# *BYLAWS*
# *OF THE*
# *MEDICAL STAFF*

***Rev. 10/2024***


***975 East Third Street***
***Chattanooga, Tennessee 37403***

## TABLE OF CONTENTS

## P R E A M B L E

The Board of Directors of Erlanger Health (the "Board") has delegated to the Medical Staff (the "Medical Staff") of Erlanger Health System (the "Health System") responsibility for the quality of patient care. The cooperative efforts of the Board, the management and the Medical Staff are essential to fulfill the Health System's obligation to their patients. The physicians, practicing within the facilities owned and/or operated by the authority, accept and assume this responsibility and organize themselves in conformity with the Bylaws, Rules and Regulations, and policies and procedures promulgated by same.

These Bylaws are adopted to provide for the organization of the Medical Staff of Erlanger Health and to provide a framework for government in order to permit the Medical Staff to discharge its responsibilities in matters involving medical care. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with management and the Board, and relations with members of and applicants to the Medical Staff.

The Medical Staff of the Health System recognizes the ultimate authority for the operation of the Health System lies with the Board.

The Board has designated the campus upon which it operates as Erlanger Health System. The Health System, as defined here, is comprised of Baroness Erlanger Health System, Children's Health System at Erlanger, Kennedy Children's Outpatient Center, Willie D. Miller Eye Center, Plaza Ambulatory Care Center, Erlanger North Health System, Erlanger East Health System, Erlanger Bledsoe Health System, Erlanger Sequatchie Valley, the Southside and Dodson Avenue Community Health Centers, and other related inpatient and outpatient medical care facilities.

## D E F I N I T I O N S

1. "Active Staff" members shall be those Physicians licensed in the state of Tennessee that have and consistently maintain the privilege of admitting patients, holding office, and voting.

2. "Advanced Practice Provider or "APP" means an individual, other than a Physician, who is qualified to render direct or indirect medical or surgical care under the supervision of a Physician who has been afforded privileges to provide such care in the Health System. Such APPs shall include, without limitation, psychologists, physician assistants, advance-practice nurse practitioners, midwives, nurse anesthetists, and other such professionals. The authority of an APP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications. APPs do not have privileges to admit patients to the Health System.

3. Allied Health Professionals or "AHP" is a blanket term for all non-physician clinicians within the Health System. AHPs may be APPs but may also include, without limitation, pharmacists, nurses not employed by the Health System, surgical first assistants, licensed clinical social workers. AHPs do not have privileges to admit patients to the Health System.

4. "Appendix A" means the Fair Hearing Plan incorporated into these Bylaws.

5. "Appendix B" means the Health System Policy Regarding Impaired Practitioners incorporated into these Bylaws.

6. "Appendix C" means the Health System Policy Regarding Disruptive Practitioner Conduct incorporated into these Bylaws.

7. "Board" means the Board of Director of Erlanger Health.

8. "Board Certification" means certification in a member board of the American Board of Medical Specialties, the American Board of Osteopathic Specialists or the American Board of Oral and Maxillofacial Surgery.

9. "Chief Executive Officer" or "CEO" means the individual appointed by the Board to provide for the overall management of the Health System, or designee.

10. "Chief of Staff" means the member of the Active Medical Staff, who is duly elected in accordance with these Bylaws to serve as chief officer of the Medical Staff of the Health System, or, designee.

11. "Chief Medical Officer" or "CMO" means the individual appointed by the CEO to provide management of medical affairs of the Health System, or designee.

12. "Clinical Privileges" means the Board's recognition of the practitioners' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services.

13. "Designee" means one selected by the CEO, Chief of Staff or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these Bylaws.

14. "Erlanger Health" means Erlanger Health, Inc.

15. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

16. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a Physician's clinical privileges are adversely affected by a determination based on the Physician's professional conduct or competence.

17. "Health System" is comprised of Baroness Erlanger Health System, Children's Health System at Erlanger, Kennedy Children's Outpatient Center, Willie D. Miller Eye Center, Plaza Ambulatory Care Center, Erlanger North Health System, Erlanger East Health System, Erlanger Bledsoe Health System, Erlanger Sequatchie Valley, the Southside and Dodson Avenue Community Health Centers, and other related medical care facilities.

18. "Licensed Practitioner" means any individual permitted by law and by the Medical Staff and Board to provide care and services within the scope of the individual's license, and consistent with individually granted clinical privileges.

19. "Medical Executive Committee" or "MEC" means the Executive Committee of the Medical Staff.

20. "Medical Staff" or "Organized Medical Staff" means the formal organization of Physicians who have been granted privileges by the Board to care for patients in the Health System.

21. "Medical Staff Bylaws" means the Bylaws of the Medical Staff and the accompanying Rules and Regulations, Fair Hearing Plan, policies and such other departmental rules and regulations as may be adopted by the Medical Staff subject to the approval of the Board.

22. "Medical Staff Year" means calendar year.

23. "Member" means a Physician who has been granted Medical Staff membership (with or without clinical privileges) pursuant to these Bylaws.

24. "National Practitioner Data Bank" or "Data Bank" means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986 for the purposes of reporting of certain adverse actions and Medical Staff malpractice information. The National Practitioner Data Bank is an electronic information repository containing information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers and suppliers.

25. "Officers' Council of the MEC" means, collectively, the Chief of Staff, Vice-Chief of Staff, Secretary and Past Chief of Staff.

26. "Oral and Maxillofacial Surgeon" (OMFS) means an individual who has successfully completed a post graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education. As determined by the Medical Staff, the individual must be currently competent to perform a complete history and physical examination in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s).

27. "Peer Review Policy" means the policy and procedure as adopted by the Medical Executive Committee to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all Physicians and practitioners with delineated clinical privileges, evaluate the competence of Physician and practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards.

28. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in Tennessee and who has been granted clinical privileges at the Health System. For purposes of these Bylaws, the term "Physician" also refers to an OMFS who has been granted clinical privileges at the Health System.

29. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these Bylaws and in other Health System and Medical Staff policies.

30. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.

31. "Telemedicine" means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from or within a different site at the Health System.

## ARTICLE I
## NAME

The name of this organization shall be the Medical Staff of Erlanger Health.

## ARTICLE II
## PURPOSES & RESPONSIBILITIES

### 2.1 PURPOSE

The purposes of the Medical Staff are:

**2.1**(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of staff membership may be fulfilled;

**2.1**(b) To foster cooperation with administration and the Board while allowing staff members to function with relative freedom in the care and treatment of their patients;

**2.1**(c) To provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Health System shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay with the organization, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other performance improvement activities in accordance with the Health System's performance improvement program**;**

**2.1**(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all Physicians and AHPs authorized to practice in the Health System through delineation of clinical privileges, ongoing review and evaluation of each Physician's performance in the Health System, and supervision, review, evaluation and delineation of duties and prerogative of AHPs;

**2.1**(e) To promulgate, maintain and enforce Bylaws and Rules and Regulations for the proper functioning of the Medical Staff;

**2.1**(f) To participate in educational activities and scientific research with approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds or other equipment that are or can be made available;

**2.1**(g) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences;

**2.1**(h) To provide a means by which issues concerning the Medical Staff and the Health System may be discussed with the Board or the CEO;

**2.1**(i) To accomplish its goals through appropriate committees and departments;

**2.1**(j) To work with the Board and management to develop a strategy to maintain medical costs within reasonable bounds and meet evolving regulatory requirements;

**2.1**(k) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill; and

**2.1**(l) To provide a means through which the Medical Staff may cooperate with medical schools and other educational institutions in undergraduate, graduate and continuing education.

