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**MEDICAL STAFF BYLAWS
THE UNIVERSITY OF TENNESSEE MEMORIAL HOSPITAL**

PREAMBLE

WHEREAS, The University of Tennessee Memorial Research Center and Hospital (“Hospital”) is an academic teaching hospital providing patient care facilities and services, including the provision of specialized care, which is customarily available at academic medical centers to the underserved population of its service area; and

WHEREAS, a part of the mission of the Hospital is the support of medical research and education; providing a patient base for training physicians, dentists, nurses and other health professionals; supporting clinical and basic research and research training; and

WHEREAS, The University of Tennessee (“University”) has delegated, pursuant to the statutory authorizations of Tennessee Code Annotated Section 49-9-112 and 49-9-1301, et seq., the governance, management and operation of the Hospital to University Health System, Inc. (“UHS”); and

WHEREAS, The Board of Directors of UHS, as defined in the Charter of UHS, pursuant to this delegation of authority is the Governing body of the Hospital with the full power to oversee and direct the operations of the Hospital; and

WHEREAS, the Governing Body has delegated to the Medical Staff the initial responsibility to monitor the quality of medical care in the Hospital and the Medical Staff must accept and discharge this responsibility, subject to the ultimate authority of the Governing body; and

WHEREAS, the Medical Staff and others as outlined under these Bylaws along with UHS cooperate, pursuant to 45CFR§164.501 regarding activities contemplated by the Health Insurance Portability and Accountability Act of 1996; and

WHEREAS, it is recognized that the cooperative efforts of the Medical Staff, Hospital Administration and the Governing Body are necessary to fulfill the Hospital’s responsibility to its patients; and

WHEREAS, these Bylaws may not be unilaterally amended by either party;

NOW, THEREFORE, these bylaws are adopted to organize the Medical Staff as part of the Hospital for the purposes described and to establish a framework within which these purposes may be carried out, subject to amendment from time to time, and subject to the ultimate authority of the Governing Body.

DEFINITIONS

The following terms as used in these Bylaws shall have the meaning ascribed to them unless the context clearly requires otherwise.

1. **“ACGME/AMA”** means the Accreditation Council for Graduate Medical Education of the American Medical Association.
2. **“ADVERSE ACTION”** means an action which adversely affects a Practitioner’s appointment to or status as a member of the Medical Staff, or a Practitioner’s request for or exercise of Clinical Privileges.
3. **“ADVERSE RECOMMENDATION”** means a recommendation which would, if implemented, adversely affect a Practitioner’s appointment to or status as a member of the Medical Staff, or a Practitioner’s request for or exercise of Clinical Privileges.
4. **“ALLIED HEALTH PROFESSIONAL”** or **“AHP”** includes psychologists, podiatrists and other persons as recommended by the Medical Staff and approved by the Governing Body, who are licensed to practice their profession in Tennessee and who are permitted by law to perform defined patient care services appropriate to an inpatient setting independent of direct Physician supervision.
5. **“AOA”** means The American Osteopathic Association.
6. **“BYLAWS”** means the Bylaws of the Medical Staff.
7. **“CHANCELLOR”** means the individual who is the Chancellor of The University of Tennessee, Memphis.
8. **“CHIEF ADMINISTRATIVE OFFICER”** means the individual designated by the President and Chief Executive Officer of UHS to act in their behalf in the overall management of the Hospital.
9. **“CLINICAL PRIVILEGES”** means the rights granted by the Governing Body to Practitioners or AHPs to provide specific patient care services in the Hospital within defined limits, based on the individual’s license, education, training, experience, competence, health status and judgement; and based also on the available facilities, services and capacity of the Hospital.
10. **“CODA/ADA”** means the Commission on Dental Accreditation of the American Dental Association.
11. **“CREDENTIALS COMMITTEE”** means the Credentials Committee of the Medical Staff.
12. **“DEAN”** means the chief academic and administrative officer of the Graduate School of Medicine as appointed by the Chancellor with the concurrence of the President and

Chief Executive Officer of UHS. The Dean shall also serve as the Director of Health Professions Education for Hospital.

13. **“DECISION-MAKING BODY”** means the Executive Committee in all cases where the Executive Committee makes an Adverse Recommendation or takes an Adverse Action, and means the Governing Body in all cases where the Governing Body proposes to take an Adverse Action.
14. **“DENTIST”** means an individual holding a D.D.S., (Doctor of Dental Surgery or Doctor of Dental Science) or D.M.D. (Doctor of Dental Medicine) degree.
15. **“EXECUTIVE COMMITTEE”** means the Executive Committee of the Medical Staff.
16. **“GOOD STANDING”** means a Medical Staff member, at the time the issue is raised, has met the attendance and committee participation requirements during the previous Medical Staff year and has not received a suspension or curtailment of his/her appointment or Clinical Privileges in the previous 12 months other than for medical records delinquency.
17. **“GOVERNING BODY”** means the Board of Directors of UHS as defined under the Charter of UHS.
18. **“GSM”** means The University of Tennessee Graduate School of Medicine located in Knoxville.
19. **“HOSPITAL”** or **“UTMH”** means The University of Tennessee Memorial Research Center and Hospital.
20. **“HOSPITAL ADMINISTRATION”** means the Chief Administrative Officer and individuals designated by the Chief Administrative Officer as Directors of the major operational divisions of the Hospital, and the Chairs, Directors, Managers and/or Chiefs of the various Hospital Services, Departments and Divisions as a group.
21. **“HOSPITAL POLICY”** means the policies and procedures adopted from time to time by the Governing Body with respect to the operations of the Hospital.
22. **“HOSPITAL REPRESENTATIVES”** means the Governing Body; the Chief administrative officer or designees; the Medical Staff organization and all Medical Staff members and committees that have responsibility for collecting, verifying and/or evaluating an applicant’s credentials or acting upon his/her application; all Hospital employees who have any responsibility for collecting, verifying and/or evaluating an applicant’s credentials or acting upon his/her application: and anyone assisting any of the foregoing.
23. **“JCAHO”** means the Joint Commission on Accreditation of Healthcare Organizations.

24. **“MEDICAL STAFF”** means the organization of Physicians and Dentists who have been granted membership on the Medical Staff of the Hospital by the Governing Body.
25. **“NOTICE”** means a writing that is sent to its intended recipient via certified or registered mail, return receipt requested, or by overnight courier service such as FedEx or UPS, or is delivered by hand, and, if sent by Hospital, that is sent or delivered to the most current address of the intended recipient on file with the Hospital.
26. **“PHYSICIAN”** means an individual holding the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy).
27. **“PRACTITIONER”** means a Physician or Dentist.
28. **“RULES AND REGULATIONS”** means the General Rules and Regulation of the Medical Staff and the various Departmental Rules and Regulations.
29. **“UHS”** – a Tennessee non-profit corporation, established pursuant to actions of the General Assembly of the State of Tennessee under Tennessee Code Annotated Section 49-9-112 and 49-9-1301 et seq., having as one its functions the responsibility for governance, management, and operation of The University of Tennessee Memorial Research Center and Hospital.
30. **“THE UNIVERSITY”** means The University of Tennessee.
31. **“THE UNIVERSITY OF TENNESSEE MEDICAL CENTER AT KNOXVILLE”** or **“UTMCK”** means the Hospital, including all patient care facilities in Knoxville and all activities associated therewith and also include all units of the GSM.

RULES OF CONSTRUCTION

These Bylaws, as adopted and as amended from time to time are intended to provide reasonable notice of the standards for medical staff membership and Clinical Privileges as well as to set forth provisions for the organization and operation of the Medical Staff. Procedures set forth and related procedural deadlines are intended to be guidelines. The Medical Staff shall be entitled to apply such guidelines with flexibility and failure on the part of the Medical Staff to follow them strictly shall not be a basis for any cause of action. These Bylaws are not intended to create a contract, except where express agreements required of Practitioners are set forth. In cases of dispute, the interpretation of the Governing Body shall be final. Whenever the context hereof requires, the gender of all words shall include the masculine, feminine, and neuter, and the number of all words shall include the singular and plural.

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of The University of Tennessee Memorial Research Center and Hospital.

ARTICLE II. PURPOSES AND RESPONSIBILITIES

SECTION 1. PURPOSES

The purposes of the Medical Staff are:

- a. to strive to assure that all patients admitted to or treated in the Hospital receive the best possible medical care consistent with the resources available;
- b. to be accountable to the Governing Body for the quality and appropriateness of the professional performance of all individuals exercising Clinical Privileges in the Hospital;
- c. to assist the Governing Body to provide and to maintain an appropriate educational setting that will elevate scientific standards and lead to advancement in professional knowledge and skills of Practitioners and enrolled students, and that will support high quality research programs;
- d. to recommend, and to regularly, and as necessary, review and propose revisions to, the Bylaws and the Rules and Regulations consistent with all applicable laws, regulations and standards;
- e. to provide a means whereby issues concerning the Medical Staff and the Hospital may be discussed by representatives of the Medical Staff with the Chief Administrative Officer and representatives of the Governing Body;
- f. to cooperate with the medical programs of The University;
- g. to participate in long range planning for the Hospital in order to assist Hospital Administration and the Governing Body in effectively meeting their continuing responsibility for the appropriate development of programs and facilities; and
- h. to initiate and maintain rules and regulations for self-government of the Medical Staff.

SECTION 2. RESPONSIBILITIES

- a. to be accountable for and to continuously seek improvement of the quality and appropriateness of patient care provided in the Hospital, and to strive to assure the protection of the rights of each patient, through the following measures:
 - i. a credentialing process, including mechanisms for appointment and reappointment, and the matching of clinical privileges to be exercised or of specified services to be performed, with the verified credentials and current demonstrated performance and abilities of the applicant, staff member, Allied Health Professional or other health professionals;

- ii. a continuing education program, based at least in part on needs demonstrated through the performance improvement process of the Medical Staff;
 - iii. a utilization management program to allocate inpatient and outpatient medical and health services based upon patient specific determinations of individual medical needs;
 - iv. an organizational structure that allows continuous monitoring of patient care practices as well as continuous efforts to improve organizational performance, and
 - v. review and evaluation of the quality of the patient care, and protection of patient rights through a valid and reliable patient care audit procedure intended, among other things, to seek to assure that all patients with the same health problems are receiving the same level of care throughout the Hospital.
- b. to recommend action to the Governing Body with respect to appointments, reappointments, Medical Staff category, Clinical Privileges, and corrective action,
 - c. to initiate and pursue corrective action with respect to Practitioners and Allied Health Professions, when warranted,
 - d. to provide an educational environment wherein medical doctors, dentists, students, interns, residents, fellows and other health care professionals may have the opportunity to become highly skilled in their particular discipline and where other Physicians and health professionals may return for continuing education,
 - e. to develop, administer and seek compliance with these Bylaws, the Rules and Regulations, and other patient care related Hospital policies,
 - f. to work to assure compliance with the JCAHO standards, all applicable licensure regulations and the conditions of participation for hospitals in Medicare and Medicaid or any successor programs,
 - g. to work with the Hospital in meeting the requirements of any third party payor or managed care plan with which the Hospital has a contract or seeks a contract, and
 - h. to provide leadership in Hospital-wide, multidisciplinary improvement efforts through the following measures:
 - i. by establishing a process to design, monitor, analyze, and improve the clinical activities of the Hospital;
 - ii. by establishing a process for the continuous monitoring of the professional performance of all individuals in each department who have delineated Clinical Privileges;
 - iii. for continuous assessment and improvement of the quality of care and services provided;
 - iv. for maintenance of quality control programs (as appropriate);
 - v. for communicating the findings, recommendations, and actions from this process to the appropriate Medical Staff members, including department chairs when practitioner-specific issues are identified;

- vi. for reporting at least quarterly to the Performance Improvement Council, the Executive Committee, and the Governing Body.
- i. to exercise the authority granted by these Bylaws as necessary to fulfill the foregoing responsibilities.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege which shall be extended only to professionally competent Physicians and Dentists who continuously meet the qualifications, standards and requirements set forth in these Bylaws, the Rules and Regulations and in Hospital policies, and who obtain, where required, an academic appointment to the faculty of the GSM. Membership on the Medical Staff is in the nature of a license to exercise only such Clinical Privileges within the Hospital as are specifically granted by the Governing Body in accordance with these Bylaws. A member of the Medical Staff is neither an employee nor an independent contractor of the Hospital, unless such a relationship (a) is separately established by contract between the Hospital and such Medical Staff member or (b) is otherwise recognized in writing by the Hospital.

SECTION 2. QUALIFICATIONS FOR MEMBERSHIP

Every Practitioner who requests or has been granted medical Staff membership must, at the time of appointment and continuously thereafter, demonstrate to the satisfaction of the Medical Staff and the Governing Body the following qualification.

- a. **Licensure.** A currently valid license issued by the State of Tennessee to practice medicine, osteopathy or dentistry.
- b. **Professional Preparedness.** Professional education, training, experience and clinical results, confirmed by reliable documentation, that reasonably assure the ability to provide patient care services for which Clinical Privileges are requested, of a quality acceptable to the Medical Staff and the Governing Body. This requirement shall include documentation and attendance at continuing education as required by any state or federal law, by any clinical department(s) in which the practitioner is appointed, or as otherwise required by the Medical Staff and as otherwise applicable to him/her. On and after the final approval of these Bylaws all applicants when considered by the Governing Body for initial staff appointment shall be required to have demonstrated satisfactory completion of a residency program accredited by the ACGME/AMA, the AOA or the CODA/ADA.
- c. **Authorization to Prescribe.** Currently valid and unrestricted authorization, from both State and Federal governments, to prescribe medications. The practitioner may possess a restricted authorization provided that the practitioner possessing such restricted authorization must actively participate in and comply with all requirements of an advocacy program recognized by or under the direction of the Tennessee Board of Medical Examiners, The Tennessee Board of Dental Examiners, or The Tennessee Board of Osteopathic Examiners.

- d. **Professional Conduct and Willingness to Assist in Fulfilling Staff Responsibilities.** A willingness and capability, based on evidence of performance and documented references:
- i. to work with and relate to other Medical Staff members, members of other health disciplines, Hospital Administration, Hospital employees, and Hospital Representatives, visitors and the community in general, in a positive, cooperative and professional manner that is consistent with the need of the Hospital to maintain a harmonious working environment for all of its employees, and an environment conducive to quality patient care,
 - ii. to participate equitably in the discharge of Medical Staff obligations and the responsibilities of Medical Staff membership,
 - iii. to adhere to the standards of ethics applicable to his/her profession,
 - iv. to give complete and accurate information in all documents and records relating to care provided in the Hospital, and also in all communications with Hospital Representatives and Medical Staff committees, and to acknowledge that dishonesty or intentional misrepresentation, including material omissions, in any such document, record or communication may be a basis for denial or termination or restriction of Medical Staff membership or Clinical Privileges, and
 - v. to cooperate, in all respects, with the corrective action process provided for in the Bylaws.
- e. **Professional Liability Insurance.** Maintenance and provision of evidence of professional liability insurance in not less than the minimum amount, if any, established by resolution of the Executive Committee and approved by the Governing Body, and with an insurance company and on terms, including, when necessary, to provide full coverage with respect to services provided at the Hospital, “prior acts” or “tail” coverage, acceptable to the Governing Body. The limits of insurance required may vary depending on the individual’s employment status, specialty, category of Medical Staff membership and the Clinical Privileges granted.
- f. **Clinical Activity.** Performance of a sufficient number of procedures, management of a sufficient number of cases, or otherwise have sufficient patient care contact with the Hospital to permit the Medical Staff to assess and monitor the Practitioner’s current competency for all Clinical Privileges, whether being requested or previously granted. Any Practitioner requesting to perform a procedure/task/activity/privilege not included within the then current list of privileges for the particular category of privileges for the specific Practitioner will be required to submit appropriate evidence of additional qualifications and competencies, as well as, evidence that the requested activity/task/procedure can be supported by and will be conducted within the hospital.
- g. **Absence of Impairment.** Freedom from any significant physical, mental or behavioral impairment that interferes with, or presents a substantial probability of

interfering with patient care, the exercise of Clinical Privileges, the assumption or discharge of required responsibilities, or cooperative working relationships.

- h. **Compliance with Bylaws, etc.** Continued Medical Staff membership shall require the Practitioner's compliance with these Bylaws, the Rules and Regulations, applicable Hospital policies and, when appropriate, the Principles of Medical Ethics of the American Medical Association, or the code of ethics of the American Dental Association, and all of which are incorporated by reference as part of these Bylaws.

SECTION 3. OTHER CONSIDERATIONS REGARDING MEMBERSHIP ELIGIBILITY

- a. **Hospital and Community Need, and Ability to Accommodate.** In acting on new applications for Medical Staff membership and Clinical Privileges, consideration must be given to, and an explicit finding made concerning, the Hospital's current and projected patient care needs and the Hospital's ability to provide the facilities, beds and support services that will be required if the application is acted upon favorably. In making these required need/ability determinations, consideration will be given to utilization patterns, present and projected patient mix, actual and planned allocations of physical, financial and human resources to general and specialized clinical and support services, and the Hospital's and Medical Staff's general and specific goals and objectives as reflected in the Hospital's short and long range plans.
- b. **Effect of Other Affiliations.** No Practitioner has any right to membership on the Medical Staff or to the exercise of particular clinical privileges merely because he is licensed to practice in this or any other state, because of membership in any professional organization, because of certification of any clinical board or for any other reason. Nor does any Practitioner have any right to appointment, reappointment or particular privileges merely because he had, or presently has, staff membership or those particular privileges at the Hospital.
- c. **Nondiscrimination.** No aspect of Medical Staff membership or particular Clinical Privileges shall be denied on the basis of age, sex, race, creed, color, handicap or national origin.

SECTION 4. RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Unless specifically provided otherwise in these Bylaws, each member of the Medical Staff, regardless of the member's assigned Medical Staff category, and each Practitioner exercising temporary privileges under these Bylaws, shall:

- a. provide care to his/her patients with that degree of skill, diligence and efficiency practiced by, or expected of, a reasonably prudent Practitioner in the same field of practice or specialty under comparable circumstances;
- b. discharge in a timely and effective manner all Medical Staff, committee and Hospital functions for which he is responsible;

- c. abide by the Bylaws, the Rules and Regulations, and by all other established standards, policies and rules of the Medical Staff or, where applicable, of the Hospital;
- d. prepare and complete in timely fashion the medical and other required records, including but not limited to, history and physical examination, for all patients he admits or in any way provides care to in the Hospital;
- e. abide by the standards of ethics applicable to his/her profession;
- f. satisfy the continuing education requirements established by the Medical Staff or otherwise applicable to him/her;
- g. promptly notify the Chief Administrative Officer in writing of, and provide written consent for the release to the Chief Administrative Officer of all records or other documentation relating to:
 - i. any voluntary or involuntary loss, reduction, restriction, or relinquishment of his/her staff membership or clinical privileges held at any other hospital or other health care institution which has occurred since such information was last furnished to the Hospital;
 - ii. any pending investigation or focused review, known to the Practitioner, initiated by any other hospital or other health care institution or its medical staff which has occurred since such information was last furnished to the Hospital;
 - iii. any successful or currently pending challenge to any licensure or registration issued to him/her by any state or federal agency or the imposition of any other sanction or restriction by any such entities, or the voluntary relinquishment of such licenses or registration;
 - iv. the payment on his/her behalf, of any sum, or the entry of any final adverse judgment as a result of allegations of professional liability;
 - v. any loss or restriction of his/her professional liability insurance coverage, or
 - vi. any notice from a Professional Review Organization (PRO), or any successor organization, confirming a final adverse adjudication of violation by him/her of any Medicare standards or requirements relating to the quality of care provided by the member or relating to inappropriate utilization of services by him/her;
- h. efficiently and effectively utilize the Hospital's services and facilities while not compromising quality of care;
- i. agree to be available to provide coverage to patients in the Hospital's emergency department as requested and to respond promptly when called to render such service;
- j. agree to accept consultation assignments and committee assignments;

- k. refrain from disclosing any information, which is confidential under any state or federal law or which is determined to be confidential by any committee on which he is serving, to anyone not authorized to receive it;
- l. observe attendance requirements for meetings of the Medical Staff, departments and committees as provided in these Bylaws;
- m. cooperate with any review of any Practitioner's credentials, including his/her own, and refrain from interfering with such review by refusing to serve on committees, refusing to participate as a witness or to provide information otherwise (including providing or arranging for the provision of any type of information listed in Article III, Section 4.g. of these Bylaws) or interfering in any other way;
- n. be currently registered at both the state and federal levels to prescribe medications;
- o. maintain a practice and be located in sufficient proximity to the Hospital to assure the member's ability to provide, and actually provide, continuous care consistent with the member's Clinical Privileges and category of Medical Staff membership, if available, patient needs and emergency situations; and
- p. provide care to patients at the Hospital who are unable to pay or to pay fully for health care services including, without limitation, providing emergency services as requested without regard to the patient's insurance coverage or ability to pay and providing necessary follow-up care for such patients; and
- q. comply, to the extent applicable, with the Hospital's compliance efforts and with all applicable federal, state and local laws, rules and regulations regarding the provision of medical care in the Hospital and the required documentation therefor.

