BEAUMONT HEALTH SYSTEM

BYLAWS OF THE MEDICAL STAFFS

Approved by the Board of Directors

February 17, 2015

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DEFINITIONS

1. **APPLICANT** means a physician, dentist, or other health care professional eligible to apply for membership on the Medical Staff, who applies or reapplies for such membership.

2. **BOARD OF DIRECTORS** means the governing body of Beaumont Health System (the Corporation).

3. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted to a Medical Staff member or Mid-Level Providers to render specific patient services.

4. **DEPARTMENT** means a segment of the Medical Staff sharing both an Academic Portfolio of educational and research programs and a Clinical Portfolio of academic and clinical expertise in a particular area of medicine. Departments shall be headed by a Department Chief who shall discharge his or her duties as set forth in these Bylaws.

5. **DOCTOR:** means allopathic, osteopathic, dental and podiatric practitioners as defined by Michigan law.

6. **HOSPITAL**(s) means Beaumont Hospital, Royal Oak (RO), Beaumont Hospital, Troy (Troy), Beaumont Hospital, Grosse Pointe (GP) divisions of Beaumont Health System, a Michigan non-profit corporation.

7. **MEDICAL STAFF** or **STAFF** means all physicians, dentists, and other health care professionals who have been granted recognition as members of the Medical Staff according to the terms of these Bylaws.

8. **MEDICAL STAFF YEAR** means the period from January 1 to December 31 of each year.

9. **MEMBER** or **STAFF MEMBER** means, unless otherwise expressly limited, any physician, dentist, or other health care professional, holding a current license if required by law to practice in the State of Michigan, who is a member of the Medical Staff.

10. **MID-LEVEL PROVIDER (MLP)** means an advanced clinical medical professional who is licensed to care for patients in accordance with delineated clinical privileges and / or job description under the supervision of a physician. Mid-level providers include nurse practitioners (NP), physician assistants (PA), certified registered nurse anesthetists (CRNA) and certified nurse midwives (CNM). Mid-level providers may not be members of the Medical Staff of Beaumont Health System, but are eligible for clinical privileges.

11. **SECTION** means section of a Department of the Medical Staff sharing both an Academic Portfolio of educational and research programs and a Clinical Portfolio of academic and clinical expertise in a particular area of medicine. Sections shall be headed by a Section Head who shall discharge his or her duties as set forth in these Bylaws.

12. **PHYSICIAN-IN-CHIEF** means the physician(s) appointed by the Board of Directors to be responsible for general management of the medical activities of the Hospital(s). May also be referred to as Senior Vice President and Physician-in-Chief

BYLAWS OF THE MEDICAL STAFF
OF BEAUMONT HEALTH SYSTEM

PREAMBLE

These Bylaws are promulgated by direction of the Board of Directors, as the governing body of Beaumont Health System, to establish procedures for selection and organization of a Medical Staff which will enable the Divisions of Beaumont Hospital, Royal Oak, Beaumont Hospital, Troy and Beaumont Hospital, Grosse Pointe to be utilized effectively for the health care, education and research purposes for which the Corporation was formed.

To attain these purposes, there are herein created provisions for: (1) the appointment of Staff members dedicated to the goals of the Corporation and of the community which it serves; (2) the organization of Staff members along the lines of their specialization so as to promote efficient formulation and administration of policy, accurate evaluation of professional performance, enhancement of the quality and safety of health care, research and educational training, efficiency in the utilization of facilities and in its budgetary processes; (3) the monitoring and evaluation of general functions not solely limited by area of specialization through the establishment of oversight committees; (4) the periodic review and evaluation of these governing procedures so as to facilitate the Corporation's maintenance of its standing as a comprehensive health care corporation.

ARTICLE I ETHICS AND ACCREDITATION

1.1 ETHICS AND ACCREDITATION

A member of the Staff shall at all times abide by the appropriate Codes of Ethics of the American Medical Association, American Osteopathic Association, American Dental Association, American Podiatric Medical Association, or if a member of another health care profession, the professional principles or codes of ethics appropriate to their profession, and as a condition of appointment and reappointment pledge to: (1) provide competent, humane, and efficient patient care, seeking consultation with other professionals where appropriate to do so; (2) delegate in the Staff member's absence the responsibility for diagnoses or care of his / her patients only to a practitioner who is qualified to undertake this responsibility; (3) refrain from grant or receipt of any inducements for patient referral; (4) refrain from entering into any arrangement to directly or indirectly share or divide fees received in connection with the rendering of professional services, except in cases where a partnership, association or an employee relationship exists: (5) treat other Staff members and Hospital employees with dignity, courtesy and respect.

All members of the Staff shall agree to cooperate, and accept responsibility, to maintain the applicable standards and meet the applicable requirements of state and federal law and of the Michigan Department of Community Health, of the Joint Commission, of the United States Department of Health and Human Services, of other third-party payers, and licensing, accrediting, regulatory and peer review organizations so that the Division may be fully licensed, accredited and qualified for third-party reimbursement.

1.2 CORPORATE ETHICS STRUCTURE

The Corporate Institutional Ethics Committee (I.E.C.) consists of members representing each of the Hospitals in the Beaumont system and the community. The I.E.C. reports to the Chief Medical Officer and through him to the Board of Directors through the Patient Care and Quality Committee.

The directors / chairpersons of the Ethics Consultation Services / Committees at the Royal Oak, Troy, and Grosse Pointe Hospitals report to the Corporate Director of Clinical Bioethics, and with the Corporate Director of Clinical Bioethics comprise the Corporate Office of Clinical Bioethics.

ARTICLE II MEDICAL STAFF RULES / REGULATIONS / POLICIES

2.1 MEDICAL STAFF RULES / REGULATIONS / POLICIES

To facilitate competent, orderly and efficient provision and administration of health care services at the Hospital and otherwise provide for implementation of the principles set forth in these Bylaws, the Medical Executive Boards shall prepare the Rules / Regulations / Policies to govern the Staff and promulgate them in a Physician's Handbook which will be updated at least every three (3) years. Rules / Regulations / Policies are amended as set forth in these Bylaws.

The Physician-in-Chief is delegated authority to temporarily suspend an existing Rule or Regulation or Policy in the interest of patient care until the matter is considered by the Medical Executive Boards and the Board of Directors.

The Medical Executive Board is delegated the authority to approve, on behalf of the Medical staff, such amendments to the Rules / Regulations / Policies as are, in its judgment, strictly clerical modifications or clarifications such as punctuation, spelling or other errors in grammar, expression or intent.

2.2. DEPARTMENT AND SECTION RULES / REGULATIONS / POLICIES

Each Hospital Medical Staff, Department and Section may adopt rules, regulations, and policies for the administration of its own activities. No such rules, regulations, or policies may conflict with the Corporate Bylaws or Rules / Regulations / Policies of the Medical Staff.

ARTICLE III STAFF APPOINTMENT AND REAPPOINTMENT

3.1. STAFF MEMBERSHIP REQUIRED

Except as provided for in these Bylaws and otherwise specified herein, no person shall exercise clinical privileges in the Hospital unless and until he or she applies for and receives an appointment to the Staff with clinical privileges.

The Board of Directors shall determine which categories of health care practitioners, in accordance with state law, may be eligible for membership on the Medical Staff, as well as which categories of health care practitioners are eligible for Medical Staff membership and privileges only as employees of the Hospital, and which categories, if any, are not allowed Medical Staff membership but are eligible for privileges.

3.2. QUALIFICATIONS FOR STAFF MEMBERSHIP

All members of the Staff shall be graduates of Medical, Osteopathic, Dental or Podiatric schools or post-graduate programs appropriate to membership on the Bioscientific Staff, and currently licensed to the extent required to practice their profession in the State of Michigan. Staff membership is a privilege and no one is entitled to such membership or the exercise of clinical privileges in the Hospital merely by virtue of licensure in Michigan, membership in a professional organization, past or present membership on the Staff, or membership or privileges in any other Hospital. The applicant shall have the burden of producing information satisfactory to the Hospital for a proper evaluation of all relevant criteria and resolving any doubt about their qualifications.

Gender, race, creed, and national origin shall not be used in making decisions regarding the granting or denying of Medical Staff membership or clinical privileges.

3.3. TERMS OF APPOINTMENT

Appointment to the Staff shall be made by the Board of Directors upon the recommendations of the Medical Executive Boards and the Patient Care and Quality Committee and shall be for a period not to exceed two (2) calendar years unless the appointment is earlier terminated by the Board of Directors. Failure by any Staff member to deliver health care services in the Hospital and to abide by all provisions of the Corporate and Medical Staff Bylaws and the Rules / Regulations / Policies of the Medical Staff, Department or Section may be cause for termination of clinical privileges and termination of Staff membership or any other sanction authorized by these Bylaws. During the term of any appointment the Staff member must maintain all relevant qualifications and commitments that were a part of his / her application and appointment. Reappointments shall be considered and, where deemed appropriate, shall be made by the Board of Directors.

3.3.1. CONDITIONAL APPOINTMENT / REAPPOINTMENT. Recommendations for appointment and reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., Professional Conduct Policy) or to clinical issues (e.g., performance improvement steps such as general consultation requirements, proctoring, completion of CME requirements). Newly-appointed physicians must have a Focused Professional Practice Evaluation within the first six months of appointment, and reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's compliance with any condition that may be imposed.

A recommendation for conditional appointment or reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

3.4. APPOINTMENT RECORDS

The Central Credentialing Office(s) designated by the Chief Medical Officer shall maintain appropriate records concerning each Staff member, including without limitation, the Staff application, reappointment application, a record of licensure, health status, peer review records, category of Staff membership, and delineation of privileges. Access to these confidential peer review materials and records shall be limited to those involved in specific peer review activities delegated by the Hospital and / or the Board of Directors, including the Physician-in-Chief(s) or their designee(s), the President of the Medical Staff, the Staff member's Chief or Vice-Chief of Department, or Head of Section or appropriately designated individuals. Individual Staff members may access those portions of their records not maintained in peer review confidentiality. The individual Staff member will be notified of any record, which may have an adverse effect on his / her Staff membership or privileges.

3.5. APPLICATION FOR APPOINTMENT

No application for Staff membership or reappointment shall be accepted unless it is complete and the applicant is eligible for Staff membership as described in this Article. Failure to accurately complete and update the application form as required in these Bylaws, the withholding of requested information, or the providing of false or misleading information, shall, in and of itself, constitute a basis for denial or revocation of Medical Staff appointment. If all required materials and documentation are not satisfactorily provided to complete the application within one hundred eighty days (180) from the initial submission of the application the application may be deemed withdrawn. The following procedure shall be employed for Staff appointment and reappointment:

3.5.1. APPLICATION CRITERIA. Acceptance for membership on the Staff shall be based upon individual merit without regard to association with the Hospital or members of the Staff. Application shall be made according to a prescribed form which shall require the applicant to state and, if required, to document, among other things, the applicant's:

3.5.1.1. Identification by means of a current state or federal-issued identification containing a photograph of the applicant;

3.5.1.2. Background, experience, qualifications and references;

3.5.1.3. Freedom from, or full control over, any significant physical, mental, or behavioral illness or impairment that interferes with, or presents a substantial probability of interfering with patient care, the exercise of privileges, the assumption and discharge of required responsibilities, or cooperative working relationships, in accordance with the prevailing standard of professional practice; and agreement to cooperate openly and fully in any required health assessment;

3.5.1.4. Good Standing:

(a) whether applicant’s practice or request for any medical staff appointment or reappointment, clinical privileges, employment, membership, provider status, right to practice or participate at another hospital, ambulatory care or health care facility or entity or with a health maintenance organization, preferred provider or managed care plan (HMO, PPO, etc, or any thirdparty payor (such as Blue Cross/Blue Shield) has ever been: denied; withdrawn; resigned while under formal or informal investigation or before a decision

was rendered by the governing body of such entity or organization; suspended, diminished, limited, revoked, not renewed or involuntarily or voluntarily relinquished, or subject to focused monitoring, probation or other condition; or subject to any proceedings or investigations relating to clinical competence or professional conduct;

(b) whether applicant's license to practice in any state / district / country / jurisdiction has ever been or sought to have been denied, limited or restricted, suspended, revoked, involuntarily or voluntarily relinquished, or made subject to probation or otherwise investigated, or has ever been fined or reprimanded by any state licensure board;

(c) whether applicant's state controlled license or federal narcotic license has ever been or sought to have been limited, suspended, revoked, or denied, involuntarily or voluntarily relinquished or ever had any conditions placed on them;

(d) whether applicant has ever been or sought to have been sanctioned, suspended, excluded or expelled or otherwise precluded from participating in Medicare, Medicaid or any other federal, state or private health insurance program or has ever been subjected to civil money penalties under the Medicare or Medicaid programs;

(e) whether applicant's membership in any medical society or specialty certification board has ever been subject to disciplinary action or has been sought to have been suspended, terminated or voluntarily relinquished and the outcome of any such proceedings(s);

(f) whether applicant is currently either under indictment or formally charged with, or has ever been convicted of, or entered a plea of guilty or no contest to, any felony or whether such charges are pending;

(g) whether applicant is currently either under indictment or formally charged with, or has ever been convicted of, or entered a plea of guilty or no contest to any misdemeanor other than a traffic citation or whether such charges are pending;

(h) whether applicant has ever been involved in any medical liability litigation, including malpractice claims, Notices of Intent, suits, settlements or arbitrations and the outcome of such proceedings(s);

(i) evidence of malpractice insurance coverage, acceptable under the Hospital's current policy; and

(j) evidence of participation in relevant or required continuing medical education.

3.5.1.5. Request for clinical privileges, specification of the facilities of the Hospital which are required and the projected use of Hospital facilities by the applicant based upon the geographic location of the applicant's office and patients, type of practice, and stated intentions and availability;

3.5.1.6. Areas of research, medical education, and continuing education in which applicant is professionally interested and applicant's indication of willingness to participate in accordance with the terms of these Bylaws as a student or instructor, where qualified;

3.5.1.7. Acknowledgment of understanding of the application procedures and Bylaws and Rules / Regulations / Policies furnished in connection therewith and pledge to abide by the principles or codes of ethics pertinent to profession, as well as the Bylaws and Rules / Regulations / Policies of the Staff and to abide by and participate in the Hospital's Corporate Compliance Plan and policies;

3.5.1.8. Willingness to appear for interviews or meetings as requested in regard to all matters concerning the application, Staff membership, or clinical privileges;

3.5.1.9. Authorization for release of information, release of medical information, and waiver of any medical or physician-patient privilege necessary to determine whether the applicant can perform duties and requested privileges with or without reasonable accommodation and whether he / she can do so without posing a threat to themselves or others, and release of the Hospital, its agents, employees, and all members of its Board of Directors, Trustees, administration and Staff from any and all liability to the fullest extent permitted by law regarding:

(a) consultation with individuals or entities who have been associated with the applicant and who may have information concerning the applicant's competence, qualifications, performance, or ethics, or with any other person or entity who may have information bearing thereon;

(b) inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested;

(c) statements made or any action taken in good faith and without malice by any person or entity with consideration of the application, reapplication, reduction, suspension, or termination of Staff membership or privileges of the applicant, or in connection with any other form of review of professional practices of Staff members in the Hospital;

(d) information, records, documents, or professional opinions relating to the applicant's physical, mental, or behavioral health necessary to determine whether the applicant can perform his or her duties as a Staff Member with or without reasonable accommodation and whether he or she can do so without posing a direct threat to themselves or others;

(e) disclosures to other hospitals, medical associations, licensing boards, government agencies and entities and to other similar organizations as required by law, of any information regarding the applicant's professional or ethical standing that the Hospital or Staff may have;

3.5.1.10. Agreement to release all individuals, entities or organizations providing the information, opinions, records or documents described above to the Hospital or its agents, employees, members of the Board of Directors, Trustees, administration and Staff, from any and all liability to the fullest extent permitted by law;

3.5.1.11. Agreement that all records, information, data and knowledge respecting professional practice or peer review functions of the Hospital are to be kept confidential as required by law, including without limitation, proceedings in connection with application, reapplication, reduction, suspension, or termination of Staff membership or privileges, the work of committees and individuals assigned professional practice or peer review functions pursuant to these Bylaws, Rules / Regulations / Policies, and the policies and procedures of the Hospital

and Staff, and the applicant's specific agreement to keep all such information confidential; and

3.5.1.12. Pledge as a condition of Staff membership to provide for continuous care as set forth in the Medical Staff Physician Handbook (Rules / Regulations / Policies) and to accept new patients and perform emergency call coverage obligations as requested by the Chief of Department or Head of Section.

3.5.2. BOARD CERTIFICATION. Prior to application to the Staff, all physicians must have specialty board certification in the area in which they are seeking privileges by a certifying board recognized or approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists, the American Dental Association or the Council on Podiatric Medical Education and the American Medical Association Council on Medical Education.

3.5.2.1. **BOARD RECERTIFICATION.** Once accepted for Staff membership, all physicians / dentists must maintain certification.

3.5.2.2. **EXCEPTIONS.** Recent graduates from a training program as identified above must achieve the required specialty board certification within three (3) years of the earliest date on which they could have become board certified as determined by the specialty board. Physicians achieving specialty board certificates, or its equivalent, in foreign countries may be considered as an exception to the above, based on individual merit and on the clinical, educational and research needs of the Department / Section and the Hospital.

3.5.3. APPLICATION PROCEDURE. Applications for Staff membership and privileges at any Hospital in the Corporation shall be uniformly processed and considered. Applications will be received and processed at the central Credentialing Office. An applicant for Staff membership at more than one Hospital of the Corporation may submit one application indicating the Hospitals at which he or she seeks Staff Membership and privileges. All applications for new Staff appointments and privileges, and changes in privileges by current Staff members, shall be considered and acted upon at least every two months.

Applications and supporting materials for Staff membership and privileges which are deemed complete and verified to the extent possible will be provided to the appropriate Chief / Head.