## 2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

**2.2**(a) Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all Physicians and AHPs authorized to practice in the Health System, by taking action to:

(1) Assist the Board and CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;

(2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;

(3) Provide a continuing medical education (CME) program addressing issues of performance improvement and including the types of care offered by the Health System;

(4) Implement a utilization review program, based on the requirements of the Health System's Utilization Review Plan;

(5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHPs;

(6) Initiate and pursue corrective action with respect to Physicians and AHPs, when warranted;

(7) Develop, administer and enforce these Bylaws, the Rules and Regulations of the Medical Staff and other Health System policies related to medical care;

(8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment;

(9) Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Impaired Practitioner Policy, which is incorporated herein and attached as Appendix "B" hereto.

**2.2**(b) Maintaining confidentiality with respect to the records and affairs of the Health System, except as disclosure is authorized by the Board or required by law.

**2.2**(c) Assisting the Board in maintaining the accreditation status of the Health System; and

**2.2**(d) Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the National Practitioner Data Bank.

## 2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Health System and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Health System and the Medical Staff members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Health System's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Health System and the Medical Staff**.**

Nothing in this Section shall be construed to create a partnership, joint venture, employer-employee or other relationship by and between the Medical Staff and the Health System that would increase the potential liability of either of the parties for the acts or the omissions of the other party. It is the express intention of the parties that this designation shall be limited to the purpose of compliance with HIPAA and shall in no other way alter the traditional relationship by and between said parties.

## ARTICLE III
## MEDICAL STAFF MEMBERSHIP

### 3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Health System, and is not a right of any person. Membership on the Medical Staff or the exercise of temporary privileges shall be extended only to professionally competent Physicians who continuously meet the qualifications, standards and requirements set forth in these Bylaws. Membership on the Medical Staff shall confer on the Physician only such clinical privileges and prerogatives as have been granted by the Board in accordance with these Bylaws. No person shall admit patients or provide services to patients in the Health System unless he/she is a member of the Medical Staff with appropriate privileges, or has been granted temporary privileges as provided herein.

### 3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

#### 3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those Physicians legally licensed in Tennessee, who continuously:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Health System. Unless specifically waived for good cause shown, such minimum training requirement shall include but not be limited to graduation from an approved school or certification by ECFMG and completion of an approved residency/fellowship program;

(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of staff responsibilities;

(3) Comply and have complied with federal, state and local requirements, if any, for their medical practice, including, but not limited to, any such requirements with respect to liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Health System;

(4) Have professional liability insurance that meets the requirements of these Bylaws;

(5) Are graduates of an approved educational institution holding appropriate degrees;

(6) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals and have the physical and mental health to adequately practice his/her profession;

(7) Have skills and training to fulfill a patient care need existing within the Health System, and be able to adequately provide those services with the facilities and support services available at the Health System;

(8) Practice in such a manner as not to interfere with orderly and efficient rendering of services by the Health System or by other Physicians and practitioners within the Health System;

(9) Show evidence of forty (40) CME hours every two (2) years, including any required CME mandated by the State's Board of Medical Examiners. The education should be related to the physician's specialty and to the provision of quality patient care in the Health System; and

(10) For applicants requesting clinical privileges, meet one of the following requirements:

(i) Board certification by a Specialty Board which is a member of the American Board of Medical Specialties, the American Osteopathic Association, or the American Board of Oral and Maxillofacial Surgery; or

(ii) Any provider credentialed pursuant to §7.3 shall have and maintain cross coverage with an appropriate and otherwise qualified Active Staff Physician practice, who also has and maintains Board certification by a Specialty Board as set forth in this Section 3.2(a)(10); or

(iii) Board certification within desired scope of practice within five (5) years after completion of residency or fellowship training.

The requirement in (iii) shall not apply to any Physician already a member of the Medical Staff as of January 1, 2001.

(iv) Once achieved and except as otherwise provided in this Section 3.2(a)(10) or in Section 4.7(a) below, Physician's primary specialty board certification or, for those physicians practicing in a subspecialty, his/her subspecialty board certification in the subspecialty practiced, shall be maintained at all times with no lapse in certification. Any failure to maintain board specialty certification in accordance with this Section may result in the immediate loss of privileges. Notwithstanding the foregoing, however, in the event a physician's board certification shall lapse, the Medical Executive Committee is authorized, though in no instance required, to extend such physician's appointment in order to allow additional period of time for the physician to complete the applicable recertification process before taking action as to the physician's privileges. Such additional period of time shall be determined by the individual specialty board testing cycle. To request an extension, the Physician shall direct his/her request, in writing, to the Medical Executive Committee. Primary board certification for subspecialists is and shall be encouraged; however, it is not a condition for maintaining privileges.

The requirement in (iv) shall not apply to any Physician already a member of the Medical Staff as of January 1, 2017.

**3.2**(b) **Effects of Other Affiliations**

No person shall be automatically entitled to membership on the Medical Staff or to exercise the particular clinical privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff membership at this Health System or at another health care facility or in another practice setting.

**3.2**(c) **Non-Discrimination**

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, creed, color, religion, sexual orientation, gender identity, national origin, citizenship status, pregnancy, age, disability, veteran status, or any other status protected under federal, state, or local law (except as such may impair the Physician's ability to provide quality patient care or fulfill his/her duties under these Bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Health System, to professional ability and judgment, or to community need.

**3.2**(d) **Ethics**

The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the member's certification that he/she has in the past, and agrees that he/she will in the future, abide by the lawful principles of Medical Ethics of the American Medical Association, or the American Osteopathic Association, or other applicable codes of ethics.

## 3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

**3.3**(a) Provide his/her patients with continuous safe and quality care, meeting the professional standards of Medical Staff of this Health System;

**3.3**(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;

**3.3**(c) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules and Regulations of the Medical Staff, department rules and regulations, and other Health System policies, procedures and standards as may be applicable;

**3.3**(d) Discharge the staff, department, committee and Health System functions for which he/she is responsible by staff category assignment, appointment, election or otherwise;

**3.3**(e) Cooperate with other members of the Medical Staff, management, the Board and employees of the Health System;

**3.3**(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Health System;

**3.3**(g) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the Health System drug testing program;

**3.3**(h) Refuse to engage in improper inducements for patient referral;

**3.3**(i) Notify the CMO and Chief of Staff immediately if:

(1) His/Her professional licensure in any state is suspended, revoked, or voluntarily surrendered in lieu of adverse disciplinary action;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) He/She has been excluded from any federal or state health program, including Medicare and Medicaid or

(5) His/Her clinical privileges at any other Health System have been restricted, suspended or revoked (excluding restrictions, suspensions or revocations that are contractually required upon the termination or expiration of an employment relationship or professional services contract), voluntarily surrendered in lieu of adverse action or voluntarily not renewed in lieu of adverse medical staff action, or sanctions of any kind have been imposed by any health care facility, professional review organization or licensing agency.