The foregoing lists of the responsibilities of and the qualifications for membership shall not be deemed exclusive of other qualifications and conditions reasonably deemed by the Medical Staff or the Governing Body to be relevant in considering an applicant's qualifications for Medical Staff membership and/or for Clinical Privileges.

SECTION 5. CONDITIONS AND DURATION OF APPOINTMENT

- a. **Appointments.** Initial appointments and reappointments to the Medical Staff shall be made by the Governing Body. The Governing Body shall act on appointments only after there has been a recommendation from the Medical Staff as provided in these Bylaws, except that in the event of unwarranted delay on the part of the Medical Staff, the Governing Body may act without such recommendation on the basis of reliable evidence of the applicant's or Medical Staff member's professional and ethical qualifications.
- b. **Provisional Membership.**
 - i. All new members of the Medical Staff shall serve a provisional membership. This provisional membership shall be for an initial period of at least one year from the date of appointment. The performance of each provisional appointee shall be observed during such period by the chairman of the

department to which such appointee is assigned. At the end of such provisional period, the department chairman shall review such appointee's work and make a recommendation (which may be to grant regular Medical Staff Membership, continue the provisional period, or terminate Medical Staff membership) to the Credentials Committee regarding the provisional appointee's eligibility for regular Medical Staff Membership. The Credentials Committee shall consider the recommendation of the department chairman and then shall issue its recommendation to the Executive Committee, which in turn shall issue its recommendation to the Governing Body for final approval. If the provisional appointee's competency, qualifications or ability to fulfill his/her responsibilities as a member of the Medical Staff are in doubt, regular Medical Staff Membership shall not be recommended or granted, but the provisional period may be extended for up to one additional year or until such time as the Governing Body acts on a recommendation from the Executive Committee or on its own initiative concerning the individual's provisional status. For purposes of this subsection, b) Provisional Membership, Regular Medical Staff Membership shall mean the category of medical staff membership requested by the provisional member on the application for initial appointment;

- ii. In order to be granted regular Medical Staff membership, a provisional appointee shall be required to participate in sufficient clinical activities for his/her competence to be evaluated by the department chair. If by the end of the second provisional year the provisional appointee's clinical activities are determined by the Executive Committee and the Governing Body to be insufficient to permit an informed judgement regarding competence to be made, such lack of activity shall be deemed to constitute a voluntary resignation from the Medical Staff and of all Clinical Privileges effective at the end of the second provisional year. A provisional appointee who is deemed to have resigned shall not be entitled to the hearing or appeal rights accorded by these Bylaws.
 - iii. The term of provisional appointment shall not exceed two years from the date of initial appointment. Except in cases involving a lack of clinical activity as provided above, by the end of such period the Executive Committee shall recommend to the Governing Body either that the provisional appointee to granted regular Medical Staff Membership or that the provisional appointee's, Medical Staff membership and Clinical Privileges be terminated. If the Executive Committee's recommendation is to terminate the provisional appointee's Medical Staff membership and Clinical Privileges (for reasons other than lack of clinical activity as provided above), final action on such Adverse Recommendation shall not be taken until after such provisional appointee has exercised or waived his/her hearing and/or appellate review rights under these Bylaws.
- c. **Duration of Regular Appointments.** Upon completion of the provisional membership, the initial regular appointment shall be valid for a period of not less than one year nor more than two years following such appointment and until the

Governing Body takes final action regarding the Practitioner's reappointment application, such period to be of the duration necessary to incorporate the practitioner into the regular reappointment schedule. Thereafter, reappointments shall be processed in accordance with the schedule recommended by the Chief Administrative Officer in accordance with Article V, Section 4.b. and shall be valid for a period of up to two years and until the Governing Body takes final action regarding the Practitioner's reappointment application.

- d. **Clinical Privileges Conferred by Appointment.** Appointment to and membership on the Medical Staff does not include any authorization to exercise Clinical Privileges, but Medical Staff Membership shall be a prerequisite to the grant of any Clinical Privileges to a Practitioner. Only such Clinical Privileges as may be specifically recommended by the Executive Committee and granted by the Governing Body, in accordance with these Bylaws may be exercised by Practitioners and others granted Clinical Privileges.

SECTION 6. DEPARTMENT ASSIGNMENT

Each applicant for Medical Staff membership shall designate a clinical department to which he requests to be appointed. After an application is deemed to be complete by the Chief Administrative Officer, it will be referred to the appropriate departmental chairman for the initiation of the review process.

SECTION 7. PHYSICIANS AND DENTISTS IN EDUCATIONAL PROGRAMS

Notwithstanding the provisions of Section 2 and Section 3 of this Article III, Physicians and Dentists who are appointed to a residency or fellowship program in graduate medical or dental education at the Hospital are qualified to be members of this Medical Staff.

SECTION 8. ABANDONMENT OF MEDICAL STAFF MEMBERSHIP

Any Practitioner (i) who voluntarily gives up his/her license to practice; or (ii) who leaves the community without providing notice to the Hospital or giving clear indication of his/her intent to return and resume practice at the Hospital; or (iii) who has not used the Hospital facilities in his/her professional capacity for at least six (6) months and fails to respond within thirty (30) days to a written request from the Credentials Committee to clarify his/her status as a Medical Staff member; shall be deemed to have abandoned his/her membership on the Medical Staff and his/her Clinical Privileges upon report by the Credentials Committee, through the Chief Administrative Officer of the facts indicating abandonment to the Governing Body and upon assent from the Governing Body. Written notice of any such abandonment shall be sent to the last known address of the affected Practitioner by certified mail, return receipt requested. If no objection is received from the affected Practitioner within two weeks from the date such notice is sent, no further review of the Governing Body's decision shall be available. If timely objection is received, the Governing Body shall reconsider the matter and shall decide whether or not the former member's privileges and membership should be reinstated. The Governing Body may or may not permit a hearing before it decides. The decision of the Governing Body shall be final.

ARTICLE IV. CATEGORIES OF THE MEDICAL STAFF

SECTION 1. CATEGORIES

The Medical Staff shall be divided into Active, Courtesy, Associate, Resident, Senior, Affiliate and Emeritus categories.

SECTION 2. THE ACTIVE MEDICAL STAFF

- a. **Eligibility.** The Active Medical Staff shall consist of Practitioners who:
 - i. meet all of the qualifications for Medical Staff Membership set forth in Article III, Section 2;
 - ii. regularly admit, consult, attend patients at, or refer patients to, the Hospital;
 - iii. maintain a practice and be located in sufficient proximity to the Hospital to provide continuous care to their patients; and
 - iv. members, nominated by their department chairman, who are senior physicians and are retired or semi-retired from active practice and who may be qualified for membership on the Senior and/or Emeritus Medical Staff. Such members shall be of outstanding reputation and have made significant, long term, contributions to the Hospital and/or the GSM. Such members shall not be required to meet the requirements of section ii and iii of Section 2.

Membership on the Active Medical Staff shall be restricted to Practitioners who apply for and obtain an academic appointment to the GSM, who maintain an office practice in facilities owned, leased or otherwise controlled by or affiliated with the Hospital or, who upon application to the Credentials Committee for waiver of the academic appointment, obtain a waiver of the academic appointment from the Governing Body based upon recommendation of the Credentials Committee to the Executive Committee with both the Credentials Committee and Executive Committee finding that it is in the best interest of the Hospital to waive the requirement for academic appointment

- b. **Prerogatives.** The prerogatives of a member of the Active Medical Staff shall be to:
 - i. participate fully in the care of patients through the admission of patients, limited only by bed availability, and through exercise of Clinical Privileges granted by the Governing Body provided such Practitioner is eligible for Active Staff Membership pursuant to subparagraph a.i. above;
 - ii. serve on standing or special Medical Staff committees and attend the meetings of the Medical Staff and of the department and committees of which they are members;
 - iii. vote on all matters presented at the general and special meetings of the Medical Staff, and at meetings of the department and committees of which they are members; and

- iv. hold Medical Staff office provided such Practitioner is eligible for Active Staff membership pursuant to subparagraph a.i. above.
- c. **Responsibilities.** Each member of the Active Medical Staff shall meet all of the basic responsibilities of Medical Staff membership set forth in Article III, Section 4 of these Bylaws.

SECTION 3. THE ASSOCIATE MEDICAL STAFF

- a. **Eligibility:** The Associate Medical Staff shall consist of Practitioners who:
 - i. Except for those requirements set forth in Article III, Section 2, Paragraph f, Clinical Activity; meet all the qualifications for Medical Staff membership set forth in Article III, Section 2;
 - ii. May apply for and obtain an academic appointment to the GSM;
 - iii. May NOT admit, consult or attend patients in the hospital or hospital departments or serve as a medical staff officer;
 - iv. Have chosen to align their outpatient practice primarily with the programs and services offered by the University of Tennessee Medical Center and members of its Medical Staff.
- b. **Prerogatives:** The prerogatives of a member of the Associate Medical Staff shall be to:
 - i. Refer patients to the hospital to a member of the Medical Staff with admitting privileges who can assume responsibility for a patient's hospital treatment;
 - ii. Make rounds to see and provide recommendations on the care of any such referred patient. Such recommendations to the Attending Practitioner may be offered orally or documented in the progress notes section of the patient record;
 - iii. Serve on standing or special Medical Staff committees and attend the meetings of the Medical Staff and of the departments and committees of which they are members;
 - iv. Vote on all matters presented at the general and special meetings of the Medical Staff, and at meetings of the department and committees of which they are members; and
 - v. Attend the continuing education programs offered by the hospital.

c. Responsibilities:

Each member of the Associate Medical Staff shall meet all of the basic responsibilities of Medical Staff membership set forth in Article III, Section 4 of the Bylaws. They shall be required to apply for appointment to the Medical Staff through submission of a complete membership application to an appropriate medical staff department. For reappointment, the member shall be required only to document a valid license to practice medicine, osteopathy or dentistry in the State of Tennessee, provide evidence of professional liability insurance as required by these Bylaws and submit two peer references from individuals who have recent and extensive personal experience in observing and working with the applicant and who are able to provide specific written, substantive comments pertaining to the applicant's current professional competence, ethical character and ability to work cooperatively with others.

SECTION 4. THE COURTESY MEDICAL STAFF

The Courtesy Medical Staff shall consist of Practitioners who:

- a. **Eligibility.** The Courtesy Medical Staff shall consist of Practitioners who:
 - i. meet all of the qualifications for Medical Staff membership set forth in Article III, Section 2;
 - ii. only occasionally admit, consult on, attend or refer patients at the Hospital;
 - iii. reside and practice in sufficient proximity to the Hospital to provide continuous care to their patients; and
 - iv. continuously maintain at one or more other hospitals in the Hospital's community active medical staff membership and clinical privileges that include all Clinical Privileges requested by the Practitioner from, or granted to the Practitioner by, the Governing Body.

Members of the Courtesy Medical Staff may, but are not required, to hold an academic appointment to the GSM.

- b. **Prerogatives.** The prerogatives of a member of the Courtesy Medical Staff shall be to:
 - i. participate in the care of patients through the admission of or the performance of invasive diagnostic or therapeutic procedures on not more than 25 patients in any calendar year; provided however, that the appropriate department chairman may, at his discretion, authorize an additional 25 patients, to a maximum of 50 patients in any calendar year; and through the exercise of Clinical Privileges approved and granted by the Governing Body;
 - ii. attend the general and special meetings of the Medical Staff and of the department of which they are members.

Members of the Courtesy Medical Staff shall not be eligible to vote, hold Medical Staff office or serve on Medical Staff committees.

- c. **Responsibilities.** Each member of the Courtesy Medical Staff shall meet all of the basic responsibilities of Medical Staff membership set forth in Article III, Section 4 of these Bylaws.

SECTION 5. THE CONTRACT MEDICAL STAFF

- a. **Eligibility.** The Contract Medical Staff shall consist of Practitioners in the following special categories:
 - i. “University of Tennessee-Knoxville Student Health Service Physicians” as designated by contracted with The University; and
 - ii. such other Practitioners as are employees or independent contractors of the Hospital who are not covered by subparagraph i. above, but who are within any additional special categories recommended by the Credentials Committee and the Executive Committee and approved by the Governing Body. Such approval must be given before any Practitioner is approved for Contract Medical Staff membership in such category.

Members of the Contract Medical Staff may, but are not required, to hold an academic appointment to the GSM.

- b. **Prerogatives.** The prerogatives of a member of the Contract Medical Staff:
 - i. to participate in the care of patients to the extent contemplated by the contract governing their relationship with the Hospital; including the exercise of such Clinical Privileges as are approved and granted by the Governing Body; and
 - ii. to attend the general and special meetings of the Medical Staff and of the department and Medical Staff committee(s) of which he is a member.

Members of the Contract Medical Staff shall not be eligible to vote or hold Medical Staff office.

- c. **Responsibilities.** Each member of the Contract Medical Staff shall meet all of the basic responsibilities of Medical Staff membership set forth in Article III, Section 4 of these Bylaws.

SECTION 6. THE RESIDENT MEDICAL STAFF

- a. **Eligibility.** The Resident Medical Staff shall consist of Practitioners who hold valid, unrestricted regular or special training licenses, or a valid licensure waiver, issued in accordance with Tennessee law and who are appointed to residency or fellowship programs in graduate medical or dental education in the GSM. Verification of appropriate licensure or waiver of licensure shall be the responsibility of the GSM. Such residency programs must be under the aegis of the GSM and accredited by the ACGME/AMA or by the CODA/ADA. It is recognized that certain fellowship programs of the GSM may not be accredited by the ACGME/AMA or by the CODA/ADA; however, the failure of such fellowship to be accredited shall not affect the eligibility of a participant in such fellowship program who otherwise meets the requirements of this section.

- b. **Prerogatives.** The prerogatives of a member of the Resident Medical Staff shall be to:
 - i. participate in the care of patients under the supervision and control of a member of the Active Medical Staff and within the duties and responsibilities assigned to meet the requirements of the residency program in which the member is enrolled;
 - ii. attend without voting privileges the general and special meetings of the Medical Staff and of the department of which he/she is a member; and
 - iii. attend with voting privileges the meetings of any Medical Staff committee, standing or special, to which he has been assigned.

Members of the Resident Medical Staff shall be appointed to the Medical Staff in accordance with Article V, Section 5 of these Bylaws.

- c. **Responsibilities.** Each member of the Resident Medical Staff shall meet all of the basic responsibilities of Medical Staff membership set forth in Article III, Section 4 of these Bylaws.

Members of the Resident Medical Staff shall have no right to hearing and appellate review under Article IX of these Bylaws.

SECTION 7. THE SENIOR MEDICAL STAFF

- a. **Eligibility.** The Senior Medical Staff shall consist of Practitioners who no longer practice in the Hospital and who have retired from active practice.
- b. **Prerogatives.** Senior Medical Staff members may neither admit patients nor be granted or exercise Clinical Privileges. They may attend Medical Staff and educational meetings, but shall not be eligible to vote, and they shall not hold office or serve on standing Medical Staff committees. Notwithstanding the foregoing, they may serve, upon request and with voting privileges, on special Medical Staff committees. Members of the Senior Medical Staff may, but are not required, to hold an academic appointment to the GSM.
- c. **Responsibilities.** Senior Medical Staff members shall be required to comply with the basic responsibilities of Medical Staff membership listed in Article III, Section 4.c. and e. They shall be exempt from the reappointment process.

SECTION 8. THE AFFILIATE MEDICAL STAFF

- a. **Eligibility.** The Affiliate Medical Staff shall consist of Practitioners who:
 - do not reside and practice in sufficient proximity to the Hospital to provide continuous care to patients of the Hospital and who therefore are ineligible for membership on the Active or Courtesy Medical Staff.
- b. **Prerogatives.** The prerogatives of a member of the Affiliate Medical Staff shall be to:
 - i. refer patients to the Hospital to a member of the Active or Courtesy Medical Staff who is responsible for the patient's Hospital treatment;

- ii. make rounds to see and provide suggestions on the care of any such referred patient;
- iii. attend the continuing education programs offered by the Hospital;
- iv. attend, without voting privileges, the regular meetings of the Medical Staff.

Members of the Affiliate Medical Staff may, but are not required, to hold an academic appointment to the GSM.

Members of the Affiliate Medical Staff shall not be granted or exercise any Clinical Privileges and shall not be permitted to write orders or make other entries into the patient's medical record.

- c. **Responsibilities.** Affiliate Medical Staff members shall be required to comply with the basic responsibilities of Medical Staff membership listed in Article III, Section 4. They shall be required to apply for appointment to the Medical Staff but in lieu of reappointment shall be required only to document that they possess a currently valid license to practice medicine, osteopathy or dentistry in the State of Tennessee and that they are in compliance with the professional liability insurance requirements of these Bylaws.

SECTION 9. THE EMERITUS MEDICAL STAFF

- a. **Eligibility.** The Emeritus Medical Staff shall consist of Practitioners who are of outstanding reputation, not active in the Hospital and who are to be honored by the Medical Staff.
- b. **Prerogatives.** Emeritus Medical Staff members may neither admit patients nor be granted or exercise Clinical Privileges. They may attend Medical Staff meetings and educational programs, but shall not be eligible to vote, hold office or serve on standing Medical Staff committees. Notwithstanding the foregoing, they may serve, upon request and with voting privileges, on special Medical Staff committees. Nominations for Emeritus status should be made to the Executive Committee and appointment shall become effective upon approval by the Governing Body.
- c. **Responsibilities.** Emeritus Medical Staff members shall be required to comply with the basic responsibilities of Medical Staff membership listed in Article III, Section c. and e. They shall be exempt from the reappointment process.

ARTICLE V. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION 1. APPOINTMENT PROCEDURE

- a. **Role of Chief Administrative Officer.** The Chief Administrative Officer, or his/her designee, shall function and act throughout the application and appointment process, and any subsequent reappointment or other review of any individual's Medical Staff membership or Clinical Privileges as provided in these Bylaws, and in doing so shall be deemed to be acting on behalf of the Credentials Committee.

b. **Application for Appointment.**

- i. all applications for appointment to the Medical Staff shall be in writing, shall be signed by the applicant, and shall be submitted to the Chief Administrative Officer on a form prescribed by the Executive Committee. A separate record shall be maintained for each individual requesting Medical Staff membership or Clinical Privileges. The form shall include a statement notifying the applicant generally of the scope and extent of the authorization, confidentiality, immunity and release provisions of these Bylaws. Prior to submission of the application, the applicant shall be provided with a copy of these Bylaws and the Rules and Regulations including a description of the mechanisms for appointment or reappointment and initial granting and renewal or revision of Clinical Privileges.
- ii. the application shall require detailed chronological information without any gaps in time, regarding all activities of applicant from date of professional degree to the present. Additionally, the applicant shall provide detailed information concerning the applicant's professional qualifications, including applicant's education, training and experience; shall request the names, addresses and telephone numbers of at least 3 persons who have had recent and extensive personal experience in observing and working with the applicant and who will provide specific written, substantive comments pertaining to the applicant's current professional competence, ethical character, and ability to work cooperatively with others; shall request information as to whether the applicant's membership status and/or clinical privileges at any other hospital or health care institution have ever been voluntarily or involuntarily revoked, suspended, reduced or not renewed or subject to any condition or limitation whatsoever; shall request information regarding any focused investigation, pending or closed, of the applicant or any other challenges to the applicant's clinical privileges or medical staff membership at any hospital or other health care institution; shall request information regarding the applicant's malpractice claims history, including all judgments against and all settlements involving payment by or on behalf of the applicant; and shall request information as to whether his/her membership in local, state or national medical societies, or his/her license to practice any profession in any jurisdiction, or his/her DEA or state narcotics registration, has ever been voluntarily or involuntarily limited, suspended or terminated. On and after the final approval of these Bylaws, all applicants shall be required to submit with their applications certification of satisfactory completion of a residency program accredited by the ACGME/AMA, the AOA, or the CODA/ADA, and in the case of applications considered by the Governing Body after the final approval of these Bylaws, applicants shall be required to supplement their previously submitted applications with such certification, if not previously provided, prior to consideration of the application by the Governing Body. When submitted, the completed application must also be accompanied by documentary evidence of:

- (a) current licensure to practice medicine, osteopathy or dentistry in Tennessee;
- (b) current Drug Enforcement Administration Certification, and
- (c) proof of professional liability insurance coverage in compliance with the requirements of these Bylaws.