Applications will be processed and considered consistent with the Processing Guidelines set forth below. At any time during the processing and consideration of an application the applicant may contact the central Credentialing Office of the corporation and be provided information on the status of his / her application.

3.5.4. DEPARTMENT AND SECTION EVALUATION PROCEDURE. Upon completion of the application with receipt of all of the supporting documentation, the Department Chief(s) and / or Section Head(s) shall consider and evaluate the application and supporting materials, including appropriate references and other pertinent information. The Department Chief(s) and / or Section Head(s) shall investigate, evaluate and / or verify the applicant's ethical standing, character, physical and mental health to perform the privileges requested, interpersonal skills and judgment, professional qualifications and other relevant criteria, including, without limitation: medical / clinical knowledge; technical and clinical skills; clinical judgment; interpersonal skills; communication skills; and professionalism. The Department Chief(s), and / or Section Head(s) shall work with the Medical Staff Office to promptly notify the applicant of any difficulties encountered in obtaining satisfactory information on such matters, and it shall be the applicant's obligation to obtain the required information. Section Heads will coordinate their reviews and recommendations with their Department Chiefs.

3.5.5. DEPARTMENT AND SECTION CONSIDERATIONS. The evaluating Department Chief and / or Section Head shall review the application and supporting materials with reference to, among other things:

(a) The Hospital's ability to provide facilities and support services to the applicant and his or her patients;

(b) The willingness and ability of the applicant to advance patient care and the Hospital's education and research needs;

(c) The needs of the Department(s) and / or Section(s) to which the applicant is applying;

(d) The privileges sought by the applicant;

(e) The geographic location of the applicant and the applicant's office;

(f) Any policies and plans officially adopted or instituted by the Medical Staff of the Hospital and the Board of Directors; and

(g) Any other matters deemed relevant to a recommendation concerning the application.

3.5.6. DEPARTMENT AND SECTION RECOMMENDATION. Department Chiefs and / or Section Heads or designees shall make a written recommendation concerning the applicant to that Hospital's Credentials and Qualifications Committee. The Department Chief or Section Head must specifically recommend the clinical privileges to be granted and may recommend probationary conditions related to clinical privileges.

3.5.7. COMMITTEE APPOINTMENT RECOMMENDATION. The Hospital's Credentials and Qualifications Committee shall review the completed application together with the report of the Department Chief(s) under all of the guidelines and criteria set forth in these Bylaws, and all policies and plans adopted and instituted by the Medical Staff of the Hospital and the Board of Directors, and make a recommendation and report regarding approval of the application for Medical Staff membership and specific clinical privileges to the Corporate Credentials and Qualifications Committee.

3.5.8. PROCESSING GUIDELINES. Accepted applications for Staff appointments shall be considered in a timely manner by all persons and committees required by these Bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications:

(a) review and recommendation by Section / Department(s): thirty (30) days after receipt of all necessary documentation and verification of completeness;

(b) review and recommendation by Hospital(s) and Corporate Credentials and Qualifications Committees and Committee: ninety (90) days after receipt of all necessary documentation;

(c) review and recommendation by Medical Executive Board(s) at its next regular meeting;

(d) review and recommendation by the Patient Care and Quality Committee at their next regular meeting: and

(e) final action at the next regular meeting of the Board of Directors.

The Patient Care and Quality Committee may exercise through the Committee or a sub-Committee including at least two (2) voting members of the Hospital's Board of Directors, the authority of this Committee and of the Board of Directors pertaining to initial appointments to Medical Staff membership and the granting of privileges, reappointment to Medical Staff membership, or renewal or modification of privileges.

3.6. APPLICATION FOR REAPPOINTMENT AND MODIFICATION

3.6.1. REAPPLICATION PROCEDURE. Staff members shall receive a reappointment application form at least (5) months prior to the expiration of the Staff member's current appointment period. An applicant for Staff reappointment at more than one Hospital of the Corporation may submit one reappointment application indicating the Hospitals at which he or she seeks reappointment. The member shall then have forty-five (45) days to complete the application and submit it along with other required information to the Medical Staff Office of the Hospital(s) where he or she has privileges, or a central Medical Staff Office as directed. If a completed reappointment packet is not returned within the time period specified, the member will be processed as a voluntary resignation effective on the date his / her appointment expires. The Central Credentialing Office shall review the application and supporting material and verify all matters to the extent possible. The Central Credentialing Office shall provide the Chief / Head(s) with the application for reappointment and supporting materials.

3.6.2. EVALUATION PROCEDURE. At least two (2) months prior to the expiration date of current Staff appointment (except for temporary appointments) appropriate Chief(s) and / or Head(s) shall review the status of each member of the Staff and recommend reappointment, termination, or any modification in Staff status or clinical privileges to the relevant Hospital Credentials and Qualifications Committee. A Staff member who seeks a modification in Staff category or clinical privileges may submit a request at any time, except that such application may not be filed within six (6) months of the time a similar request has been denied or following confirmation of an adverse action.

The appropriate Chief(s) and / or Head(s) will make a recommendation to the relevant Hospital Credentials and Qualifications Committee regarding the reappointment or modification of Staff status or clinical privileges based on the following:

(a) A complete, accurate and updated information form which all members of the Staff shall be required to file with the Central Credentialing Office upon request. This form shall include all information necessary to update and evaluate the qualifications of the member including matters set forth in Section 3.5.1., as well as other relevant matters;

(b) Reports of the applicable Department Chiefs and / or Section Heads any other peer review committees, mechanisms or entities which may produce information deemed relevant by the Chief and / or Heads and / or the Hospital and Corporate Credentials and Qualifications Committees;

(c) The result of ongoing and focused professional practice evaluations of the Staff member's professional competence and judgment in treatment of patients; clinical or technical skills; ethical standards of conduct; board certification / re-certification status; participation in educational and research functions; adherence to the Medical Staff Bylaws and Medical Staff Physician Handbook (Rules / Regulations / Policies); attendance at required service, departmental, section, and general Medical Staff meetings; cooperation with other Staff members, Hospital employees / personnel and patients; and efficient utilization of the Hospital's resources and facilities for patients; and

(d) Hospital Activity Guidelines and office assessments may be used among the criteria for reappointment to the Medical Staff and / or modification of clinical privileges. The appropriate Chief or Head, Credential and Qualifications Committees, Medical Executive Boards, Patient Care and Quality Committee and Board of Directors have the discretion to conduct an expanded safety and quality assessment of the practitioner's activity in the office or at another institution in lieu of or to supplement the usual review of inpatient admissions, consultations or procedures in specific situations where the physicians have not met Hospital Activity Guidelines or where such additional review is requested by the practitioner's Department Chief or Section Head or any of the Committees or Boards involved in Beaumont Health System credentialing processes.

(e) The recommendations of the respective Hospital's Credentials and Qualifications Committee shall be forwarded to the Corporate Credentials and Qualifications Committee and after its action to the appropriate Medical Executive Board(s). Thereafter the effect and procedural processing of the application for reappointment or modification of Staff status or clinical privileges is the same as that set forth under Sections 3.7. - 3.8., except that if the Corporate Credentials and Qualifications Committee recommends that a Staff member is not to be reappointed or his / her clinical privileges are to be reduced or modified, the appropriate Physician-in-Chief shall notify the Staff member prior to the date such actions are to be considered by the respective Medical Executive Board(s).

3.7. CREDENTIALS AND QUALIFICATIONS COMMITTEE RECOMMENDATION

3.7.1. COMMITTEE RECOMMENDATIONS. The Credentials and Qualifications Committee of each Hospital shall review the completed applications for appointment and reappointment for Medical Staff membership together with the report(s) of the Chief(s) of Department(s) and Head(s) of Section(s) and specific clinical privileges recommended under all of the guidelines and criteria set forth in these Bylaws, and all policies and plans adopted and instituted by the Medical Staff of the Hospital and the Board of Directors, and make a recommendation and report regarding approval of the application for appointment or reappointment for Medical Staff membership and specific clinical privileges recommended to the Corporate Credentials and Qualifications Committee. The Corporate Credentials and Qualifications Committee shall review that report and recommendation and make a recommendation to the appropriate Medical Executive Board(s).

3.7.2. APPOINTMENT / REAPPOINTMENT TO MULTIPLE HOSPITALS. Differing circumstances and assessments will always be considered, recognizing that appropriate consistency and rationales for divergent recommendations in the evaluations of Medical Staff applications for appointment or reappointment throughout the Corporation are to be encouraged. Accordingly, whenever a Staff member has submitted an application for appointment or reappointment and privileges at more than one Hospital of the Corporation, or when an individual who is a Staff member on one Hospital of the Corporation submits an application for reappointment and privileges at another Hospital(s) of the Corporation, the Chairs of each involved Hospital Credentials and Qualifications Committee shall meet or mutually communicate prior to any Hospital Committee's or Corporate Credentials and Qualifications Committee's consideration of such reappointment application(s), and, if necessary, shall meet or mutually communicate again after any Corporate Credentials and Qualifications Committee's action but prior to any consideration of such reappointment application(s) at any Medical Executive Board.

3.8. MEDICAL EXECUTIVE BOARD RECOMMENDATION

At the regular meetings after receipt of the Corporate Credentials and Qualifications Committee report and recommendation, or as soon thereafter as is practicable, each Medical Executive Board shall consider the recommendation and any other relevant information. A Medical Executive Board may request additional information, return the matter to the Corporate Credentials and Qualifications Committee for further investigation or conduct its own investigation or interview. Each Medical Executive Board shall forward to the Patient Care and Quality Committee a recommendation as to the approval, deferral or rejection of any application, reapplication and clinical privileges sought or modified. The reasons for each recommendation shall be stated.

3.9. PATIENT CARE AND QUALITY COMMITTEE AND BOARD OF DIRECTORS ACTION

The Patient Care and Quality Committee shall review the recommendations of the Medical Executive Boards as to approval, deferral or rejection of any application or reapplication. If the Patient Care and Quality Committee does not concur with the recommendations submitted to it for approval, the recommendations shall be returned for further discussion and resubmission to the Medical Executive Boards. Recommendations from the Patient Care and Quality Committee shall be submitted to the Board of Directors, which shall make the final determination concerning Staff appointments, re-appointments, and clinical privileges. At its discretion the Board of Directors may return recommendations submitted to it to the Patient Care and Quality Committee for reconsideration. Notice of the final decision shall be given to the Chief Medical Officer, the appropriate Physician-in-Chief, the Medical Executive Boards, the Corporate Credentials and Qualifications Committee, the Department Chief and / or Section Head concerned, the applicant or Staff member involved, and Hospital Administration.

The Patient Care and Quality Committee may exercise through the Committee or a subCommittee including at least two (2) voting members of the Hospital's Board of Directors, the authority of this Committee and of the Board of Directors pertaining to initial appointments to Medical Staff membership and the granting of privileges, reappointment to Medical Staff membership, or renewal or modification of privileges.

If an application for reappointment has not been fully processed by the expiration date of the Staff member's appointment, the Staff member may be reappointed for a limited time, up to one (1) year (with a definitive explanation), unless the delay is due to the Staff member's failure to timely provide documentation or cooperation, in which case the appointment shall terminate. Any extension of an appointment pursuant to this section does not create a vested right in the member for continued appointment through the entire next term but only until such time as processing of the application is concluded.

3.10. REAPPLICATION AND REPROCESSING AFTER REJECTION / DENIAL / TERMINATION

3.10.1. No person whose application, reapplication and / or clinical privileges has / have been rejected, denied, or whose Staff membership has been terminated or revoked shall be entitled to have a new application accepted for reprocessing within three (3) years following the rejection, denial, termination or revocation. However, nothing in this policy shall prohibit a Medical Executive Board from at any time inviting an applicant to reapply for Staff membership when the circumstances that resulted in the rejection, denial, termination or revocation, have changed.

3.10.2. Physicians whose application, reapplication and / or clinical privileges have been rejected, denied, terminated or revoked may not request Staff membership and / or clinical

privileges until they show that there has been a significant change in their qualifications or circumstances in order to justify reconsideration of the same.

3.10.3. Before a reapplication after rejection, denial, termination or revocation may be accepted for reprocessing by the Corporate Credentials and Qualifications Committee, Chief of Department or Head of Section shall investigate and recommend to the Committee his / her determination that the reapplication be accepted or rejected for reprocessing based on the following criteria:

(a) There has been significant change in qualifications or circumstances in order to justify reconsideration for appointment; and

(b) The person who is reapplying has not engaged, directly or indirectly, in any activity or conduct inimical or in any way contrary to the best interests of Beaumont Health System.

3.10.4. The person who is reapplying shall have the burden of providing information for the adequate evaluation of the above criteria and shall not be entitled to a reprocessing of an application if such burden is not sustained.

3.11. EMPLOYED STAFF MEMBERS AND MID-LEVEL PROVIDERS

Staff Members and Mid-Level Providers (MLP) employed by Beaumont Health System shall apply for membership on the Medical Staff and / or privileges in the same manner as prescribed for other individuals, and shall be subject to the same provisions as set forth above. Any Beaumont-employed Staff Member or MLP who has a grievance or whose employment has been terminated may invoke the Beaumont Health System Grievance Procedure for such employed individuals then in effect. That procedure is the employee's exclusive remedy to redress any dispute, claim, grievance, or adverse action concerning his or her employment or its termination. The rights of a terminated Staff Member or MLP employee to continue on the Medical Staff of the Hospital and / or exercise privileges are governed by the provisions of these Bylaws concerning such Medical Staff and privileging rights unless the written contract of the terminated employee with the Hospital expressly provides otherwise.

3.12. EXCLUSIVE DEPARTMENTS OR AREAS

3.12.1. EXCLUSIVITY STATUS. To improve patient care and promote more efficient Hospital operations, adequacy of coverage, maintenance of standards, more efficient use of facilities, quality assurance, and to serve other Hospital policies as may be determined by the Board of Directors, certain Hospital facilities may be used on an exclusive basis. Applications for appointment, reappointment and clinical privileges relating to those Hospital facilities and services will not be accepted for processing, except for applications by professionals who have been granted exclusivity status and professionals employed or engaged by the professionals granted exclusive rights.

3.12.2. FACILITIES AND AREAS SUBJECT TO THE EXCLUSIVITY POLICY. The Board of Directors reserves the right, in its sole discretion, to make any Hospital facilities and area subject to the exclusivity and to exclusive arrangements with certain professionals.

3.12.3. EFFECT OF CONTRACT EXPIRATION OR TERMINATION OF EXCLUSIVITY STATUS. The expiration or termination of exclusivity status shall be determined by the Board of Directors in its sole discretion. No action, recommendation or decision by the Hospital or the Board of

Directors with regard to the expiration, termination or failure to renew any such exclusivity status with a professional shall be subject to or conditioned upon any proceedings or exercise of rights under these Bylaws.

3.13. LEAVE OF ABSENCE

3.13.1. LEAVE PROCEDURE. Members of the Staff whose professional or personal circumstances require them to interrupt Hospital activities for a period of more than three (3) months may request a leave of absence not to exceed one (1) year. The request shall be in writing, specify the reasons therefore, and be addressed to the appropriate Physician-in-Chief and applicant's Department Chief or Section Head. Approval and any extension beyond one (1) year, however, shall not be granted without review and approval of the Corporate Credentials and Qualifications Committee and the Medical Executive Board(s). No Staff member shall be entitled to an appeal under
Article VI of a denial of a request for leave of absence or the requirement of an application for reappointment.

3.13.2. INACTIVE STATUS. During the period of leave, the Staff member shall not exercise clinical privileges at a Hospital of the Corporation and his / her membership rights and responsibilities shall be inactive.

3.13.3. RETURN FROM LEAVE. Staff Members returning from approved educational leaves of absence may resume clinical privileges and membership rights and responsibilities upon written notification to the Chief of Department or Head of Section. In all other circumstances, the following procedures apply: (1) at least thirty (30) days prior to the termination of the leave of absence, the Staff member shall submit a summary of relevant activities and whatever information may be necessary for the Hospital Credentials and Qualifications Committee to verify the current competence of the Staff member, (2) the Hospital Credentials and Qualifications Committee, in its discretion, may require a new application for appointment to the Staff, (3) return from leave of absence must be recommended by the Chief of the Department to which the member is assigned and the Hospital Credentials and Qualifications Committee, and approved or disapproved by the Medical Executive Board(s). (4) an application for reappointment after a leave of absence shall be processed under the Application for Staff Membership provisions of these Bylaws.

3.13.4. REAPPOINTMENT / REINSTATEMENT. A Staff member whose term of appointment would expire during the leave of absence will be required to submit a timely application for reappointment / reinstatement concurrently with notification to the appropriate Physician-in-Chief of anticipated date of return. Failure, without good cause, to request reappointment in such circumstances shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and privileges.

3.14. OBLIGATION TO NOTIFY Appropriate Physician-in-Chief of Adverse Actions; Significant Illness; Felony or Misdemeanor Indictment / Charge / Conviction; Involuntary or Voluntary Changes in Licensure or Clinical Privileges or Employment by or at Another Institution, or Any Legal Action Relating to the Practice of Medicine:

3.14.1. NOTIFICATION OF INITIATION OF ACTION. Each Staff member or other individual granted clinical privileges in the Hospital must notify the appropriate Physician-in-Chief within ten

(10) days following the receipt of a notice of adverse actions being initiated against him or her. Such adverse actions where notice of initiation of proceedings is required include, without limitation:

(a) any process which could result in an exclusion, revocation, involuntary or voluntary termination, reduction, suspension, or other limitation of membership, privileges, prerogatives, participation rights or employment,

(b) any process which could result in a termination, suspension, probation, reprimand, fine or limitation relating to any state or federal license and / or right to prescribe any medication;

(c) any institution of probation or a requiring of consultation or supervision; or

(d) any denial of appointment, reappointment or requested change in a membership, privilege or right related to the delivery of health care services.