**3.3**(j) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including, without limitation, the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Health System.

**3.3**(k) If, at any time, the Health System does not have adequate coverage for the provision of Emergency Services for the physician's scope of privileges, any physician on the Active Staff clinically treating patients shall be obligated to take emergency call for their scope of privileges on a rotating basis with the other Active Staff members.

**3.3**(l) Refrain from engaging in business practices which are harmful (be it financial, reputational or otherwise) to the Health System or the community.

**3.3**(m) Comply with the following requirements concerning history and physical ("H&P") examinations:

Each patient admitted or registered for a procedure at the Health System shall have a complete H&P examination recorded by a qualified physician (or other Licensed Practitioner who has been credentialed and granted privileges to perform an H&P examination) within twenty-four (24) hours of admission, and immediately prior to any surgical procedure(s) requiring anesthesia. A written admission note shall be entered at the time of admission, documenting the diagnosis and reason for admission. Oral/maxillofacial surgeons may be granted privileges to perform part or all of the H&P examination,

including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. This report shall include an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission. In the case of infants, children or adolescents, the report shall include immunization status and other pertinent age-specific information. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the H&P shall specifically document the circumstances surrounding the need for additional acute care. Should the physician fail to ensure that the patient's H&P is finalized in the patient's chart within twenty-four (24) hours after admission, the record shall be considered delinquent and the Chief of Staff (or his/her designee) or the CEO (or designee) may take appropriate steps to ensure compliance.

An H&P may also be performed within thirty (30) days prior to any Health System admission or outpatient procedure by a Licensed Practitioner, who is not a Physician or OMFS (e.g., nurse practitioner, physician assistant) and who has not otherwise been credentialed or granted privileges to perform an H&P examination, so long as the patient's medical record further contains legible documentation by a Physician indicating that the H&P was reviewed, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the H&P, those must be documented within twenty-four (24) hours of admission or the outpatient procedure, and immediately prior to any surgical procedure(s) requiring anesthesia.

**3.3**(n) In the case of a condition or illness which interferes with ability to carry out duties as a member of the Medical Staff, notify the Department Chief of same; the Department Chief will evaluate the situation and take appropriate action as necessary and/or refer the matter to the Officers' Council or Medical Executive Committee.

**3.3**(o) Except as otherwise stated in these Bylaws, pay Medical Staff dues as set forth in Section 14.6.

## 3.4 CONTRACTED PHYSICIANS

**3.4**(a) A Physician employed by the Health System in a clinical capacity must be a member of the Medical Staff appointed in accordance with Article III and granted clinical privileges in accordance with Article VII of these Bylaws. In the case of a Health System employee, such Physician's membership and clinical privileges shall not be contingent upon the Physician's continued employment relationship with the Health System.

**3.4**(b) A Physician that is providing services to the Health System in a clinical capacity as an employee or member of a group or entity that has an expressly exclusive contract with the Health System (an "Exclusive Contract") must be a member of the Medical Staff appointed in accordance with Article III and granted clinical privileges in accordance with Article VII of these Bylaws (such Physician being an "Exclusive Physician"). In the case of an Exclusive Physician, his or her membership and clinical privileges shall not be contingent upon the continuation of the Exclusive Contract unless otherwise specifically provided in the Exclusive Contract. Further, in the case of an Exclusive Physician, his or her membership and clinical privileges, or any parts thereof, pertaining to categories of medical services, specialties and/or sub-specialties that are not expressly subject to the exclusivity terms in the Exclusive Contract shall not be contingent upon the continuation of the Exclusive Contract.

**3.4**(c) A Physician that is providing services to the Health System in a clinical capacity as an employee or member of a group or entity that has a contract with the Health System that is not an Exclusive Contract must also be a member of the Medical Staff appointed in accordance with Article III and granted clinical privileges in accordance with Article VII of these Bylaws (such Physician being a "Non-Exclusive Physician"). In the case of a Non-Exclusive Physician, his or her membership and clinical privileges shall not be contingent upon the continuation of the contract.

## 3.5 DURATION OF APPOINTMENT

### **3.5**(a) **Duration of Initial Appointments**

All initial appointments to the Medical Staff shall be for a period not to exceed three (3) years. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

### **3.5**(b) **Declaration of Moratorium**

The Board may from time to time declare a moratorium in the granting of Medical Staff privileges when the Board, in its discretion, deems such a moratorium to be in the best interest of the Health System and in the best interest of the health and patient care capable of being provided by the Health System and its staff. Prior to declaring a moratorium, the Board will seek the input of the Medical Staff regarding the needs of the Health System and the patient community. Further, prior to implementing any moratorium, the Board shall provide to the MEC and the affected Clinical Department Chair at least ninety (90) days' written notice of the Board's intent to declare such moratorium. A moratorium may apply to individual medical specialties, or any combination thereof, and a denial of privileges based on such moratorium shall not be considered adverse in nature, shall not be reported to the National Practitioner Data Bank or pursuant to T.C.A. § 63-32-101 *et seq.*, T.C.A. § 68-11-218 or any similar law or regulation relating to the reporting of adverse actions, and shall not otherwise entitle an applicant to the procedural rights set forth in Appendix "A" hereto.

### **3.5**(c) **Reappointments**

Reappointment to the Medical Staff shall be for a period not to exceed three (3) years.

### **3.5**(d) **Modification in Staff Category & Clinical Privileges**

The MEC may recommend to the Board that a change in staff category of a current staff member or the granting of additional privileges to a current staff member be made in accordance with the procedures for initial appointment as outlined herein.

## 3.6 LEAVE OF ABSENCE

### **3.6**(a) **Leave Status**

A staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time period

of the leave, which may not exceed one (1) year. If the leave is granted by the MEC, all rights and privileges of Medical Staff membership shall be suspended from the beginning of the leave period until reinstatement.

**3.6**(b) **Termination of Leave**

(1) At least sixty (60) days prior to the termination of leave or such less time as determined in the discretion of the MEC, or at any earlier time, the staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the CEO or his/her designee for transmittal to the MEC. The staff member shall submit a written summary of his/her relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges. Failure to request reinstatement in a timely manner shall result in automatic termination of staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action, shall not be reported to the National Practitioner Data Bank or pursuant to T.C.A. § 63-32-101 *et seq.,* T.C.A. § 68-11-218 or any similar law or regulation relating to the reporting of adverse actions. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

(2) If a member requests a leave of absence for the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC receives evidence of completion of such training and/or the MEC has satisfied itself as to the continuing competency of the returning staff member.

Any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.

(3) Reinstatement will ordinarily be automatic if a leave of absence is an armed services commitment and otherwise in compliance with the Service Members Civil Relief Act (50 U.S.C. §§ 3901-4043) and any other applicable law. However, if such a leave of absence occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

(4) If a member requests a leave of absence for reasons other than further medical training or an armed services commitment, the MEC may, prior to reinstatement, require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to ensure continuing competence.