Maintenance of licensure, drug DEA certification, and proof of professional liability insurance coverage will be a condition of having an appointment to the Medical Staff. Change in status of any condition shall be reported promptly to the Chief of Staff and Chief Administrative Officer. Any false or misleading information provided during the appointment or reappointment process or any material omission from the application will be grounds for refusal to process further the application or, if discovered after appointment, for loss of Medical Staff membership and Clinical Privileges.

c. **Effect of Application.**

- i. **General.** The applicant must sign the application and in so doing and in consideration for all of the time, effort and expense to review such application, the applicant:
 - (a) attests to the correctness and completeness of all information furnished;
 - (b) signifies the applicant's willingness to appear for interviews in connection with his/her application or any other subsequent review of his/her Medical Staff membership or Clinical Privileges;
 - (c) certifies that he has received and is charged with knowledge of these Bylaws and the Rules and Regulations, and agrees to abide by the terms of the Bylaws, the Rules and Regulations, and the policies of the Medical Staff and those of the Hospital if granted membership and/or Clinical Privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or Clinical Privileges are granted;
 - (d) commits, if appointed to the Medical Staff, to maintain, and provide upon request of the Credentials Committee or Chief Administrative Officer, evidence from time to time in the form of a certificate of coverage issued by the insurance carrier of professional liability insurance in not less than the minimum amount, if any, set by the Governing Body (which minimum amount may vary depending upon specialty, category, employment status or other factors deemed relevant by the Governing Body) with an insurance company and on terms, including, when necessary to provide full coverage with respect to services provided at the Hospital, "prior acts" or "tail" coverage, acceptable to the Governing Body, and acknowledges that the commitment to maintain "prior acts" or "tail" coverage shall continue notwithstanding the fact that he is no longer on the Medical Staff

until such time as the statute of limitations shall have extinguished any possible claims relating to his/her performance while on the Medical Staff, and agrees that any failure to do so shall entitle the Hospital to recover from him/her any loss incurred by the Hospital as a result of such failure, and also to injunctive relief to require him/her to comply with this promise;

- (e) agrees to abide by and satisfy all of the responsibilities of Medical Staff membership set forth in these Bylaws;
- (f) authorizes and consents to Hospital Representatives consulting with prior associates or others who may have information bearing on the applicant's personal, professional or ethical qualifications and competence and consents to Hospital Representatives inspecting, and agrees to provide copies of (as requested if in applicant's possession or subject to his/her control) all records and documents that may be relevant or lead to information relevant to evaluation of said qualifications and competence, including without limitation copies of office medical records (Practitioner may take reasonable steps to meet applicable requirements regarding office medical records provided);
- (g) releases from any liability both in connection with the application process as well as any subsequent reappointment process or any other review of the applicant's qualifications, any Hospital Representatives and all others who, in good faith and without malice, review, act on or provide information, including otherwise privileged or confidential information, regarding the applicant's competence, professional conduct, performance, character, health status or other qualifications for Medical Staff appointment or Clinical Privileges;
- (h) waives any right to object to the adequacy of the procedures set forth in the Bylaws, the Rules and Regulations or set forth in any policies of the Governing Body or the Medical Staff, as amended from time to time, unless, with respect to any amendments or any policies adopted subsequent to the date the application is submitted, he submits in writing an objection and the grounds therefor to the Governing Body within 30 days of any change in the Bylaws or the Rules and Regulations or within 30 days of notice to the Medical Staff of any such policy;
- (i) agrees that if he is appointed to the Medical Staff he will notify the Chief of Staff and the Chief Administrative Officer promptly, and in no case later than (10) days after any occurrence or event that would change in any material respect the information contained in the application if the application were to be submitted after such occurrence or event, including, without limitation, any change in medical malpractice insurance coverage; any adverse judgement or

settlement in any medical malpractice litigation; any notice that disciplinary action has been taken or proposed with respect to his/her license, DEA registration or with respect to his/her membership or privileges at any other hospital or health care institution; any criminal charges against him/her; etc.; and

(j) pledges, if appointed to the Medical Staff and/or granted Clinical Privileges, to provide continuous care for his/her patients.

- ii. **Special Covenant.** In addition to the foregoing subsection i.a-j., by applying for, reapplying for, requesting, or exercising staff status or Clinical Privileges, and in consideration for the review of such application or of the exercise of such privileges, each Practitioner covenants and agrees that in the event such Practitioner institutes litigation regarding an action or proposed action giving rise to Practitioner's right to hearing and appellate review under Article IX of these Bylaws, and the relief and/or damages requested by such Practitioner in such litigation are not granted or substantially granted by final judgment of a court of competent jurisdiction, then such Practitioner shall promptly pay to the Hospital an amount equal to the reasonable attorneys' fees and other reasonable expenses incurred by the Hospital and/or any other Hospital Representatives named as defendants in defense of such litigation, but not in excess of \$75,000, for appropriate distribution by The Hospital as determined in its sole discretion. By approving these Bylaws, the Governing Body hereby gives notice that the costs of defending any litigation instituted are significant. While neither the Governing Body nor the Hospital has any desire to inhibit the legitimate exercise and pursuit of legal rights by Practitioners, the Governing Body and the Hospital believe that Practitioner litigation against the Hospital and their representatives has increased the cost of delivering health care to patients even though the relief and/or damages requested in such litigation are in many cases not granted or substantially granted. Accordingly, this section is included in these Bylaws, the Practitioners make the covenant provided herein, in the interest of containing the cost of delivering health care to patients and of preserving the financial integrity of the Hospital. In the event any court holds this provision to be unenforceable, such holding shall not affect the enforceability, effectiveness or application of the other provisions of this section.
- d. **Processing the Application and Subsequent Review.**
- i. **Applicant's Burden.** The applicant, or the Practitioner with respect to any subsequent review if his/her qualifications, has the burden of establishing his/her competence and qualifications and of producing adequate information for a proper evaluation of his/her experience, training, demonstrated ability, current competence, and willingness and ability to meet the responsibilities of a member of the Medical Staff, and of resolving any doubts about these or any of the other qualifications required for Medical Staff membership or Clinical Privileges, and of satisfying any reasonable requests for information or clarification made by appropriate Medical Staff or Governing Body authorities. Failure on the part of the applicant to provide information

requested within a reasonable time frame set by the person requesting the information and after one subsequent warning with at least two weeks prior written notice of the result of such failure, shall be deemed to constitute an abandonment of the application or of the applicant's Medical Staff membership and Clinical Privileges if he is then a staff member, without right of hearing or appeal.

- ii. **Verification of Information.** The completed application shall be submitted to the Chief Administrative Officer. The Chief Administrative Officer or his/her designee shall then make inquiry of the references, and shall verify, from the primary sources, whenever feasible, information about the applicant's licensure, specific training, current competence and other qualification evidence submitted and shall promptly notify the applicant of any problems in obtaining the information required. Upon such notification, it is the applicant's obligation to obtain the required information. The Chief Administrative Officer or his/her designee also shall submit an appropriate inquiry regarding the applicant to the National Practitioner Data Bank and shall seek information concerning the applicant from such other sources as the Credentials Committee may require from time to time.

When such collection of information and verification is accomplished, the Chief Administrative Officer shall deem the application preliminarily complete and shall transmit it and all supporting material to the Chairman of the clinical department(s) in which the applicant has requested Clinical Privileges.

- iii. The Chairman of every department in which the Practitioner seeks Clinical Privileges shall provide the Credentials Committee with specific, written recommendations for delineating the Practitioner's clinical privileges, and these recommendations shall be made a part of the report.
- e. **Credentials Committee Review and Recommendation.**
 - i. After transmission of an application for membership by the Chief Administrative Officer and within 90 days determination by the Credentials Committee that the application is complete, the Credentials Committee shall make a written report and recommendation regarding the application to the Executive Committee. Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including an appraisal from the clinical department(s) in which Clinical Privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of Medical Staff membership and the Clinical Privileges requested by him/her.
 - ii. If the Credentials Committee finds that the application is not complete, or if there is any doubt as to the appropriate scope of Clinical Privileges to be granted, action on all or any portion of the application shall be deferred until the necessary information can be obtained from the applicant or other

sources. It shall be the responsibility of the Credentials Committee to verify that the applicant has obtained where required an academic appointment to the faculty of the GSM before recommending membership on the Active Medical Staff. The Credentials Committee may recommend provisional membership without a faculty appointment provided that a faculty application has been filed and recommended by the appointment, promotion and tenure committee of the GSM or provided the applicant has requested a waiver of the requirement for academic appointment. Together with its report, the Credentials Committee shall transmit to the Executive Committee the completed application and a recommendation that the applicant either be appointed to the Medical Staff or rejected for Medical Staff membership, or that the application be deferred for further consideration. If the Credentials Committee recommends rejection or deferral of the application, it shall include with its recommendation a clear statement of the factual basis or reasons for it.

- f. **Executive Committee Review and Recommendation.**
- i. At its next regular meeting after receipt of the application and the report and recommendation of the Credentials Committee, or at any special meeting called for such purpose, the Executive Committee shall determine whether to recommend to the Governing Body that the applicant be appointed to the Medical Staff, that be rejected for Medical Staff membership, or that his/her application be deferred for further consideration. All recommendations for appointment to the Medical Staff must also specifically recommend the Clinical Privileges to be granted, which may be qualified by probationary conditions relating to such Clinical Privileges.
 - ii. When the recommendation of the Executive Committee is to defer the application for further consideration, it must be followed up within 60 days, or such longer period determined to be necessary by the Executive Committee under the circumstances, with a subsequent recommendation for appointment with specified Clinical Privileges, or for rejection for Medical Staff membership.
 - iii. When the recommendation of the Executive Committee is favorable to the applicant, the Chief Administrative Officer shall promptly forward it, together with all supporting documentation, to the Governing Body.
 - iv. When the recommendation of the Executive Committee is an Adverse Recommendation, the Chief Administrative Officer shall promptly give Notice, in accordance with Article IX, Section 2.a. of these Bylaws, of the Adverse Recommendation and the reasons for it to the applicant. No such Adverse Recommendation shall be forwarded to the Governing Body until after the applicant has exercised or has been deemed to have waived his/her right to a hearing and/or appellate review as provided in Article IX of these Bylaws.

g. **Governing Body Action.**

- i. At its next regular meeting after receipt of a favorable Executive Committee recommendation, the Governing Body or its duly authorized committee shall act in the matter. If the Governing Body's decision would constitute Adverse Action if implemented, the Chief Administrative Officer shall promptly give Notice, in accordance with Article IX, Section 2.a. of these Bylaws, of such proposed Adverse Action, and such Adverse Action shall be held in abeyance until the Practitioner has exercised or has been deemed to have waived his/her hearing and/or appellate review rights under Article IX of these Bylaws. The fact that the Adverse Action is held in abeyance shall not be deemed to confer privileges where none existed before.
- ii. In any case where an applicant has properly invoked, or has been deemed to have waived, his/her hearing and/or appellate review rights, the Governing Body shall render its final decision in accordance with Article IX of these Bylaws.
- iii. When the Governing Body's decision is final, it shall send Notice of such decision through the Chief Administrative Officer to the Executive Committee and to the applicant.

SECTION 2. INACTION OF MEDICAL STAFF

Notwithstanding any provision of these Bylaws to the contrary, if the Medical Staff fails to act within any time frame set forth in these Bylaws, and if the Governing Body deems it appropriate to do so under the circumstances, the Governing Body may take action on its own initiative. If such action is favorable, it shall become effective as the final decision of the Governing Body. If such action is an Adverse Action, the Chief Administrative Officer shall promptly give Notice, in accordance with Article IX, Section 2.a. of these Bylaws, of such adverse decision, and such adverse decision shall be held in abeyance until the Practitioner has exercised or has been deemed to have waived his/her hearing and/or appellate review rights under Article IX of these Bylaws. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

SECTION 3. REAPPLICATION AFTER ABANDONMENT, WITHDRAWAL OR ADVERSE APPOINTMENT DECISION

- a. An applicant who has been deemed to have abandoned or who has withdrawn his/her application, or who has been deemed to have abandoned his/her membership on the Medical Staff or particular Clinical Privileges, is not eligible to reapply for Medical Staff membership or for any such clinical privileges for a period of twelve (12) months from the date of such event.
- b. An applicant who has received a final decision that constitutes an Adverse Action regarding Medical Staff appointment or clinical privileges, or who has abandoned or withdrawn his/her application, Medical Staff membership or particular clinical privileges in lieu of a proceeding or proposed proceeding which, if successful, would have constituted an Adverse Action, is not eligible to reapply for Medical

Staff membership or for any such clinical privileges for a period of twenty-four (24) months from the date of such event.

- c. Notwithstanding subsections a. and b. above, any reapplication subsequent to the actions as outlined in Subsections a and b above shall be processed as an initial application and the applicant must submit all such new information as the Medical Staff or Governing Body may require of any applicant, but in addition he shall be required to demonstrate that the basis for any earlier Adverse Action no longer applies.

SECTION 4. REAPPOINTMENT PROCESS AND REQUIREMENTS

- a. **Availability of Forms.** The Chief Administrative Officer shall provide Medical Staff reappointment application forms and forms for requests to expand or modify Clinical Privileges previously approved. Any such application or request shall be deemed to have the same effect and be subject to the same representations as were made at the time of an initial application.
- b. **Reappointment Schedule.** Members of the Medical Staff who have provisional status shall apply for reappointment as of the date specified in the notice of provisional appointment or any subsequent notice modifying that date; after advancement from provisional status, members of the Medical Staff shall apply for reappointment no less frequently than once every two years, and may be required to apply for reappointment as frequently as annually. The schedule for reappointment may be staggered for members of the Medical Staff and shall be recommended by the Chief Administrative Officer after consultation with the Chief of Staff and approved by the Credentials Committee and the Governing Body and shall be announced by the Chief of Staff to the Medical Staff.
- c. **Application for Reappointment.** Each Medical Staff member who desires to apply for reappointment shall be sent a reappointment application one hundred twenty (120) days before the expiration of his/her current appointment and such Medical Staff members shall return the completed reappointment application at least sixty (60) days before expiration of his/her current appointment to the Chief Administrative Officer or his/her designee. The application for reappointment must include the following information: previously successful or currently pending challenges to any licensure or registration of the applicant (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration; voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and the applicant's malpractice claims history, including all judgments against and all settlements involving payment by or on behalf of the applicant. Failure, without good cause, to file a complete and timely application for reappointment shall result in automatic expiration of Medical Staff membership and all Clinical Privileges at the end of the member's current term. Upon receipt of the reappointment application, the Chief Administrative Officer or his/her designee shall submit an appropriate inquiry to the National Practitioner Data Bank.

- d. **Conditions for Reappointment.** Reappointment of a Medical Staff member and renewal or approval of Clinical Privileges upon reappointment shall be based upon the individual's:
- i. current professional competence, performance history and judgment, as indicated in part by departmental recommendations;
 - ii. clinical and/or technical skills, as indicated in part by the results of departmental quality assessment and improvement activities;
 - iii. ethics and conduct;
 - iv. attendance at Medical Staff meetings, department meetings, committee meetings and participation in Medical Staff affairs and efforts to improve organization performance;
 - v. documented participation in relevant continuing education programs in accordance with Department guidelines;
 - vi. compliance with these Bylaws, the Rules and Regulations, and applicable Hospital Policy;
 - vii. cooperation with Hospital personnel and relations with other Medical Staff members;
 - viii. efficient and effective utilization of Hospital facilities for treatment of patients;
 - ix. general attitude toward patients, the Hospital and the public and reputation in the community; and
 - x. ability to demonstrate that he has continuously met the qualifications and fulfilled the responsibilities imposed upon Medical Staff members by these Bylaws.
- e. **Faculty Appointment.** Except as outlined in Article IV, Section 2.a. of these Bylaws, in order to be reappointed to the Active Medical Staff, a Practitioner must maintain his/her appointment to the faculty of the GSM.
- f. **Inadequate Basis to Measure Performance.** If a Practitioner's activities in the Hospital during the applicable period reviewed are insufficient to make any reasonable determination of current competence based on his/her performance in the Hospital, the Practitioner shall be given an opportunity to present evidence of his/her performance at other hospitals and practice settings, including, but not limited to, physicians' offices during the period under review. If satisfactory evidence demonstrating current competence cannot be provided for all or part of the clinical privileges previously granted to the Practitioner, then consideration shall be given to recommending revocation of those clinical privileges for which there is insufficient evidence of current competence.
- g. **Procedure for Reappointment.** Upon receipt by the Chief Administrative Officer or his/her designee of a completed application for reappointment, the procedures and requirements provided in this Article V relating to review of and recommendations on applications for initial appointments shall be followed.

SECTION 5. APPOINTMENT OF RESIDENT MEDICAL STAFF

- a. Notwithstanding any provision of these Bylaws to the contrary, appointments to the Resident Medical Staff shall be deemed to have been made without the need for application as provided in these Bylaws, based on the educational program agreement between the GSM and the Hospital, for periods not to exceed one year. Termination from such educational program, for whatever reason, shall automatically result in termination from the Resident Medical Staff and of all Clinical Privileges, without right to a hearing or appellate review. Reappointment shall occur on an annual basis throughout the duration of the residency and shall be based on evidence of satisfactory progress in scholarship and professional growth and the availability of training positions.
- b. Recommendations for appointments to the Resident Medical Staff shall be initiated by the respective Departmental Chairmen and are to be based on review of the applicants' academic records and references after verification of the qualifications of such applicants. Such recommendations for appointment shall be made to the GSM who, in turn, will review the applications and supporting documents and endorse those which appear to be in order. Those which are in order shall be referred to the Chief Administrative Officer for final appointment.
- c. Members of the Resident Medical Staff cannot be transferred to any other category of Medical Staff membership. Such individuals who desire membership in another Medical Staff category during or after completion of the educational program must apply for such membership in the same manner as any other Practitioner and serve a provisional membership. The foregoing shall not be construed to preclude an individual who is otherwise eligible from applying for a different category of Medical Staff membership in accordance with these Bylaws.

ARTICLE VI. CLINICAL PRIVILEGES

SECTION 1. CLINICAL PRIVILEGES RESTRICTED

Every Practitioner practicing at the Hospital by virtue of Medical Staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those Clinical Privileges specifically and expressly granted to him/her by the Governing Body bases upon recommendations made by the Medical Staff in accordance with these Bylaws. A decision regarding Medical Staff appointment or reappointment is not a grant of Clinical Privileges and such decision shall be separate from the decision regarding granting, renewing, or revising clinical Privileges. Clinical Privileges granted shall be limited to those within the scope of the licensure, certification, or other legal limitations authorizing the individual's practice, and shall be related to an individual's documented experience in categories of treatment areas or procedures, the results of treatment, and the conclusions drawn from organization performance-improvement activities when available.

- a. **Applications for Clinical Privileges.** Every initial application for Medical Staff appointment must contain a request for the specific Clinical Privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's

- documented education, training, experience, demonstrated current competence and the quality of care provided by him/her, judgment, references and other relevant information, including an appraisal by the clinical department(s) in which such privileges are sought. The applicant shall have the burden of establishing his/her qualifications for and competency to exercise the Clinical Privileges he requests. Criteria for departmental membership and Clinical Privileges shall be set forth in the Departmental Rules and Regulations required by Article XVIII, Section 1.b.
- b. **Periodic Redetermination.** The scope of a Practitioner's Clinical Privileges shall be redetermined at the time of reappointment. Such periodic redetermination shall be based upon the direct observation of care provided, review of the records of patients treated in the Hospital and review of the records of the Medical Staff that document the evaluation of the member's participation in the delivery of medical care as well as all such other information and evidence as may be relevant to the individual's competence and qualifications. If requested, the Practitioner must submit any reasonable evidence of current ability to perform his/her Clinical Privileges. Care provided at other hospitals, practice settings or in the practitioner's office may be considered and it shall be the Practitioner's responsibility to provide copies of medical records reflecting such care when requested to do so. Practitioner may take reasonable steps to meet applicable requirements regarding confidentiality of medical records provided.
- c. **Applications for Additional Clinical Privileges.** Applications for additional Clinical Privileges, or for any other modification of existing Clinical Privileges, must be in writing, on a prescribed form and may be submitted at any time. The application for additional Clinical Privileges must include the following information: previously successful or currently pending challenges to any licensure or registration of the applicant (state or district Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration: voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and the applicant's malpractice claims history, including all judgments against and all settlements involving payment by or on behalf of the applicant. The type of Clinical Privileges desired and the applicant's relevant recent training and/or experience must be specifically stated, together with such other information as the Chief Administrative Officer or the Credentials Committee shall deem necessary. Such applications shall be processed in the same manner as applications for initial appointment and shall be evaluated in accordance with the criteria established in this Article VI for initial requests for Clinical Privileges.
- d. **Dentist's Surgical Privileges.** In addition to the requirements applicable to all Practitioners seeking Clinical Privileges, the scope and extent of Clinical Privileges for any surgical procedures that a dentist may apply to exercise shall be specifically delineated and granted in the same manner as all other surgical privileges. Clinical Privileges exercised by dentists shall be under the overall supervision of the Chairman of the Department of Oral and Maxillofacial Surgery/General Dentistry. All dental patients shall receive the same basic

medical appraisal as patients admitted to other surgical services. Those dentists with full oral and maxillofacial surgical privileges shall provide a medical appraisal with appropriate physician consultation when indicated. All general dentistry patients not under the care of a qualified oral and maxillofacial surgeon must have a presurgical physical evaluation provided by a Physician member of the Medical Staff. Such Physician shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during the patient's presence in the Hospital and such Physician shall be identified in the patient's medical record.