Notification of initiation of adverse actions is required when the matter arises at:

(a) another hospital, ambulatory care or health care facility or entity where such individual was / is employed or held / holds membership or has / had rights or privileges related to the delivery of health care services;

(b) a government entity, agency, or program including for instance Medicare or Medicaid (except when the Staff member voluntarily chooses not to participate in such program); or

(c) any health maintenance organization, preferred provider organization or managed care plan (HMO, PPO, etc) or any other third party payor such as Blue Cross / Blue Shield of Michigan (BCBSM).

The affected Staff member shall provide the Hospital with complete information satisfactory to the Hospital as to the reasons for the initiation of adverse action and the progress of the proceeding.

3.14.2. SIGNIFICANT ILLNESS. Staff members or other individuals granted clinical privileges in the Hospital shall immediately notify the appropriate Physician-in-Chief if they develop or acquire any significant physical, mental, or behavioral illness or impairment that interferes with, or presents a substantial probability of interfering with patient care.

3.14.3. FELONY OR MISDEMEANOR CHARGE OR CONVICTION. Staff members or other individuals granted clinical privileges in the Hospital shall immediately notify the appropriate Physician-in-Chief if they are indicted, formally charged, or convicted of a felony or misdemeanor other than a traffic citation.

3.14.4. INVOLUNTARY OR VOLUNTARY CHANGES IN LICENSURE, CLINICAL PRIVILEGES OR EMPLOYMENT. Staff members or other individuals granted clinical privileges in the Hospital shall immediately notify the Physician-in-Chief of involuntary or voluntary changes of licensure or involuntary or voluntary termination of Medical Staff membership, clinical privileges or employment at other institutions.

3.14.5 LEGAL ACTION. Staff members or other individuals granted clinical privileges in the Hospital shall immediately notify the Physician-in-Chief of any filed or served malpractice suit or arbitration action related to the practice of medicine.

ARTICLE IV

CLINICAL PRIVILEGES

4.1. EXERCISE OF CLINICAL

PRIVILEGES

Except as otherwise provided in these Bylaws, a Staff member providing clinical services at this Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board of Directors. Said privileges and services must be within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to these Bylaws and the Rules / Regulations / Policies of the Medical Staff and the Department and / or Section and to the authority of the Chief Medical Officer, Department Chief and / or Section Head, the Medical Executive Board and the Board of Directors.

4.2. DELINEATION OF PRIVILEGES IN GENERAL

4.2.1. REQUESTS. Each application for appointment and reappointment to the Staff must contain a request for the specific clinical privileges desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, subject to the provisions of Section 3.6., but such requests must be supported by documentation of training and / or experience supportive of the request.

4.2.2. BASIS FOR PRIVILEGES DETERMINATION. Requests for clinical privileges shall be evaluated on the basis of the following ongoing and focused review of: (1) the member's education, training and experience; (2) demonstrated professional competence and judgment; (3) clinical performance, and the documented results of patient care and other quality review and peer or professional review monitoring which the Staff deems appropriate; (4) the Hospital's ability to provide facilities and support services to the member or applicant and his or her patients and the needs of the Department(s) or Section(s) in which the privileges are sought; and (5) participation in relevant continuing medical education. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where an applicant or member exercised clinical privileges.

4.2.3. PROCEDURE. Privileges granted to Staff members upon original application or subsequent review shall be recommended by the Department Chief(s) and / or Section Heads, subject to review by the Hospital(s) and Corporate Credentials and Qualifications Committees, and forwarded to the appropriate Medical Executive Board. The recommendation of that Medical Executive Board is then forwarded to the Patient Care and Quality Committee and Board of Directors for final determination.

4.2.4. HISTORY AND PHYSICAL EXAMINATION. The attending physician, dentist, or podiatrist shall be responsible for the preparation of a complete medical record for each patient. Documentation and assessment / reassessment of each patient must include a pertinent history and physical examination no more than thirty (30) days before or twenty-four (24) hours after admission. A history and physical examination, or pre-procedure evaluation must be performed by a physician or other qualified licensed individual in accordance with State law and Hospital policy.

If a medical history and physical examination has been performed within thirty (30) days prior to admission, such as in the Advance Testing program, or within a private office, it may be used as the history and physical examination for the admission provided that it has been updated within twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia, and any changes in the patient's condition must be incorporated into the report.

The minimum content required in a history and physical examination is delineated in the Rules / Regulations / Policies.

All history and physicals and pre-procedure evaluations must be signed (including ID number), timed and dated.

4.3. CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

4.3.1. ADMISSIONS. Dentists, podiatrists and other limited license practitioner members of the Staff may only admit patients if an M.D. or D.O. member of the Staff conducts or directly supervises the admitting history and physical examination and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

4.3.2. SURGERY. Surgical procedures performed by dentists, podiatrists or other limited license practitioner members of the Staff shall be under the overall supervision of the appropriate Chief of Department or Head of Section or their designee.

4.3.3. MEDICAL APPRAISAL. All patients admitted for care in a Hospital by a dentist, podiatrist or other limited license practitioner shall receive the same basic medical appraisal as patients admitted to other Departments, and an M.D. or D.O. Staff member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between an M.D. or D.O. Staff member and a limited license practitioner member based upon medical or surgical factors outside the scope of licensure of the limited license practitioner member, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department Chief or Section Head.

4.4. TEMPORARY CLINICAL PRIVILEGES

4.4.1. CIRCUMSTANCES. The circumstances for which the granting of temporary clinical privileges are acceptable:

- To fulfill an important patient care, treatment, and service need.
- When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Board and Board of Directors.

4.4.1.1. Temporary clinical privileges may be granted to a physician, dentist or other non-physician provided that the procedures described below have been followed.

4.4.1.2. Such person may attend only patients for a period not to exceed 120 days.

4.4.2. APPLICATION AND REVIEW. Upon receipt of a completed application and supporting documentation from a physician, dentist, or other non-physician authorized to practice in Michigan, the appropriate Physician-in-Chief may grant temporary clinical privileges to an

applicant who appears to have qualifications, ability and judgment consistent with the standards utilized in evaluating applications for Staff membership, if:

4.4.2.1. there is no evidence of current or previously successful challenge to licensure or registration, involuntary termination of medical staff membership at another organization, involuntary limitation, reduction, denial, or loss of clinical privileges;

4.4.2.2. verification of the following, at a minimum, is obtained:

- Current licensure
- Relevant training or experience
- Current competence
- Ability to perform the clinical privileges requested
- Query and evaluation of the National Practitioner Databank (NPDB) information
- Acceptable malpractice insurance coverage

4.4.2.3. the appropriate Department Chief, or Section Head has interviewed the applicant (unless waived for good cause) and has approved the competence and ethical standing of the individual requesting such clinical privileges;

4.4.2.4. the applicant is recommended for appointment by the local Credentials and Qualifications Committee unless good cause requires prior approval in the interest of patient care safety;

4.4.2.5. the applicant's file, including the recommendation of the Department Chief, Section Head is forwarded to the appropriate Physician-in-Chief for grant or denial of such clinical privileges. If that Physician-in-Chief approves the grant, he shall notify the applicant and Staff member(s) involved as well as necessary Hospital personnel.

4.4.3. GENERAL CONDITIONS. If granted Temporary privileges, the applicant shall act under the supervision of the Department Chief, or Section Head who shall clearly designate the privileges accorded the applicant and ensure that the Chief, or their designee, is kept closely informed as to his or her activities within the Hospital.

4.4.3.1. Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by a Medical Executive Board upon recommendation of the Department Chief or Hospital or Corporate Credentials and Qualifications Committee or unless affirmatively renewed.

At any time, temporary privileges may be terminated by the Department Chief / Section Head or his / her designee with the concurrence of the appropriate Physician-in-Chief or his / her designee(s). In such cases, the appropriate Department Chief / Section Head or in their absence, the appropriate Physicianin-Chief or his / her designee, shall assign a member of the Staff to assume responsibility for the care of such Staff member's patient(s) still in the Hospital. The wishes of the patient shall be considered in the choice of a replacement Staff member.

Notwithstanding anything to the contrary contained in these Bylaws, there shall be no right to any hearing or appeal because a request for temporary privileges is refused or because all or any portion of temporary privileges are terminated or suspended.

All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules / Regulations / Policies of the Staff, Department, and Section.

4.5. TEMPORARY PATIENT CARE PRIVILEGES

4.5.1. IMPORTANT URGENT PATIENT CARE NEED. Appropriately licensed physicians who have not applied for Staff membership may be granted temporary clinical privileges for rare, exceptional instances of treatment of a specific inpatient only upon recommendation from the Department Chief, with written approval by the Physician-in-Chief and after the practitioner signs an acknowledgment of having read and agreeing to abide by and be bound by applicable provisions of the Bylaws. Such privileges shall only be granted when there is a documented important urgent patient care need at one of the hospitals requiring treatment by a physician with specialized training or experience not available from the present Medical Staff, and the transfer of the patient is impossible or impractical. Such temporary clinical privileges shall be restricted to three (3) patients in any calendar year.

4.5.2. TEMPORARY PRIVILEGES FOR AN IMPORTANT URGENT PATIENT CARE NEED MAY ONLY BE GRANTED FOLLOWING VERIFICATION OF THE FOLLOWING, AT A MINIMUM:

- Current licensure
- Current competence
- Query and evaluation of the National Practitioner Databank (NPDB) information
- Acceptable malpractice insurance coverage

4.6. TEMPORARY CONSULTING PRIVILEGES

4.6.1 CIRCUMSTANCES. Temporary consulting privileges may be granted to licensed physicians and dentists who may not necessarily be Board certified, but who may be called upon to offer a medical opinion.

4.6.2 REVIEW. Temporary consulting privileges shall be granted on a per-case basis by the appropriate Physician-in-Chief, or his / her designee, upon recommendation of the Department Chief, Section Head, or his / her designee.

4.6.3 GENERAL CONDITIONS.

4.6.3.1 If granted the temporary consulting privileges, the physician or dentist shall act under the supervision of the Department Chief and / or Section Head or his / her designee, but may not render direct care.

Temporary consulting privileges automatically terminate at the end of the consultation for the specific patient. Notwithstanding anything to the contrary contained in these Bylaws, there shall be no right to any hearing or appeal because a request for temporary consulting privileges is refused or because all or any portion of temporary consulting privileges are terminated or suspended.

At any time, temporary consulting privileges may be terminated by the Department Chief and / or Section Head or his / her designee, with concurrence of the appropriate Physician-in-Chief, or his / her designee(s). If necessary, the appropriate Chief and / or Head, or in his / her absence, the appropriate Physician-in-Chief, or his / her designee, shall assign a member of the Medical Staff to assist in the care of the patient still in the Hospital. The wishes of the patient shall be considered in the choice of a replacement physician.

4.6.3.2. All persons requesting or receiving temporary consulting privileges shall be bound by the Bylaws, Rules / Regulations / Policies of the Staff and Department and Section.

4.7. EMERGENCY PRIVILEGES

In the case of an emergency in which the situation requires immediate action to save the life of, or avoid serious harm to, a patient, any member of the Staff, to the degree permitted by his or her license and regardless of Department, Section, Staff status or clinical privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The Staff member shall make every reasonable effort to communicate promptly with the Department Chief, or Section Head, or his / her designee concerning the need for emergency care and to request assistance by members of the Staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the Department Chief / Section Head with respect to further care of the patient at the Hospital.

4.8. MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the Corporate Credentials and Qualifications Committee, or pursuant to a request under Section 4.2.1., a Medical Executive Board may recommend a change in the clinical privileges or Departmental / Section assignments of a Staff member.

4.9. PRIVILEGES OF EMPLOYED INDIVIDUALS

Notwithstanding other provisions of this article, Hospital-employed supervised individuals whose job description delineates specific clinical privileges may exercise those privileges within the terms of their job description and their employment relationship with the Hospital.

4.10. SCOPE OF PRACTICE OF MID-LEVEL PROVIDERS

Mid-level providers may exercise clinical privileges granted by the Board of Directors at the Hospital. The grant of privileges shall be for a period not to exceed two (2) years. The applicant shall have the burden of producing information satisfactory to the Hospital for a proper evaluation of all relevant criteria and resolving any doubt about their qualifications. Failure by such individual granted privileges to abide by all relevant provisions of the Corporate and Medical Staff Bylaw and the Rules / Regulations / Policies of the Medical Staff, Department or Section may be cause for termination of such privileges. Renewals of the grants of such privileges shall be considered and, where deemed appropriate, shall be made by the Board of Directors.

Records pertaining to such individuals shall be maintained as directed by the Chief Medical Officer.

4.10.1 CREDENTIALS AND QUALIFICATIONS COMMITTEE RECOMMENDATION. The Credentials and Qualifications Committee of each Hospital shall itself, or through the establishment of a Mid-Level Provider Sub-Committee which reports to the Hospital Credentials and Qualifications Committee, review the completed applications for the grant of privileges and all relevant reports, including reports by peers of the applicant. The Hospital Credentials and Qualifications Committee shall make recommendations to the Corporate Credentials and Qualifications Committee, which shall review those recommendations and make recommendations to the appropriate Medical Executive Boards. The Hospital Medical Executive Boards shall review and make recommendations on such applications and refer the application to the Patient Care and Quality Committee and Board of Directors for final approval, deferral or rejection of any application or reapplication, or other action.

4.10.2 MID-LEVEL PROVIDER APPEALS. Notwithstanding any provisions in these Medical Staff Bylaws to the contrary, Mid-level Providers shall not be entitled to the procedural rights to a Hearing and Appeal as set forth in Article VI of these Medical Staff Bylaws. In the event of an adverse action made final by the Board of Directors pertaining to the privileges of a Mid-Level Provider, the Mid-Level Provider shall be notified of the adverse action by the Physician-in-Chief by special notice and shall have thirty (30) days to submit a written request for an appeal to the Corporate Credentials and Qualifications Committee.

The appeal shall be scheduled within sixty (60) days of receipt of a timely request and shall be held by the Corporate Credentials and Qualifications Committee at a time and place determined by the Chair of that Committee with a peer of the appealing Mid-Level Provider added to the Committee by the Chair for this limited purpose. The Mid-Level Provider may submit any information prior to or during the appeal pertaining to his / her qualifications to exercise clinical privileges. The Mid-level Provider may not be accompanied by an attorney. The Hospital shall have the initial duty to present evidence for each case or issue in support of its decision or recommendation. The Mid-level Provider shall be obligated to present evidence in response and throughout the appeal shall bear the burden of demonstrating by a preponderance of the evidence that the adverse action was unreasonable or unwarranted. The Chair of the Committee shall conduct the appeal and determine all procedural matters. At the close of the appeal the Committee shall deliberate in closed session and render a recommendation with ten (10) working days after the final adjournment of the appeal recommending affirmation, modification or reversal of the original adverse action. Its decision shall be reported to the Medical Executive Boards of the Hospital(s) for its / their further consideration and recommendation to the Board of Directors.

ARTICLE V CORRECTIVE, IMMEDIATE & OTHER GROUNDS FOR ACTION

5.1. CORRECTIVE ACTION

5.1.1. CRITERIA FOR INITIATION. Any person may provide confidential "information" to a Medical Executive Board member or Medical Staff member about the conduct, performance, or competence of its Staff members. When reliable information indicates that a Staff member may have exhibited acts, demeanor, or conduct reasonably likely to be: (1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws or Rules / Regulations / Policies; (4) below applicable professional standards; or (5) disruptive to the operation of the Hospital, a request for a peer review investigation or action against such Staff member may be initiated.

5.1.2. INITIATION. A request for such a peer review investigation may be submitted to a Medical Executive Board, or to the appropriate Physician-in-Chief, and supported by reference to specific activities or conduct alleged. If a Medical Executive Board initiates the request, it shall make an appropriate recordation of the investigation and the reasons.

5.1.3. INVESTIGATION. If a Medical Executive Board itself or through its Chair concludes that a peer review investigation is warranted, such an investigation may be undertaken. The Medical Executive Board may conduct the investigation itself, or the task may be assigned to an appropriate Medical Staff Officer, Medical Staff Department or Section, standing or ad hoc committee or subcommittee of the Medical Staff, or of a Medical Executive Board. Such Officer, committee or subcommittee shall proceed with the investigation in a prompt manner and shall forward a confidential written report of the investigation to the Medical Executive Board initiating the investigation as soon as practicable. The report may include recommendations for appropriate corrective action. The Staff member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating officer or body investigating the matter deems appropriate. The officer or body investigating the matter may conduct interviews with persons involved. However, such investigation shall not constitute a "hearing" as that term is used in Article VI, nor shall procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times a Medical Executive Board shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

5.1.4. MEDICAL EXECUTIVE BOARD ACTION. As soon as practical after the conclusion of the investigation, the Medical Executive Board initiating the investigation shall take action, if it finds by a preponderance of the evidence that action should be taken, which may include, without limitation:

(a) determining that no corrective action be taken and if that Medical Executive Board determines that there was not credible evidence of the referral in the first instance, removing any adverse information from the Medical Staff member's file;

(b) deferring action for a reasonable time where circumstances warrant;

(c) issuing letters of instruction, admonition, censure, reprimand or warning, although nothing in this Section shall be deemed to preclude the appropriate Physician-inChief, Department Chiefs, or Section Heads from issuing written or oral instructions or warnings outside of the mechanism for corrective action. In the event such letters are

issued, the Medical Staff member may make a written response, which shall be placed in the Medical Staff member's file;

(d) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

(e) recommending reduction, modification, suspension or revocation of clinical privileges; or

(f) taking other actions deemed appropriate under the circumstances.

5.1.5. INFORMAL ACTION.

(a) During any phase of the process, the appropriate Physician-in-Chief and / or his or her designee may informally meet with the Medical Staff member to consider informal resolution of the problem. Any mutually agreed upon informal resolution resulting from such meeting and reduced to writing, shall not give rise to a right to a hearing and appeal under these Bylaws.