## ARTICLE IV
## CATEGORIES OF THE MEDICAL STAFF

### 4.1 CATEGORIES

The staff shall include Active, Active Provisional, Honorary, Associate, Courtesy, Referring, Telemedicine and those special privilege categories set forth in Article VII.

### 4.2 ACTIVE STAFF

#### **4.2**(a) **Qualifications**

The Active Staff shall consist of Physicians who:

(1) Meet the basic qualifications set forth in these Bylaws;

(2) He/she shall be physically located within forty-five (45) miles of the Health System, or distance/time as required by specific program or contractual requirements, for the full duration of any clinical duties (including call obligations) in order to be continuously available for provision of care to his/her patients, as determined by the Board;

(3) Regularly admit, either directly or indirectly, to the Health System, or are otherwise regularly involved in the care of patients in the Health System. For purposes of determining whether a Physician is "regularly involved" in the care of patients, a patient encounter or contact shall be deemed to include a minimum of twenty-four (24) of any of the following patient encounters annually: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the Health System setting; performance of any inpatient surgical or diagnostic procedure; or interpretation of any inpatient diagnostic procedure or test; and

(4) Have served a minimum of one (1) year on the Medical Staff with satisfactory completion of their designated term in the Active Provisional category.

#### **4.2**(b) **Prerogatives**

The prerogatives of an Active Staff member shall be:

(1) To admit or refer for admission patients without limitation unless otherwise provided in the Medical Staff Bylaws and Rules and Regulations;

(2) To exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(3) To vote on all matters presented at general and special meetings of the Medical Staff;

(4) To vote and hold office in the staff organization, departments and on committees to which he/she is appointed; and

(5) To vote in all Medical Staff elections.

**4.2**(c) **Responsibilities**

Each member of the Active Staff shall:

(1) Meet the basic responsibilities set forth in Section 3.3;

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Health System for whom he/she is providing services, or arrange an explicit coverage alternative (e.g., a member of the Active or Active Provisional Medical Staff within his/her specialty) acceptable in the opinion of the MEC for such care and supervision, as further defined in Rules and Regulations; including an initial assessment of all patients within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit no later than two (2) hours after admission or sooner if warranted by the patient's condition;

(3) Actively participate:

(i) in Health System sanctioned quality and safety programs and other patient care evaluation and monitoring activities required of the Medical Staff and possess the requisite skill and training for the oversight of care, treatment and services in the Health System;

(ii) in supervision of other appointees where appropriate;

(iii) in the emergency department on-call rotation, as more specifically described in the Medical Staff Rules and Regulations, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician;

(iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and

(v) in discharging such other staff functions as may be required from time-to-time.

(4) Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff;

(5) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the departments and committees of which he/she is a member; and

(6) Assume and perform teaching or equivalent services if assigned by the appropriate academic program.

(7) Be required to pay Medical Staff dues pursuant to Section 14.6.

**4.2**(d) **Failure**

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership and privileges.

## 4.3 ACTIVE PROVISIONAL STAFF

**4.3**(a) **Qualifications**

All new applications for appointment to the Medical Staff, if accepted, shall be placed on the Medical Staff with Active Provisional status for a period of one (1) year. The staff member with Active Provisional status should be reevaluated periodically or at re-credentialing for promotion to Active Staff or Courtesy status and is expected to qualify for advancement, at most, by the end of three (3) years. If, at the end of three (3) years, the applicant has not satisfied the requirements of staff eligibility, his/her Active Provisional status shall automatically be terminated. The Active Provisional Staff shall consist of physicians each of who meet the basic qualifications delineated in these Bylaws, and who are physically present within forty-five (45) miles of the Health System for the complete duration of any and all clinical responsibilities including call coverage.

**4.3**(b) **Prerogatives**

(1) Prerogatives of an Active Provisional Staff member shall be to:

(i) treat patients without limitation, but not less than twenty-four (24) encounters per year, unless otherwise provided in the Medical Staff Bylaws and Rules and Regulations; and

(ii) exercise such clinical privileges as are granted to him/her pursuant to Article VII.

(2) Active Provisional Staff shall not hold office nor be eligible to vote in the Medical Staff organization.

**4.3**(c) **Responsibilities**

Each member of the Active Provisional Staff shall:

(1) Discharge the basic responsibilities specified in Section 3.3;

(2) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Health System for whom he/she is providing service;

(3) Satisfy the requirements set forth in these Bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member;

(4) To the extent deemed appropriate by the Chief of Staff and/or the CEO, and approved by the MEC, participate in Health System-sanctioned quality and safety

programs required of the Medical Staff, the emergency on-call rotation, and discharge such other staff functions as may be required from time to time;

(5) Discharge the duties of a preceptee as outlined in the Peer Review Policy; and

(6) Serve on and attend the majority of the meetings for at least one (1) committee, if requested by the Chief of Staff.

(7) Be required to pay Medical Staff dues pursuant to Section 14.6.

**4.4 [Section Omitted]**

**4.5 COURTESY STAFF**

**4.5**(a) **Qualifications**

The Courtesy Staff shall consist of Physicians who:

(1) meet the basic qualifications set forth in the Bylaws;

(2) remain physically present within 45 miles of the Health System for the complete duration of any and all clinical responsibilities including call coverage.

(3) have at least one (1) not more than twenty-three (23) encounters per year at the Health System. Physicians having more than twenty-three (23) encounters at the Health System shall not qualify for Courtesy Staff and will be transitioned to Active Staff.

**4.5**(b) **Prerogatives**

The prerogatives of the Courtesy Staff shall be to:

(1) admit patients to and have encounters within the Health System within the limitations provided in Section 4.5(a)(3) and under the same conditions as specified for Active staff members.

(2) exercise such clinical privileges as are granted pursuant to the Medical Staff Bylaws.

To the extent deemed appropriate by the Chief of Staff and/or the CEO, and approved by the MEC, participate in Health System-sanctioned quality and safety programs required of the Medical Staff, and attend meetings of the Medical Staff and the department.

(3) Each member of the Courtesy Staff shall be required to discharge the basic responsibilities specified in the Medical Staff Bylaws and further shall retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Health System for whom he/she is providing services, or arrange a suitable alternative for such care and supervision.

Courtesy Staff members who admit patients or regularly care for patients at the Health System in excess of the limits set forth above shall, upon review of the department Chief, be transitioned to the Active Staff.

Courtesy Staff members shall not be obligated to pay Medical Staff dues.

## 4.6 HONORARY STAFF

### **4.6**(a) **Qualifications**

The Honorary Staff shall consist of Physicians who are not active in the Health System and who are honored by emeritus positions. These may be:

(1) Physicians who have retired from active Health System service, but continue to demonstrate a genuine concern for the Health System; or

(2) Physicians of outstanding reputation in a particular specialty, whether or not a resident in the community.

Honorary Staff members shall not be required to meet the qualifications set forth in Section 3.2(a) of these bylaws.

### **4.6**(b) **Prerogatives**

(1) Prerogatives of an Honorary Staff member shall be:

(i) attending by invitation any such meetings that he/she may wish to attend as a non-voting visitor.

(2) Honorary Staff members shall not in any circumstances admit patients to the Health System or be the Physician of primary care or responsibility for any patient within the Health System. Honorary Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

(3) Honorary Staff members shall not be obligated to pay Medical Staff dues.

