in the assessment of a reappointment late fee, which must be paid prior to the application being processed, and the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Services Department and the Medical Staff Leaders. If an individual's privileges lapse due to a processing delay, subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application in accordance with the expedited process set forth in Section 3.A.7.

(c) Reappointment shall be for a period of not more than three years.

(d) The application shall be reviewed by the Medical Staff Services Department to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(e) The Medical Staff Services Department shall also oversee the process of gathering and verifying relevant information and shall also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

(a) The Medical Staff Services Department shall forward the application to the relevant department chair and/or section chief and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

5.A.5. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 8.A.1(a) of the Medical Staff Bylaws, such conditions do not entitle an individual to request the procedural rights set forth in Article 8 of the Bylaws.

(b) Reappointments may be recommended for periods of less than the term described in 5.A.3. in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for reappointment for a period of less than the term described in 5.A.3. does not, in and of itself, entitle an individual to the procedural rights set forth in Article 8 of the Bylaws.

(c) In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than the term described in 5.A.3. may be granted pending the completion of that process.

5.A.6. Potential Adverse Recommendation:

(a) If the Credentials Committee or the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chair will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.

(b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.

(c) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be accompanied by legal counsel at this meeting and no recording (audio or video) of the meeting shall be permitted or made.

5.A.7. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

CONFLICT OF INTEREST GUIDELINES

(**Appendix A** to this Policy is a chart that summarizes these conflict of interest guidelines.)

6.A.1. General Principles:

(a) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.

(b) It is also essential that peers participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

6.A.2. Self or Immediate Family Members:

No practitioner may participate in the review of his or her own application or care, except to provide information. Similarly, no immediate family member (spouse, parent, child, sibling, or in-law) of a practitioner whose application or care is being reviewed shall participate in any aspect of the review process, except to provide information.

6.A.3. Treatment Relationship:

An individual who has provided professional health services to a practitioner whose application or care is under review shall not participate in the review process regarding the practitioner except as follows:

(a) if the patient-physician relationship has terminated and the review process does not involve the health condition for which the practitioner sought professional health services;

(b) to provide information that was not obtained through the treatment relationship; or

(c) to provide information that was obtained through the treatment relationship, as authorized by the practitioner.

6.A.4. Employment or Contractual Relationship with the Hospital:

Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not, in and of itself, preclude an individual from participating in credentialing and

professional practice evaluation activities. Rather, participation by such individuals shall be evaluated as outlined in the paragraphs below.

6.A.5. Actual or Potential Conflict Situations:

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

(a) significant financial relationship exists (e.g., members of small, single specialty group; significant referral relationship; partners in business venture);

(b) the existence of a physician-patient relationship (including situations where the individual under review is the treating physician as well as when the individual under review is a patient receiving treatment);

(c) being a direct competitor;

(d) close friendship;

(e) a history of personal conflict;

(f) personal involvement in the care of a patient which is subject to review;

(g) raising the concern that triggered the review; or

(h) prior participation in review of the matter at a previous level.

Any such individual shall be referred to as an "Interested Member" in the remainder of this Article for ease of reference.

6.A.6. Guidelines for Participation in Credentialing and Professional Practice Evaluation Activities:

An Interested Member shall have the obligation to disclose any actual or potential conflict of interest. When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines shall be used.

(a) Initial Reviewers. An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited to, the following situations:

(1) participation in the review of applications for appointment, reappointment, and clinical privileges because of the Credentials Committee's and MEC's subsequent review of credentialing matters; and

(2) participation as case reviewers in professional practice evaluation activities because of a Peer Review Committee's subsequent review of peer review matters.

(b) Credentials Committee, Peer Review Committee or Professional Standards Committee Member. An Interested Member may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the MEC. However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence would inhibit full and fair discussion of the issue or would skew the recommendation or determination of the committee.

(c) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

(d) MEC. An Interested Member will be recused and may not participate as a member of the MEC when the MEC is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

(e) Board. An Interested Member will be recused and may not participate as a member of the Board when the Board is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

6.A.7. Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

(a) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria;

(b) participate in the discussions or actions of the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chair of the Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but

(c) not participate in the discussions or actions of the MEC when it is considering its final recommendation to the Board regarding the criteria or participate in the final discussions or action of the Board related to the criteria.

6.A.8. Rules for Recusal:

(a) When determining whether recusal in a particular situation is required, the President of the Medical Staff or committee chair shall consider whether the Interested Member's presence would inhibit full and fair discussion of the issue before the committee, skew the recommendation or determination of the committee, or otherwise be unfair to the practitioner under review.

(b) Any Interested Member who is recused from participating in a committee or Board meeting must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer questions and provide input before leaving.

(c) Any recusal will be documented in the committee's or Board's minutes.