(b) Any matter not mutually agreed upon to the satisfaction of the appropriate Physician-in-Chief or the affected Medical Staff member, and / or any matter requiring action by the Board of Directors, shall be referred by the appropriate Medical Executive Board to the Patient Care and Quality Committee for its review and recommendation to the Board of Directors.

5.2. IMMEDIATE ACTION AND PROBATION

5.2.1. CRITERIA FOR INITIATION. Whenever a Staff member's conduct appears to require that immediate action be taken to protect the life or wellbeing of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient(s), prospective patient, or other person, or when the overriding interests of patient care merit, the appropriate Physician-in-Chief, a Medical Executive Board, or the Chief of the Department or designee in which the Staff member holds privileges may summarily restrict, suspend or terminate the Medical Staff membership or clinical privileges of such member. Unless otherwise stated, such immediate restriction, suspension or termination shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the Staff member, the Board of Directors, the Medical Executive Board(s) and Hospital Administrations. Within forty-eight (48) hours of such immediate action the action must be confirmed or rescinded by the appropriate Physician-in-Chief.

5.2.2. MEDICAL EXECUTIVE BOARD ACTION. At its next meeting, the appropriate Medical Executive Board shall review and consider the action. Upon request, the Staff member may attend and make a statement concerning the issues under investigation, on such terms and conditions as that Medical Executive Board may impose, although in no event shall any meeting of a Medical Executive Board, with or without the member, constitute a "hearing" within the meaning of Section 6.1., nor shall any right to counsel or other procedural rules apply. That Medical Executive Board may modify, continue or end the immediate restriction, suspension or termination, but in any event it shall furnish the Staff member with notice of its decision.

5.2.3. PROCEDURAL RIGHTS. Unless the Medical Executive Board reviewing the matter under the immediately above section of these Bylaws promptly ends the immediate restriction,

suspension or termination, the Staff member shall be entitled to the procedural rights afforded by Article VI.

5.2.4. PROBATION. The Chief of the Department or appropriate Physician-in-Chief may impose a period of testing or trial under supervision on a Staff member. Such probation, except for Associate Staff members, requires confirmation by the appropriate Physician-in-Chief in writing within forty-eight (48) hours and, if confirmed, the matter will be referred to the appropriate Medical Executive Board at its next meeting for approval, rejection or modification.

5.3. OTHER GROUNDS FOR ACTION

Other grounds for action shall include, but not be limited to, the following:

(a) License: A Staff member whose license, certificate, or other legal credentials authorizing practice and / or the prescription of controlled substances federally or in Michigan is revoked, suspended, or lapsed shall be automatically suspended from the Staff without appeal;

(b) Providing of false or misleading information on the reappointment application is grounds for revocation of Medical Staff membership and privileges;

(c) Failure to notify the appropriate Physician-in-Chief of adverse action, disciplinary action, significant physical, mental or behavioral illness or impairment, charge with, conviction of, or plea of guilty or no contest to a felony or misdemeanor (other than a traffic violation), involuntary or voluntary changes in licensure, clinical privileges at or employment by another institution as outlined in these Bylaws is grounds for revocation of Medical Staff appointment;

(d) Sanctioning from participating in any private, federal (Medicare / Medicaid), or state health insurance program as set forth in these Bylaws is a grounds for revocation of Medical Staff membership and privileges;

(e) Failure to abide by the Professional Conduct Policy as stated in the Medical Staff Physician Handbook is grounds for revocation of Medical Staff membership and privileges;

(f) Failure to obtain or maintain Board Certification as required by these Bylaws is grounds for revocation of Medical Staff membership and privileges;

(g) Failure to pay Medical Staff dues is grounds for suspension of all privileges for a time period as specified or termination of Medical Staff membership and privileges;

(h) Failure to complete medical records is grounds for temporary suspension of all privileges for a time frame as specified;

(i) Failure to provide continuous care, to accept new patients and perform emergency call coverage as requested by the Chief of Department or Head of Section is grounds for temporary suspension of all privileges for a time frame as specified or other correction action.

(j) Failure to maintain the required level of professional liability insurance with an approved insurance carrier is grounds for temporary suspension of all privileges for a time period as specified or revocation of Medical Staff membership and privileges;

(k) Failure to consent to the administration and release of an appropriate drug and / or alcohol screening when requested to consent to the same by a Physician-in-Chief, Department Chief, or Head of Section, or his / her designee, upon reasonable suspicion of impairment while at, or while performing services on behalf of, the Hospital is grounds for suspension of all clinical privileges for a time period as specified or revocation of Medical Staff membership and privileges.

(l) Failure to comply with requirements for tuberculosis evaluation or influenza vaccination or mandatory education (eg. Computer-based training) as required by Hospital policy may result in loss of inpatient privileges or may be construed by the Medical Executive Board a voluntary resignation from the Medical Staff. If compliance is demonstrated within thirty (30) days reinstatement may be considered.

(m) Failure of a practitioner to meet with or appropriately respond to their Department Chief and / or Physician-in-Chief when reasonably requested may be subject to corrective action.

(n) Failure of a practitioner to comply with a request of an established peer review committee when reasonably requested may result in corrective action; and / or

(o) Violation of law, Beaumont policies or written agreement pertaining to confidentiality of protected health information.

(p) Any disciplinary or corrective action at one Beaumont Hospital imposed or affirmed by the Board of Directors will automatically apply to all divisions within the Beaumont Health System at which the practitioner has Medical Staff membership.

ARTICLE VI HEARINGS AND APPEALS

6.1. HEARINGS AND APPEALS

6.1.1. EXHAUSTION OF REMEDIES. If adverse action as described in the immediately below section is taken, the applicant or Medical Staff member must exhaust the remedies afforded by these Bylaws or waive them before resorting to legal action.

6.1.2. GROUNDS FOR HEARINGS. Except as otherwise specified in these Bylaws, any one or more of the following actions shall be deemed adverse action and constitute grounds for a hearing with the exception of loss of license for a felony conviction.

6.1.2.1. denial of appointment or reappointment to Medical Staff membership by the Board of Directors;

6.1.2.2. reduction, or denial of requested change, in Medical Staff membership, status or category by the Board of Directors;

6.1.2.3. suspension, revocation, or termination of Medical Staff membership by the Board of Directors;

6.1.2.4. denial, involuntary reduction, suspension, or total termination of clinical privileges (except temporary privileges) by the Board of Directors; or

6.1.2.5. confirmation of probation by a Medical Executive Board (excluding probation incidental to Associate Staff status).

6.1.3. REQUEST FOR HEARINGS.

6.1.3.1. **NOTICE OF ACTION OR PROPOSED ACTION.** An appropriate Physician-in-Chief shall mail notice to the applicant or Staff member involved by registered mail within ten (10) days of an adverse action. This notice shall identify the adverse action, the factual basis upon which the decision was premised, and the right of the individual to request a hearing pursuant to this Article, within thirty (30) days. Counsel for the corporation shall review the notice prior to its being given.

6.1.3.2. **REQUEST FOR A HEARING**. An applicant or Staff member who wishes to contest the adverse action may within thirty (30) days of the transmittal date indicated on the notice, file a written request for a hearing with the Physician-in-Chief who notified him or her of their right to a hearing. This written request shall also set forth the basis of the hearing and appeal, including facts upon which the appellant or member relies, the identity of any persons who may be called as witnesses in support of the hearing and appeal, the substance of their proposed testimony, any documents that may be offered in support of the hearing and appeal and the substance thereof. Failure to submit such a written request within the thirty (30) days described above shall constitute a waiver of the right to a hearing and appeal. Failure to include within that written request the identity of proposed witnesses, the substance of their proposed testimony and any documents that may be offered in support of the hearing appeal constitutes a waiver of the right to present such witnesses or documents at the hearing and appeal.

6.1.3.3. **HEARING COMMITTEE.** When a hearing is requested, a Medical Executive Board, upon recommendation of the appropriate Physician-in-Chief, or his / her designee, shall appoint a hearing committee consisting of the five (5) members of the active category of the Staff who are not in direct economic competition with

the physician involved and who have not actively participated in the matter contested. One committee member shall be designated by the same Medical Executive Board to act as Chair. The Committee appointed shall be representative of the Staff at large, but to the extent possible at least one committee member must have the same professional practice licensure as the appellant if such service on the hearing committee would meet the other criteria for hearing committee membership described in this provision.

6.1.3.4. **TIME AND PLACE FOR HEARING.** Any hearing requested shall be held not less than thirty (30), nor more than ninety (90), days after receipt of the request. The appropriate Physician-in-Chief, or his / her designee, shall schedule the date, time and location of the hearing giving reasonable consideration to the wishes of the appellant. The date, time and location of the hearing and list of Hospital witnesses shall be confirmed in a notice under the signature of the appropriate Physician-in-Chief to the appellant at least ten (10) days prior to the scheduled date of the hearing. Postponement of the hearing beyond the ninety (90) days shall be made only with the mutual written consent of the appellant and the hearing committee. Unless postponed by mutual consent, failure of the hearing committee to convene within ninety (90) days will signify the affirmation of the appellant's position. Failure without good cause of the appellant to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the adverse action involved.

Notwithstanding anything to the contrary above, when the request for hearing is received from a Staff member appealing an "Immediate Action" taken under Section 5.2., if the Staff member so requests and / or agrees the hearing shall be held as soon as arrangements may be reasonably made, but not to exceed thirty (30) days from the receipt of the request.

6.1.4. HEARING PROCEDURE.

6.1.4.1. **CONDUCT OF HEARING.** The Chair of the hearing committee shall preside over the hearing to determine the order of procedure during the hearing, to assure that all participants in the hearing have a reasonable opportunity to present oral and / or documented evidence, and to otherwise maintain professional decorum. Three (3) members of the committee shall constitute a quorum.

6.1.4.2. **REPRESENTATION.** Both the appellant involved and the Hospital or a Medical Executive Board shall be entitled to be accompanied by and represented by a member of the Staff in good standing, by a member of a local professional society, and / or legal counsel.

6.1.4.3. **RECORD OF THE HEARING.** A stenographic reporter shall be present to make a record of the hearing proceedings. The cost of attendance of the reporter shall be borne by the Hospital, but the cost of a transcript, if any, shall be borne by either or both parties requesting it. The hearing committee may require that oral evidence shall be taken under oath by any person lawfully authorized to administer such oath.

6.1.4.4. **CONFIDENTIALITY OF HEARING.** The hearing committee's functions constitute peer or professional review. All participants in the hearing process, including without limitation, the applicant, witnesses, and members of the hearing committee, and all records, data, and knowledge collected for or by the committee are bound by the provisions of Sections 3.4, 11.1.4, and 14.1.8 providing such information and

materials are kept confidential under federal and state law as well as these Bylaws.

6.1.4.5. **PRESENTATION OF EVIDENCE.**

6.1.4.5.1. The reports, recommendations and other documents relied upon by the Medical Executive Board(s) involved in the matters under review and other appropriate Staff committees shall be presented as required at the hearing by representatives of such committees upon due consultation with Hospital counsel who, together with the appropriate Physician-in-Chief or his / her designee, shall be responsible for the organization and presentation of the Hospital or Medical Executive Board's position.

6.1.4.5.2. The appellant and the Hospital, Medical Executive Board(s) or other Staff committee representatives shall have the right to call and examine or cross-examine witnesses, including the appellant, for relevant testimony and to present or rebut any evidence. The committee may question and / or call its own witnesses. Procedures concerning presentation may be agreed upon in advance of the hearing so long as the record reflects the basis of the parties' understanding.

6.1.4.5.3. **MISCELLANEOUS RULES.** Rules of evidence and procedure applicable to court proceedings shall not limit the presentation of the parties.

6.1.4.5.4. **BURDENS OF PRESENTING EVIDENCE AND PROOF.** At the hearing, unless otherwise determined for good cause, the Medical Executive Board(s) or the Hospital shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The appellant shall be obligated to present evidence in response and throughout the hearing shall bear the burden of demonstrating by a preponderance of the evidence that the adverse action or recommendation was unreasonable or unwarranted.

6.1.4.5.5. **WRITTEN STATEMENTS.** Although they are not required to, either or both parties may submit concise written statements at the close of the hearing under terms established by the committee Chair.

6.1.4.5.6. **ADJOURNMENT AND CONCLUSION.** The Chair of the hearing committee may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Upon conclusion of the oral and written evidence, or the receipt of written statements, if requested, the hearing shall be closed.

6.1.5. DECISION OF THE HEARING COMMITTEE.

6.1.5.1. **DELIBERATION.** At the close of the hearing, the hearing committee shall deliberate in closed session on evidence introduced at the hearing, including all logical reasonable inferences from the evidence and testimony. To preserve the integrity of the hearing and appeals procedure, no member of the hearing committee who has not been present during the entire hearing may be present in the deliberations or vote in the hearing committee's decision.

6.1.5.2. **DECISION.** The hearing committee will render a recommendation within three (3) working days after final adjournment of the hearing recommending affirmation, modification, or reversal of the original adverse action. Their decision shall be reported in writing to the Medical Executive Board appointing such committee. A copy of the hearing committee recommendation shall be delivered to the appellant by the appropriate Physician-in-Chief within five (5) days after the involved Medical Executive Board's next meeting after receipt of the recommendation from the hearing committee.

6.1.6. MEDICAL EXECUTIVE BOARD ACTION. The involved Medical Executive Board shall consider the recommendation of the hearing committee at its next regular meeting and shall affirm, modify, or reverse its previous recommendation. In the event that prior to reaching its decision that Medical Executive Board desires to receive from either the appellant or representatives of the Hospital new matters not contained in the record, that Medical Executive Board upon majority vote shall arrange a mutually convenient time for the presentation and rebuttal limited solely to such issues. In the interests of time and the desirability of promoting a final judgment, such procedure shall be employed as required for unusual circumstances. The decision of that Medical Executive Board, including a statement of the basis for the decision, shall then be transmitted to the Patient Care and Quality Committee and then to the Board of Directors for final consideration.

6.1.7. BOARD OF DIRECTORS ACTION. The Board of Directors may affirm, modify, or reverse the recommendation or decision of the involved Medical Executive Board and / or Patient Care and Quality Committee, or it may refer the matter back to either entity for further review and recommendation. Upon decision by the Board of Directors regarding the recommended or actual adverse action, that action shall become final. The decision of the Board of Directors, including a statement of the basis for the decision, will be delivered to the appellant by registered mail within thirty (30) days.

6.1.8. RIGHT TO ONE HEARING. No applicant or Medical Staff member shall be entitled to more than one (1) hearing and one (1) review of that hearing as delineated above on any matter, which shall have been the subject of adverse action or recommendation

ARTICLE VII STAFF ORGANIZATION

7.1. COMPOSITION OF THE MEDICAL EXECUTIVE BOARDS

7.1.1. DUTIES. The Medical Staff of Beaumont Health System shall be governed by a Medical Executive Board at each Hospital. Each Medical Executive Board shall engage in or direct ongoing and focused peer review activities including, without limitation, the necessity, appropriateness or quality of care and the qualifications, competence or performance of health care providers, and shall coordinate the activities and general policies of the various Departments, act for the Staff as a whole, receive and act upon reports of all standing and special committees, make recommendations, and account to the Board of Directors on Medical Staff issues and the quality of the overall medical care rendered to patients at each of the hospitals within the Beaumont Health System by the Medical Staff.

7.1.1.1. Each Medical Executive Board shall meet regularly on a basis determined by it and maintain a permanent record of its proceedings and actions. It shall be governed by the most recent edition of Robert's Rules of Order Revised.

7.1.1.2. A quorum of the Committee shall be the majority of its members eligible to vote. The action of a more than one half (1/2) of the voting members present at a

meeting at which a quorum exists shall be the action of the Committee. Members must be present at the time of any vote. Absentee ballots will not be permitted.

7.1.2. BEAUMONT HOSPITAL, ROYAL OAK MEDICAL EXECUTIVE BOARD. Will be composed of the following Members:

The following will be voting members:

Sr. Vice President and Physician-in-Chief, Beaumont Hospital, Royal Oak (Chair)
President of the Medical Staff
Secretary-Treasurer of the Medical Staff
Four (4) elected Representatives of the Medical Staff on a rotational basis
Patient Safety Officer
Chair, Hospital Credentials and Qualifications Committee
Chair, Multi-Disciplinary Peer Review and Best Practice Committee Chiefs of Departments and Section Heads as listed below:

- Anesthesiology
- Cardiovascular Medicine
- Colon & Rectal Surgery
- Diagnostic Radiology
- Emergency Medicine
- Family Medicine and Community Health
- General Internal Medicine
- General Surgery
- Internal Medicine
- Medical Oncology / Hematology
- Neurology
- Obstetrics and Gynecology
- Ophthalmology
- Orthopaedic Surgery
- Pathology and Laboratory Medicine
- Pediatrics
- Physical Medicine & Rehabilitation
- Psychiatry
- Radiation Oncology
- Surgery Urology
- Section Head-at-large, representing the remaining sections of Internal Medicine appointed on a rotational basis by the Physician-In-Chief (twoyear term)

Director, Graduate Medical Education
Director, Infection Control
Director, Operating Room Services

The following members will be ex officio, without a vote:

President and Chief Executive Officer
President, Beaumont Physician Partners
Executive Vice President and Chief Medical Officer
Executive Vice President and Chief Operating Officer
Sr. Vice President and President, Beaumont Hospital, Royal Oak
Sr. Vice President and Chief Quality and Safety Officer

Vice President and Chief Medical Informatics Officer
Vice President, Research
Vice President, Nursing
Chief Academic Officer
Two (2) Representatives of the Board of Directors / Trustees
Representative from Department of Legal Affairs

Physicians-in-Chief at Troy and Grosse Pointe, Health System Chairs, and other invited guests may attend at the discretion of the Physician-in-Chief.