SECTION 2. DELINEATION OF CLINICAL PRIVILEGES FOR NEW PROCEDURES

- a. **Development of Qualifications for New Procedures.** Threshold qualifications for Clinical Privileges to perform any new procedures suggested to be provided at the Hospital shall be developed and proposed by the appropriate department or by a committee appointed by the Chief of Staff. The proposed criteria shall be forwarded to the Credentials Committee for review. The Credentials Committee shall review and forward its recommendations to the Executive Committee. The Executive Committee shall review and consider such proposed criteria, and shall either (a) recommend approval of the criteria to the Governing Body; (b) recommend disapproval of the criteria to the Governing Body; or (c) refer the proposed criteria back to the department or committee that developed them, or to another department, if appropriate, for further review. Upon receipt of a recommendation on proposed criteria for new procedures from the Executive Committee, the Governing Body shall either (a) approve the criteria; (b) disapprove the criteria; or (c) refer the proposed criteria back to the Executive Committee or to the department or committee that developed them, or to another department, if appropriate, for further review. The proposed criteria shall become effective upon approval by the Governing Body.
- b. **Application for Clinical Privileges for New Procedures.** Any member of the Medical Staff who desires Clinical Privileges to perform a new procedure for which qualifications have been established pursuant to the preceding paragraph shall be reviewed in accordance with the procedures established in Article VI, Section 1.a. relating to requests for additional Clinical Privileges. If no qualifications have been established, application may be made for such Clinical Privileges, but the applicant shall be required to submit with his/her application a proposed statement of qualifications which shall be reviewed together with the request for such Clinical Privileges. Action on such application may be deferred indefinitely and the application deemed incomplete to allow for the approval of the proposed qualifications in accordance with Article VI, Section 2.a. The Clinical Privileges applied for subject to this provision shall become effective upon approval by the Governing Body; provided, however, that Chief Administrative Officer or his/her designee may grant such privileges on a temporary and provisional basis to the applicant, pending final action on the application by the Governing Body, if the Executive Committee has recommended that such privileges be granted.

SECTION 3. TEMPORARY PRIVILEGES

Temporary Clinical Privileges for Practitioners may be granted under the following circumstances and subject to the conditions indicated:

- a. **Pending Application for Appointment or Reappointment.** Upon receipt of an application for Medical Staff membership or reappointment from an appropriately licensed and qualified Practitioner, including evidence of the existence of appropriate professional liability insurance, the Chief Administrative Officer may, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the departmental chairman concerned and of the chairman of the Executive Committee, grant temporary admitting and Clinical Privileges, or extend the current admitting and Clinical Privileges, to the applicant; but in exercising such privileges, the applicant shall act under the supervision of the chairman of the department to which he is assigned. Such temporary privileges may not exceed the maximum period of time allowable under any applicable law, rule or regulation.
- b. **Care of Specific Patient.** Temporary Clinical Privileges for the care of a specific patient may be granted by the Chief Administrative Officer to a Practitioner who is not an applicant for membership in the same manner and upon the same conditions as set forth in subparagraph a. of this Section 3, provided that there shall first be obtained such Practitioner's signed acknowledgement that he has received and is charged with knowledge of these Bylaws and the Rules and Regulations, and that he agrees to be bound by the terms thereof in all matters relating to his/her temporary Clinical Privileges. Such temporary Clinical Privileges shall be restricted to the treatment of not more than four (4) patients in any one year by any Practitioner, after which such Practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients. Any denial of, or revocation or restriction imposed on, the exercise of Clinical Privileges by a Practitioner pursuant to this subparagraph shall not entitle such Practitioner to any right to a hearing, to appeal, or any other procedural rights. The power to deny, revoke or restrict temporary Clinical Privileges may be exercised at any time with or without cause by any person authorized to participate in the decision to grant such Clinical Privileges and shall be effective upon notice to the Practitioner, either verbal or written.
- c. **Locum Tenens.** Upon receipt of a written request and such information as the Chief Administrative Officer may reasonably require, the Chief Administrative Officer may permit a Physician intended to serve as a locum tenens for a member of the Medical Staff to attend patients for a period not to exceed 120 days in any twelve (12) month period. All of his/her credentials and the Clinical Privileges to be exercised shall first be approved by the departmental chairman concerned and by the chairman of the Executive Committee. Any Physician seeking such authorization shall sign an acknowledgment that he has received and is charged with knowledge of these Bylaws and the Rules and Regulations, and that he agrees to be bound by the terms thereof in all matters relating to his/her temporary Clinical Privileges. Any denial of, or revocation or restriction imposed on, the

exercise of Clinical Privileges by a Practitioner pursuant to this subparagraph shall not entitle such Practitioner to any right to a hearing, to appeal, or any other procedural rights. The power to deny, revoke or restrict temporary Clinical Privileges may be exercised at any time with or without cause by any person authorized to participate in the decision to grant such Clinical Privileges and shall be effective upon notice to the Practitioner, either verbal or written. Any physician serving as locum tenens under this paragraph who anticipates that continued service will be required for a period of time in excess of 120 days in any twelve (12) month period must apply for and be granted Medical Staff membership under these Bylaws.

- d. **Special Requirements.** Special requirements of supervision and reporting may be imposed by the departmental chairman concerned or the chairman of the Executive Committee on any Practitioner granted temporary Clinical Privileges. Temporary Clinical Privileges shall be immediately terminated by the Chief Administrative Officer or chairman of the Executive Committee upon notice of any failure by the Practitioner to comply with such special conditions.
- e. **Termination of Temporary Clinical Privileges: Assignment of Patients.** In the event any temporary Clinical Privileges granted to a Practitioner are terminated, the appropriate departmental chairman or in his/her absence, the chairman of the Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of such terminated Practitioner's patient(s) until they are discharged from the Hospital. The wishes of the patient(s) and/or responsible family member shall be considered, where feasible, in selection of such substitute Practitioner.

SECTION 4. EMERGENCY/DISASTER PRIVILEGES

- a. In an emergency and/or disaster and for so long as the emergency and/or disaster continues, provided there is no Medical Staff member available who is qualified, authorized and available to provide the necessary service without the assistance of another Practitioner, any member of the Medical Staff, and any other Practitioner, to the degree permitted by his/her license to practice, as issued by any appropriate State, Federal or other regulatory agency, and without regard to the scope of approved privileges in the Hospital, shall be permitted and assisted to do everything possible to save the life of, or avoid serious permanent harm to, any person requiring emergency assistance, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. Approval of such Practitioner shall be made by the Chief Administrative Officer; based upon information readily available regarding licensure, training and competence. When an emergency and/or disaster situation no longer exists, such Medical Staff member or Practitioner, if he desires to continue to participate in the care of the patient, must request the Clinical Privileges necessary for him/her to continue to treat the patient as otherwise provided in these Bylaws. In the event such Clinical Privileges are denied or he does not desire to request such Clinical Privileges, the patient shall be assigned by the chairman of the department concerned, or in his/her absence the chairman of the Executive

Committee, to an appropriate member of the Medical Staff. For the purpose of this section, the following definitions shall apply:

- i. Emergency is defined as a condition in which serious permanent harm would result to a person or in which the life of a person is in immediate danger and any delay in administering treatment would add to that danger. Any Practitioner providing the emergency services shall document the need for his or her emergency services following the rendering of such services.
 - ii. Disaster is defined as any period of time during which the local and/or Hospital's emergency preparedness plan has been activated.
- b. The procedures implementing this section shall be in accordance with the Hospital's emergency preparedness plan.

SECTION 5. PRIVILEGES AND RESPONSIBILITIES OF THE RESIDENT MEDICAL STAFF

Each member of the Resident Medical Staff shall be assigned by the chairman of the department to which he is assigned, or his/her designee, for clinical supervision by members of the Active Medical Staff. Neither the resident's Clinical Privileges nor his/her clinical responsibilities shall exceed in scope those of his/her supervising Medical Staff member. A resident's responsibilities shall include patient care activities within the scope of his/her Clinical Privileges, attendance at clinical rounds and seminars, timely completion of medical records, and other responsibilities as assigned or are required of all members of the Medical Staff. The supervising Physician or Dentist shall make clinical assignments to each assigned resident consistent with the resident's experience and demonstrated clinical competence, and strive to ensure that each resident performs assigned duties in an appropriate manner.

SECTION 6. MEDICAL AND DENTAL STUDENTS ON CLINICAL AFFILIATION

Students who are enrolled in accredited colleges of medicine and dentistry and under the supervision of the GSM may be assigned by their faculty to the Hospital for clinical affiliations which provide for academic credit. Such assignments must be approved by the Dean and the student must remain in good standing in his/her respective school. The Dean shall make clinical assignments and strive to assure compliance of all activities with applicable requirements, and shall notify the Chief Administrative Officer of all such assignments. The activities of these students are limited to those duties which are assigned by their instructor, who must be a member of the Active Medical Staff.

ARTICLE VII. CLINICAL PRIVILEGES FOR ALLIED HEALTH PROFESSIONALS AND CREDENTIALING OF OTHERS

SECTION 1. ALLIED HEALTH PROFESSIONALS.

Allied Health Professionals (AHP) may apply for Clinical Privileges at the Hospital in the same manner, with the same effect, subject to the same qualifications and conditions,

and in accordance with the same procedures for appointment and reappointment as those governing applications for appointment and reappointment to the Medical Staff, but only to the extent such may reasonably and appropriately be applied to the AHP. AHPs shall not be members of the Medical Staff and shall not have admitting privileges. All AHPs must apply for Clinical Privileges through a specific clinical department; such applications for all AHPs performing surgical services shall be reviewed and approved by the Department of Surgery, the Department of Oral and Maxillofacial Surgery or the Department of Obstetrics and Gynecology. A separate application form and a separate application for renewal of Clinical Privileges for AHPs will be designated by the Chief Administrative Officer after consultation with the chairman of the Executive Committee. The Credentials Committee shall review each such request and make a recommendation in a report to be forwarded and handled in the same manner and within the same time frames as applications for Medical Staff appointments except that the only right to appeal or to seek further review of the recommendation of the Executive Committee or the decision of the Governing Body on any such request shall be as provided in subparagraph d. of this Section 1. Any credentials approved based on such a request must be reviewed at least every two years and are subject to immediate revocation or modification by the Chief Administrative Officer or the chairman of the Executive Committee at his/her sole discretion, subject, however to the fair hearing and appeal process as provided in subparagraph d. of this Section 1 and ratification by the Governing Body.

- a. **Additional Qualifications.** In addition to meeting the qualifications, and, with respect to applications for renewal of Clinical Privileges, the conditions for reappointment applicable to members of the Medical Staff to the extent they may reasonably be applied to the AHP, where appropriate, the Executive Committee may recommend and the Governing Body may approve, in the Rules and Regulations or by appropriately adopted policy, particular qualifications and conditions for renewal of Clinical Privileges required of a specific category of AHP, provided that such qualifications and conditions are not arbitrary or unreasonably discriminatory and are not contrary to law.
- b. **Prerogatives.** The Executive Committee may recommend and the Governing Body may establish particular prerogatives of a specific category of AHP. Subject to any such specific prerogatives, the general prerogatives of an AHP shall be to:
 - i. provide specified patient care services for which he has Clinical Privileges granted by the Governing Body;
 - ii. write orders to the extent permitted by Hospital policy, but not beyond the scope of the AHP's license, certificate or other restrictions imposed by law;
 - iii. serve without a vote on Medical Staff and Hospital committees except as otherwise expressly provided in these Bylaws;
 - iv. attend, without voting privileges, the meetings of the Medical Staff and the department to which he is assigned; and
 - v. attend the continuing education programs offered by the Medical Staff or the Hospital.

- c. **Responsibilities.** Each AHP, in addition to the responsibilities applicable to Medical Staff members that may reasonably be applied to him/her, shall be responsible:
- i. within his/her area of professional competence, to provide for the care and supervision of each patient in the Hospital for whom he is providing services, or to arrange a suitable alternative for such care and supervision;
 - ii. to be sure, subject to any exceptions in the Rules and Regulations, that a Physician member of the Medical Staff has performed a history and physical exam on, and is responsible for the medical aspects of patient care for, each patient to whom the AHP provides services; and
 - iii. to participate, as appropriate, in patient care audit and other quality review, evaluation and monitoring activities required by the Medical Staff, in supervising initial appointees of his/her same profession during the observation period, and in discharging such other Medical Staff functions as may be required from time to time.
- d. **Fair Hearing and Appeal Process**
- i. if at any time it appears that it is in the best interest of Hospital, or the patients, employees or others in the Hospital, the Chief of Staff, the Department Chairman of the Department to which the AHP is assigned, or the Chief Administrative Officer may deny, terminate, restrict, suspend, modify or otherwise change the AHP's right to practice or scope of practice in the Hospital without the consent of the AHP;
 - ii. in the event the above take any action authorized by paragraph Dai. above, the Chief of Staff shall immediately communicate the decision to the AHP and shall set forth in writing the reasons for the decision;
 - iii. any AHP shall have the right to meet with the Chief of Staff to discuss the action taken or proposed under paragraph d.i. above. This meeting shall be informal and shall not be considered a hearing. Following this meeting, the Chief of Staff shall make a final decision and inform the AHP in writing;
 - iv. if the AHP disagrees with the final decision of the Chief of Staff the AHP shall be entitled to have the matter reviewed by the Medical Staff Credentials Committee in accordance with Section d.v. below.
 - v. Review of Adverse Decision:
 - (a) Haps are not entitled to the hearing and appeals procedures set forth elsewhere in these Bylaws. However, in the event an AHP is not granted permission to practice in the Hospital or the scope of practice and clinical privileges requested; or has that permission or scope of practice terminated, restricted, suspended, modified or otherwise changed by the Chief of Staff without the consent of the AHP, AHP and any supervising/employing physician, shall have the right to request that the matter be reviewed by the Credentials Committee of the Medical Staff.

- (b) the AHP must request, in writing, review by the Credentials Committee within five (5) business days after notification of any final adverse decision of the Chief of Staff. Should the AHP request a review in a timely manner, the AHP and the Credentials Committee shall be informed by the Chief of Staff in writing of the general nature of the reasons for the recommendation/action at least ten (10) calendar days prior to the review.
- (c) the AHP and the Chief of Staff shall have the opportunity to meet with the Credentials Committee to discuss, explain, refute, or present facts concerning the recommendation or action.
- (d) after considering the information presented, the Credentials Committee shall make a written report and give its recommendations to the Chief Administrative Officer who shall make a final decision concerning the matter.
- (e) review by the Credentials Committee shall not constitute a hearing and the AHP shall not be entitled to representation by an attorney at any meeting with the Credentials Committee.
- (f) nothing in this section shall be construed so as to give any right to hearing and appellate review under Article IX of these Bylaws or any other section of these Bylaws.

SECTION 2. DEPENDENT PROFESSIONALS

Medical Staff members and Allied Health Professionals may apply to utilize and have credentialed paramedical personnel in their employ as their agents in providing patient care services to patients in the Hospital under their supervision. Such paramedical personnel may include, but shall not be limited to, audiologists, bacteriologists, chemists, clinical pharmacologists, dental auxiliaries, EMG technicians, nurse anesthetists, nurse practitioners, registered nurses, orthopedic and other surgical technicians, physician's assistants, physicists, physiologists, psychiatric social workers, speech pathologists, and qualified therapists (e.g., occupational, physical or respiratory). Medical Staff members and AHPs wishing to use any such paramedical personnel must present to the Credentials Committee a request in writing to approve the patient care services intended to be provided by each such individual. The written request must contain:

- a. a description of the patient care services proposed to be rendered to patients in the Hospital by the Practitioner's or AHP's employee, on his/her behalf (i.e., job description or protocol);
- b. evidence of the employee's current license or certification, if applicable;
- c. a description of the employee's qualifications, training and experience;
- d. representation concerning the employee's competence to provide the patient care services (i.e., job description) requested for approval;
- e. agreement that the employee will act as an agent of the applying Practitioner or AHP at all times, and that the applicant assumes full responsibility for the actions and the performance of his/her employee; and

- f. evidence of current liability insurance coverage for the employee in an amount, with an insurer and on terms satisfactory to the Governing Body.

The Credentials Committee shall review each such request and make a recommendation in a report to be forwarded and handled in the same manner and within the same time frames as applications for Medical Staff appointments except that there shall be no right to appeal or to seek further review of the recommendation of the Executive Committee or the decision of the Governing Body on any such request. The status of each individual authorized to provide services in the Hospital pursuant to this section shall be reviewed and reconsidered at least bi-annually. Any authorization to provide patient care services pursuant to this section is subject to immediate revocation or modification by the Chief Administrative Officer or the chairman of the Executive Committee at his/her sole discretion, provided any such action is promptly reported to the Governing Body for its subsequent ratification. Authorization to provide patient care services as an employee of a Practitioner or AHP pursuant to this section shall not be deemed a grant of Clinical Privileges.

SECTION 3. OTHER DEPENDENT PRACTITIONERS WITHOUT ADEQUATE JOB DESCRIPTION

All other persons intending to provide or to continue to provide medical or other patient care services in the Hospital who are not otherwise required by these Bylaws to make application for Clinical Privileges or to seek authorization to provide patient care services in the Hospital as an employee of a Practitioner or AHP, and whose qualifications and job description are deemed by the Chief Administrative Officer to warrant review and a recommendation from the Medical Staff, shall submit a “Dependent Practitioner (Other)” application to the Chief Administrative Officer for review by the Credentials Committee. Any such person may be either an employee of the Hospital or authorized to work in the Hospital based upon a contractual relationship between the Hospital and such person or a third party. The application shall be on a form provided by the Chief Administrative Officer that requires specific information including: name, qualifications, training and experience, confirmation of any license, certification or registration to the extent applicable to the authorization requested (including a copy of the current one); in addition, for non-Hospital employees, verification of liability insurance coverage on terms including “prior acts” or “tail” coverage, in amounts and with an insurance company satisfactory to the Governing Body with respect to the authorization requested in the form of a certificate of coverage issued by the insurer; a description of the patient care services for which authorization is requested; and such other information as the Chief Administrative Officer shall deem appropriate. Applications submitted by an individual certified as a physicians’ assistant and employed by the Hospital must include the agreement of a least one Physician on the Active Medical Staff to act as supervising physician for that assistant. All applications submitted pursuant to this section shall require, prior to a final determination by the Governing Body, a recommendation from the Chief Administrative Officer or his/her designee, and the Chairman of the Executive Committee or the Medical Staff member who will be most involved with the supervision of the patient care services to be provided. The application shall be handled in the same manner and within the same time frames provided in these Bylaws for applications for Medical Staff appointment, and the Credentials Committee’s recommendation will be

subject to review by the Executive Committee which will in turn make its recommendation to the Governing Body for final approval; provided, however, any approvals granted by the Governing Body pursuant to this provision shall not be deemed to change the individual's employment or contract status and the authorization to provide the patient care services described is subject to revocation or modification by the Chief Administrative Officer at his/her sole discretion. No person whose job description is approved pursuant to this section shall have any right to appeal or seek review of the decision by the Governing Body on such application or of any revocation or modification of a prior authorization. The status of any person whose application is approved hereunder and who has not had his/her authorization to provide patient care services revoked shall be reviewed and reconsidered at least bi-annually by the Credentials Committee, the Executive Committee and the Governing Body.

SECTION 4. TEMPORARY PRIVILEGES FOR ALLIED HEALTH PROFESSIONALS AND OTHERS

Temporary Clinical Privileges for Professionals under this Article VII may be granted under the following circumstances and subject to the conditions indicated:

- a. **Pending Application for Appointment or Reappointment.** Upon receipt of an application for Clinical Privileges from an appropriately licensed and qualified Professional, including evidence of the existence of appropriate professional liability insurance, the Chief Administrative Officer may, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the departmental chairman or his designee concerned and of the chairman of the Executive Committee, grant temporary Clinical Privileges, or extend the current Clinical Privileges, to the applicant; but in exercising such privileges, the applicant shall act under the supervision of the chairman of the department to which he is assigned. Such temporary privileges may not exceed the maximum period of time allowable under any applicable law, rule or regulation.
- b. **Care of Specific Patient.** Temporary Clinical Privileges for the care of a specific patient may be granted by the Chief Administrative Officer to a Professional who is not an applicant for membership in the same manner and upon the same conditions as set forth in subparagraph a. of this Section 4, provided that there shall first be obtained such Professional's signed acknowledgment that he has received and is charged with knowledge of these Bylaws and the Rules and Regulations, and that he agrees to be bound by the terms thereof in all matters relating to his temporary Clinical Privileges. Such temporary Clinical Privileges shall be restricted to the treatment of not more than four (4) patients in any one year by any Professional, after which such Professional shall be required to apply for Clinical Privileges under this Article VII before being allowed to attend additional patients. Any denial of, or revocation or restriction imposed on, the exercise of Clinical Privileges by a Professional pursuant to this subparagraph shall not entitle such Professional to any right to a hearing, to appeal, or any other

procedural rights. The power to deny, revoke or restrict temporary Clinical Privileges may be exercised at any time with or without cause by any person authorized to participate in the decision to grant such Clinical Privileges and shall be effective upon notice to the Professional, either verbal or written.

c. **Emergency/Disaster Privileges.**

i. In an emergency and/or disaster and for so long as the emergency and/or disaster continues, provided there is no Medical Staff member or Professional available who is qualified, authorized and available to provide the necessary service, Professional to the degree permitted by his/her license to practice, as issued by any appropriate State, Federal or other regulatory agency, and without regard to the scope of approved privileges in the Hospital, shall be allowed, to the extent of such licensure, to do everything possible to save the life of, or avoid serious permanent harm to, any person requiring emergency assistance, using every facility of the Hospital necessary. Approval of such Professional shall be made by the Chief Administrative Officer; based upon information readily available regarding licensure, training and competence. When an emergency and/or disaster situation no longer exists, Professional, if he desires to continue to participate in the care of any patient, must request the Clinical Privileges appropriate for him/her to continue to participate in the care of the patient as otherwise provided in these Bylaws. For the purposes of this section, the following definitions shall apply:

(a) Emergency is defined as a condition in which serious permanent harm would result to a person or in which the life of a person is in immediate danger and any delay in administering treatment would add to that danger. Any Professional providing the emergency services shall document the need for his or her emergency services following the rendering of such services.