(d) Whenever possible, an actual or potential conflict should be brought to the attention of the President of the Medical Staff or committee/Board chair, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

6.A.9. Other Considerations:

(a) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the President of the Medical Staff (or to the President-Elect if the President of the Medical Staff is the person with the potential conflict), or the applicable committee/Board chair. The member's failure to notify will constitute a waiver of the claimed conflict. The President of the Medical Staff or the applicable committee/Board chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.

(b) No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.

(c) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity, shall not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 7

CONFIDENTIALITY AND PEER REVIEW PROTECTION

7.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to the Medical Staff Bylaws, the Policy on Advanced Practice Providers and Other Practitioners, and this Policy shall be strictly confidential. Individuals participating in, or subject to, credentialing and professional practice evaluation activities (including collegial interventions, investigations, and hearings) shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

(1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and professional practice evaluation activities;

(2) when the disclosures are authorized by a Medical Staff or Hospital policy; or

(3) when the disclosures are authorized, in writing, by the CEO or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality must immediately inform the CEO, the MMC CMO, or the President of the Medical Staff (or the President-Elect if the President of the Medical Staff is the person committing the claimed breach).

7.B. PEER REVIEW PROTECTION

(1) All credentialing and professional practice evaluation activities pursuant to this Policy and related Medical Staff documents shall be performed by "Peer Review Committees" in accordance with Michigan law. These committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) all departments and sections;

(c) hearing panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, including but not limited to department chairs, section chiefs, committee chairs and members, officers of the Medical Staff, the MMC CMO, the System CMO, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of the Michigan peer review laws and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

(2) All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq*.

ARTICLE 8

HOSPITAL EMPLOYEES

(a) Except as provided below, the employment of an individual by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship and/or written contract will apply.

(b) Except as noted in (a) above, Hospital-employed members are bound by all of the same conditions and requirements in this Policy that apply to non-Hospital employed members.

(c) A request for appointment, reappointment, clinical privileges, or scope of practice, submitted by an applicant or member who is seeking employment or who is employed by the Hospital, shall be processed in accordance with the terms of this Policy and the Medical Staff leadership shall determine whether the individual is qualified for the privileges requested. A report regarding each practitioner's qualifications shall then be made to Hospital management or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

(d) If a concern about an employed member's clinical competence, conduct or behavior arises, then the concern may be reviewed and addressed in accordance with this Policy, in which event a report will be provided to Hospital management or Human Resources (as appropriate). This provision does not preclude Hospital management or Human Resources from addressing an issue in accordance with the Hospital's employment policies/manuals or in accordance with the terms of any applicable employment contract.

ARTICLE 9

AMENDMENTS AND ADOPTION

(a) The amendment process for this Policy is set forth in the Bylaws.

(b) This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____

Approved by the Board: _____

APPENDIX A

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Professional Standards	Peer Review	MEC	Ad Hoc Investigating		
Family member	Y	N	R	R	R	R	N	N	R
Treatment relationship*	Y	N	R	R	R	R	N	N	R
Employment relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Reviewed at prior level	Y	Y	Y	Y	Y	R	N	N	R
Raised the concern	Y	Y	Y	Y	Y	R	N	N	R

* A "relevant treatment relationship" exists (1) if the individual and the practitioner are in a current patient-physician relationship or (2) if the patient-physician relationship has terminated but the review process involves the health condition for which the practitioner sought professional health services.

** An individual may provide information that was not obtained through the treatment relationship. However, the individual may provide information that was obtained through the treatment relationship only after obtaining the practitioner's HIPAA-compliant authorization for the disclosure.

Y – (green "Y") means the Interested Member may serve in the indicated role, no extra precautions are necessary.

Y – (yellow "Y") means that the Interested Member may generally serve in the indicated role. It is legally-permissible for such Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review, and the fact that the Peer Review Committee, Credentials Committee, and Professional Standards Committee do not have disciplinary authority. In addition, the Chair of the Credentials Committee, Professional Standards Committee, or Peer Review Committee always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would inhibit the full and fair discussion of the issue before the committee, skew the recommendation or determination of the committee, or otherwise be unfair to the practitioner under review.

N – (red "N") means the individual may not serve in the indicated role.

R – (red "R") means the individual must be recused in accordance with the rules for recusal.

APPENDIX A

CONFLICT OF INTEREST GUIDELINES (*cont'd.*)

Rules for Recusal

- Interested Members must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer questions and provide input before leaving.

- If an Interested Member is recused on a particular issue, the recusal shall be specifically documented in the minutes.

- Whenever possible, an actual or potential conflict should be raised and resolved prior to meeting by the committee or Board chair and the Interested Member informed of the recusal determination in advance.

- No Medical Staff member has the RIGHT to demand the recusal of another member – that determination is within the discretion of the Medical Staff Leaders in accordance with these guidelines.

- Voluntarily choosing to refrain from participating in a particular situation is not a finding or an admission of an actual conflict or any improper influence on the process.