7.1.3. BEAUMONT HOSPITAL, TROY MEDICAL EXECUTIVE BOARD. Will be composed of the following Members:

The following will be voting members:

Sr. Vice President and Physician-in-Chief, Beaumont Hospital, Troy (Chair)
President of the Medical Staff
Secretary-Treasurer of Medical Staff
Three (3) elected Representatives of the Medical Staff on a rotational basis
Medical Co-Chair, Utilization Management Committee
Patient Safety Officer
Chair, Hospital Credentials and Qualifications Committee Chiefs of Departments:

Anesthesiology
Cardiovascular Medicine
Diagnostic Radiology
Emergency Medicine
Family Medicine and Community Health
Pathology and Laboratory Medicine
Medical Oncology / Hematology
Medicine
Obstetrics and Gynecology
Pediatrics
Radiation Oncology
Surgery

The following members will be ex officio, without a vote:

President and Chief Executive Officer
President, Beaumont Physician Partners
Executive Vice President and Chief Medical Officer
Executive Vice President and Chief Operating Officer
Sr. Vice President and President, Beaumont Hospital, Troy
Sr. Vice President and Chief Quality and Safety Officer
Vice President and Chief Medical Informatics Officer
Vice President, Research
Vice President, Nursing
Chief Academic Officer
Two (2) Representatives of the Board of Directors / Trustees
Director, Graduate Medical Education
Representative from Department of Legal Affairs

Physicians-in-Chief at Royal Oak and Grosse Pointe, Health System Chairs, and other invited guests may attend at the discretion of the Physician-in-Chief

7.1.4. BEAUMONT HOSPITAL, GROSSE POINTE MEDICAL EXECUTIVE BOARD. Will be composed of the following Members:

The following will be voting members:

- Sr. Vice President and Physician-in-Chief, Beaumont Hospital, Grosse Pointe (Chair)
- President of the Medical Staff
- Secretary-Treasurer of Medical Staff
- Three (3) elected Representatives of the Medical Staff on a rotational basis
- Patient Safety Officer
- Chair, Hospital Credentials and Qualifications Committee
- Chair, Quality Care and Safety Committee
- Chair, Utilization Management Committee
- Chair, Primary Care Network Council
- Chiefs of Departments:
  - Anesthesiology
  - Cardiovascular Medicine
  - Diagnostic Radiology
  - Emergency Medicine
  - Family Medicine and Community Health
  - Pathology and Laboratory Medicine
  - Medical Oncology / Hematology
  - Medicine
  - Obstetrics and Gynecology
  - Pediatrics
  - Surgery

The following members will be ex officio, without a vote:

- President and Chief Executive Officer
- President, Beaumont Physician Partners
- Executive Vice President and Chief Medical Officer
- Executive Vice President and Chief Operating Officer
- Sr. Vice President and President, Beaumont Hospital, Grosse Pointe
- Sr. Vice President and Chief Quality and Safety Officer
- Vice President and Chief Medical Informatics Officer
- Vice President, Research
- Vice President, Nursing
- Chief Academic Officer
- Two (2) Representatives of the Board of Directors / Trustees
- Director, Graduate Medical Education
- Director, Quality Care
- Representative from Department of Legal Affairs

Physicians-in-Chief at Royal Oak and Troy, Health System Chairs, and other invited guests may attend at the discretion of the Physician-in-Chief.

7.1.5. APPOINTMENT TO ADDITIONAL / VACATED POSITION.

In the event any member serves on a Medical Executive Board by virtue of the position he or she holds and is at the same time holding another position provided for on the membership of the same Medical Executive Board, the additional office may be filled by the appropriate Physician-in-Chief by appointment of an additional member of the Staff, or if such member is an elected Representative of the Medical Staff by the President of the Medical Staff.

7.2. STAFF OFFICERS

The Officers of the Staff shall consist of the Physicians-in-Chief, Health System Chairs, and the Secretary-Treasurer appointed by the Board of Directors.

7.2.1. PHYSICIAN-IN-CHIEF. The appropriate Physician-in-Chief at each Hospital, as appointed by the Board of Directors, shall be the Chair of that Hospital's Medical Executive Board, shall be a member ex-officio of all Hospital committees, and have general supervision of all of the medical affairs of the Hospital. Their term shall be without fixed duration.

7.2.2. HEALTH SYSTEM CHAIR. The Health System Chair shall be responsible for promoting excellence in clinical care, research and education in the Departments across the Beaumont Health System in collaboration with hospital and medical administrative leadership. They shall have overall responsibility for ensuring optimal functioning of the Departments and any Sections thereof, and may delegate authority to a Chief of a Department in each Hospital.

They may serve up to five (5) year terms with mandatory performance review before reappointment by the Board of Directors

7.2.3. SECRETARY-TREASURER. The Secretary-Treasurers, as appointed biennially by the Board of Directors, shall: (1) keep accurate and complete minutes of all meetings, (2) attend to other correspondence, (3) account where there are funds to be accounted for, (4) supervise the election process for the positions of President of the Staff and Staff representatives at large to the Medical Executive Boards, and (5) perform such other duties as ordinarily pertain to such office.

7.2.4. TERM OF OFFICE. The term of office of the Officers of the Staff is outlined above. All officers shall be eligible to succeed themselves without restriction as to the number of terms.

7.3. ELECTED POSITIONS

The elected positions of the Medical Staff shall consist of the President of the Medical Staff and the Representatives of the Medical Staff.

No individual may simultaneously serve as President of the Medical Staff or Member at Large and as a Beaumont Chief Medical Officer, President of Beaumont Physician Partners, Physician in Chief, Health System Chair or Department Chief.

7.3.1. PRESIDENT OF THE MEDICAL STAFF. The duties of the President of the Medical Staff of each Hospital will be to: serve as a member of the Corporate Credentials and Qualifications Committee, the Patient Care and Quality Committee and the Medical Executive Board of that Hospital; to serve as a liaison between the Staff and Hospital / Medical Administration; to serve in the highest elected position of the Staff of that Hospital; to represent the views, policies, needs and grievances of the Staff to the appropriate Physician-in-Chief, the Medical Executive Board, and the Chief Medical Officer. The term of the position will be

four (4) calendar years, and the President may serve only two (2) consecutive terms without a break in service.

The President of the Medical Staff shall: (1) chair regular Medical Staff meetings and the President's Council; (2) serve on Hospital committees; (3) manage the Medical Staff Fund and present a summary of the annual budget at the Medical Executive Board; (4) coordinate the activities of the elected Representatives; (5) plan and coordinate Medical Staff events.

7.3.2. REPRESENTATIVES OF THE MEDICAL STAFF. Six (6) Representatives of the Medical Staff known as Members at Large shall be elected to represent the Medical Staff at each Hospital of the Corporation. They shall serve three (3) calendar year terms, with two (2) positions becoming vacant and filled by election in each year in consecutive rotation. They may serve no more than three (3) consecutive terms without a break in service. At all times the six (6) serving Members at Large shall be elected one (1) each from Staff Members of the following categories / specialties:

- 1 from Surgery
- 1 from Medicine
- 1 from Employed / Hospital-Based Physicians
- 1 from the Ambulatory Staff
- 2 from Primary Care (such as Family Medicine, Internal Medicine, Obstetrics / Gynecology; and Pediatrics)

The Nominating Committee of each Hospital's Medical Staff, in consultation with the President of the Medical Staff, may delineate differing initial terms of service for Members at Large at the inception of the six (6) Members at Large panel in order to establish the above representation and an appropriate rotation. Thereafter the Nominating Committee shall establish, in consultation with the President of the Medical Staff, the categories / specialties from which each Member at Large may be nominated and elected. The President of the Medical Staff has the authority to name appropriate individuals to fill Members at Large positions between Medical Staff Elections.

The duty of a Member at Large to the Medical Staff is to represent the Medical Staff as a voting member of their Medical Executive Board on a rotational basis established by the serving Members at Large and the President of the Medical Staff; to serve on Hospital and / or Medical Staff committees upon request; to assist the President of the Medical Staff in discharging his / her responsibilities; to serve on the President's Council and to accept assignments directed by that Hospital's President of the Medical Staff in collaboration with its Physician-in-Chief.

7.3.3. NOMINATION AND ELECTION PROCESS. Any member of the Medical Staff may make nominations for the elected positions of the Medical Staff. Nominees shall be solicited by the Secretary-Treasurer through email, written publication and / or by announcements at meetings no later than three (3) months prior to the Annual Medical Staff Meeting. At least two months before the annual Medical Staff meeting, a Nominating Committee shall be convened, comprised of the elected representatives of the Medical Staff and the Secretary-Treasurer, who will serve as chairperson. Individuals may not participate in the nomination process for any position for which they are running.

7.3.3.1. **NOMINATING COMMITTEE PROVISIONS.**

(a) The Nominating Committee shall prepare a slate of nominees for each position that is open. A minimum of two (2) candidates for each position shall be nominated. For the position of President of the Medical Staff the Nominating Committee will give consideration to individuals who have had the experience of serving as a Member at Large;

(b) The Nominating Committee shall confirm each nominee's eligibility, standing in their respective departments, and willingness to run for the position before announcing the nominations;

(c) The slate of candidates shall be reviewed by the appropriate Physician-inChief in consultation with the Chief Medical Officer for approval prior to its finalization;

Election of the members representing the Staff from among the list of candidates proposed by the Nominating Committee shall be accomplished by mail, electronic voting, or any other method which in the opinion of the Nominating Committee assures the integrity of the process. They shall be elected by a plurality vote of the eligible voting members of the Medical Staff.

7.4. REMOVAL / RECALL

7.4.1. OFFICERS / POSITIONS APPOINTED BY THE BOARD – REMOVAL. Those Medical Staff Officers / Positions appointed by the Board of Directors, the Physicians-in-Chief, Health System Chairs, the Secretary-Treasurers and the Department Chiefs or Section Heads may be removed from office / position for failure to appropriately discharge the responsibilities of their office / position, as set forth in these Bylaws, in the Bylaws of the Corporation, and as otherwise decided by the Board of Directors under removal policies and procedures determined by the Board of Directors.

7.4.2. POSITIONS ELECTED BY THE MEDICAL STAFF – RECALL. The Presidents of the Staff and the Representatives of Medical Staff to the Medical Executive Boards ("Members-at-large") may be recalled by the Board of Directors or the Medical Staff on appropriate grounds, including, without limitation, for failure to appropriately discharge the responsibilities of the position as set forth in these Bylaws; failure to appropriately represent the Medical Staff; and in the case of the President of the Staff, for failure to act as appropriate liaison between the Staff and the Hospital / Medical Administration; or in any case where there is a loss of confidence by the Medical Staff in the Presidents or Representatives of the Medical Staff.

7.4.2.1. **RECALL.** The recall of such elected positions may occur at a Medical Staff meeting or by the Board of Directors at any time. If the recall is by the Board of Directors, it shall occur under such terms and procedures as determined by the Board of Directors. If the recall is by the Medical Staff it must be initiated by a petition of at least one hundred (100) signatures submitted to the Chief Medical Officer prior to a Medical Staff meeting. The matter will then be put on the agenda and a paper ballot will be used. If a recall vote is sustained by a majority of those voting, then the nomination and election process, as described above, shall be put into effect for the next Medical Staff meeting.

7.5. ORGANIZATION OF DEPARTMENTS AND SECTIONS

A Chief of each Department and a Head of each Section, each of whom shall be a member of the Staff, shall be appointed every two (2) years by the Board of Directors who shall give due

consideration to the recommendations of the appropriate Physician-in-Chief, Health System Chair, and the Medical Executive Board. There shall be no restriction upon the number of terms to which a Department Chief or Section Head may be appointed, provided that such appointment may be terminated by the Board of Directors at any time, for any reason, with or without cause.

7.5.1. DEPARTMENT CHIEFS AND SECTION HEADS. The Chief of each Department and Head of each Section shall be responsible for the assignment and organization of members within their respective Department and Section under the authority of the Health System Chair and the Physician in Chief of the respective Hospital**.**

7.5.2. RESPONSIBILITIES. The Chief of each Department and Head of each Section shall be responsible for:

(a) Clinically related activities of the Department and / or Section;

(b) Administratively related activities of the Department and / or Section;

(c) Education-related activities of the Department and / or Section (UME, GME and CME);

(d) Research-related activities of the Department and / or Section (Basic Science, Translational and Clinical Research Programs);

(e) Continuing surveillance of the professional performance of all individuals in the Department and / or Section based on individual assessment and on information supplied by the audit and peer review procedures, as well as the information supplied by other Hospital committees reviewing Staff performance;

(f) Recommending to the Staff the criteria for clinical privileges that are relevant to the care provided in the Department and / or Section;

(g) Recommending clinical privileges for each Member of the respective Department and / or Section;

(h) Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the organization;

(i) The integration of the Department and / or Section into the primary functions of the organization;

(j) The coordination and integration of inter and intra Department and / or Section services;

(k) The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

(l) The recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(m) The determination of the qualification and competence of Department and / or Section personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(n) The continuous assessment and improvement of the quality of care, treatment, and services;

(o) The maintenance of quality control programs as appropriate;

(p) The orientation and continuing education of all persons in the Department and / or Section;

(q) Recommending space and other resources needed by the Department and / or Section; and

(r) When applicable, assuring effective communication with and resource support to the department's residency, fellowship and medical student program directors to enable them to fulfill their educational and administrative duties and responsibilities.

7.5.3. A Vice Chief, or other Medical Staff Member may discharge the duties and responsibilities of such Chief in their absence with the permission and knowledge of the Physician-in-Chief and Health System Chair. In the absence of such appointment, the Physician-in-Chief may designate an individual to carry out the Chief's duties in their absence.

7.5.4. The Officers of the Medical Staff, and the Corporate Medical Staff Officers such as the Executive Vice President and Chief Medical Officer, Senior Vice President and Physicians-in-Chief and Senior Vice President and Chief Quality and Safety Officer, may designate another Medical Staff Member to discharge the duties and responsibilities assigned to them under these Bylaws in their absence.

ARTICLE VIII DEPARTMENTS AND SECTIONS OF THE MEDICAL STAFF

8.1. ORGANIZATION OF THE STAFF

Notwithstanding the Hospital Medical Staff structure set forth below, the Medical Staff may establish Services and Integrated Service Lines across the Hospitals of the Corporation. In such circumstances the medical leadership of the Service and Integrated Service Line will be appointed by, and report to, the Chief Medical Officer of the Corporation or his / her designee. The Medical Staff shall be organized along the following lines:

8.2. FOR BEAUMONT HOSPITAL, ROYAL OAK:

8.2.1. DEPARTMENT OF ANESTHESIOLOGY AND PERI-OPERATIVE MEDICINE, THE SECTIONS OF WHICH ARE:

1. Critical Care Anesthesiology
2. General Anesthesiology and Peri-Operative Medicine
3. Pain Medicine

8.2.2. DEPARTMENT OF CARDIOVASCULAR MEDICINE

8.2.3. DEPARTMENT OF COLON AND RECTAL SURGERY

8.2.4. DEPARTMENT OF DIAGNOSTIC RADIOLOGY, THE SECTIONS OF WHICH ARE:

1. Body Imaging
2. Breast Imaging
3. Emergency Radiology
4. Musculoskeletal Radiology
5. Neuroradiology
6. Nuclear Medicine
7. Pediatric Radiology
8. Vascular / Interventional Radiology

8.2.5. DEPARTMENT OF EMERGENCY MEDICINE, THE SECTIONS OF WHICH ARE:

1. Emergency Observation Medicine
2. Pediatric Emergency Medicine

8.2.6. DEPARTMENT OF FAMILY MEDICINE AND COMMUNITY HEALTH, THE SECTIONS OF WHICH ARE:

1. Integrative Medicine

8.2.7. DEPARTMENT OF GENERAL SURGERY, THE SECTIONS OF WHICH ARE:

1. Acute Care / Trauma Surgery
2. Minimally Invasive / Bariatric Surgery
3. Oncologic Surgery
4. Transplantation Surgery

8.2.8. DEPARTMENT OF INTERNAL MEDICINE, THE SECTIONS OF WHICH ARE:

1. Allergy / Immunology
2. Dermatology
3. Endocrinology / Metabolism
4. Gastroenterology and Hepatology
5. General Internal Medicine
6. Geriatric Medicine
7. Hospital Medicine
8. Infectious Disease and International Medicine
9. Nephrology
10. Nutrition and Preventive Medicine
11. Occupational Medicine
12. Palliative Medicine
13. Pulmonary and Critical Care Medicine
14. Rheumatology

8.2.9 DEPARTMENT OF MEDICAL ONCOLOGY / HEMATOLOGY

8.2.10 DEPARTMENT OF NEUROLOGY

8.2.11. DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, THE SECTIONS OF WHICH ARE:

1. Gynecology
2. Maternal Fetal Medicine
3. Obstetrics
4. Obstetric Ultrasound and Fetal Imaging
5. Oncology
6. Reproductive Endocrinology
7. Urogynecology

8.2.12. DEPARTMENT OF OPHTHALMOLOGY, THE SECTIONS OF WHICH ARE:

1. Cornea and External Diseases
2. General Ophthalmology

3. Glaucoma
4. Neuro-ophthalmology
5. Oculoplastic Ophthalmology
6. Pediatric Ophthalmology
7. Refractive Surgery
8. Vitreoretinal Diseases and Surgery

8.2.13. DEPARTMENT OF ORTHOPAEDIC SURGERY, THE SECTIONS OF WHICH ARE:

1. Foot and Ankle
2. Hand and Upper Extremity
3. Joint Replacement
4. Pediatrics
5. Podiatry
6. Shoulder
7. Spine
8. Sports Medicine
9. Trauma
10. Tumor

8.2.14. DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE, THE SECTIONS OF WHICH ARE:

1. Autopsy Pathology
2. Blood Bank and Transfusion Medicine
3. Chemistry and Specialized Testing
4. Coagulation and Hemostasis
5. Cytogenetics & Molecular Genetics
6. Cytology
7. Electron Microscopy
8. Flow Cytometry
9. Hematopathology
10. Immunopathology and Molecular Pathology
11. Microbiology and Virology
12. Surgical Pathology