## 4.7 ASSOCIATE STAFF

### **4.7**(a) **Qualifications**

The Associate Staff shall consist of Physicians in residency or fellowship training programs intending to perform clinical services at the Health System outside of their residency or fellowship program (i.e., moonlighting) shall:

(1) Except meeting the requirements for board eligibility and/or board certification as set forth in Section 3.2(a)(10) above, shall otherwise meet the basic qualifications set forth in these Bylaws;

(2) Are currently enrolled in one of the recognized teaching programs affiliated with the University of Tennessee College of Medicine, Chattanooga;

(3) Secure the recommendation and approval by their training department's clinical chairman and the program director, if applicable; and

(4) Remain in good standing with his/her teaching program. If the member loses his/her good standing status, his/her membership and privileges will be automatically terminated, although such termination shall not be reported to the National Practitioner Data Bank or pursuant to T.C.A. § 63-32-101 *et seq.*, T.C.A. § 68-11-218 or any similar law or regulation relating to the reporting of adverse actions, unless legally required in the opinion of Health System counsel.

**4.7**(b) **Prerogatives**

The prerogatives of a member of the Associate Staff shall be to provide approved services in the Health System under the supervision of a physician member of the Active Staff. The management of each member's patients shall be the ultimate responsibility of the supervising physician member of the Active Staff. Members of the Associate Staff shall not be eligible to vote or hold Medical Staff office.

**4.7**(c) **Responsibilities**

Each member of the Associate Staff shall be required to discharge the basic responsibilities specified in these Bylaws and, further, shall retain responsibility within his/her area of professional competence for the continuous care of each patient in the Health System for whom he/she is providing service, or arrange a suitable alternative for such care. Each member shall comply with the provisions of the Rules and Regulations, which shall delineate the scope of supervision and services with regard to Associate Staff. Associate Staff members shall not be obligated to pay Medical Staff dues.

## 4.8 REFERRING STAFF

### 4.8(a) Qualifications

The Referring Medical Staff shall consist of members who meet Sections 3.2(a)(1) and 3.2(a)(3) above, but are not permitted to provide patient or otherwise admit patient within the Health System.

**4.8**(b) **Prerogatives**

Except as otherwise provided, the Referring Staff member shall be entitled to:

(1) Refer patients to the Health System for outpatient testing and/or procedures;

(2) Refer patients to Active Staff members or Hospitalists for inpatient treatment. Referring Staff may review patients' medical records and receive information concerning patients' medical condition and treatment, but may not participate in any inpatient treatment or make any entries in the medical record; and

(3) Attend Continuing Medical Education programs at the Health System;

**4.8** (c) Limitations

Members of the Refer and Follow Medical Staff shall not be eligible to:

(1) Vote or hold offices in the Medical Staff;

(2) Admit and/or treat patients;

(3) Order tests on inpatients;

(4) Hold offices in the Medical Staff; or

(5) Exercise any clinical privileges.

**4.8**(d) **Responsibilities**

Members of the Refer and Follow Medical Staff will be expected to:

(1) Adhere to the ethics of their respective professions;

(2) Be able to work cooperatively with others;

(3) Cooperate with the MEC in the ensuring compliance with the basic qualification set forth in this Section;

(4) Submit to a National Practitioner Data Bank query;

(5) Review all results of tests ordered and provide for such further outpatient medical care as the patient's condition may indicate. Since such patient care shall occur outside of the Health System, neither the Medical Staff nor the Health System shall be responsible for reviewing such care through the Performance/Quality Improvement Process or otherwise.

(6) Members of the Referring shall not be obligated to pay Medical Staff dues.

## 4.9 TELEMEDICINE STAFF

**4.9**(a) **Qualifications**

Telemedicine Staff shall consist of Physicians ("Telemedicine Staff") who:

(1) Meet the basic qualifications set forth in these Bylaws;

(2) Involved in the provision of care and treatment via telemedicine as to patients in the Health System; and

(3) Shall be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. If the Telemedicine Staff's site is also accredited through a national accrediting agency that CMS has provided with deeming authority (e.g., DNV, Joint Commission, etc.) and otherwise warrants compliance with 42 C.F.R. §§482.12 and 483.22, and the Telemedicine Staff is privileged to perform the services and procedures for which privileges are being sought in the Health System, then the Telemedicine Staff's credentialing information from that site may be relied upon to credential the Telemedicine Staff in the Health System. However,

the Health System will remain responsible for primary source verification of licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the National Practitioner Data Bank. The Health System shall further conduct the verification procedures for an adequate number of hospitals, health care organizations and/or practice settings with whom the applicant is or has previously been affiliated in order to ensure competency, but not less than the ten (10) practice settings in which the applicant provides or has provided the greatest volume of patient care services.

**4.9**(b) **Prerogatives**

The Medical Staff shall make recommendations to the Board regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

Except as otherwise provided, the Telemedicine Staff shall be entitled to:

(1) To exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(2) Refer patients to the Health System for testing and/or procedures;

(3) Refer patients to Active Staff members or Hospitalists for inpatient treatment; and

(4) Attend Continuing Medical Education programs at the Health System.

**4.9**(c) **Limitations**

Telemedicine Staff are not members of the Medical Staff and shall not be eligible to vote or hold offices in the Medical Staff.

**4.9**(d) **Responsibilities**

Telemedicine Staff shall be required to:

(1) Adhere to the ethics of their respective professions;

(2) Be able to work cooperatively with others;

(3) Cooperate with the Medical Staff in the ensuring compliance with the basic qualifications set forth in these Bylaws;

(4) Members of the Referring shall not be obligated to pay Medical Staff dues.

## 4.10 APPOINTMENT AND REAPPOINTMENT REQUIREMENTS

At initial appointment and each subsequent reappointment (every three (3) years), information concerning the following shall be collected from the applicant and verified, if applicable:

(1) Current licensure (in good standing) to practice medicine, osteopathy, or dentistry in this State;

(2) Adequate education and training;

(3) Appropriate physical and mental health status;

(4) Professional liability insurance that meets the requirements of these Bylaws;

(5) DEA registration/controlled substance certificate if applicable;

(6) Any current criminal charges pending against the applicant and any past convictions or pleas. The Physician shall notify the CEO or his/her designee and the Chief of Staff within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Health System's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

(7) Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid.

## 4.11 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws and by the Medical Staff Rules and Regulations.

## 4.12 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the Department Chief, or pursuant to a request by a member under Section 6.5, the MEC may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

## ARTICLE V
## ALLIED HEALTH PROFESSIONALS

### 5.1 CATEGORIES

Allied Health Professionals ("AHPs") shall be identified as any person(s) other than Physicians who are granted privileges to practice in the Health System and are directly involved in patient care. Such persons may be employed by Physicians on the Medical Staff; but whether or not so employed, must be under the direct supervision and direction of and otherwise engage a member of the Active Medical Staff to admit patients and not exceed the limitations of practice set forth by their respective licensure or delineated privileges.

### 5.2 QUALIFICATIONS

Only AHPs holding a license, certificate or other official credential as provided under State law shall be eligible to provide specified services in the Health System, as delineated by the MEC and approved by the Board.