(b) Disaster is defined as any period of time during which the local and/or Hospital's emergency preparedness plan has been activated.

ii The procedures implementing this section shall be in accordance with the Hospital's emergency preparedness plan.

ARTICLE VIII. CORRECTIVE ACTION

SECTION 1. ROUTINE CORRECTIVE ACTION

a. **Request for Investigation.** Whenever the activities or professional conduct of any member of the Medical Staff may be detrimental to any patient's safety or quality patient care, or may be disruptive of Hospital operations or fails to adhere to the standards of ethics applicable to his profession, or may be in violation of these Bylaws, the Rules and Regulations, or policies of the Medical Staff or the Hospital, procedures for investigating the need to recommend corrective action against the Practitioner may be initiated through a written request for an

investigation of the matter in question and for the Executive Committee to make a determination upon completion of the investigation of whether or not corrective action should be considered. Such written request for investigation may be made only by an officer of the Medical Staff, by the chairman of any clinical department, by the chairman of any standing committee of the Medical Staff, by the Chief Administrative Officer, or by the Governing Body, each of whom may act independently, or upon the complaint or suggestion of any person. The request for investigation shall be submitted to the Executive Committee through the Chief of Staff or, if the Chief of Staff is not reasonably available or is the subject of the request for investigation, through the Chief of Staff Elect. All requests for an investigation shall be supported by reference to the specific activities or conduct which constitute the grounds for the request. If acting upon the complaint or suggestion of another person, the requesting individual or body, before submitting the request for investigation shall have conducted an initial assessment of such complaint or suggestion, and such assessment shall, in the opinion of the requesting individual or body, have revealed credible allegations, which if proven to be true would be likely to result in a recommendation for the imposition of a form of corrective action.

- b. **Alternative Procedures.** Any individual or body authorized by these Bylaws to request an investigation of the need to recommend corrective action may, in the alternative, refer the matter to the Physician Well Being Committee, to the extent the guidelines of such committee are or may be applicable to the situation.
- c. **Executive Committee Investigation and Recommendation.**
 - i. The Chief of Staff, or Chief of Staff-Elect if he received the request, shall present the request to the Executive Committee and the Executive Committee shall promptly make a determination of what if any investigation is required and the means by which any investigation shall be conducted in order to ascertain, if possible, grounds for corrective action exist. The Chief of Staff, or Chief-of Staff-Elect if he received the request, may, prior to presenting the request to the Executive Committee, appoint an ad hoc investigative committee made up of members of the Active Medical Staff to conduct the investigation if he deems it appropriate to do so under the circumstances. Any such action shall be reported to the Executive Committee at a regular or special meeting held within thirty (30) days of such appointment. If an investigative committee has not been appointed prior to presentation of the request to the Executive Committee, the Executive Committee may direct that one be appointed by the Chief of Staff or Chief of Staff-Elect. Any action to appoint an investigative committee shall be deemed to have been taken on behalf of the Executive Committee. No investigation conducted pursuant to this section shall be deemed to be a “hearing” as described in Article IX of these Bylaws. The Practitioner with respect to whom an investigation has been requested shall be notified if any investigation is commenced by a committee appointed to investigate the matter and of the general nature of the matter being investigated except where the person

appointing the committee determines that such notice might prejudice the investigation and so notifies the committee in writing.

- ii. If an ad hoc investigative committee is appointed, the investigative committee shall keep the Executive Committee apprised of its progress during the course of the investigation and shall submit to the Executive Committee a written report of the investigative committee's findings and conclusions as soon as practicable for the investigative committee to do so. Prior to the making of such report, the Practitioners with respect to whom an investigation has been requested shall have an opportunity for an interview with the investigative committee. Prior to such interview, he shall be informed of the general nature of any charges against him/her or of any particular areas of focus by the investigative committee, and shall be invited to respond. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings apply thereto. A record of such interview shall be made by the investigative committee and included with its report to the Executive Committee. The foregoing shall not preclude the investigative committee from holding any other preliminary meetings or interviews with the affected Practitioner if the investigative committee deems such to be appropriate under the circumstances.
- iii. Within sixty (60) days following the conclusion of any necessary investigation, the Executive Committee shall determine whether or not to recommend corrective action. If the Executive Committee is considering an Adverse Recommendation, the affected Practitioner may, at the election of the Executive Committee, be invited to make an appearance before the Executive Committee prior to its making a recommendation. This appearance, if any, shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply thereto. A record of any such appearance shall be made by the Executive Committee.
- iv. The action of the Executive Committee following a request for investigation may be to recommend that the Governing Body (i) take no further action; (ii) issue a warning, a letter of admonition, or a letter of reprimand; (iii) impose terms of probation or a requirement for consultation; (iv) reduce, suspend or revoke all or any portion of the Practitioner's Clinical Privileges; (v) terminate, modify or sustain an already imposed summary suspension of Clinical Privileges; (vi) suspend or revoke the Practitioner's Medical Staff membership; or (vii) some combination of the foregoing options.
- v. The Chairman of the Executive Committee shall promptly notify the Chief Administrative Officer in writing of all requests for investigation received by the Executive Committee and shall continue to keep the Chief Administrative Officer fully informed of all action taken in connection therewith. After the Executive Committee has determined its recommendation in the matter, the procedure to be followed shall be as provided in Article V, Section 1.f. iii. or iv. and, if applicable, in Article IX of these Bylaws.

SECTION 2. GOVERNING BODY AUTHORITY TO TAKE CERTAIN ACTIONS

The Governing Body of the Hospital has the ultimate responsibility for, and must strive to maintain and improve, the quality of care provided in the Hospital. The Governing Body also has ultimate responsibility for, and, through Hospital Administration, must strive to create and maintain a harmonious and productive environment in the Hospital for Hospital employees, those who exercise Clinical Privileges there and others on the premises. It is recognized that upon occasion a member of the Medical Staff may engage in behavior not necessarily reflective of incompetence or substandard clinical skills, but that may interfere with the attainment of these necessary goals and objectives of the Governing Body and Hospital Administration or may put the Hospital at substantial risk of liability to some third party. Accordingly, and notwithstanding any provision of these Bylaws to the contrary, the Governing Body shall have and specifically hereby retains the power and authority to take such disciplinary action against members of the Medical Staff, and in so doing to follow such procedures as it deems appropriate under the circumstances. Such actions may include, without limitation, suspension or revocation of Clinical Privileges and/or Medical Staff membership. Such actions may be taken whenever the behavior of a member of the Medical Staff, though not necessarily demonstrative or indicative of incompetence or substandard clinical performance, does have the potential to have a material, detrimental effect on persons working or exercising Clinical Privileges at the Hospital or others properly on the premises. The behavior that may justify direct action by the Governing Body pursuant to this section includes, without limitation, behavior that is abusive or that constitutes sexual harassment or racial discrimination or that otherwise exposes the Hospital to substantial risk of liability to any third party for reasons other than inadequate patient care services.

SECTION 3. SUMMARY SUSPENSION

- a. **Imposition.** A summary suspension of a Practitioner's right to exercise all or a portion of his/her Clinical Privileges may be imposed by either the chairman of the Executive Committee, the chairman of a clinical department or the Chief Administrative Officer, each of whom shall be deemed to be acting on behalf of the Executive Committee; the Executive Committee itself, or the Governing Body, as follows:
 - i. **For Preliminary Investigation.** A summary suspension may be imposed for a period of up to fourteen (14) days in order to investigate and determine whether or not there is a need to take further immediate action. Such summary suspension shall terminate automatically at the end of such 14-day period unless a summary suspension based upon aggravated circumstances is imposed.
 - ii. **For Aggravated Circumstances.** A summary suspension may be imposed whenever (a) the failure to take action may result in an imminent danger to the health of any individual or (b) a Practitioner willfully disregards or grossly violates these Bylaws, the Rules and Regulations or other Medical Staff or Hospital policies, or (c) the activities of Practitioner are likely materially to disrupt, or are materially disrupting, the operations of the

Hospital to a point that the quality of patient care or patient well-being may be endangered or compromised.

- b. **Suspension Effective Immediately; Assignment of Patients.** Any summary or preliminary suspension shall become effective immediately upon imposition and verbal or written notice to the Practitioner. In the event of any such suspension, the patients of such Practitioner then in the Hospital shall be assigned to another Practitioner by the appropriate department chairman. The wishes of the patient shall be considered, where feasible, in choosing another Practitioner.
- c. **Notice of Summary Suspension and Subsequent Procedures.** Whenever an individual's Clinical Privileges are summarily suspended in whole or in part based upon aggravated circumstances or to conduct a preliminary investigation, the persons or body responsible for such suspension shall give immediate Notice to the individual, and shall inform the Chief Administrative Officer and the Governing Body. Preliminary notice may be given verbally followed by a written Notice that states the reasons why the summary suspension was imposed. As soon as possible after such summary suspension, but in no event later than ten (10) days after written Notice of such summary suspension is sent or delivered to the affected Practitioner, a meeting of the Executive Committee shall be convened to review and consider the summary suspension. No such meeting shall be deemed to be a "hearing" as described in Article IX of these Bylaws. The affected Practitioner shall be provided Notice of such meeting (which may be included in the notice of summary suspension) and may request an interview with the Executive Committee during such meeting. After review and consideration of the summary suspension, the Executive Committee shall either make a determination that the summary suspension should be terminated or make a recommendation to the Governing Body that the summary suspension continue. The suspended individual shall be given notice of such determination or recommendation. If the Executive Committee recommends upholding the summary suspension, the suspended individual shall be informed of the reasons for the recommendations, and of his/her right to a hearing and appellate review, and such recommendation shall constitute a request for an investigation and a determination of the need to take permanent corrective action. Such investigation shall be conducted in accordance with Article VIII of these Bylaws.
- d. **Deferral of Hearing.** Notwithstanding any provision of these Bylaws to the contrary, the scheduling of any hearing regarding a summary suspension shall be deferred for not more than ninety (90) days to allow the investigation required by subsection c., above to take place and a recommendation concerning corrective action to be made by the Executive Committee. If within such ninety (90) day period a report of an ad hoc committee appointed to investigate the matter is submitted to the Executive Committee, the scheduling of the hearing shall be further deferred until the Executive Committee makes its recommendation of corrective action in accordance with Article VIII, Section 1.c.iv. and v., so that any such hearing can, in one consolidated proceeding, address both the summary suspension and the Executive Committee recommendation. If, however, such investigative committee report has been requested, but is not received by the

Executive Committee within such ninety (90) day period, then the Executive Committee shall meet promptly to review the status of the investigation. At such meeting the chairman of the ad hoc committee appointed to investigate the matter shall report on the status of the investigation and the steps yet to be taken and shall provide an estimate of the additional time he expects will be needed to conclude the investigation. The suspended individual may attend such meeting and may comment on the reasonableness of the time estimated to be required for the investigation. The Executive Committee shall then determine whether or not there is good cause to continue deferral of the hearing until the Executive Committee makes its recommendation concerning corrective action in the matter. The scheduling of a hearing shall not be delayed for more than one hundred eighty (180) days from the date such summary suspension was first upheld by the Executive Committee without the agreement of the suspended individual.

SECTION 4. AUTOMATIC ACTIONS

- a. **Medical Records Violations.** A Practitioner who unjustifiably fails to complete medical records within the time specified in the Rules and Regulations shall be subject to automatic suspension of all Clinical Privileges. Such suspension shall become effective seven (7) days following written notice to the Practitioner of intent to automatically suspend because of a delinquent medical record(s) and shall remain in place until the medical records are completed; provided, however, that upon review by the Chief of Staff, failure to complete the medical record(s) within sixty (60) days of such notice shall constitute abandonment of the medical record and the Practitioner shall be deemed to have resigned from the Medical Staff. A Practitioner whose Clinical Privileges are suspended or who is deemed to have resigned pursuant to this subsection shall not have a right to a hearing or appellate review pursuant to Article IX of these Bylaws.
- b. **Licensure.** Medical Staff membership and all Clinical Privileges of a Practitioner or any other individual authorized to exercise Clinical Privileges in the Hospital shall immediately and automatically be suspended if such individual's license, certificate or other official credential authorizing practice in the State of Tennessee is revoked, suspended, or lapses and such membership or privileges shall be revoked automatically and immediately without notice if such action by the State is not set aside within ninety (90) days of its imposition. Neither suspension nor revocation pursuant to this subsection shall give rise to any right to a hearing or appellate review pursuant to Article IX of these Bylaws.
- c. **Drug Enforcement Agency (DEA) Certificate.** A Practitioner or AHP whose DEA Certificate is revoked, suspended, or lapses shall immediately and automatically lose the authority to prescribe medication conferred by the number. As soon as practicable after such automatic loss, the Executive Committee shall convene to review and consider the circumstances under which the DEA Certificate was revoked or suspended. The Executive Committee shall then take such further corrective action as is appropriate to the facts disclosed in the investigation. Loss of the authority to prescribe medications covered by a

- revoked DEA number pursuant to this subsection shall not give rise to a right of a hearing or appellate review pursuant to Article IX of these Bylaws.
- d. **Malpractice Insurance.** If a Practitioner or other individual required to maintain professional liability insurance coverage fails to maintain such professional liability insurance as is required as a qualification for membership and/or Clinical Privileges, his/her Medical Staff membership and/or Clinical Privileges shall be suspended automatically until he has provided evidence of such insurance coverage. Failure to provide evidence of such coverage within six (6) months after the suspension shall be deemed a voluntary resignation of Medical Staff membership and all Clinical Privileges. A Practitioner who is deemed to have resigned pursuant to this subsection shall not have a right to a hearing or appellate review pursuant to Article IX of these Bylaws.
 - e. **Failure to Cooperate With Investigation and to Provide Records.** Any unreasonable failure to cooperate with an investigation or failure to provide to cause others to provide records necessary to any determination of the competence or professional conduct of any member of the Medical Staff or other individual authorized to exercise Clinical Privileges, as determined by the Executive Committee and concurred by the Governing Body, shall result in automatic suspension of such individual's Medical Staff membership and/or Clinical Privileges. Practitioner may take reasonable steps to meet applicable requirements regarding confidentiality of medical records provided. Any unreasonable failure to cooperate for a period of thirty (30) days or more after an automatic suspension imposed pursuant to this subsection shall be deemed a voluntary resignation of Medical Staff membership and all Clinical Privileges effective upon Notice to Practitioner. A Practitioner who is deemed to have resigned pursuant to this subsection shall not have a right to a hearing or appellate review pursuant to Article IX of these Bylaws.
 - f. **Loss of Faculty Appointment.** A member of the Active Medical Staff whose faculty appointment where required is terminated or not renewed:
 - i. shall automatically be reassigned, if eligible, to the Courtesy Medical Staff upon termination or non-renewal of the faculty appointment; provided however, that such reassignment to the Courtesy Staff shall not be effective for ninety (90) days from such termination or expiration.
 - ii. may apply for a waiver of the requirement of faculty appointment under Article IV, Section 2.a. of these Bylaws. Such member's Active staff status shall continue until the application process under Article IX, Section 2.a. is complete.
 - g. **Courtesy Staff Failure to Maintain Other Hospital Privileges.** Any failure by a member of the Courtesy Staff continuously to maintain Active staff membership and clinical privileges at one or more other hospitals in the community as required by Article IV, Section 3.a.iv. shall result in automatic suspension without any right to hearing or appellate review of such individual's Medical Staff membership and Clinical Privileges upon Notice to such Practitioner. If such failure is not corrected within ninety (90) days from the date the suspension

becomes effective, the Practitioner shall be deemed to have resigned his/her Medical Staff membership and Clinical Privileges automatically without the need for further notice and without any right to hearing or appellate review.

- h. **Failure to Attend Mandatory Meeting.** Any Practitioner who fails to attend a department or committee meeting with respect to which he was given reasonable notice that attendance was mandatory, unless excused by the meeting chairman upon a showing of good cause, shall be subject to automatic suspension of all or any portion of his Clinical Privileges, as directed by the Executive Committee. Such suspension shall remain in effect until the matter is resolved through any mechanism that may be appropriate. In the event that such suspension results in the initiation of an investigation under Article VIII, Section 1 of these Bylaws, the affected practitioner shall have the right to a hearing and appellate review pursuant to Article IX of these Bylaws.
- i. **Enforcement.** The Chief Administrative Officer shall cooperate with the Chief of the Medical Staff in imposing and enforcing all automatic suspensions.
- j. **Coverage of Patients.** Upon the occurrence of an automatic suspension or termination, the Chief of Staff, in consultation with the chairman of the appropriate department, shall provide for alternative coverage for patients of the suspended individual in the Hospital. The wishes of the patient shall be considered, when feasible, in arranging for such coverage. The suspended individual shall confer with person providing such coverage to the extent necessary to safeguard any patient.

SECTION 5. REPORTING

The Chief Administrative Officer shall be responsible to make such reports to the applicable licensing Board for the State of Tennessee and/or to the National Practitioner Data Bank, or any successor thereto, as are deemed required by law to be made by the Chief Administrative Officer or on behalf of the Hospital in respect of actions taken or conduct observed by the Hospital or the Medical Staff relating to the competence or professional conduct of a Practitioner or AHP.

ARTICLE IX. HEARING AND APPELLATE REVIEW PROCEDURES

SECTION 1. RIGHT TO HEARING AND TO APPELLATE REVIEW

A Practitioner shall be entitled to a hearing pursuant to these Bylaws after an Adverse Recommendation or an Adverse Action is made or taken by a Decision-Making Body, unless such right to a hearing is expressly withdrawn by these Bylaws and except where the basis for the action taken has been the subject of a prior hearing.

SECTION 2. REQUESTS FOR HEARING

- a. **Notice of Adverse Recommendation or Adverse Action.** The Chief Administrative Officer shall give prompt written Notice of an Adverse Recommendation or an Adverse Action to any affected Practitioner who is entitled to request a hearing with

respect thereto. Such Notice shall include a written statement of such recommendation or action together with a statement of the grounds on which the recommendation or action is based, a statement of the Practitioner's right to request a hearing pursuant to this Article IX, and a summary of his/her rights with respect to the hearing.

- b. **Deferral of Consideration by the Governing Body.** When the Executive Committee proposes to make an Adverse Recommendation to the Governing Body and the affected Practitioner is entitled to request a hearing with respect thereto, the Governing Body's consideration of such recommendation shall be deferred for at least thirty (30) days following the date of Notice of such recommendation to the affected Practitioner. If within such thirty (30) day period the Practitioner requests a hearing in accordance with Article IX, Section 2.c. of these Bylaws, the Governing Body's consideration of the Adverse Recommendation shall be deferred until the conclusion of the hearing and any appellate review.
- c. **Request for Hearing.** A Practitioner shall have thirty (30) days following receipt of Notice of an Adverse Recommendation or Adverse Action to request a hearing before an ad hoc Hearing Committee. Such request shall be made by written Notice to and received by the chairman of the Executive Committee within such thirty (30) day period. To be effective, such Notice must respond, point by point, to each finding or ground relied upon by the Decision-Making Body in support of the Adverse Recommendation or Adverse Action. The response must clearly indicate in what respect, from the Practitioner's point of view, each finding or ground, as well as the Adverse Recommendation or Adverse Action itself, is in error. A Practitioner who fails to request a hearing to which he is entitled in accordance with these Bylaws within the time and in the manner herein provided shall be deemed to have accepted the Adverse Recommendation or Adverse Action involved and to have waived his right to a hearing and to any appellate review to which he/she might otherwise have been entitled. The proposed Adverse Recommendation or adverse Action shall thereupon become the final recommendation or action, as the case may be, of the Decision-Making Body. Such final recommendation or action, if not made by the Governing Body, shall then be considered by the Governing Body at its next meeting and the Governing Body shall take final action in the matter in accordance with Article IX, Section 7.

SECTION 3. NOTICE OF HEARING

Within thirty (30) days after receipt of an effective request for hearing, the chairman of the Executive Committee or the chairman of the Governing Body, whichever is appropriate, shall schedule and arrange for the hearing and shall, through the Chief Administrative Officer, notify the Practitioner of the time, place and date of the hearing. The date the hearing commences shall be not less than thirty (30) days from the date of the Notice to the Practitioner of the hearing; provided, however, that when a request for a hearing is received from a Practitioner who is under suspension then in effect, the hearing may be held as soon as arrangements may reasonably be made if the Practitioner's request for hearing includes a request for an early hearing. The Notice of the hearing also shall contain a list of the witnesses, including the name of the spokesman for the

Decision-Making Body, expected to testify at the hearing on behalf of the Decision-Making Body.