8.2.15. DEPARTMENT OF PEDIATRICS, THE SECTIONS OF WHICH ARE:

1. Adolescent Medicine
2. Allergy / Immunology
3. Ambulatory Pediatrics
4. Cardiology
5. Dermatology
6. Developmental and Behavioral Pediatrics
7. Endocrinology / Metabolism
8. Gastroenterology
9. General Inpatient Pediatric
10. General Pediatrics

11. Genetics
12. Hematology / Oncology
13. Infectious Disease
14. Neonatology
15. Neurology
16. Pediatric Critical Care
17. Pulmonology

8.2.16. DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION

8.2.17. DEPARTMENT OF PSYCHIATRY

8.2.18. DEPARTMENT OF RADIATION ONCOLOGY

8.2.19. DEPARTMENTS OF SURGERY, THE SECTIONS OF WHICH ARE:

1. Cardiovascular Surgery
2. Neurosurgery
3. Oral and Maxillofacial Surgery and Dentistry
4. Otolaryngology
5. Pediatric Surgery
6. Plastic Surgery
7. Surgical Critical Care
8. Thoracic Surgery
9. Vascular Surgery

8.2.20. DEPARTMENT OF UROLOGY, THE SECTIONS OF WHICH ARE.

1. Endourology / Laparoscopy
2. Female Urology
3. Infertility
4. Pediatric Urology
5. Sexual Dysfunction
6. Transplantation
7. Urodynamics
8. Urologic Oncology
9. Vascular Pathology

8.3. FOR BEAUMONT HOSPITAL, TROY:

8.3.1. DEPARTMENT OF ANESTHESIOLOGY AND PERIOPERATIVE MEDICINE, THE SECTIONS OF WHICH ARE:

1. Critical Care Anesthesiology
2. General Anesthesiology and Peri-Operative Medicine
3. Pain Medicine

8.3.2. DEPARTMENT OF CARDIOVASCULAR MEDICINE

8.3.3. DEPARTMENT OF DIAGNOSTIC RADIOLOGY, THE SECTIONS OF WHICH ARE:

1. Body Imaging - CT / MR
2. Breast Imaging
3. Musculoskeletal Radiology
4. Neuroradiology
5. Nuclear Medicine
6. Vascular / Interventional Radiology
7. Ultrasound

8.3.4. DEPARTMENT OF EMERGENCY MEDICINE

8.3.5. DEPARTMENT OF FAMILY MEDICINE AND COMMUNITY HEALTH, THE SECTIONS OF WHICH ARE:

1. Behavioral Medicine
2. Integrative Medicine
3. Sports Medicine – Medical

8.2.6. DEPARTMENT OF MEDICAL ONCOLOGY / HEMATOLOGY

8.3.7. DEPARTMENT OF MEDICINE, THE SECTIONS OF WHICH ARE:

1. Allergy
2. Dermatology
3. Endocrinology
4. Gastroenterology
5. Infectious Diseases
6. Internal Medicine
    a. Geriatric Medicine
    b. Hospital Medicine
7. Nephrology
8. Neurology
9. Palliative Medicine
10. Physical Medicine
11. Psychiatry
12. Pulmonary and Critical Care Medicine
13. Rheumatology

8.3.8. DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, THE SECTIONS OF WHICH ARE:

1. Maternal Fetal Medicine
2. OB Ultrasound / Fetal Imaging

8.3.9. DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE

8.3.10. DEPARTMENT OF PEDIATRICS, THE SECTIONS OF WHICH ARE:

1. Pediatric Allergy
2. Pediatric Cardiology

3. Pediatric Neurology
4. Neonatology

8.3.11. DEPARTMENT OF RADIATION ONCOLOGY

8.3.12. DEPARTMENT OF SURGERY, THE SECTIONS OF WHICH ARE:

1. Cardiovascular Surgery
2. Colon / Rectal Surgery
3. General Surgery
4. Hand Surgery
5. Neurosurgery
6. Ophthalmology
7. Oral and Maxillofacial Surgery and Dentistry
8. Orthopedic Surgery
   a. Podiatry
   b. Sports Medicine - Surgical
9. Otolaryngology
10. Pediatric Surgery
11. Plastic Surgery
12. Spine Surgery
13. Thoracic Surgery
14. Urology
    a. Pediatric Urology 15.

Vascular Surgery

8.4. FOR BEAUMONT HOSPITAL, GROSSE POINTE:

8.4.1 DEPARTMENT OF ANESTHESIOLOGY

8.4.2. DEPARTMENT OF CARDIOVASCULAR MEDICINE

8.4.3. DEPARTMENT OF DIAGNOSTIC RADIOLOGY, THE SECTIONS OF WHICH ARE:

1. Radiation Oncology
2. Nuclear Medicine

8.4.4. DEPARTMENT OF EMERGENCY MEDICINE

8.4.5. DEPARTMENT OF FAMILY MEDICINE AND COMMUNITY HEALTH

8.4.6. DEPARTMENT OF MEDICAL ONCOLOGY / HEMATOLOGY

8.4.7. DEPARTMENT OF MEDICINE, THE SECTIONS OF WHICH ARE:

1. Allergy
2. Dermatology
3. Endocrinology

4. Gastroenterology
5. Geriatrics
6. Hospital Medicine
7. Infectious Diseases
8. Internal Medicine
9. Nephrology
10. Neurology
11. Physical Medicine and Rehabilitation
12. Psychiatry
13. Pulmonary and Critical Care
14. Rheumatology

8.4.8 DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, THE SECTIONS OF WHICH ARE:

1. Gynecological Oncology

8.4.9. DEPARTMENT OF PATHOLOGY AND LABORATORY MEDICINE

8.4.10. DEPARTMENT OF PEDIATRICS, THE SECTIONS OF WHICH ARE:

1. Neonatology

8.4.11. DEPARTMENT OF SURGERY, THE SECTIONS OF WHICH ARE:

1. Colon / Rectal Surgery
2. General Surgery
3. Plastic / Hand Surgery
4. Neurosurgery
5. Ophthalmology
6. Oral and Maxillofacial Surgery and Dentistry
7. Orthopedic Surgery
   a. Podiatry
8. Otolaryngology
9. Pediatric Surgery
10. Pediatric Ophthalmology
11. Pediatric Otolaryngology
12. Pediatric Orthopedics
13. Thoracic Surgery
14. Urology
15. Vascular Surgery

ARTICLE IX CATEGORIES OF THE MEDICAL STAFF

9.1. CATEGORIES

The categories of each Medical Staff shall include the following: Attending, Associate, Adjunct, Institutional, Ambulatory, Bioscientific, Limited, Honorary / Consulting, Affiliate, Emeritus, and Retired Staff. The categories of the Medical Staff members shall be determined by the Board of Directors, at each appointment or reappointment.

9.2. ATTENDING STAFF

9.2.1. QUALIFICATIONS. The Attending Staff shall consist of all duly appointed Staff members who are Board certified and who do not belong to another category described in this Article. They shall pay Staff dues.

9.2.2. PREROGATIVES. Members of the Attending Staff may:

(a) admit patients and exercise clinical privileges as are granted under Article IV;

(b) vote at general and special meetings of the Staff and of the Department, Section or committee of which they are a member;

(c) hold office on the Staff or one of its subdivisions and committees; and (d) pursue a hearing and appeal of adverse actions as delineated in Article VI.

Note: A member of the Attending Staff category will be automatically transferred to the appropriate Adjunct Staff category if he / she becomes a full-time employee of or is in a similar compensated relationship in the opinion of the Hospital Credentials and Qualifications Committee with an institution that has no established formal relationship with Beaumont Hospital, as defined in Section 9.5.1.

9.3. ASSOCIATE STAFF

9.3.1. QUALIFICATIONS. Except in unusual circumstances, appointment of all new physicians and dentists will be made to this category. Members so appointed shall be considered to be on a probationary status with their performance supervised and reviewed by their Department Chief or Section Head for a minimum of one (1) year and until the member receives Board certification. At the completion of this period, the Department Chief or Section Head may recommend approval or disapproval of the member's advancement to Attending Staff in writing to the appropriate Physician-in-Chief. This recommendation will be based on the member's contribution to the Hospital in the areas of patient care, Staff participation and education during the time spent as a member of the Associate Staff. They shall pay Staff dues.

9.3.2. PREROGATIVES. Members of the Associate Staff may:

(a) admit patients and exercise clinical privileges as are granted under Article IV;

(b) vote at general and special meetings of the Staff and of the Department, Section or committee of which they are a member;

(c) not hold office on the Staff or one of its subdivisions and committees; and

(d) pursue a hearing and appeal of adverse actions as delineated in Article VI.

Note: A member of the Associate Staff category will be automatically transferred to the appropriate Adjunct Staff category if he / she becomes a full-time employee of or is in a similar compensated relationship in the opinion of the Hospital Credentials and Qualifications Committee with an institution that has no established formal relationship with Beaumont Hospital, as defined in Section 9.5.1.

9.4. ADJUNCT STAFF

9.4.1. QUALIFICATIONS. The Adjunct Staff shall consist of all duly appointed Staff members who are Board certified and are appointed or transferred to this category to attend to occasional patients in the Hospital, those duly appointed Staff members who are full-time employees of or are in a similar compensated relationship in the opinion of the Hospital Credentials and Qualifications Committee with institutions that have no established formal relationship with Beaumont Health System, as defined in Section 9.5.1. For this category "occasional" is defined by the Department Chief or Section Head with the concurrence of the appropriate Physician-in-Chief. This category may be used only to satisfy the special needs of a Department or Section as determined by the Department Chief or Section Head. The duration of appointment to this Staff category shall not exceed two (2) years, whereupon the appointment may be renewed or terminated. They shall pay Staff dues.

9.4.2. PREROGATIVES. Members of the Adjunct Staff may:

(a) admit patients and exercise clinical privileges as are granted under Article IV;

(b) not vote at general and special meetings of the Staff and of the Department, Section or committee of which they are a member;

(c) not hold office on the Staff or one of its subdivisions and committees; and

(d) pursue a hearing and appeal of adverse actions as delineated in Article VI.

9.5. INSTITUTIONAL STAFF

9.5.1. QUALIFICATIONS. The Institutional Staff shall consist of duly appointed members who are Board certified and are full-time employees of an institution which has an established formal relationship with Beaumont Health System. Upon discontinuance of their relationship with such institution or upon severance of their institution's relationship with Beaumont Health System, the Staff member will relinquish this appointment. A Staff member terminated solely by reason of such discontinuance will be eligible to reapply to the Staff on an individual basis without a waiting period as required in Section 3.8.1. Institutional Staff members shall pay Staff dues.

(a) If an existing member of the Staff subsequently becomes a full-time employee of an institution having a formal relationship with Beaumont Health System, he / she will be transferred to this category of the Staff;

(b) For purposes of this category of Staff membership, institution and established formal relationship with Beaumont Health System will be defined by the Beaumont Health System’s Board of Directors on the recommendation of the Medical Executive Boards; and

(c) Members so appointed to this category shall be considered to be in a probationary status with their performance supervised and reviewed by their Department Chief or Section Head for a minimum of one (1) year and until the Member receives Board certification. At the completion of this period the Department Chief or Section Head

may recommend advancement to a non-probationary status in writing to the appropriate Physician-in-Chief. This recommendation will be based on the Member's contribution to the Hospital in areas of patient care, Staff participation and education during the time spent in the probationary status.

9.5.2. PREROGATIVES. Members of the Institutional Staff may:

(a) admit patients and exercise clinical privileges as are granted under Article IV;

(b) vote at general and special meetings of the Staff and of the Department, Section or committee of which they are a member;

(c) not hold office on the Staff or one of its subdivisions and committees; and

(d) pursue a hearing and appeal of adverse actions as delineated in Article VI. No hearing or appeal may be taken if the termination of Staff membership is related to the existence, discontinuance, status, or conditions of the institution's relationship with Beaumont Health System.

9.6 ADMINISTRATIVE STAFF

9.6.1. QUALIFICATIONS. The Administrative Staff category shall consist of physicians who are not otherwise eligible for another staff category and who are employed by the Health System solely to perform ongoing medical administrative activities or are appointed as faculty for the purpose of teaching in the Oakland University / William Beaumont School of Medicine. Such individuals shall meet the general qualifications for Medical Staff membership set forth in Article III of these Bylaws except that the applicant need not demonstrate qualifications for clinical privileges under Article IV of these Bylaws. Such appointment will be automatically relinquished upon termination of employment or faculty appointment. They do need to maintain a current Michigan medical license but do not have to maintain Board Certification. They shall pay staff dues

9.6.2. PREROGATIVES. Members of the Administrative Staff may:

(a) not admit patients or exercise any clinical privileges;

(b) vote at general and special meetings of the Staff and of the Department, Section or committee of which they are a member;

(c) hold office on the Staff or one of its subdivisions and committees; and

(d) pursue a hearing and appeal of adverse actions as delineated in Article VI.

9.7. AMBULATORY STAFF

9.7.1. QUALIFICATIONS. The Ambulatory Staff shall consist of physicians who provide officebased care only but wish to maintain a strong relationship with Beaumont Health System. Appointment of new physicians and dentists may be made directly to this category, rather than into the Associate category, upon completion of a satisfactory office assessment and the normal Staff appointment process. They shall pay staff dues.

9.7.2. PREROGATIVES. Members of the Ambulatory Staff may:

(a) not admit patients or exercise any inpatient clinical privileges at any Hospital;

(b) visit the Hospital and render advice, teach, but may not write inpatient orders;

(c) may render consultations only with specific prior approval by the Department Chief;

(d) vote at general and special meetings of the Staff and the Department, Section or committee of which they are a member;

(e) pursue a hearing and appeal of adverse actions as delineated in Article VI.

(f) May exercise office-based clinical procedures in ambulatory settings as defined in their privileges / job description if compensated by Beaumont Health System. Note: A member of the Ambulatory Staff category will be transferred to an appropriate Staff category (Adjunct) if he / she becomes a full-time employee of or is in a similar compensated relationship in the opinion of the Hospital Credentials and Qualifications Committee with an institution that has no established formal relationship with Beaumont Health System, as defined in these Bylaws.

9.8. BIOSCIENTIFIC STAFF

9.8.1. QUALIFICATIONS. Hospital employees with a doctorate degree in any of the health care scientific disciplines designated by the Board of Directors as eligible for membership in this category may apply for membership on the Bioscientific Staff. They must have the appropriate licenses, certificates, or other legal credentials required by Michigan law to authorize them to provide professional services. Applicants for membership on the Bioscientific Staff shall apply for such membership and privileges as set forth in Articles III and IV. Members of the Bioscientific Staff shall be assigned to one or more appropriate Departments or Sections. Insofar as they do not conflict with this section, other provisions of the Medical Staff Bylaws, Rules / Regulations / Policies shall apply to members of the Bioscientific Staff. As a condition of such membership, the individual shall maintain status as an employee of the Hospital. They shall pay Staff dues.

9.8.2. PREROGATIVES. Members of the Bioscientific Staff may:

(a) be accorded privileges and prerogatives and abide by terms and conditions as approved for the relevant category of health care practitioner by the Board of Directors. Department or Section privileges, scope of activity and quality of work of each member of the Bioscientific Staff will be defined and supervised by the Department Chief or Section Head, within the terms and conditions established by the Board of Directors for such category of Bioscientific Staff;

(b) vote at general and special meetings of the Staff and of the Department, Section or committee of which they are a member;

(c) hold office on the Staff or one of its subdivisions and committees; and

(d) appeal an adverse appointment decision by invoking the appeals procedure set forth in Article VI. Members of the Bioscientific Staff who have a grievance or whose employment has been terminated may invoke the grievance procedure for physician employees set forth in Section 3.9.

9.9. LIMITED STAFF

9.9.1. QUALIFICATIONS. The Limited Staff shall consist of appropriately licensed physicians who are employed clinical fellows or physicians employed on a contingent basis to provide a needed service but who are not otherwise members of the Medical Staff. They have Staff privileges but limited tenure. Their Staff membership ceases when their employment ends. They shall perform duties as defined in the job descriptions / clinical privileges approved by the appropriate Department or Section. They do not pay Staff dues.

9.9.2. PREROGATIVES. Members of the Limited Staff:

(a) may not admit patients or be the attending physician of record, but may write orders on behalf of the Attending Staff member responsible for the admission;

(b) are not required to attend Staff or Departmental meetings;

(c) must abide by all Department, Section and Staff Rules / Regulations / Policies;

(d) will be subject to any and all disciplinary actions as provided by these Bylaws;

(e) may not vote at general and special meetings of the Staff and of the Department or Section;

(f) may not hold office on the Staff or one of its subdivisions and committees;

(g) Members of the Limited Staff who have a grievance or whose employment has been terminated may only invoke the grievance procedure for physician employees set forth in Section 3.11.

9.10. HONORARY CONSULTING STAFF

9.10.1. **QUALIFICATIONS.** The Honorary Consulting Staff shall consist of medical and dental practitioners in the community and other distinguished scientists who have attained distinctive status by virtue of academic achievements or special skills, who are not members of another category of the Staff, and who have signified willingness to accept such appointment of an honorary and temporary nature. Physicians and dentists associated with academic institutions and physicians and dentists of outstanding professional stature and other distinguished scientists may also be appointed in this capacity, even though their primary affiliation is other than the Hospital. They do not pay Staff dues.

9.10.2. PREROGATIVES. Members of the Honorary Consulting Staff may:

(a) not admit patients, but shall exercise clinical privileges as are granted under Article IV;

(b) not vote at general and special meetings of the Staff and of the Department, Section or committee of which they are a member;

(c) not hold office on the Staff or one of its subdivisions and committees; and

(d) pursue a hearing and appeal of adverse actions as delineated in Article VI.