**5.2**(a) AHPs must:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Health System;

(2) Establish, on the basis of documented references, that they will adhere strictly to the ethics of their respective professions, work cooperatively with others and are willing to participate in the discharge of AHP responsibilities;

(3) Have professional liability insurance in the amount required by these Bylaws;

(4) Document their certification by their appropriate certifying board or body. Certification will be verified prior to recommending appointment to the AHP staff. Additionally, maintenance of certification is required and will be verified prior to reappointment to the AHP staff. Failure to achieve certification/recertification will result in termination of membership and privileges on the AHP staff.

(5) Provide a needed service within the Health System; and

(6) Unless permitted by law the Health System, the Medical Staff, and the Board to practice independently, provide written documentation that a Physician who is a member of the Medical Staff with active privileges has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

### 5.3 PREROGATIVES

Upon establishing experience, training and current competence, AHPs, as identified in Section 5.1, shall have the following prerogatives:

**5.3**(a) Exercise judgment within the AHP's area of competence, providing that a Physician of the Medical Staff has the ultimate responsibility for patient care;

**5.3**(b) Participate directly, including writing orders to the extent permitted by law and delineated scope, the Health System, the Medical Staff, and the Board, in the management of patients under the supervision or direction of a member of the Medical Staff; and

**5.3**(c) Participate as appropriate inpatient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time.

## 5.4 CONDITIONS OF APPOINTMENT

**5.4**(a) AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of Physicians. Each AHP shall be assigned to one (1) of the clinical Departments and shall be granted clinical privileges relevant to the care provided in that Department. The Board, in consultation with the MEC, shall determine the scope of the activities/procedures which each AHP may undertake/perform. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these Bylaws.

**5.4**(b) Appointment of AHPs must be approved by the MEC and Board and may be terminated upon recommendation by the MEC to the Board. Adverse actions or recommendations affecting AHP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to request to be heard before the Credentials Committee's with an opportunity to rebut the basis for termination. Upon receipt of a written request, the Credentials Committee shall afford the AHP an opportunity to be heard by the Credentials Committee concerning the AHP's grievance. Before the appearance, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto. In addition, the Credentials Committee may, at its sole discretion, solicit general input from formal AHP committee leaders (e.g., "the Health System AHP Council") that may inform the Credentials Committee action or recommendation. A record of the appearance shall be made. The Credentials Committee shall, after conclusion of the investigation, submit a written recommendation simultaneously to the MEC and to the AHP.

**5.4**(c) The AHP shall have a right to petition the MEC regarding any recommendation rendered by the Credentials Committee. Any request for petition must be made within fifteen (15) days after the date of the receipt of the Credentials Committee's recommendation. The written request shall be delivered to the Chief of Staff and shall include a brief statement of the reasons for the petition. If the AHP fails to petition the MEC within such period the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If a petition is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the AHP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board

members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

**5.4**(d) AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising physician member, unless another qualified Physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising Physician's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan.

**5.4**(e) The AHP may continue his/her membership and privileges on the AHP Staff should his/her supervising physician member change. Written notification of the change in supervision must be received by the Medical Staff Office prior to the AHP exercising any privileges in the Health System under the supervision of the new supervising Physician member.

**5.4**(f) If the supervising Physician employs or directly contracts with the AHP for services, the Physician shall indemnify the Health System and hold the Health System harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP,- negligence of such AHP, the failure of such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges. If the supervising Physician does not employ or directly contract with the AHP, the Physician shall indemnify the Health System and hold the Health System harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by, or arising from improper or inadequate supervision of the AHP by the Physician in question.

## 5.5 RESPONSIBILITIES

Each AHP shall:

**5.5**(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

**5.5**(b) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules and Regulations of the Medical Staff, and personnel policies of the Health System, if applicable;

**5.5**(c) At all times, act within the scope of privileges delineated and approved by the MEC and the Board. Failure to adhere to the scope of approved privileges may result in termination of membership and privileges;

**5.5**(d) Discharge any committee functions for which he/she is responsible;

**5.5**(e) Cooperate with members of the Medical Staff, management, the Board and employees of the Health System;

**5.5**(f) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

**5.5**(g) Abide by the ethical principles of his/her profession and specialty; and

**5.5**(h) Notify the CEO or designee and the Chief of Staff immediately if:

(1) His/Her professional license in any state is suspended, revoked, or voluntarily surrendered;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) He/She ceases to meet any of the standards or requirements set forth herein for continued enjoyment of AHP appointment and/or clinical privileges, including but not limited to certification/recertification in his/her field of practice;

(5) He/She has been excluded from any federal or state health program, including Medicare and Medicaid; or

(6) He/She changes supervising Physician on the Medical Staff.

**5.5**(i) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Health System.

**5.5**(j) Participate in performance improvement activities and in continuing professional education.

## 5.6 REVISIONS TO SCOPE OF PRIVILEGES

The MEC shall have the power and authority, subject to approval by the Board, to revise the scope of privileges which may be granted under these Bylaws to AHPs to reflect regulatory changes made by the Tennessee State Board of Medicine or other applicable regulatory body in Tennessee. Following approval by the Board, the MEC shall give not less than thirty (30) days written notice of such change in the scope of privileges' revision to the Medical Staff prior to the revision becoming effective. The scope of privileges for each individual AHP shall nevertheless be determined on a case-by-case basis.

## ARTICLE VI
## PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

### 6.1 GENERAL PROCEDURES

The Medical Staff, through its designated Committees and Departments, shall investigate and consider each fully completed and compliant application for appointment or reappointment to the staff and each request for modification of staff membership status and privileges, and shall adopt and transmit recommendations thereon to the Board which shall be the final authority on granting, extending, terminating or reducing Medical Staff privileges. The Board shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each individual requesting Medical Staff and AHP membership or clinical privileges. By applying to the Medical Staff for appointment or reappointment, the applicant acknowledges responsibility to first review these Bylaws and agrees that throughout any period of membership, that individual will comply with the responsibilities of Medical Staff and AHP membership and with the Bylaws and Rules and Regulations of the Medical Staff as they exist and as they may be modified from time to time.

### 6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (required for all physicians and DEA-eligible AHPs. Exclusions include Pathologists, Telemedicine-only Radiologists) , a signed Medicare penalty statement, and a certificate of insurance must be submitted with the application. Applicants shall supply the Health System with all information requested on the application. Each application for appointment to the Medical Staff must be submitted at least ninety (90) days prior to the date of practice commencement, submitted to the Medical Staff Office, Tennessee Physicians Quality Verification Organization, or other quality verification organization or function as may be utilized by the Health System from time to time (hereinafter referred to collectively as the "QVO") on the prescribed form and signed by the applicant. The QVO will notify the CEO, or designee, when an application has been received. The applicant will then be forwarded a copy of the Medical Staff Bylaws and, the Rules and Regulations as well as key policies and procedures governing the practice of medicine in the Health System.

The applicant agrees that he/she will exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her staff membership, staff status, and/or clinical privileges.

The application form shall include, at a minimum, the following:

**6.2**(a) Acknowledgment & Agreement: A statement that the applicant has received and read the Bylaws, Rules and Regulations and Fair Hearing Plan of the Medical Staff and that he/she agrees:

(1) to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and

(2) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted membership and/or clinical privileges.