SECTION 4. COMPOSITION OF HEARING COMMITTEE

- a. When a hearing relates to an Adverse Recommendation or Adverse Action of the Executive Committee, the Chief of Staff shall appoint an ad hoc Hearing Committee of not less than three (3) nor more than seven (7) members, none of whom are members of the Governing Body and none of whom are in direct economic competition with the affected Practitioner, and at least three (3) of whom shall be members of the Active Medical Staff. One of the members shall be designated as chairman. No Medical Staff member who has actively participated in the consideration of the matter previously shall be appointed as a member of the ad hoc Hearing Committee. Those members in excess of the three members of the Active Medical Staff may be from outside the Active Medical Staff and the Hospital and need not be physicians.
- b. When a hearing relates to an Adverse Action of the Governing Body, the chairman of the Governing Body or his/her designee shall appoint an ad hoc Hearing Committee of not less than three (3) nor more than seven (7) members, none of whom are in direct economic competition with the affected Practitioner, and shall designate one of the members of the ad hoc Hearing Committee as chairman. At least one member of the Active Staff shall be included on such ad hoc Hearing Committee when feasible. The other members need not be members of the Governing Body and may be from outside the Hospital.
- c. Alternatively, and notwithstanding the preceding two subsections, the Decision-Making Body may, in its discretion, appoint a hearing officer to conduct the hearing. The hearing officer may, but is not required to be, an attorney. The individual serving as hearing officer should be experienced in conducting hearings and shall fulfill all of the duties required of an ad hoc Hearing Committee in this Article IX.

SECTION 5. CONDUCT OF HEARING AND PRELIMINARY PROCEDURES

- a. **Quorum; Voting.** A majority of the members of the Hearing Committee shall constitute a quorum, and a quorum must be present at all times during the hearing. No member of a Hearing Committee may vote by proxy, and the action of a majority of the Hearing Committee members present shall constitute the action of the Hearing Committee.
- b. **Record of Hearing.** The Hearing Committee shall engage a court reporter to record and transcribe the evidentiary portion of the hearing. Copies of the transcription may be obtained by the affected Practitioner upon payment of any fees associated with the preparation thereof.
- c. **Presence of Practitioner.** The personal presence of the affected Practitioner shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have accepted voluntarily the proposed Adverse Recommendation or Adverse Action and to have waived

his/her right to a hearing and to any appellate review to which he might otherwise have been entitled. The proposed Adverse Recommendation or Adverse Action shall thereupon become the final recommendation or action of the Decision-Making Body. Such final recommendation or action, if not made by the Governing Body, shall then be considered by the Governing Body at its next meeting and the Governing Body shall take final action in the matter in accordance with Article IX, Section 7.

- d. **Postponements and Extensions.** Postponements of hearings and extensions of time beyond the times set forth in this Article IX shall be effective if agreed to by the affected Practitioner and the Decision-Making Body, or their duly authorized counsel or other representative. Postponements and extensions also may be granted by the ad hoc Hearing Committee or its chairman upon written request from the affected Practitioner or the Decision-Making Body based on good cause shown.
- e. **Representation.**
 - i. The affected Practitioner shall be entitled to be represented at the hearing by an attorney or other individual of his/her choice. The Practitioner shall be required to notify the Decision-Making Body of his/her intent to be represented by counsel as soon before the hearing as possible but in no event less than fourteen (14) days before the hearing; failure to give such notice shall constitute waiver of the right to be represented by counsel at the hearing. Such notification, to be effective, must include the full name, office address and telephone number of the Practitioner's representative.
 - ii. The Decision-Making Body shall appoint a spokesman who shall present at the hearing a complete statement of the proposed Adverse Recommendation or Adverse Action, and the basis for such recommendation or action. Any other witnesses, materials, documents or argument to be presented, offered or made at the hearing on behalf of the Decision-Making Body may be presented or offered by the spokesman of the Decision-Making Body or its counsel.
- f. **Presiding Officer.** The chairman of the Hearing Committee, or the hearing officer if one is appointed shall be referred to hereinafter as the "Presiding Officer", 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 relevant oral and documentary evidence, and to maintain decorum. The Presiding Officer shall have the authority and discretion to make all rulings on questions pertaining to procedure or the admissibility of evidence.
- g. **Disclosure of Witnesses.** At least seven (7) days before the hearing, the affected Practitioner shall identify and submit to the chairman of the Decision-Making body and the Presiding Officer a list of witnesses expected to testify in his/her behalf at the hearing with names, telephone numbers and business addresses for each and a brief description of the subject matter expected to be covered by each such witness in his/her testimony, and, if the witness is to be utilized as an expert, a statement of the expert's qualifications along with a copy of the expert's

- curriculum vitae. The chairman of the Decision-Making Body shall likewise identify and submit to the affected Practitioner and the Presiding Officer a list of any witnesses who have not previously been identified with names, telephone numbers and addresses and a brief description of the subject matter expected to be covered by each such witness in his/her testimony and, if the witness is to be utilized as an expert, a statement of the expert's qualifications along with a copy of the expert's curriculum vitae. Unjustified failure of the Practitioner to comply with the requirements of this section shall be deemed a waiver of his/her hearing rights and any further right to appellate review. Unjustified failure on the part of the chairman of the Decision-Making Body to comply with the requirements of this section shall entitle the affected Practitioner to a postponement of the hearing.
- h. **Miscellaneous Rules.** The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. The Hearing Committee, in its discretion, may interrogate witnesses or call additional witnesses or request the presentation of additional information. The Practitioner may be called and examined as if under cross-examination. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rule which might make evidence inadmissible over objection in a civil or criminal action. The affected Practitioner and the Decision-Making Body may, prior to or during or after the close of the hearing, submit written memoranda concerning any issue or procedure or fact and such memoranda shall become a part of the hearing record.
- i. **Order of Presentation: Burden of Proof.**
- i. **Order of Presentation: Burden of Proof.** If the hearing is occasioned by a recommendation of denial of initial Medical Staff appointment or requested Clinical Privileges or any other issue with respect to which these Bylaws require an individual to establish his/her qualifications, then the affected Practitioner shall present first and shall have the burden of proving, by a preponderance of the evidence, that the Adverse Recommendation or Adverse Action lacks any substantial factual basis or that the basis or the conclusions drawn therefrom and necessary to support the action taken or recommended are either arbitrary or capricious. In all other cases, the Decision-Making Body shall present first and shall be required to present evidence in support of the Adverse Recommendation or Adverse Action; thereafter, the affected Practitioner shall have the burden of proving, by a preponderance of the evidence, that the Adverse Recommendation or Adverse Action lacks any substantial factual basis or that the basis or the conclusions drawn therefrom and necessary to support the action taken or recommended are either arbitrary or capricious.
- ii. **Additional Grounds of Information.** The Hearing Committee shall not be bound by the statement of grounds on which the proposed action or recommendation of the Decision-Making Body was based. The Hearing Committee may continue the hearing to call such additional witnesses and/or to obtain such additional information as it deems necessary to a

proper decision, and the Hearing Committee, may, upon giving supplemental Notice to the Practitioner and the Decision-Making Body of the additional grounds, broaden the issues under examination and may base its decision, wholly or in part, upon information not originally considered or listed. The Practitioner and the Decision-Making Body shall have thirty (30) days following the date of receipt of such supplemental Notice to respond to the additional grounds, and the time for continuation of the hearing shall be adjusted accordingly; provided, that at the written request of the Practitioner, any or all of the thirty day period to respond to the additional grounds may be waived.

- j. **Rights of the Affected Practitioner.** The affected Practitioner shall have the following rights, subject to the authority of the Presiding Officer: to call and examine witnesses, to introduce relevant evidence, to cross-examine any witnesses on any matter relevant to the issue of hearing, to challenge any witness and to rebut any evidence.
- k. **Adjournment and Conclusion.** The Presiding Officer may, without special notice, adjourn the hearing and reconvene the same at the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence and argument, oral and written, the hearing shall be closed. Final adjournment of the hearing shall be deemed to occur when the Hearing Committee has received the transcript of the hearing and all post-presentation written submission authorized.
- l. **Hearing Committee Report and Recommendation.** The Hearing Committee shall deliberate at a time convenient to itself, in private, with counsel if it so elects, but outside of the presence of the court reporter and the hearing participants, before rendering its written report and recommendation. Within fourteen (14) days after final adjournment of the hearing, the Hearing Committee shall make a written report and recommendation and shall forward the same, together with the hearing record and all other documentation, to the Chief Administrative Officer. The report may recommend confirmation, modification, or rejection of the original Adverse Recommendation or Adverse Action of the Decision-Making Body and shall include findings of fact sufficient in detail to enable the Practitioner and the Decision-Making Body to determine the basis for the Hearing Committee's recommendation on each matter contained in the Notice to the Practitioner of the proposed Adverse Recommendation or Adverse Action. The Chief Administrative Officer shall, within seven days of receipt, transmit the Hearing Committee's report and recommendation to the Executive Committee and to the Governing Body, and to the affected Practitioner in accordance with the procedures for giving Notice under these Bylaws.

SECTION 6. APPELLATE REVIEW

- a. **Request for Appellate Review.** Within fifteen (15) days after receipt of the report and recommendation of the Hearing Committee, either the affected Practitioner or the Decision-Making Body may request appellate review by the

- Governing Body. Such request shall be made by written Notice to the Governing Body delivered through the Chief Administrative Officer, with a copy to the opposing party. Such Notice shall include a brief statement of the reasons or basis for the appeal, and shall state whether or not oral argument is requested.
- b. **Waiver by Failure to Request Appellate Review.** If appellate review is not requested by a Practitioner within the time and in the manner specified, the Practitioner shall be deemed to have waived his/her right to the same. Such waiver shall have the same force and effect as that provided in Section 2.c. of this Article IX.
 - c. **Reasons for Appeal.** The following are the sole reasons for appeal from the report and recommendation of the Hearing Committee:
 - i. substantial failure of any person to comply with the procedures required by this Article IX or applicable law in the conduct of the hearing and rendering of the decision so as to deny a fair hearing;
 - ii. the lack of substantive rationality of a Medical Staff Bylaw, Rule or Regulation, or policy relied upon by the Hearing Committee in reaching its decision; or
 - iii. a Hearing Committee decision that is arbitrarily, unreasonably, or capriciously made.
 - d. **Notice of Time and Place for Appellate Review.** Within thirty (30) days after receipt of a request for appellate review in conformance with these Bylaws, the Chairman of the Governing Body or his/her designee shall schedule a date to meet and conduct such review, and shall specify a time and place for oral argument if such has been requested and granted, and shall, through the Chief Administrative Officer, give Notice to the affected Practitioner of the same.
 - e. **Appellate Review Body.** The chairman of the Governing Body shall determine whether the appellate review shall be conducted by the Governing Body as a whole, or by a duly appointed Appellate Review Committee. If an Appellate Review Committee is used, it shall be appointed by the chairman of the Governing Body and shall include at least five (5) members of the Governing Body plus any additional members that the chairman of the Governing Body deems appropriate; those members in excess of the five (5) members of the Governing Body need not be members of the Governing Body. If an Appellate Review Committee is appointed, one of its members will be designated as chairman by the chairman of the Governing Body.
 - f. **Written Statements.** The affected Practitioner and the Decision-Making Body shall have access to the evidentiary record of the hearing and may submit a written statement detailing those factual and procedural matters with which there is disagreement. This written statement may cover any matters considered at any step in the hearing process, and legal counsel may prepare and/or assist in its preparation. Such written statement shall be submitted to the appellate review body through the Chief Administrative Officer, with a copy to the opposing party, at least five (5) days prior to the scheduled date for the appellate review.

- g. **Appellate Review Proceedings.** The appellate review proceedings shall be in the nature of an appellate hearing based on the record of the hearing before the Hearing Committee. Unless otherwise demonstrated by specific reference to the hearing record, there shall be a presumption that the hearing committee or the hearing officer, as the case may be, acted reasonably and in accordance with these Bylaws. The appellate review body may, in its sole discretion, permit the affected Practitioner and the Decision-Making Body, or their designated representative, to personally appear and make oral argument. A majority of the members of the appellate review body shall constitute a quorum, and a quorum must be present at all times during the appellate review proceedings. At the conclusion of the appellate review proceeding, the appellate review body shall conduct at a time convenient to itself, deliberations outside the presence of the court reporter and the participants.
- h. **The Record on Appeal.** The appellate review body may engage a court reporter to record and transcribe any oral argument portions of the appeal. Copies of any transcription, in the event one is produced, may be obtained by the affected Practitioner upon payment of any fees associated with the preparation thereof.
- i. **Consideration of New or Additional Matters.** New or additional matters or evidence not raised or presented during the original hearing or in the Hearing Committee report and not otherwise reflected in the record shall only be introduced at the appellate review under unusual circumstances, and the appellate review body shall in its sole discretion determine whether such new matters shall be accepted. The party seeking to introduce such new or additional information shall provide the appellate review body and the opposing party a written, substantive description of the matter or evidence requested to be considered and the reasons it could not have been discovered in time to be considered at the hearing. Such description shall be submitted no fewer than five (5) days prior to the scheduled date of the appellate review.
- j. **Report by Appellate Review Committee.** If the appellate review is conducted by an Appellate Review Committee, such committee shall, within fifteen (15) days after the closure of the appellate review, either deliver to the chairman of the Governing Body a written report to the Governing Body recommending that the Governing Body affirm, modify, or reverse the recommendation of the Hearing Committee, or refer the matter back to the Executive Committee for further review and recommendation within a specified time period. Such referral may include a request that the Executive Committee arrange for a further hearing to resolve disputed issues and make its recommendation to the Appellate Review Committee within the specified time period. Within fifteen (15) days of receipt of such recommendation, the Appellate Review Committee shall make its report to the Governing Body as specified above.
- k. **Conclusion of Appellate Review.** The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Section 6 have been completed or waived.

SECTION 7. FINAL DECISION BY THE GOVERNING BODY

Within forty-five (45) days after a Practitioner has been deemed to have waived his/her right to a hearing and/or appellate review, or within forty-five (45) days after the conclusion of the appellate review by the Governing Body, or within forty-five (45) days of the receipt by the Governing Body of the report of any Appellate Review Committee, the Governing Body shall make its final decision in the matter and shall send Notice thereof, through the Chief Administrative Officer, to the Executive Committee, and the affected Practitioner.

SECTION 8. RIGHT TO ONLY ONE HEARING

Notwithstanding any other provision of these Bylaws, no Practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of review by either the Executive Committee or a Hearing Committee appointed pursuant to these Bylaws, or the Governing Body or an Appellate Review Committee appointed pursuant to these Bylaws, or both.

ARTICLE X. OFFICERS

SECTION 1. OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be a Secretary, a Chief of Staff-Elect, a Chief of Staff, and an Immediate Past Chief of Staff.

SECTION 2. QUALIFICATIONS OF OFFICERS

The officers of the Medical Staff must be qualified based on training, experience and ability to direct the medico-administrative aspects of Hospital and Medical Staff activities. All officers of the Medical Staff will be required to undergo training for Medical Staff officers as prescribed by the Chief of Staff. All officers of the Medical Staff must have demonstrated loyalty to the Medical Staff and the Hospital, an absence of any conflict of interest that might be likely to divide loyalty to the Hospital because of significant commitments to another hospital or organization, and shall act, in all of their official functions, only in the best interest of the Medical Staff and the Hospital. Additionally, officers must be members in Good Standing of the Active Medical Staff at the time of nomination and election and at the time they take office, and must remain Active Medical Staff members in Good Standing during their term in office. Failure to maintain such status shall immediately create a vacancy in the office involved.

SECTION 3. TERM OF OFFICE

The Chief of Staff-Elect and Secretary shall be elected at the annual meeting of the Medical Staff for a one-year term. The one-year term of office shall begin January 1 and end December 31 of the calendar year commencing immediately subsequent to the annual meeting at which they are elected. The Chief of Staff-Elect shall, at the conclusion of his/her term, automatically accede to the office of Chief of Staff for a one-year term and then to the office of Immediate Past Chief of Staff for a one-year term.

SECTION 4. ELECTION OF OFFICERS

The procedure for the election of officers shall be as follows:

- a. At the third quarterly staff meeting each year, the Nominating Committee pursuant to Article XII, Subsection 2.g. shall present to the Medical Staff the names of candidates for each elective office, together with such other nominations as are required by such Section.
- b. After presentation of the Nominating Committee's nominees, further nominations may be made from the floor by an Medical Staff member entitled to vote.
- c. After the third quarterly staff meeting, a ballot shall be prepared under the direction of the Nominating Committee on which is entered all the candidates for office. Such ballot, together with a return envelope, shall be mailed not later than November 1 of each year to each member of the Medical Staff entitled to vote. Medical Staff members shall vote by completing the ballot and returning it, unsigned, not later than December 1. The Nominating Committee shall then count the votes and report the results of the election at the annual meeting: the nominee receiving the largest number of votes cast shall be elected to office.
- d. Only members of the Active Medical Staff in Good Standing shall be eligible to vote for the election of officers.

SECTION 5. SECTION 5. REMOVAL OF OFFICERS

A Medical Staff officer may be removed by a two-thirds vote of the Executive Committee. Grounds for removal shall include, but not be limited to, mental and/or physical impairment or any other circumstance or condition resulting in the inability of such officer to perform the duties and responsibilities of his/her office. In instances of malfeasance in office, the Governing Body shall have the authority to remove any officer of the Medical Staff on its own motion.

SECTION 6. VACANCIES IN OFFICE

Vacancies in an elected office or in the office of Immediate Past Chief of Staff shall be filled by the Executive Committee. A vacancy in the office of Chief of Staff shall be filled by the Chief of Staff-Elect. No officer may succeed himself or herself.

SECTION 7. DUTIES OF OFFICERS

- a. **Chief of Staff.** The Chief of Staff, as the principal elected official representative of the Medical Staff, shall:
 - i. act in coordination and cooperation with the Chief Administrative Officer in all matters of mutual concern within the Hospital;
 - ii. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
 - iii. serve as Chairman of the Executive Committee;

- iv. serve as ex officio member of all other medical staff committees without vote, unless otherwise delineated in the committee description;
 - v. be responsible for the enforcement of the Bylaws and the Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where an investigation has been requested or corrective action recommended against a Practitioner;
 - vi. appoint committee members to all standing, special, and multi-disciplinary Medical Staff committees, except as provided otherwise in these Bylaws;
 - vii. represent the Medical Staff and its views, policies, needs and grievances to the Governing Body and the Chief Administrative Officer;
 - viii. receive, and interpret the policies of the Governing Body to the Medical Staff and report to the Governing Body on the performance and maintenance of quality with respect to the Medical Staff's responsibility to provide medical care;
 - ix. be responsible in conjunction with the GSM for the educational activities of the Medical Staff;
 - x. be the spokesman for the Medical Staff in its external professional and public relations; and
- b. **Chief of Staff-Elect.** In the absence of the Chief of Staff, the Chief of Staff-Elect shall assume all of the duties and have all of the authority of the Chief of Staff. The Chief of Staff-Elect shall be a member of the Executive Committee and the Credentials Committee. He/she shall automatically assume the office of Chief of Staff if it should become vacant. He/she shall serve as the Medical Staff representative to the American Medical Association-Hospital Medical Staff Section Assembly Meetings.
- c. **Immediate Past Chief of Staff.** The immediate Past Chief of Staff shall serve as Chairman of the Credentials Committee and as a member of the Executive Committee.
- d. **Secretary.** The Secretary shall be a member of the Executive Committee. The Secretary shall be responsible to keep accurate and complete minutes of all Medical Staff meetings (or arrange for such to be kept), to give proper notice of all Medical Staff meetings on order of the appropriate authority, and to perform such other duties as ordinarily pertain to his/her office.

ARTICLE XI. CLINICAL DEPARTMENTS

SECTION 1. ORGANIZATION OF CLINICAL DEPARTMENTS

The Medical Staff shall be divided into clinical departments, each having a chairman who shall be responsible for the overall supervision of the clinical work within his/her department. The clinical departments shall be as follows:

Anesthesiology, Emergency Medicine, Family Medicine, Internal Medicine, Medical Genetics, Obstetrics and Gynecology, Oral and Maxillofacial Surgery/General Dentistry, Pathology, Pediatrics, Radiology and Surgery.

SECTION 2. DEPARTMENT CHAIRMEN

The department chairmen shall be appointed by the Governing Body upon recommendation of the Chief Administrative Officer and the Dean for a one (1) year term. Each chairman shall be a member in Good Standing of the Active Medical Staff well qualified by training, experience and demonstrated ability for the position. He/She shall be certified by an appropriate specialty board or shall affirmatively establish through the privilege delineation process that he/she possesses comparable competence and experience.