9.11. AFFILIATE STAFF (CLOSED TO NEW APPOINTMENTS)

9.11.1. QUALIFICATIONS. The Affiliate Staff shall consist of appropriately licensed physicians and dentists in the community who may not necessarily be Board certified, and who are not otherwise members of the Staff, but whose patients receive care at the Hospital. Members of the Affiliate Staff are encouraged to visit their patients. They may be temporarily appointed to this Medical Staff category for the limited purposes described in this Section. They shall pay Staff dues.

9.11.2. PREROGATIVES. Members of the Affiliate Staff:

(a) may not admit patients or exercise any clinical privileges;

(b) may review the clinical chart;

(c) may use the Hospital medical library and dining rooms;

(d) are not required to attend Staff meetings;

(e) may not vote at general and special meetings of the Staff and of the Department or Sections;

(f) may not hold office on the Staff or one of its subdivisions and committees; and

(g) may pursue a hearing and appeal of adverse actions as delineated in Article VI.

9.12. EMERITUS STAFF

9.12.1. QUALIFICATIONS. The Emeritus Staff shall consist of Staff physicians and dentists who have retired from the practice of medicine or dentistry. Appointment must be supported and approved by either the Department Chief or Section Head based on outstanding contributions to the Hospital. They need not pay Staff dues.

9.12.2. PREROGATIVES. Members of the Emeritus Staff:

(a) will have no clinical privileges and may not attend patients;

(b) will be exempt from regular biennial reappointment process;

(c) may not vote at general and special meetings of the Staff and of the Department, Section or committee of which they are a member;

(d) may teach physical diagnosis to medical students at the discretion of the Department Chief.

(e) may not hold office on the Staff or one of its subdivisions and committees, except upon authorization of the Department Chief. They may participate in educational activities and attend meetings; and

(f) may pursue a hearing and appeal of adverse actions as delineated in Article VI.

9.13. RETIRED STAFF

9.13.1. **QUALIFICATIONS**. The Retired Staff shall consist of Staff physicians and dentists who have retired from the practice of medicine or dentistry, but desire to remain part of the Medical Staff. They need not pay dues.

9.13.2. PREROGATIVES. Members of the Retired Staff:

(a) will have no clinical privileges and may not attend patients;

(b) will be exempt from regular biennial reappointment process;

(c) may not vote at general and special meetings of the Staff and of the Department, Section or committee of which they are a member;

(d) may not hold office on the Staff or one of its subdivisions and committees, except upon authorization of the Department Chief. They may participate in educational activities and attend meetings; and

(e) may pursue a hearing and appeal of adverse actions as delineated in Article VI.

ARTICLE X DIVISION STAFF MEETINGS

10.1. REGULAR MEETINGS

Each Division's Medical Staff shall meet three times per year, one meeting of which shall be designated as the annual meeting.

10.2. SPECIAL MEETINGS

Shall be called by the appropriate Physician-in-Chief or President of the Staff by any of the following methods:

10.2.1. at any time upon his or her own initiative, or

10.2.2. at any time upon such written request of the appropriate Medical Executive Board or Board of Directors, or

10.2.3. within fourteen (14) days of written request signed by fifty (50) members of the Attending Staff stating the reason and purpose for such meeting.

10.3. QUORUM

Ten percent (10%) of the current members of the Medical Staff entitled to vote under these Bylaws shall constitute a quorum at any regular or special meeting of the Medical Staff. Each Department and Section shall establish the required quorum for its respective meetings.

10.4. ATTENDANCE

Each member of the Staff, except for Emeritus-Retired, Honorary-Consulting, and Affiliate members shall be expected to attend at least one (1) of the three (3) regular Medical Staff meetings.

10.5. AGENDA

10.5.1. REGULAR MEDICAL STAFF MEETINGS. The agenda format for the regular Medical Staff meetings will be as follows and will be distributed five (5) days prior to the scheduled meeting. The most recent edition of Robert's Rules of Order Revised will be used to guide parliamentary procedures:

(a) Call to order by the President of the Staff

(b) Reading and approval of the minutes of the last regular and all special meetings held since the last regular meeting

(c) Report of the Secretary-Treasurer

(d) Report of Medical Staff President

(e) Report of the Physician-in-Chief

(f) Communications, announcements and elections when appropriate

(g) Report(s) of Medical Administration, Department Chiefs, Section Heads and Committee Chairs, when indicated

(h) Unfinished business

(i) New business

(j) Adjournment

10.5.2. SPECIAL MEETINGS. The agenda format for special meetings of the Staff will be as follows and will be distributed five (5) days before the meeting:

(a) Reading of the notice calling for the meeting

(b) Transaction of the business for which the meeting was called (c) Adjournment

10.6. NOTICE

Notice of the date, time and place of all annual and regular meetings shall be provided to all members of the Staff at least fourteen (14) days prior to the meeting by the appropriate Medical Executive Board unless the emergency nature of a special meeting makes that notice impractical.

10.7. DEPARTMENT AND SECTION MEETINGS

Each Department and Section of the Staff as determined shall be required to hold meetings of its membership for the purpose of reviewing the medical or dental work done by that Department / Section and to communicate findings, conclusions and recommendations and actions taken to improve organizational performance. These Departmental and Section meetings should provide for a comprehensive review of all clinical care activities including any significant morbidities and all mortalities. The frequency of these meetings shall be determined by Department Chief or Section Head, but must occur at least quarterly. Members of the Attending and Associate Staff are required to attend fifty percent (50%) of the required Departmental and Section meetings. Failure to comply with this attendance requirement will be considered in the evaluation of the Staff member's request for reappointment and may result in modification of the Staff member's clinical privileges. Minutes of the Departmental / Section meetings shall be recorded and submitted to the Department Chief, or Section Head.

ARTICLE XI COMMITTEES

11.1. COMMITTEE ESTABLISHMENT AND PROCEDURE

To further implement policies and procedures governing the Staff and the monitoring of its activities, the appropriate Physician-in-Chief shall, with the approval of the appropriate Medical Executive Board, appoint members and chairs to the following committees. These committees are created and established to, among other duties, conduct peer review activities in review of the professional practices of the Hospital employees and Staff members for the purpose of reducing morbidity and mortality and for the improvement of the care of patients in the Hospital. The most recent edition of Robert's Rules of Order Revised will be used to guide parliamentary procedures.

11.1.1. QUORUM. A quorum of any of the following committees shall be a majority of its members.

11.1.2. ACTION. The action of a majority of members present at a meeting at which a quorum is present shall be the action of the committee.

11.1.3. MINUTES. A secretary for each committee will be appointed by the committee Chair. The committee secretary shall keep minutes and forward one copy of those minutes to the appropriate Physician-in-Chief, while retaining another copy as a permanent record of that committee's activities.

11.1.4. CONFIDENTIALITY OF COMMITTEE FUNCTIONS. Confidentiality is essential to the effective functioning of each of the following committees. Accordingly, all records, data and knowledge collected for or by the committees or individuals operating under the direction of such committees shall be confidential to the fullest extent as provided by law. All such records, data, and knowledge shall be used only for the purposes for which the respective committees have been formed and shall not be public record. These committees, and individuals and entities providing information or data to them, when conducting review functions as defined in law are protected, privileged and immune from suit or production of information under State and / or Federal law.

11.1.5. TERM OF APPOINTMENT. Unless otherwise specified in the appointment, appointments to a Medical Staff Committee shall be for a term of one (1) year or until a replacement member is appointed.

11.1.6. DELEGATION. Individuals appointed to a Medical Staff Committee who are unable to attend a meeting of such Committee may delegate their Committee membership for that meeting to another Medical Staff member or qualified individual with the concurrence of the Chair of such Committee with the concurrence of the Department Chief.

11.2. BLOOD AND TISSUE COMMITTEE (CORPORATE)

The Blood and Tissue Committee shall consist of representatives from the Medical Staff of each Hospital and other individuals appointed by the Chief Medical Officer. Its voting membership shall include the Blood Bank Medical Director and Supervisor of each Hospital and physician representatives from major medical and surgical departments that regularly order blood products and use tissue products. Its membership may include as non-voting members representatives from nursing from each Hospital and as ex officio non-voting members appropriate representatives of other Corporate or Hospital departments such as Hospital Administration, Finance, Information Technology, Biomedical Engineering, the Research Institute and / or Medical Information Services. Its Chair shall be a physician appointed by the Chief Medical Officer on a rotating basis. One physician from each of the Hospitals may be appointed as a Vice-Chair to the Committee. The Committee is responsible for ensuring safe, high quality, evidence-based and cost effective use of blood products and tissue at all hospitals within the Beaumont Health System. It shall also: facilitate coordination of clinical services required for compliance with regulatory and accreditation requirements related to blood and tissue utilization; develop reports and recommendations for implementation and maintenance of safe transfusion and tissue use practices and policies, reduction of related errors, and optimal blood and tissue utilization; provide peer review services relating to blood and tissue use at the Hospitals; and provide education for Staff and employees on such issues. The Committee shall be supported by both standing and ad hoc subcommittees consisting of Medical Staff and other appointed individuals as focused experts that recommend policies and practices to the Committee and assist it in the discharge of its functions. The Committee shall meet at least quarterly and report to the Medical Executive Board for each Beaumont Hospital.

11.3. BYLAWS COMMITTEE (CORPORATE)

The Bylaws Committee shall be appointed by the Executive Vice President and Chief Medical Officer and shall be composed of members from each Hospital Staff, including at least six (6) Attending Staff members, at least one (1) physician employee of the Hospital, one (1) or more representative(s) of Medical Administration, and one (1) elected Representative of the Medical Staff from each Hospital, as well as a representative from the Department of Legal Affairs, exofficio, without vote. One Committee member shall serve as Chair of the Committee as appointed by the Chief Medical Officer. Committee members representing each of the Hospitals may be appointed as Vice Chairs to represent the Committee at matters before their Hospital's Medical Executive Board. The Committee shall meet at least annually to review the Bylaws of the Staff to ensure that they remain current and properly reflect developments in administration and procedure and to make recommendations for revision or amendment to the Medical Executive Boards. The Medical Executive Boards may also, prior to the consideration of any proposal, refer proposed amendments or revisions of the Bylaws to the Bylaws Committee for review. At the inception of its annual review, the Bylaws Committee shall notify the Staff in writing and request written suggestions for revision and amendment. If there are recommended changes, the Committee shall submit a written report to the Medical Executive Boards at least annually.

11.4. CANCER COMMITTEE (CORPORATE)

The Corporate Cancer Committee shall consist of at least one (1) board-certified physician representative from surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, pain control, hospice, and shall include the cancer liaison physician. Non-physician membership shall include representatives from Network administration, nursing (IP/OP), social services, cancer registry, clinical cancer trial, pharmacy, nutrition, and quality management.

The purpose of this Committee is to develop and evaluate the annual goals and objectives for the clinical, community outreach, quality improvement, and programmatic endeavors related to cancer. The Corporate Cancer Committee stimulates lifetime follow-up, multidisciplinary consultation and maintenance of a tumor education program compatible with the requirements of the American College of Surgeons for designation as a Network cancer program. This Committee is specifically charged with the responsibility to organize, implement, and evaluate tumor conferences, to assure that cancer rehabilitation services are available and are being used, to review the need for cancer prevention programs, to review the adequacy of cancer patient, pre-treatment, work-up and staging, to document patterns of recurrence of malignancies, and to organize, evaluate, and provide support for the Cancer Registry in its efforts to provide long-term follow-up of all cancer patients treated at the Hospitals and to publish follow-up studies and statistics by primary cancer site. It shall meet every other month in accordance with the American College of Surgeons guidelines and will report to the Chief Medical Officer.

11.5. CONTINUING MEDICAL EDUCATION (CME) COMMITTEE (CORPORATE)

The System CME Committee shall consist of the Chairman of the Committee, the Chiefs (or their representatives) from Medicine, Surgery, Diagnostic Radiology, Emergency Medicine, Obstetrics and Gynecology, and Pediatrics as well as individuals such as the Director of CME, Director of Graduate Medical Education, the Medical Librarian, and other parties with similar interest in CME. The mission of the Committee is to provide high-quality opportunities for life-long learning to practicing physicians and other health care providers, so that they may maintain and improve their knowledge and skills in the care of their patients. The Department of CME and CME Committee are responsible for planning, implementation and coordination of all continuing medical education

programs at Beaumont Hospitals. The Committee establishes policy and assumes responsibility for implementation of Accreditation Council for CME (ACCME) and American Osteopathic Association (AOA) institutional requirements pertaining to Category 1 continuing medical education and reports to the Chief Medical Officer and the Medical Executive Boards. Meetings are held on alternate months with at least four meetings annually.

11.6. CPR COMMITTEE (CORPORATE)

The CPR Committee shall consist of at least two (2) representatives from the Medical Staff of each Hospital and selected representatives from each of the Hospitals and in such areas of nursing, pharmacy, Hospital and Medical administration, inventory control and biomechanical engineering. Its Chair shall be appointed by the Chief Medical Officer on a rotating basis. One physician from each of the Hospitals may be appointed as a Vice-Chair to the Committee. The Committee may be co-chaired by a non-physician member from Nursing as requested by the Chair The CPR Committee strives to ensure appropriate care of patients who experience a cardiopulmonary arrest or similar medical emergency. It is responsible for policies and practices of the CPR Teams, determination of appropriate content and location of resuscitation equipment, and improvement of the CPR process. Where possible, initiatives coming from this committee will be implemented system wide to standardize processes and reduce redundancy. The Committee shall meet no less than twice a year and report to the Medical Executive Board for each Beaumont Hospital. The Committee may be supported by subcommittees representing select disciplines or targeted areas.

11.7. CREDENTIALS AND QUALIFICATIONS COMMITTEES (CORPORATE)

The Corporate Credentials and Qualifications Committees and each Hospital's Credentials and Qualifications Committee are peer review committees to ensure the competent and representative evaluation of Staff appointments, extension of privileges and assignments to various Departments and Sections as well as the discharge of those other review functions as are entrusted to them. The Corporate Credentials and Qualifications Committee shall consist of the Physician-in-Chief of each Hospital; the President of the Medical Staff of each Hospital and the Chair of each Hospital's Credentials and Qualifications Committee with one such Hospital Committee Chair serving as Chair of the Corporate Credentials and Qualifications Committee on a rotating basis as established by the Chief Medical Officer. Three (3) members of the Board of Directors or Trustees and a representative of the Department of Legal Affairs shall serve as nonvoting members. Department Chiefs shall attend as invited. The Corporate Committee, and the Hospital Committees, shall meet as specified in these Bylaws and / or as directed by the Chief Medical Officer.

The voting members of the Credentials and Qualifications Committee of each Hospital shall consist of: a Chair of the Hospital Committee; the Physician-in-Chief of that Hospital; the President of the Medical Staff of that Hospital; the Director of Quality and Safety of that Hospital; the Chiefs of the Departments of Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Emergency Medicine, Family Medicine, Anesthesiology and Radiology of that Hospital; one (1) elected Member at Large of the Medical Staff of that Hospital; and a Chief of a Department of ancillary services as appointed by that Hospital's Physician-in-Chief. A member of the Board of Directors or a Trustee (who shall then become a non-voting member of the Corporate Credentials and Qualifications Committee) and non-voting representative of the Department of Legal Affairs shall serve as members.

The Credentials and Qualifications Committees of each Hospital shall: (1) review credentials and make recommendations for appointment, reappointment or changes in category status, as well as delineation of clinical privileges; (2) report to the Corporate Credentials and Qualifications Committee on each applicant for Staff membership and / or clinical privileges, including specific

consideration of the recommendations from the Departments and / or Sections in which such applicant requests privileges; (3) review periodically all information available regarding the competence and professionalism of Staff members and as a result of such reviews make recommendations for the granting of privileges, reappointments, and the assignment of practitioners to the various Staff categories, Departments and / or Sections; (4) investigate any reported breach of ethics; and (5) review reports that are referred by Medical Executive Boards, and all other Staff, audit and peer review committees.

The Hospital Credentials and Qualifications Committees shall make recommendations on the above matters to the Corporate Credentials and Qualifications Committee, which shall consider the same. The Corporate Credentials and Qualifications Committee may request additional information, return the matter to a Hospital Committee for further investigation or conduct its own investigation or review. It shall make recommendations on these matters to the respective Hospital Medical Executive Boards.

11.8. END OF LIFE CARE COMMITTEE (RO)

The End of Life Care Committee shall consist of the Medical Director of the Palliative Care Consult Service, the Nurse Manager of the Inpatient Hospice Unit, representatives from Hospital and Medical Administration, and representatives from the following departments and services (at a minimum): Anesthesiology / Pain Management, Bioethics, Care Management, Oncology, Pastoral Care, Pharmacy, and Social Work. The Committee shall meet on a regular basis to achieve the following aims: 1) ongoing evaluation of resources, educational programs and practice guidelines needed to assure optimal care for patients at or near the end of life; 2) appropriate coordination of care provided by various disciplines engaged in end of life care; and, 3) attainment of customer service excellence. The Committee shall closely coordinate its activities with those of the Institutional Ethics Committee and the Pain Management Committee; it shall report its findings and recommendations to the Quality and Safety Council.

11.9. GRADUATE MEDICAL EDUCATION COMMITTEE (CORPORATE)

The System Graduate Medical Education Committee shall be chaired by the Director, Graduate Medical Education and shall be composed of voting members to include appropriate Program Directors, other members of the faculty and residents nominated by their peers. The Committee shall be responsible for planning, implementation and coordination of all Residency and Fellowship programs at the Hospital and affiliated institutions. The Committee shall provide recommendations for continuing medical education programs to the Continuing Medical Education Committee. The Committee shall be responsible for implementation of ACGME Institutional Requirements pertaining to Graduate Medical Education. The Committee shall meet at least quarterly and report to the Chief Medical Officer and Medical Executive Boards.