**6.2**(b) Health Status: Attestation to current physical and mental health status, with the ability to produce proof of a physical examination administered not less than every three (3) years upon request, only to the extent necessary to demonstrate that the applicant is capable of performing the functions of staff membership and exercising the clinical privileges requested. In instances where there is doubt about an applicant's ability to perform the clinical privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board. Applicant agrees to be bound by the Medical Staff Impaired Physician Policy;

**6.2**(c) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws, requiring that the Health System will be notified should the applicant's coverage change at any time. Each Physician must, at all times, keep the CEO or designee informed of changes in his/her professional liability coverage;

**6.2**(d) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions;

**6.2**(e) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary or involuntary relinquishment of, any of the following:

(1) membership/fellowship in local, state or national professional organizations;

(2) specialty board and ECFMG certifications;

(3) license to practice any profession in any jurisdiction;

(4) Drug Enforcement Agency (DEA) number/controlled substance license;

(5) Medical Staff or AHP membership or limitation (voluntary or involuntary), reduction or loss of clinical privileges;

(6) the Physician's management of patients which may have given rise to investigation by the state medical board; or

(7) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The Physician shall have a continuing duty to notify the MEC, in writing through the CEO or designee within seven (7) days of receiving notice of the initiation of any of the above actions against him/her. The CEO or designee shall be responsible for notifying the MEC of all such actions.

**6.2**(f) Qualifications: Detailed information concerning the applicant's experience, education (including degree, internship, residency and fellowship information) and qualifications for the requested staff category, including information in satisfaction of the basic qualifications specified in Section 3.2(a), and the applicant's current professional license and federal drug registration numbers, if applicable;

**6.2**(g) References: The names of at least three (3) Physicians (excluding employers, employees or relatives/spouses), who have worked with the applicant within the past three (3) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character and ability to exercise the clinical privileges requested and to work with others;

**6.2**(h) Practice Affiliations: The name and address of all other health systems, health care organizations or practice settings with whom the applicant is or has previously been affiliated;

**6.2**(i) Requests: Specific requests stating the staff category and specific clinical privileges for which the applicant wishes to be considered;

**6.2**(j) Photograph: A recent, wallet sized government issued photograph of the applicant;

**6.2**(k) Professional Practice Review Data: For all new applicants and Physicians requesting new or additional privileges, evidence of the Physician's professional practice review, volumes and outcomes from organization(s) that currently privilege the applicant;

**6.2**(l) Physician Health Program Participation: Information concerning any involvement, either voluntary or involuntary in any type of physician evaluation or program, including but not limited to, physical, psychological, or chemical dependency or other such program;

**6.2**(m) Proof of Immunity and/or Vaccination: A statement whereby the physician provides evidence of immunization against communicable diseases if required;

**6.2**(n) Delineation of Privileges: A completed privilege delineation form; and

**6.2**(o) Data Base Sheet/Application: A completed data base sheet/application provided by the QVO, including past medical licenses and Medical Staff memberships as well as any practice restrictions, medical malpractice judgments.

**6.2**(p) Current Information: Current mobile phone number and e-mail address.

**6.2**(q) Medical Staff Dues: Prepayment of Medical Staff dues is required for processing of an application and must be complete prior to appointment or reappointment to the Medical Staff. However, prepaid Medical Staff dues will be refunded in the event that appointment or reappointment to the Medical Staff is denied.

## 6.3 PROCESSING THE APPLICATION

**6.3**(a) **Request for Application**

An applicant wishing to be considered for Medical Staff appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her request for an application form to the CEO, designee, or the QVO. The Health System may contract with a QVO to obtain specified information regarding each Physician's application for initial appointment and reappointment.

**6.3**(b) **Applicant's Burden**

By submitting the application, the applicant:

(1) Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for staff membership and clinical privileges;

(2) Authorizes Health System representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;

(3) Consents to the inspection by Health System representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for staff membership;

(4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Health System of any change in any of the information furnished in the application; and acknowledges that provision of false or misleading information, or omission of information, shall be grounds for immediate rejection of his/her application; and

(5) Pledges to provide continuous care for his/her patients treated in the Health System.

**6.3**(c) **Statement of Release & Immunity from Liability**

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges to practice his/her profession in the Health System during his/her term of appointment or reappointment. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment or clinical privileges the applicant expressly accepts these conditions during the processing and consideration of his/her application, and at all times thereafter, regardless of whether or not he/she is granted appointment or clinical privileges.

I hereby apply for Medical Staff appointment as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

***As an applicant for appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Health System with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the Health System or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated and acted upon. I hereby signify my willingness to appear for the interview, if requested, in regard to my application.***

***Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether***

***intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges.***

***If granted appointment, I accept the following conditions:***

***(1) I extend immunity to, and release from any and all liability, the Health System, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Health System and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:***

***(i) applications for appointment or clinical privileges, including temporary privileges;***

***(ii) periodic reappraisals;***

***(iii) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;***

***(iv) summary suspension;***

***(v) hearings and appellate reviews;***

***(vi) medical care evaluations;***

***(vii) utilization reviews;***

***(viii) any other Health System, Medical Staff, department, section or committee activities;***

***(ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and***

***(x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Health System.***

***(2) I specifically authorize the Health System and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to the Medical Staff, as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Health System and its authorized representatives upon request.***

***(3) The term "Health System" and "its authorized representatives" means the Health System, the Health System to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Health System: the members of the Board and their appointed representatives, the CEO or his/her designees, other Health System employees, consultants to the Health System, the Health System's attorney and his/her partners, associates or designees, and all appointees to the Medical Staff. The term "third parties" means all individuals, including appointees to the Medical Staff, and appointees to the Medical Staffs of other Health Systems or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether Health Systems, health care facilities or not, from whom information has been requested by the Health System or its authorized representatives or who have requested such information from the Health System and its authorized representatives.***

***I acknowledge that: (1) Medical Staff appointments at this Health System are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws and Rules and Regulations; (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final; (4) I have the responsibility to keep this application current by informing the Health System through the CEO or his/her designee, of any change in the areas of inquiry contained herein; and (5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the effective and efficient operation of the Health System. Appointment and continued clinical privileges shall be granted only on formal application, according to the Health System and these Bylaws and Rules and Regulations, and upon final approval of the Board.***

***I understand that before this application will be processed that: (1) I will be provided a copy of the Medical Staff Bylaws and such Health System policies and directives as are applicable to appointees to the Medical Staff, including these Bylaws and Rules and Regulations of the Medical Staff presently in force; and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such bylaws, policies, directives and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise clinical privileges at the Health System.***

***If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee-splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of Health System patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the Health System for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff.***

**6.3**(d) **Submission of Application &Verification of Information**

Upon completion of the application form and attachment of all required information, the applicant shall submit the form as directed by the Health System. The application shall not be processed further if one (1) or more of the following applies:

(1) Not Licensed. The Physician is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff; or