SECTION 3. RESPONSIBILITIES OF DEPARTMENT CHAIRMEN

Each department chairman shall:

- a. strive to assure that the quality and appropriateness of patient care provided within the department are monitored and evaluated, and otherwise be accountable for all professional and administrative activities within the department;
- b. be a member of the Executive Committee, giving guidance on the overall medical policies of the Hospital and making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care;
- c. maintain continuing review of the professional performance of Practitioners and others exercising Clinical Privileges in his/her department;
- d. appoint an ad-hoc departmental committee to conduct reviews of practitioner-specific occurrences or trends as required by these Bylaws;
- e. assist in the enforcement of these Bylaws and the Rules and Regulations;
- f. be responsible for implementation within his/her department of actions taken by the Executive Committee;
- g. transmit to the Credentials Committee his/her department's recommendations concerning the Medical Staff category, reappointment, and delineation of Clinical Privileges for all Practitioners assigned to his/her department;
- h. be responsible for the teaching, education and research programs of his/her department;
- i. participate in every phase of administration of his/her department through cooperation with Hospital Administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques;
- j. assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the Executive Committee, the Chief Administrative Officer or the Governing Body;

- k. assess and recommend to Hospital Administration off-site sources for needed patient care services not provided by the department or the Hospital;
- l. integrate the department into the primary functions of the Hospital;
- m. coordinate and integrate interdepartmental and intradepartmental services;
- n. develop and implement policies and procedures that guide and support the provision of services;
- o. recommend a sufficient number of qualified and competent persons to provide care or service;
- p. determine the qualifications and competence of department or service personnel who are not Practitioners and who provide patient care services;
- q. continuously assess, improve and maintain the quality of care and services provided with the department;
- r. maintain quality control programs, as appropriate;
- s. conduct the orientation and continuing education of all persons in the department or service; and
- t. make recommendations for space and other resources needed by the department.

SECTION 4. FUNCTIONS OF THE CLINICAL DEPARTMENTS

- a. Each clinical department shall establish criteria, consistent with the policies of the Medical Staff and of the Hospital and Governing Body, for the credentialing of Practitioners who exercise Clinical Privileges in the department and for credentialing for new procedures, and shall make recommendations to the Credentials Committee regarding the granting of Clinical Privileges within the department. Such professional criteria shall be designed to strive to ensure the Medical Staff and Governing Body that patients will receive quality care, and shall pertain at least to evidence of current licensure, relevant training or experience, current competence, and ability to perform the privileges requested.
- b. The clinical departments provide leadership in the multidisciplinary improvement efforts and establish processes to design, monitor, analyze, and improve the clinical activities of the Hospital. The clinical departments monitor the professional performance of all Practitioners in each department who have delineated Clinical Privileges in order to assess and improve the quality of care and services provided and to maintain quality control programs.
- c. The findings, recommendations, and actions from this process shall be communicated to the appropriate medical staff members, including department chairs when practitioner-specific issues are identified. The Medical Executive Committee and the Governing Body will receive quarterly reports of the clinical improvement activities of the Medical Staff and clinical departments; and, when generated, reports on practitioner specific issues.

- d. Aggregate reports of clinical performance improvement activities conducted by the Medical Staff and clinical departments are submitted quarterly to the performance improvement council.

SECTION 5. ASSIGNMENT TO DEPARTMENTS

The Executive Committee shall, after consideration of the recommendations of the clinical departments as transmitted through the Credentials Committee, recommend to the Governing Body initial departmental assignments for all Medical Staff members and for all other individuals exercising Clinical Privileges. The exercise of Clinical Privileges within any department is subject to the Departmental Rules and Regulations as administered by the department chairman.

ARTICLE XII. COMMITTEES

SECTION 1. STANDING MEDICAL STAFF COMMITTEES

a. Bylaws Committee

- i. **Composition.** The Bylaws Committee shall consist of the following members:
 - (a) the Chief of Staff, the Chief of Staff-Elect, the Immediate Past Chief of Staff and the Secretary of the Medical Staff, all of whom shall be voting members. The Chair of the Bylaws Committee shall be the Immediate Past Chair of the Credentials Committee;
 - (b) five (5) or more additional voting members of the Medical Staff shall be appointed annually by the Chief of Staff;
 - (c) the Committee also shall have the following non-voting ex-officio members; the Chief Administrative Officer and his/her designees.
- ii. **Duties.** The duties of the Bylaws Committee shall be to review, no less frequently than annually, the Bylaws and the Rules and Regulations, and to make recommendations to the Executive Committee and to the Medical Staff regarding necessary or desirable revisions to the Bylaws and/or the Rules and Regulations.
- iii. **Meetings.** The Bylaws Committee shall meet no less frequently than quarterly and shall maintain a permanent record of its proceedings and actions.

b. Clinical Cancer Committee

- i. **Composition.** The committee is responsible for program leadership, is multidisciplinary, and represents the full scope of cancer care. Required membership includes at least one Medical Staff member representing the following diagnostic and treatment services: diagnostic radiology, pathology, general surgery, medical oncology, radiation oncology and the cancer liaison physician (as that term is defined by the American College of Surgeons). Non-physician members shall include: cancer program administrator,

oncology nurse, social worker/case manager, certified tumor registrar, performance improvement professional, clinical research staff member, and pain control/palliative care specialists. Additional members may be added as determined by the Clinical Cancer Committee.

ii. **Duties and Responsibilities.**

The Clinical Cancer Committee shall be responsible and accountable for:

- (a) All cancer program activities at the Medical Center.
- (b) Designation of one coordinator for each of the four areas of activity of the Clinical Cancer Committee: cancer conference, quality control of cancer registry data, quality improvement and community outreach.
- (c) Establishing the cancer committee meeting schedule to meet the requirements of the American College of Surgeons Commission on Cancer (ACoS CoC) requirements and the needs of the cancer program.
- (d) Developing and evaluating the annual goals and objectives for the clinical program, community outreach, quality improvement, and programmatic endeavors related to cancer care.
- (e) Establishing the frequency and format of the cancer conferences including the attendance requirements for the members of the multidisciplinary team.
- (f) Ensuring the required numbers of cases discussed at the cancer conferences on an annual basis and the percentage of cases presented prospectively are sufficient to meet the requirements of the ACoS CoC.
- (g) Implementing a plan to evaluate the quality of cancer registry data and activity on an annual basis to include procedures which monitor casefinding, accuracy of data collection, abstracting timeliness, follow-up and data reporting.
- (h) Analyzing patient outcomes and disseminating the results of the analysis.
- (i) Following requirements outlined in the most current CoC cancer program standards.

iii. **Meetings.** The Clinical Cancer Committee shall meet at least quarterly to meet the ACoS CoC requirements. The chair of the Clinical Cancer Committee shall be appointed annually by the Chief of Staff.

c. **Credentials Committee**

i. **Composition.** The Credentials Committee shall consist of the following members:

- (a) the Chief of Staff, the Chief of Staff-Elect, the Immediate Past Chief of Staff and the Secretary of the Medical Staff, all of whom shall be voting members. The chair of the Credentials Committee shall be the Immediate Past Chief of Staff;
 - (b) a voting member from the Active Medical Staff of each department shall be elected for a two-year term. The terms of these members shall be staggered such that one-half of the departments shall have an Active Medical Staff member elected at each annual meeting of the Medical Staff. The schedule for the election of these members shall be approved by the Credentials Committee;
 - (c) the committee also shall have the following non-voting ex-officio members: the Chief Administrative Officer and his/her designees and the Dean.
- ii. **Duties.** The duties of the Credentials Committee shall be:
- (a) to review the credentials of and departmental recommendations regarding all applicants for Medical Staff membership and for Clinical Privileges and to make recommendations to the Executive Committee for Medical Staff membership, delineation of Clinical Privileges, and the assignment of practitioners to clinical departments, all in compliance with Articles V and VI of these Bylaws;
 - (b) to conduct periodic reappraisals of Medical Staff members and others who exercise Clinical Privileges and as a result of such reappraisals to make recommendations to the Executive Committee regarding reappointments and the granting of Clinical Privileges, as provided in Articles V and VI of these Bylaws;
 - (c) to investigate any breach of ethics that is reported to it;
 - (d) to review reports that are referred to it by the Executive Committee, the departmental medical care evaluation committees or by the Chief of Staff; and
 - (e) to enforce the Medical Staff Rules and Regulations which pertain to the delinquency of medical records.
- iii. **Meetings.** The Credentials Committee shall meet no less frequently than quarterly and shall maintain a permanent record of its proceedings and actions.
- d. **Executive Committee**
- i. **Composition.** The Executive Committee shall consist of the following voting members: Appointed Members – the officers of the Medical Staff, the chairman of each clinical department, and a representative from the Resident Medical Staff appointed by the Chief of Staff; Elected Members – one Active Medical Staff member from each department and three at large members of the Active Medical Staff as recommended by the Nominating Committee and elected by the Medical Staff. The Chairman of the Executive Committee

shall be the Chief of Staff. The Committee also shall have the following non-voting ex-officio members: Chief Administrative Officer and his/her designees, the Dean, the President of the University Physician's Association, the Director of Graduate Medical Education, the Medical Director, and others as appointed by the Chief of Staff, or their designees.

- ii. **Duties.** The duties of the Executive Committee shall be:
- (a) to represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
 - (b) to coordinate the patient care and activities of the various departments;
 - (c) to receive and act upon committee and other reports;
 - (d) to implement the Rules and Regulations of the Medical Staff not otherwise the responsibility of the departments;
 - (e) to provide liaison between Medical Staff, GSM Administration, Hospital Administration and the Governing Body;
 - (f) to recommend action to GSM Administration and Hospital Administration on matters of a medical and/or administrative nature;
 - (g) to make recommendations on hospital management matters to the Governing Body;
 - (h) to make recommendations to the Governing Body regarding Medical Staff structure and the mechanisms used to review credentials and to delineate individual clinical privileges;
 - (i) to make recommendations to the Governing Body regarding the participation of the Medical Staff in organization performance-improvement activities;
 - (j) to make recommendations to the Governing Body regarding the mechanism by which Medical Staff members may be terminated and the mechanism for fair-hearing procedures;
 - (k) to fulfill the Medical Staff's accountability to the Governing Body for the medical care rendered to patients in the Hospital;
 - (l) to keep the Medical Staff abreast of the accreditation status of the Hospital;
 - (m) to review the credentials of all applicants and to make recommendations to the Governing Body for Medical Staff membership, assignments to departments and delineation of Clinical Privileges;
 - (n) to review periodically recommendations for reappointments or changes in Clinical Privileges or other authorization to provide patient care services, including the review of all information available regarding performance and clinical competence;

- (o) to present to the Medical Staff a slate of Medical Staff members from which the four (4) elected members of the Nominating Committee are elected, with such slate to be presented so as to coincide with the presentment of additional names for elected office as set forth under Article XII, Section 1., e. of these Bylaws;
 - (p) to strive to maintain professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff and others who exercise Clinical Privileges, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted; and
 - (q) to report at each general Medical Staff meeting.
- iii. **Assignment of Duties.** The Medical Staff may delegate, remove or reassign a duty or duties delegated to the Executive Committee through a process set forth for amendment of these Bylaws under Article XX.
 - iv. **Effect of Removal of Committee Members.** A Medical Staff officer who is removed from his position in accordance with Article X, Section 5, will automatically be removed as a member of the Executive Committee. Where a Medical Staff officer who is a member of the Executive Committee is removed or resigns, any replacement appointed shall serve on the Executive Committee. Where a chairman of a clinical department is removed or resigns, any replacement appointed shall serve on the Executive Committee. Any other member of the Executive Committee may, upon thirty (30) days notice provided to such member by the Executive Committee, be removed from office by vote of the Executive Committee based upon a failure to perform the duties of the Executive Committee for which such member has been elected or a failure to comply with the responsibilities and requirements for Medical Staff membership as provided for in Articles III and IV of these Bylaws.
 - v. **Meetings.** The Executive Committee shall meet no less frequently than monthly and shall maintain a permanent record of its proceedings and actions.
- e. **Nominating Committee**
 - i. **Composition.** The Nominating Committee shall consist of seven (7) members. Three (3) of the members shall be the Chief of Staff serving during the year for which the Committee is appointed along with the immediate past two (2) Chiefs of Staff. The remaining four (4) members shall consist of the top four (4) vote recipients, as elected by the Medical Staff, from a slate of names composed by the Executive Committee and presented to the Medical Staff concurrently with Nominating Committee candidates as set forth in subsection ii below.
 - ii. **Duties.** The Nominating Committee shall be responsible to present to the Medical Staff the names of candidates for each elected office (i.e., Chief of Staff-Elect and Secretary) and elected committee membership (i.e., the

elected members of the Executive Committee, the Credentials Committee and the Bylaws Committee. Such nominations are to be made at the quarterly staff meeting immediately preceding the Annual Medical Staff meeting and will be presented along with the slate of candidates proposed by the Executive Committee to comprise the elected members of the Nominating Committee.

- iii. **Meetings.** The Nominating Committee shall meet as often as necessary to accomplish its duties.

d. **Nutritional Support Committee**

- i. **Composition.** The Nutritional Support Committee shall have at least one physician member from the following departments: Medicine, Surgery, Obstetrics and Gynecology, Family Practice, Pediatrics, and Oral Surgery, and one member of the resident medical staff.

Non physician members shall include one representative from the following departments: Nutrition and Food Services, Pharmacy Services, Home Health and Hospice Services, Home Infusion Care, Nutritional Support Team, Nursing Service, Quality Assurance, and Administration.

- ii. **Duties.** The Committee shall be responsible for recommending to the Executive Committee all policies and procedures relating to the nutritional care of patients at The University of Tennessee Memorial Hospital, Knoxville, Tennessee. Specific functions should include at least the following:
 - (a) recommending standards for clinical nutrition and practices;
 - (b) recommending standards for enteral and parenteral nutrition practices;
 - (c) recommending enteral products for the Formulary;
 - (d) recommending revision to the diet manual and nutritional support manual;
 - (e) serving as educator for all matters pertaining to nutrition and nutritional support and coordinating these efforts within the hospital and within the home care programs;
 - (f) reviewing annually the quality assurance plans for all areas involved in nutritional care;
 - (g) receiving regular reports on all monitoring activities and recommending corrective action as needed;
 - (h) recommending monitoring activities for new services or for any service with suspected problems.

e. **Patient Care and/or Hospital Procedures Committees**

The Chief of Staff shall appoint patient care and/or Hospital procedures committees responsible in the areas identified below, and any other areas

specified by the Executive Committee. The responsibilities of such committees, within their respective disciplines, shall be, as necessary, to evaluate and make recommendations to the Executive Committee regarding the formulation and/or improvement of the patient care or other procedures of the Hospital, and to address such other matters as the Chief of Staff or Executive Committee may direct. The committees shall meet as often as necessary to effectuate their respective purposes. These committees shall include the following:

Ambulatory Services
Endoscopy Committee
Home Care Services Committee
Infection Control Committee
Medical Record Committee
Operating Room Committee
Pharmacy, Therapeutics
Physical Medicine and Rehabilitation Committee
Nutritional Support Committee
Radioisotope Committee
Transfusion Committee
Special Care Committee

f. **Performance Improvement Committees**

- i. **Composition.** Each department shall participate in appropriate interdisciplinary performance improvement committees as established by the medical staff in cooperation with the institution.
- ii. **Duties.** The purpose of these committees includes designing, measuring, assessing, and improving those processes and outcomes related to patient care. Their activities must address the institution's ongoing accreditation and licensing requirements. These requirements are outlined in the organization's performance improvement policy, which is updated and approved annually by the Performance Improvement Council, the Executive Committee, and the Governing Body.
- iii. **Types.** The types of Performance Improvement (PI) committees include the following:
 - (a) Centers of Excellence PI Committees. Interdisciplinary committees appointed by the Chair of Performance Improvement Council in consultation with the Medical Director of each Center of Excellence to address core services, as outlined by administration and the Medical Staff.
 - (b) Hospital-Wide PI Committees. Interdisciplinary committees appointed by the Chief of Staff to address specific types of process

review, such as procedure monitoring, mortality & autopsy review, or blood use.

- (c) PI Teams. Interdisciplinary groups appointed by the Chair of the appropriate PI Committee to address specific opportunities for improvement or accreditation requirements.
- (d) Departmental PI Committees as appointed by the department chairman and as allowed under these bylaws.

iv. **Meetings.** The various PI Committees shall meet as frequently as the bodies determine to achieve their objectives and each shall maintain a record of its findings, proceedings and actions, and shall make a report thereof to the Performance Improvement Council. These committees have the authority to design special studies and make recommendations based on aggregate findings. These recommendations are forwarded to the applicable medical staff departments and Executive Committee for review. When PI committee review identifies a practice pattern or single event that reflects a significant deviation, the results are forwarded to the Department Chair for the purpose of initiating peer review in accordance with Medical Staff peer review policy.

g. **Performance Improvement Council (PIC)**

i. **Committee Composition.** Chief of Staff Elect, physician representative appointed by the Chief of Staff from each medical staff department, the chairperson of each Center of Excellence PI Committee or Vice President of each center of excellence, Patient Medical Safety Officer, Chief Executive Officer (ex-officio), Executive Vice President, Vice President For Patient Care Services, Chief Medical Officer, Medical Director for Care Management/Performance Improvement Department, Vice President for Care Management/Performance Improvement, Directors of Risk Management, Pharmacy and two representatives selected from Hospital management. The Chief of Staff is at liberty to appoint additional members as performance improvement priorities surface.

The chair of this committee is the Chief of Staff Elect; the committee is co-chaired by the Medical Director of Care Management.

ii. **Duties.** The specific responsibilities of this committee are:

- (a) To ensure an organization-wide approach to design, measure, assess, and improve processes collaboratively with the disciplines involved, in accordance with the Performance Improvement Policy.

- (b) Support the effectiveness of Strategic Planning and achievement of the established targets by linking improvement initiatives to the Strategic Plan.
- (c) To oversee the annual revision and approval of the hospital-wide performance improvement plan; ensuring the Medical Staff and Operational Departments' priorities for improvements and the respective measurements are reported and acted upon.

SECTION 2. MEETINGS.

The Performance Improvement Council will meet and report to the Executive Committee and to the Governing Body on a quarterly basis.

a. Medical Staff Wellness Committee

- i. **Composition.** The Medical Staff Wellness Committee is comprised of no less than 5 Medical Staff members appointed annually by the Chief of Staff. The activities of this Committee involve an ongoing process under Tennessee's Peer Review Statute as outlined in Tenn. Code Ann. §63-6-219. Except for initial appointments, each member shall serve a term of three (3) years, and the terms shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. Insofar as possible, members of the committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.
- ii. **Duties.** The Medical Staff Wellness Committee shall have as its purpose the improvement of the quality of care and the promotion of health and competence among Medical Staff members. The committee may receive reports related to the health, well-being or impairment of Medical Staff members and, as it deems appropriate, may investigate such reports. The committee's duties shall be:
 - (a) To educate the Medical Staff and Hospital staff about illness and impairment recognition issues specific to Practitioners;
 - (b) To develop, as appropriate, for consideration by the Medical Staff, written policies and/or Medical Staff Rules and Regulations, that address appropriate intervention, denial, revocation, or limitation of Clinical Privileges, follow-up assessment, reinstatement and the monitoring of Clinical Privileges for impaired Medical Staff members upon their re-entry; to obtain the approval of the Medical Staff for and to implement such policies and/or Rules and Regulations;

- (c) To receive self-referrals and any other report relating to the mental or physical health, well-being, or impairment of any Medical Staff member, as relevant to such person's ability to exercise the Clinical Privileges granted to, or requested by, such person, and to evaluate the credibility of, and investigate such reports to the extent necessary to protect the health, welfare, and safety of patients, other Medical Staff members, and hospital personnel;
- (d) As it deems necessary, to provide such advice, counseling, and referral to the Tennessee Medical Foundation's Physician Health Program, the Tennessee Dental Association's Concerned Dentists Committee, the Review Board for HIV, HBV or HCV Infected Workers or other appropriate referral, for diagnosis and treatment of any condition or concern;
- (e) To provide advice, counseling, resources and implementation, as requested, of the Medical Staff Code of Conduct Policy;
- (f) To maintain the confidentiality of the Practitioner seeking referral or referred for assistance; except as limited by law, ethical obligation, or when the safety of a patient is threatened;
- (g) To consider, in connection with the Committee, and/or other Committees of the Medical Staff, the results of any such tests or evaluations or the refusal to consent to such testing or evaluation; to implement any intervention or other action in accordance with these Bylaws, Rules and Regulations and Policies; and to request corrective action in accordance with the provisions of Article VIII of these Bylaws if when appropriate; and
- (h) To monitor the affected Practitioner and the safety of patients, when appropriate, until the rehabilitation or any disciplinary process is complete, or to delegate such monitoring, by agreement, to the Tennessee Medical Foundation's Physician Health Program or to the Tennessee Dental Association's Concerned Dentists Committee.

The activities of the Medical Staff Wellness Committee shall be confidential. In the event that the Practitioner refuses to consent to such testing or evaluation as is requested by the Medical Staff Wellness Committee, or if at any time the Practitioner is determined to be unable to safely perform the Clinical Privileges he or she has been granted, such may constitute grounds for denial of an application for Medical Staff membership or Clinical Privileges or for immediate suspension or

revocation of all or any portion of a Medical Staff member's Staff membership or Clinical Privileges as provided under these Bylaws.

- iii. **Meetings.** The Medical Staff Wellness Committee shall meet as often as necessary as called by its chair, but at least quarterly. The Medical Staff Wellness Committee shall maintain such records of its proceedings and actions, as it deems advisable. The Medical Staff Wellness Committee shall report its activities, as appropriate, to the Executive Committee.

b. **Special Committees**

- i. **Creation and Composition.** The Chief of Staff may appoint from time to time such special committees as he/she may deem appropriate to carry out properly the duties of the Medical Staff. The composition shall be determined by the Chief of Staff.
- ii. **Duties.** The Chief of Staff shall delineate the duties of any special committee appointed which duties shall include a written report to the Executive Committee of the work performed and any recommendations requested by the Chief of Staff.
- iii. **Meetings.** Any special committee appointed shall meet as necessary to carry out its purposes.