11.10. INFECTION CONTROL COMMITTEES

The Infection Control Committee of each Hospital shall consist of those Staff members and Hospital personnel who have special knowledge, skills or interest in the problem of hospital infection and their sequelae. These Committees shall have the responsibility for surveillance of inadvertent hospital infection potentials and cases as well as for the promotion of a preventative and corrective program designed to minimize those hazards. They shall meet at least every other month and report to the Quality and Safety Council (RO) and Medical Executive Board (RO), Medical Executive Board (TR), and Quality Care and Safety Committee (GP).

11.11. MEDICAL LIBRARY COMMITTEE (CORPORATE)

The Corporate Medical Library Committee shall consist of those Staff members and Hospital personnel whose departments are major users of the collections and services of the Library Information Services Department. The Committee shall assure itself of the adequacy and quality of the collections contained in the Medical Libraries at the Royal Oak and Troy Libraries and of the electronic knowledge-based resources networked throughout the Corporation. It shall advise the Director of the Library Information Services Department on collection development, departmental goals and objectives, performance improvement and resource allocation. It shall meet at least quarterly.

11.12 MEDICATION MANAGEMENT COMMITTEE (CORPORATE)

The Medication Management Committee shall consist of at least two (2) representatives from the Medical Staff of each Hospital and one (1) representative from each Hospital's Pharmaceutical Service, Nursing Service and Hospital Administration. Its Chair shall be appointed by the Chief Medical Officer on a rotating basis. One physician from each of the Hospitals may be appointed as a Vice-Chair to the Committee. The Committee shall be supported by subcommittees representing select medical / surgical disciplines or targeted area of medication management. The Medication Management Committee is responsible for the development and surveillance of all drug utilization policies and practices within the Beaumont Health System in order to assure optimal clinical results and a minimal potential for hazard. The Committee shall assist in the formulation of all policies concerning drugs within the Hospitals, including, but not limited to, the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, drug reactions, and the clinical use and review of all pharmaceuticals. The Committee shall meet at least every other month and report to the Medical Executive Board for each Beaumont Hospital. Subcommittee membership shall consist of Medical Staff representing that discipline and other pertinent healthcare practitioners. Component subcommittees are considered focused groups of experts that recommend medication-related policies and practices to the Medication Management Committee.

11.13. NUTRITION COMMITTEE (CORPORATE)

The Nutrition Committee shall consist of multidisciplinary voting representatives appointed by the Chief Medical Officer, including at least one physician representative from the Medical Staff of each Hospital with special expertise in nutrition; each Hospital's director or administrator of nutrition services or support, and appropriate nutrition services or support managers; one Nursing and one Pharmacy representative from any of the Hospitals; and a non-voting representative of Hospital Administration, as well as such other voting and non-voting members as may be appointed by the Chief Medical Officer on a rotating basis. One physician from each Hospital may be appointed as Vice Chair to the Committee. The Committee shall be supported by subcommittees representing subject matter areas such as enteral, parenteral, ambulatory nutrition and targeted areas of nutrition services, support and management. Subcommittee membership shall consist of Medical Staff representing the appropriate disciplines and other pertinent healthcare practitioners and shall make recommendations on policies and practices to the Nutrition Committee. The Nutrition Committee shall engage in review of clinical practices, research, education, oversight of regulatory and nutritional practices and other activities. It shall assist in ensuring that all patients of the Beaumont Health System receive safe, optimal nutrition care through the development of guidelines and procedures based on scientific evidence, clinical care standards, best management practices, education, cost containment, and performance

improvement activities. The Committee shall meet at least quarterly and report to the Medical Executive Board for each Beaumont Hospital.

11.14. OPERATING ROOM COMMITTEE (RO)

The Operating Room Committee shall consist of the Chief and Vice-Chief of the Department of Surgery, Chief of the Department of Anesthesiology, Department Chiefs and Sections Heads within Surgery, the Assistant Hospital Director for Surgery, the Operating Room Management Group (Operating Room Executive Committee), and other appropriate personnel from the Operating Room, Central Processing Department, Anesthesia, perioperative areas, Suite 100, Cancer Center and Advance Testing areas. This committee shall establish regulations, policies, procedures and standards that impact practice in the OR. In addition, the Committee shall serve as a forum for discussion and decision-making by Hospital and medical OR leadership. The OR Committee may refer issues to the OR Executive Committee. The Committee shall meet monthly and report to the appropriate Physician-in-Chief and Medical Executive Board.

11.15. PRESIDENT'S COUNCIL

Each Hospital will have a President's Council chaired by the President of the Medical Staff and include the elected Medical Staff representatives. Other individuals may be invited to participate. The Council will serve as a forum to exchange ideas and develop strategies designed to make it easier for our Medical Staff to practice excellent medicine. In addition, the Council will also advise the President on matters related to Medical Staff activities, review and approve the Medical Staff budget and unbudgeted expenditures greater than five thousand ($5,000.00) dollars. It may consider matters in review of the professional practices of the Medical Staff of the Hospital.

11.16. QUALITY AND SAFETY COUNCIL (RO)

This multidisciplinary group will meet monthly and include representation from multiple clinical areas and hospital administration. The Council will review quality and safety results to prioritize efforts and programs to ensure we attain benchmark performance. Examples of areas reviewed by this Committee will include (but not be limited to): Patient Safety (including Safety Culture and Sentinel Event Review), Infection Control, Core Measures, Pay for Performance measures, Regulatory Compliance and departmental quality metrics and initiatives. The Council will focus its monthly agenda on items requiring discussion, problem-solving and decision-making by a multidisciplinary group. Informational (such as departmental quality committee minutes) and non controversial approval items will be sent to committee members for review and approval by assent.

11.17. QUALITY CARE AND SAFETY COMMITTEE (GP)

This Committee shall consist of at least the Chiefs of the Departments of Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Anesthesiology, Pathology, Laboratory Medicine, Radiology and Emergency Medicine, and representatives from Nursing and Hospital Administrations. Such Committees shall meet at least ten (10) months a year to evaluate the quality of medical care provided all patients at the Hospital, shall recommend policy regarding patient care to their Medical Executive Board, and shall provide reports and recommendations to other committees as appropriate. This Committee shall receive reports of the Transfusion, Infection Control, Pharmacy & Therapeutics, Cancer and Special Care Units Committees and shall review all departmental audits.

The Chief of Department or Section Head shall establish audits to review procedures and the results of the examination of bodily fluids and tissues removed by members of their respective Departments.

11.18. RADIATION SAFETY COMMITTEE (CORPORATE)

The Radiation Safety Committee shall be composed of representatives from Medical Physics, Nuclear Medicine, Radiation Oncology and Diagnostic Radiology and others as appointed by the appropriate Physician-in-Chief. The Committee will be responsible for the approval and review of all radioactive materials and other modalities of ionizing radiation used at the Hospitals and the Research Institute in accordance with the regulations of the Nuclear Regulatory Commission. It shall meet at least quarterly and report to the Quality and Safety Council (RO) or Hospital Safety Committee (Troy).

11.19. SPECIAL CARE UNITS COMMITTEES

The Special Care Units Committees of each Hospital, including committees of the Adult Intensive Care Units, Cardiac Care Unit, Critical Care Unit (Troy) Obstetrical Patient Care Unit, and Pediatric and Neonatal Intensive Care Units, shall consist of relevant Department Chiefs, Section Heads and Directors of Special Care Units, as well as appropriate members of the Staff and the Nursing Administrative Staff. These committees shall establish and implement the standards of medical and nursing care of these units, assure the functioning, safety and quality of equipment, as well as the availability of properly trained personnel. They shall meet at least quarterly and report to the Quality and Safety Council (RO) or Medical Executive Board (TR).

11.20. TRAUMA CARE COMMITTEE (RO)

The Trauma Care Committee shall consist of all trauma surgeons, the trauma nurse coordinator and representatives from Neurosurgery, Orthopedic Surgery and Emergency Medicine. The Committee shall review all trauma morbidities and mortalities, communicate its findings to the involved physicians as appropriate and recommend policy or practice change through the Trauma Task Force Committee. It shall meet on a monthly basis and report to the Quality and Safety Council.

11.21 UTILIZATION MANAGEMENT COMMITTEE (RO, TROY & GP)

The Committee shall be composed of sufficient designated members to study the entire range of patient care services in order to determine those factors, which may insure proper, necessary and efficient use of the Hospital services and facilities. The purpose of the Utilization Management Committee is to aid physicians in providing quality-driven care; utilizing Hospital processes to achieve efficient care; optimizing the use of institutional resources; by serving as an educational resource; and by providing data and reports relative to efficiency and utilization issues. The committee shall meet quarterly and report to the Medical Executive Board (RO), Medical Executive Board (TR) and Medical Executive Board (GP).

11.22. SPECIAL COMMITTEES

Other special and standing committees may be appointed by the appropriate Physician-in-Chief from time to time as may be required to carry out properly the duties of the Staff and the requirements of these Bylaws. They shall not have authority to establish medical policy except as

such authority is extended by recommendation to the Medical Executive Boards with the approval of the Board of Directors.

XII

AMENDMENTS TO BYLAWS OR RULES / REGULATIONS / POLICIES

12.1. AMENDMENTS TO BYLAWS OR RULES / REGULATIONS AND POLICIES

These Bylaws and Rules / Regulations / Policies may be amended only in accordance with the following procedures. Policies may be created or amended by the Medical Executive Boards.

12.2. INITIATION OF AMENDMENTS

Recommendations for amendments to Bylaws and Rules / Regulations / Policies shall be initiated by or through the Bylaws Committee of the Medical Staff, the Physicians-in-Chief, the Medical Executive Boards, or the Board of Directors without submission to or approval of the Bylaws Committee.

12.3. PROCEDURE

If amendments to Bylaws or Rules / Regulations / Policies are proposed to be adopted by any Medical Executive Board, such proposed amendments shall first be presented at such Hospital's next regular or special Medical Staff meeting or through some other means for review and for approval in the case of a proposed Bylaw amendment. Adoption of an amendment to a Bylaw or Rule and Regulation by a Medical Executive Board shall be communicated to its Medical Staff.

If amendments to Bylaws or Rules / Regulations / Policies are proposed to be adopted by any Hospital's Medical Staff, such amendments shall first be presented at such Hospital's Medical Executive Board's next regular or special meetings or through some other means for review and approval, and shall be communicated to its Hospital's Medical Executive Board if adopted by the Medical Staff. However, any Medical Staff which does adopt such amendments may propose them directly to the Board of Directors through its Patient Care and Quality Committee for disposition as that Committee directs.

12.4. PROPOSAL AND APPROVAL, CONFLICT

Amendments of Rules / Regulations / Policies approved by any or each Medical Executive Board and amendments of these Bylaws approved by any or each Medical Executive Board(s) and / or any or each Medical Staff shall then be proposed to the Patient Care and Quality Committee and Board of Directors and shall be effective when approved by the Board of Directors. Conflicts arising out of such proposed amendments, or any other matter between the Medical Staff(s) and the Medical Executive Board(s) and or Medical Staff members, shall be addressed through the conflict resolution procedures of the Patient Care and Quality Committee as determined by its Chair.

12.5. URGENT AMENDMENTS

In cases of documented need for an urgent amendment to the Rules / Regulations / Policies necessary to comply with law or regulations, the Medical Executive Board(s) may provisionally adopt, and the Board of Directors may provisionally approve, an urgent amendment without prior notification of the Medical Staffs. In such cases, the Medical Staffs will be immediately notified by the Medical Executive Board(s). The Medical Staffs will have the opportunity for retrospective

review of and comment on the provisional amendment. If there is no conflict between the Medical Staffs and the Medical Executive Board, the provisional amendment stands. If there is conflict over the provisional amendment, that conflict shall be referred to the Patient Care and Quality Committee for resolution as determined by that Committee's Chair. If necessary, a revised amendment is then submitted to the Board of Directors for action.

12.6. ADOPTED BYLAWS AND RULES / REGULATIONS / POLICIES

Bylaws and Rules / Regulations / Policies approved by the Board of Directors shall be communicated to each Medical Staff.

XIII

AUTHORIZATIONS AND IMMUNITY FROM LIABILITY

13.1. EXPRESS CONDITIONS

The following shall be express conditions to any applicant or Staff member's application for, or exercise of Staff membership or clinical privileges at these Hospitals.

13.1.1. GOOD FAITH DISCLOSURES PRIVILEGED. Any act, communication, report, recommendation, or disclosure, with respect to the professional ability and qualifications of any such individual made in good faith and without malice at the request of an authorized representative of this or any other health facility or review entity, for the purpose of achieving and maintaining the quality of appropriate patient care in this or any other health facility, shall be privileged to the fullest extent permitted by law.

13.1.2. EXTENSION OF PRIVILEGE. Such privileges shall extend to members of the Board of Directors, the Trustees, the Staff and its officers and committees and to third parties who supply information to any of the foregoing authorized to receive, release or act on the same. For the purpose of this Article the term "third parties" means both individuals and organizations from which information has been requested by an authorized representative of the Hospital.

13.1.3. IMMUNITY FROM LIABILITY. There shall be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even where the information involved would otherwise be deemed privileged.

13.1.4. SCOPE OF IMMUNITY. Such immunity shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

(a) application for appointment or clinical privileges;

(b) periodic reappraisals for reappointment or clinical privileges;

(c) corrective action, including immediate action;

(d) hearings and appellate reviews;

(e) medical care evaluations;

(f) utilization reviews;

(g) peer or professional review organizations, activities or procedures;

(h) other Hospital, Department, Section, program or committee activities related to quality patient care and inter-professional conduct.

13.1.5. NATURE OF INFORMATION. The acts, communications, reports, recommendations and disclosures referred to in this Article may relate to an applicant or Staff member's professional qualification, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on maintaining the quality of appropriate patient care.

ARTICLE

13.1.6. **EXECUTION OF RELEASES.** Each applicant or Staff member shall upon request of the Hospitals execute releases as required by the individuals and organizations described above.

13.1.7. AUTHORIZATION FOR CONSULTATION AND REVIEW. The applicant or Staff member authorizes the Hospitals, the Board of Directors, the Trustees, the Staff and their officers and committees to consult with members of the medical staffs of other hospitals with which the applicant or Staff member is or has been associated and with others who may have information bearing on his / her competence, character and ethical qualification. Furthermore, the applicant or Staff member consents to the Hospitals' inspection of all records and documents that may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges requested or maintained as well as their moral and ethical qualifications for Staff membership. The applicant or Staff member also releases from any liability all representatives of the Hospitals and their Staff for their acts performed in good faith and without malice concerning the applicants or Staff member's competence, ethics, character and other qualifications for Staff appointment and clinical privileges, including otherwise privileged or confidential information.

13.1.8. CONFIDENTIALITY OF INFORMATION. The applicant or Staff member recognizes and agrees that all records (including, without limitation, medical records), information, data and knowledge respecting professional practice review functions of the Hospitals are required to be kept confidential pursuant to federal and state law, including without limitation, proceedings for appointment, reappointment, advancement, denial or termination of appointment; reduction, suspension or termination of privileges; transfer to any other division of the Staff; and the work of committees and individuals assigned professional practice review functions pursuant to these Bylaws, the Rules / Regulations / Policies and the policies and procedures of the Hospitals and the Staff, and that dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Staff, or with the express approval of the Medical Executive Boards or their designee(s). The applicant or Staff member specifically agrees to keep all such information confidential, recognizing that any breach of such confidentiality may result in the Medical Executive Boards undertaking such action as they deem appropriate.

XIV

DUES

14.1. CATEGORIES ASSESSED

Annual Dues, as determined by the Medical Executive Boards, shall be required of members of the Attending Staff, Associate Staff, Institutional Staff, Adjunct Staff, Administrative Staff, Bioscientific Staff, Affiliate Staff and Ambulatory Staff are payable as billed annually.

14.2. CATEGORIES NOT ASSESSED

Members of the Limited, Honorary Consulting, Emeritus, and Retired Staff shall not be assessed dues. They shall be assessed for the cost of each Hospital function (e.g., the Annual Dinner Dance, Annual Meeting) if they wish to attend.

14.3. PRORATION

Dues of members joining the Staff during the designated Staff year shall be prorated for the appropriate fraction of that Staff year.

14.4. PAYMENT OF DUES

Unless extenuating circumstances are presented to and accepted by the Medical Executive Boards non-payment of dues shall be grounds for suspension, termination, or declining reappointment to the Staff.

14.5. EXPENDITURES

At each Hospital, expenditure of funds from the Medical Staff Fund may be authorized by the Presidents of the Medical Staff. The President of the Medical Staff and the President's Council shall review and approve the Medical Staff budget and unbudgeted expenditures greater than five thousand ($5,000.00) dollars, and report a summary of such budget and all unbudgeted expenditures greater than five thousand ($5,000.00) dollars at the Medical Executive Board. The Secretary-Treasurer will submit an annual report of the Medical Staff Fund at the Medical Staff Meeting in December of each year.

ARTICLE XV STAFF DISASTER ASSIGNMENTS

15.1. ASSIGNMENTS

A written plan for the care of mass casualties coordinated with the Inpatient and Ambulatory Services of the Hospital, as currently formulated, adopted or hereafter modified, shall be maintained at all times. All members of the Attending and Associate Staffs must fulfill Staff disaster assignments. Failure to fulfill this assignment will be reported to the Medical Executive Boards and may be grounds for declining reappointment to the Staff.

15.2. DISASTER PRIVILEGING

In a state of emergency when the emergency management plan has been activated and the Hospital is unable to meet immediate patient needs, external licensed independent practitioners (LIPs) or Mid-Level Providers (who volunteer to assist the Hospital) may be privileged on an emergency basis as needed to care for the Hospital's patients. The Physician-in-Chief or designate has the authority to emergently privilege appropriate licensed independent practitioners or mid-level providers, but is not required to grant disaster privileges to any individual. Specific credentialing, privileging, and patient care oversight details are outlined in the Disaster Volunteers Policy.