ARTICLE XIII. MEDICAL STAFF MEETINGS

SECTION 1. REGULAR MEETINGS

- a. Regular meetings of the Medical Staff shall be held quarterly. The Annual Meeting of the Medical Staff shall be a regular meeting and shall be held the fourth calendar quarter of each year.
- b. Written or printed notice stating the place, day and hour of any regular meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Active Medical Staff in Good Standing not less than seven (7) days before the date of such meeting, by the Secretary at the direction of the Chief of Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each Active Medical Staff member at his/her address as it appears on the records of the Hospital. Notice may also be sent to other categories of the Medical Staff which have so requested. Attendance at a Medical Staff meeting shall constitute a waiver of notice of such meeting.

SECTION 2. SPECIAL MEETINGS

- a. A special meeting of the Medical Staff may be called by the Chief of Staff or the Executive Committee at any time. The Chief of Staff shall call a special meeting within thirty (30) days after receipt of a written request for a special meeting signed by not less than one-fourth of the member of the Active Medical Staff and

stating the purpose of such meeting. The Executive Committee shall designate the time and place of any special meeting.

- b. Written or printed notice stating the place, day and hour of any special meeting of the Medical Staff shall be delivered, either personally or by mail, to each member of the Active Medical Staff in Good Standing not less than seven (7) days before the date of such meeting, by the Secretary at the direction of the Chief of Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail, addressed to each Active Medical Staff member at his/her address as it appears on the records of the Hospital. Notice may also be sent to other categories of the Medical Staff which have so requested. Attendance at a Medical Staff meeting shall constitute a waiver of notice of such meeting. Only such business that is identified in the notice calling the special meeting shall be transacted at such meeting.

SECTION 3. QUORUM

The presence of fifty (50) percent of the total membership of the Active Medical Staff at any regular or special meeting shall constitute a quorum for purposes of amendment of these Bylaws. The Active Medical Staff present at any regular or special meeting shall constitute a quorum for all other purposes. For purposes of presence under this quorum requirement, the written proxy of any Active Medical Staff member shall constitute presence.

SECTION 4. MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the Medical Staff except as otherwise specifically provided in these Bylaws.

SECTION 5. ATTENDANCE REQUIREMENTS

Each Active member of the Medical Staff shall be required to attend at least 50% of the regular meetings of the Medical Staff in each year. Fulfillment of attendance requirements may be considered at the time of reappointment.

SECTION 6. AGENDA

- a. **Regular Meetings.** The agenda at any regular Medical Staff meeting shall include, generally:
 - i. Call to order.
 - ii. Acceptance of the minutes of the last regular and of all special meetings.
 - iii. A call for a forum to discuss ideas, advice and concerns regarding the management and activities of the Hospital.
 - iv. Unfinished business.
 - v. Communications.

- vi. Reports from Hospital administrative personnel as appropriate.
 - vii. Committee reports as appropriate.
 - viii. New business (including elections, where appropriate).
 - ix. Review and analysis of the clinical work of the Hospital.
 - x. Reports of medical committees.
 - xi. Such other business as may be appropriate, and
 - xii. Adjournment.
- b. Special Meetings.** The agenda at special meetings shall be:
- i. Reading of the notice calling the meeting,
 - ii. Transaction of business for which the meeting was called,
 - iii. Adjournment.

ARTICLE XIV. COMMITTEE AND DEPARTMENT MEETINGS

SECTION 1. REGULAR MEETING

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall hold regular meetings at least quarterly to review and evaluate the clinical work of Practitioners with privileges in the department.

SECTION 2. SPECIAL MEETINGS

A special meeting of any committee or department may be called at the request of the chairman thereof, by the Chief of Staff or by one-third of the group's Active Staff Members, but not less than two (2) members.

SECTION 3. NOTICE OF MEETINGS

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be given to each member of the committee or department not less than seven (7) days before the time of such meeting, by the person or persons calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited in the United States mail, addressed to the member or his/her address as it appears on the records of the Hospital with postage thereon prepaid. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

SECTION 4. QUORUM

- a. A quorum for the following committees shall require fifty percent (50%) of the Active Medical Staff members of the committees but not less than two (2) such members:
 - i. Executive Committee

- ii. Credentials Committee
 - iii. Bylaws Committee
 - iv. Nominating Committee
 - v. Patient Care Evaluation Committee
- b. All other committees or departments shall require a quorum of not less than two (2) Active Medical Staff members.

SECTION 5. MANNER OF ACTION

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of a committee or department. Action may be taken without a meeting by majority consent of each member entitled to vote.

SECTION 6. RIGHTS OF EX OFFICIO MEMBERS

Persons serving under these Bylaws as ex officio members of a committee shall have all rights and privileges of regular members. Ex Officio members shall be allowed to vote on any committee to which they are appointed with the exception of the Executive Committee, the Credentials Committee, the Bylaws Committee and the Nominating Committee. Voting by Ex Officio members shall be subject to the quorum requirements of Article XIV, Section 4 of these Bylaws. For purposes of this section b, any committee member who is not a member of the Active Medical Staff shall be considered an ex officio member.

SECTION 7. MINUTES

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer. Each committee and department shall maintain a permanent file of the minutes of each meeting.

SECTION 8. ATTENDANCE REQUIREMENTS

- a. Each member of the Active Medical Staff shall be encouraged to attend all scheduled meetings of his/her department and each committee of which he/she is a member in each year. Attendance requirements for departmental and committee meetings shall be established by the department chair and/or committee chair.
- b. The attendance of any Practitioner at any committee or department meeting may be required by the chairman thereof, by the Chief of Staff or by one-third of the Active Medical Staff members of the committee or department (but not less than two (2) members). Failure by the Practitioner to attend any meeting with respect to which he/she was given reasonable notice that attendance was so required, unless excused by the Executive Committee upon a showing of good cause, may result in a Summary Suspension under Article VIII, Section 3 of these Bylaws. In all other cases, if the Practitioner shall make a timely request for postponement supported by an adequate showing that his/her absence will be unavoidable, such

attendance may be postponed by the party or parties requiring such attendance, or by the Executive Committee if the chairman is the Practitioner involved, until not later than the next regular departmental or committee meeting.

ARTICLE XV. CONFLICTS OF INTEREST

SECTION 1. DUTY TO THE MEDICAL STAFF AND HOSPITAL

Members of the Medical Staff, as individual Practitioners and, when applicable, as Medical Staff officers, department officials or committee members, assume a duty to the Medical Staff and to the Hospital to take actions or make decisions in the best interests of the patients it serves and of the Hospital. Loyalty to the Medical Staff and the Hospital must remain paramount in any matter involving the Hospital or its Medical Staff.

SECTION 2. CONFLICT OF INTEREST

A conflict of interest exists whenever, in taking any action or making any decision on a matter involving the Hospital or its Medical Staff, a member of the Medical Staff has interests, whether personal or in another organization or entity with which the Medical Staff member is associated, that conflict with the interests of the Hospital and/or its Medical Staff or otherwise influence or tend to influence materially the Medical Staff member's consideration of the action to be taken or the decision to be made.

Examples of such conflicts include, but are not limited to, outside financial interests in competitive organizations, activities or involvement in healthcare entities or other entities doing business with or directly competing with the Hospital and any compensation arrangement; any of which that, in the eyes of a prudent lay person, create an actual or potential conflict of interest.

SECTION 3. PROCEDURES REGARDING CONFLICTS OF INTEREST

- a. **Disclosure; Abstention from Voting.** Any actual or potential conflict of interest on the part of any member of the Medical Staff in any matter involving the Hospital and/or its Medical Staff and with respect to which such Medical Staff member has decision-making authority shall be disclosed to the department, committee or other body considering the matter at or before the meeting at which the matter is considered. Additionally, when requested to do so Medical Staff officers, department officials and committee members shall disclose positions held at other hospitals, health care institutions, or with third party payors that have the ongoing potential to create a conflict of interest. Any Medical Staff member deemed by the body considering the matter to have a material conflict of interest in any matter shall not vote on or use his/her personal influence to affect approval or disapproval of the matter and he/she shall not be counted in determining the quorum for any meeting at which the matter is considered. Furthermore, the Medical Staff member with the conflict will excuse himself/herself from the room at the time of the vote.

- b. **Statement of Position.** The foregoing shall not be construed as preventing a Medical Staff member from briefly stating his/her position in the matter, nor from answering pertinent questions since his/her knowledge may be of great assistance to the other members of the body considering the matter.
- c. **Minutes to Show Compliance.** The minutes of any meeting at which a matter is addressed that presents an actual or potential conflict of interest for any participant in the meeting shall reflect disclosure of such conflict of interest, that the Medical Staff member concerned was not counted in determining the existence of a quorum, and that such Medical Staff member abstained from voting on such matter.
- d. **Medical Conflict of Interest Policy.** The Medical Staff shall develop and administer a medical staff policy to guide in the disclosure and remedy of an actual or potential conflict of interest among its members.

SECTION 1. MEDICAL STAFF POLICY

The Medical Staff or any department or committee may adopt a resolution stating in more detail it's position on conflicts of interest, so long as such resolution is consistent with the requirements of this Article XV, and may adopt a form or forms for the disclosure of such conflicts of interest. Any such resolution shall become effective upon approval by the Executive Committee and the Governing Body.

ARTICLE XV. CONFIDENTIALITY

SECTION 1. SCOPE OF CONFIDENTIAL INFORMATION

For purposes of this Article XVI, the term "Confidential Information" shall include:

- a. information, material or matter which, if disclosed or made available to a competitor of UTMH would result in a competitive advantage to such competitor;
- b. information, material or matter specified or identified by a member of the Medical Staff or Hospital Administration as subject to a right of privacy or contractual confidentiality obligations;
- c. information, material or matter required by state or federal law, rule or regulation to be kept confidential, including, without limitation, any matters regarding patient records and any peer review process or actions;
- d. information, material or matter that the Medical Staff or any committee of the Medical Staff may from time to time declare to be confidential; and
- e. actions taken by the Medical Staff or any committee of the Medical Staff related to information, material or matter described in a. through d. above.

SECTION 2. NONDISCLOSURE OF CONFIDENTIAL INFORMATION

Each member of the Medical Staff shall keep confidential and shall not, without the prior consent of the Executive Committee, disclose any Confidential Information presented or made available to or discussed by the Medical Staff or any department or committee of the Medical Staff, regardless of whether such confidential information was discussed, presented or made available at any formal, informal, special or regular meeting of the Medical Staff or any department or committee of the Medical Staff.

SECTION 3. EXCLUSIONS

Excluded from the restrictions of Section 1 and the definition of Confidential Information under Section 2 is any information, material or matter that:

- a. at the time of disclosure or discussion is in the public domain, or after disclosure becomes, through no fault of any member of the Medical Staff, part of the public domain as evidenced by generally available documents or publications; or
- b. was available to members of the Medical Staff on a nonconfidential basis prior to its disclosure to them as officers or Medical Staff committee members.

ARTICLE XVI. IMMUNITY FROM LIABILITY AND CONFIDENTIALITY

The following shall be express conditions to any Practitioner's application for, or exercise of, clinical privileges at this Hospital;

Any act, communication, report, recommendation, or disclosure, with respect to the Practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged and immune from liability to the fullest extent permitted by law.

The acts, communications, reports, recommendations and disclosures referred to in this Article XVII may relate to a Practitioner'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 patient care.

The privilege and immunity provided in this Article XVII shall extend to members of the Medical Staff and to the Governing Body, to all Hospital Representatives, and to any third parties who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article XVII, the term "third parties" means both individuals and organizations from whom information has been requested by a Hospital Representative. The Practitioner shall, upon request of a Hospital representative, execute releases in favor of the individuals and organizations specified in this paragraph subject to such requirements, including those of good faith and absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of Tennessee.

There shall, to the fullest extent permitted by law, for all individuals and entities involved in any review of the practice qualifications, competence or experience, be absolute immunity from civil liability arising from any such act, communication, report,

recommendation, or disclosure described above, even where the information involved would otherwise be deemed privileged.

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: (1) applications for appointment or clinical privileges, (2) periodic reappraisals for appointment or clinical privileges, (3) corrective action, including summary suspension, (4) hearings and appellate reviews, (5) medical care evaluations, (6) utilization review, and (7) other Hospital, departmental, service or committee activities related to quality patient care and interprofessional conduct.

The consents, authorizations, releases, rights, privileges and immunities provided in Article V of these Bylaws for the protection of this Hospital's Practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article XVII.

ARTICLE XVII. RULES AND REGULATIONS

SECTION 1. RULES AND REGULATIONS

The Rules and Regulations of the Medical Staff shall included General Rules and Regulations and Department Rules and Regulations, as specified below:

- a. **General Rules and Regulations.**
 - i. The Executive Committee shall adopt such General Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. Such Rules and Regulations shall relate to the proper conduct of the Medical Staff organization activities as well as the level of practice that is to be required of each Practitioner in the Hospital.
 - ii. Decisions of the Executive Committee, which constitute changes of the General Rules and Regulations shall become effective when approved by the Executive Committee, subject to the approval of the Medical Staff and the Governing Body. Such changes in the General Rules and Regulations shall be presented by the Chairman of the Medical Staff Bylaws Committee to the Medical Staff for approval at the first regular meeting of the Medical Staff called for that purpose, and such approval shall require a two-thirds vote of the Active Medical Staff present. Upon approval by the Medical Staff, they shall be forwarded to the Governing Body for its approval.
 - iii. It shall be the responsibility of each Medical Staff committee to develop and propose changes in the Rules and Regulations with regard to it's designated sphere of activity. All proposed changes in the General Rules and Regulations shall be submitted to the Medical Staff Bylaws Committee for screening for consistency with these Bylaws, and with other existing Rules and Regulations, before final action is taken by the Executive Committee.

- iv. Changes in the General Rules and Regulations may be proposed directly to the Executive Committee by individual Practitioners; however, such changes should be proposed to the appropriate Medical Staff committee when practical.
- b. **Department Rules and Regulations.** Departmental Rules and Regulations (and amendments thereto) shall be adopted by each department. The Departmental Rules and Regulations will become effective when approved by the Executive Committee and the Governing Body. All proposed changes in the Departmental Rules and Regulations shall be submitted to the Medical Staff Bylaws Committee for screening for consistency with these Bylaws, and with other existing rules and regulations, before final action is taken by the Executive Committee.
- c. **Changes Proposed by the Medical Staff.**
 - i. If the members of the Medical Staff eligible to vote propose to adopt a General or Departmental Rule or Regulation or an amendment thereto, they shall first communicate the proposal to the Executive Committee. If the Executive Committee proposes to adopt a General or Departmental Rule or Regulation or an amendment thereto, it shall first communicate the proposal to the Medical Staff.
 - ii. In cases of a documented need for an urgent amendment to the General or Departmental Rules and Regulations necessary to comply with law or regulation, the Executive Committee may provisionally adopt, and the Governing Body may provisionally approve an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Staff will be immediately notified by the Executive Committee. The Medical Staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the Medical Staff and the Executive Committee as set forth in Article XXI is implemented. If necessary, a revised amendment is then submitted to the Governing Body for action.

SECTION 2. APPROVAL BY GOVERNING BODY

Both General and Departmental Rules and Regulations and amendments thereto shall become effective when approved by the Governing Body.

ARTICLE XVIII. POLICIES

SECTION 1. POLICIES

The Medical Staff may, from time to time, promulgate Medical Staff policies, as specified below:

- i. The Executive Committee may, from time to time, adopt such policies as may be necessary to implement more specifically the general principles found within these Bylaws or the Medical Staff Rules and Regulations. Such

policies shall relate to the proper conduct of the Medical Staff organization activities, as well as, the level of practice that is to be required of each Practitioner in the Hospital.

- ii. Policies, and amendments thereto, as approved by the Executive Committee, shall become effective when approved by the Executive Committee and the Governing Body. Such policies, when approved by the Executive Committee, shall be presented to the Governing Body for its approval.
- iii. It shall be the responsibility of each Medical Staff committee to develop and propose changes or additions to Medical Staff policies with regard to its designated sphere of activity. All proposed changes to Medical Staff policies shall be submitted to the Medical Staff Bylaws Committee for screening for consistency with these Bylaws, and with the Rules and Regulations of the Medical Staff before final action is taken by the Executive Committee.
- iv. Changes to Medical Staff policies may be proposed directly to the Executive Committee by individual Practitioners; however, such changes should be proposed to the appropriate Medical Staff committee when practical.
- v. All policies promulgated by the Medical Staff pursuant to this Article XIX shall be reviewed annually by the Executive Committee.
- vi. If the members of the Medical Staff eligible to vote propose to adopt a policy or an amendment thereto, they shall first communicate the proposal to the Executive Committee. If the Executive Committee adopts a policy or an amendment thereto, it shall communicate the policy to the Medical Staff.

SECTION 2. APPROVAL BY GOVERNING BODY.

Policies of the Medical Staff, and amendments thereto, shall become effective when approved by the Governing Body.

ARTICLE XIX. AMENDMENTS

SECTION 1. AMENDMENT

These Bylaws may be amended after submission of the proposed amendment or restatement at any regular or special meeting of the Medical Staff and may not be unilaterally amended by either the Medical Staff or the Governing Body. The proposed amendment(s) will initially be presented to the Medical Staff at a regular meeting of the Medical Staff for discussion only. Action on the proposed amendment(s) will be taken at the next regular meeting of the Medical Staff or at a special meeting called for such purpose. To be adopted, an amendment shall receive the affirmative vote of two-thirds of the active Medical Staff present at such meeting.

SECTION 2. APPROVAL BY GOVERNING BODY

Amendments adopted by the Medical Staff shall not be effective until approved by the Governing Body.

ARTICLE XX. CONFLICT RESOLUTION

In the event there is a conflict between the Executive Committee and the Medical Staff on issues, including but not limited to, proposals to adopt a rule, regulation or policy or an amendment thereto, the matter shall be reviewed by a Conflict Resolution Committee composed of three members of the Executive Committee elected by vote of the Executive Committee, provided, however, that any selected member of the Executive Committee shall not be a member of the Governing Body, three members of the Medical Staff elected by vote of the Medical Staff, provided, however, that any selected member of the Medical Staff shall not be a member of the Executive Committee or the Governing Body, and three members of the Governing Body, elected by vote of the Governing Body, who may or may not also be members of the Medical Staff.

SECTION 1. CONFLICT RESOLUTION GENERALLY

In the event the Conflict Resolution Committee is constituted to resolve a conflict between the Executive Committee and the Medical Staff, as contemplated in this Section, it shall review all supporting documentation and provide a recommendation to the Executive Committee and Medical Staff within sixty (60) days of constituting the Committee.

SECTION 2. CONFLICT RESOLUTION INVOLVING SPECIFIC MATTERS

In the event the Conflict Resolution Committee is constituted to review an amendment to the Bylaws, Rules and Regulations or Policies as contemplated under this Article XXI, it shall review such proposed amendment and provide its recommendation to the Governing Body, the Executive Committee and the Medical Staff within sixty (60) days of constituting the Committee.

SECTION 3. CHANGES PROPOSED BY MEDICAL STAFF TO GOVERNING BODY

- a. Changes to the General Rules and Regulations, Departmental Rules and Regulations, Medical Staff Policies and these Bylaws may be proposed directly to the Governing Body as set forth under this Article XXI.
- b. Any amendment to the Medical Staff Bylaws proposed directly to the Governing Body shall first be adopted by the Medical Staff using the process as set forth under Article XX, Section 1 of the Bylaws. Subsequent to such adoption by the Medical Staff, the proposal shall be submitted to the Conflict Resolution Committee under this Article XXI, Section 2 for review and recommendation. Subsequent to such review and recommendation, the proposed amendment shall be submitted for consideration by the Governing Body.
- c. Any amendment to the Medical Staff Rules and Regulations or Departmental Rules and Regulations proposed directly to the Governing Body shall first be adopted by the Medical Staff using the process as set forth in the second sentence of Article XVIII, Section 1(a)(ii) of the Bylaws. Subsequent to such adoption by

the Medical Staff, the proposal shall be submitted to the Conflict Resolution Committee under this Article XXI, Section 2 for review and recommendation. Subsequent to such review and recommendation by the Conflict Resolution Committee, the proposed amendment shall be submitted for consideration by the Governing Body.

- d. Any amendment to the Medical Staff Policies proposed directly to the Governing Body shall first be adopted by the Medical Staff using the process as set forth in the second sentence of Article XVIII, Section 1(a)(ii) of the Bylaws (the procedure for amendment of Medical Staff Rules and Regulations). Subsequent to such adoption by the Medical Staff, the proposal shall be submitted to the Conflict Resolution Committee under this Article XXI, Section 2 for review and recommendation. Subsequent to such review and recommendation by the Conflict Resolution Committee, the proposed amendment shall be submitted for consideration by the Governing Body.

ARTICLE XXI. ADOPTION AND CERTIFICATION

These Bylaws were adopted and restated in their entirety by the Medical Staff on the tenth day of August, 1999, and by the Governing Body on the fifteenth day of September 1999 and include all amendments through the meeting of the Governing Body of October 26, 2011.