(2) Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the Physician has had his/her application for Medical Staff appointment at this Health System denied (for reasons unrelated to an Exclusive Contract or moratorium as set forth in Section 6.3(d)(3)), has resigned his/her Medical Staff appointment at this Health System during the pendency of an active investigation in lieu of revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Health System (for reasons unrelated to an Exclusive Contract or moratorium as set forth in Section 6.3(d)(3)); or

(3) Exclusive Contract or Moratorium. The Physician practices a specialty which is the subject of a current Exclusive Contract or a moratorium has been imposed by the Board upon acceptance of applications within the Physician's specialty; provided that the application shall be processed further to the extent that the Physician is seeking to provide categories of medical services or to practice within a specialty or sub-specialty that is not expressly subject to the terms of such current Exclusive Contract or moratorium; or

(4) Inadequate Insurance. The Physician does not meet the liability insurance coverage requirements of these bylaws; or

(5) Ineligible for Medicare Provider Status. The Physician has been excluded, suspended or debarred from any government payer program; or

(6) When applicable, provider's DEA number/controlled substance license has been revoked or voluntarily or involuntarily relinquished (this section shall not apply to pathologists, telemedicine-only radiologists or those not eligible for DEA); or

(7) Continuous Care Requirement. For applicants who will be seeking advancement to Active Staff, failure to maintain immediate availability within forty-five (45) miles of the Health System for the complete duration of clinical responsibilities; or

(8) Application Incomplete. The Physician has failed to provide any information required by these Bylaws or requested on the application or document basic qualifications required in these Bylaws or has failed to execute an acknowledgment, agreement or release required by these Bylaws or included in the application.

The refusal to further process an application form for any of the above reasons shall not entitle the Physician to any further procedural rights under these Bylaws.

The applicant shall deliver a completed application, as directed by the Health System, who shall, in timely fashion (not to exceed ninety (90) days), seek to collect and verify the applicant's credentials. The applicant shall deliver a completed delineation of clinical

privileges form to the CEO, or designee, who shall in timely fashion (not to exceed ninety (90) days), seek to collect and verify current clinical competency. When there are problems in obtaining the required information, the application will be deemed incomplete and returned to the applicant. It shall then be the applicant's obligation to obtain the required information and return it to the CEO, or designee. When collection and verification is accomplished, the CEO, or designee, shall transmit the application and all supporting materials to the appropriate department in which the applicant seeks clinical privileges.

An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the National Practitioner Data Bank, is complete.

**6.3**(e) **Description of Initial Clinical Privileges**

Medical Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the Health System. Each Physician who is appointed to the Medical Staff of the Health System shall be entitled to exercise only those clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to, exercise the clinical privileges he/she requests.

**6.3**(f) **Recommendation of Chief of Clinical Department**

The Chief of the appropriate clinical department shall review the application, the supporting documentation, reports and recommendations, and such other relevant information available to him/her, and shall transmit to the Credentials Committee on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any specific conditions to be attached to the appointment. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered. Documentation shall be transmitted with the report.

**6.3**(g) **Credentials Committee Action**

The members of the Credentials Committee shall review the application, the supporting documentation, the recommendation of the Chief of the Clinical Department and such other information available as may be relevant to consideration of the applicant's qualifications for the staff category and clinical privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee also may recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Supporting documentation shall be transmitted with the report.

**6.3**(h) **Medical Executive Committee Action**

At its next regular meeting after receipt of the Credentials Committee recommendation, but no later than thirty (30) days, the MEC shall consider the recommendation and other relevant information available to it. Where there is doubt about an applicant's ability to perform the privileges requested, the MEC may request an additional evaluation. The MEC shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(o). The MEC shall then forward to the Board a written report on the prescribed form concerning staff recommendations and, if appointment is recommended, staff category and clinical privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report.

**6.3**(i) **Effect of Medical Executive Committee Action**

(1) Deferral: Action by the MEC to defer the application for further consideration must be followed up within thirty (30) days with a recommendation for appointment with specified clinical privileges or for rejection of the application. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same.

Unless reasonable cause is shown, the MEC shall not defer action on a completed and verified application for more than thirty (30) days beyond receipt of same.

(2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO or his/her designee shall promptly forward it to the Board. Supporting documentation will be made available to the Board upon request. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.

(3) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO or his/her designee shall immediately inform the Physician by Special Notice which shall specify the reason or reasons for denial and the Physician then shall be entitled to the procedural rights as provided in the Fair Hearing Plan. The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. Upon completion of the Fair Hearing process, the Board shall act on the matter as provided in the Fair Hearing Plan.

**6.3**(j) **Board Action**

(1) Decision. The Board may accept, reject or modify the MEC recommendation. The Board shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(o). The Secretary of the Board shall reduce the decision to writing and shall set forth therein the reasons for the decision. The written decision shall not disclose

any information which is or may be protected from disclosure to the applicant under applicable laws.

(2) Favorable Action. In the event that the Board's decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO or designee shall promptly inform the applicant that his/her membership and/or privileges have been granted. The CEO or designee shall also keep each patient care area/department adequately informed concerning the current clinical privileges granted to each newly approved applicant as well as existing members of the Medical Staff. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of performance improvement that does not materially restrict the applicant's ability to exercise the requested clinical privileges.

(3) Adverse Action. In the event that the MEC's recommendation was favorable to the applicant, but the Board's action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan and no report shall be made to the National Practitioner Data Bank or pursuant to T.C.A. § 63-32-101 *et seq.*, T.C.A. § 68-11-218 or any similar law or regulation relating to the reporting of adverse actions, unless legally required in the opinion of Health System counsel. The CEO or designee shall immediately deliver to the applicant by Special Notice (certified, return, receipt requested mail), a letter enclosing the Board's written decision and containing a summary of the applicant's rights as specified in the Fair Hearing Plan.

Under no circumstances shall any applicant be entitled to more than one (1) evidentiary hearing under the Fair Hearing Plan based upon an adverse action.

(4) Conflict Resolution. Whenever the Board's proposed decision will be contrary to the MEC's recommendation, the Board shall submit the matter to the Officers' Council of the MEC for review and recommendation before making its final decision and giving notice of final decision.

**6.3**(k) **Interview**

An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) - 6.3(j). Failure to appear for a requested interview without good cause may be grounds for termination of the application process or denial of the application.

**6.3**(l) **Reapplication After Adverse Appointment Decision**

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the deficiency constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed

as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

**6.3**(m) **Time Periods for Processing**

The CEO, or designee, shall transmit an application as soon as possible to the Medical Staff upon completing the information collection and verification tasks. The applicable Chief(s) of Clinical Department and the Credentials Committee shall act on an application within sixty (60) days after receiving it from the CEO, or designee. The MEC shall review the application and make its recommendation to the Board within sixty (60) days after receiving the Credentials Committee's report. The Board, or its appropriate committee, shall then take final action on the application at its next regular meeting. The time periods specified are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the physician to have his/her application processed within those periods.

**6.3**(n) **Denial for Health System's Inability to Accommodate Applicant; Economic Credentialing**

A decision by the Board to deny Medical Staff membership, staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan:

(1) On the basis of the Health System's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or

(2) On the basis of inconsistency with the Health System's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or

(3) On the basis of Exclusive Contracts the Health System has entered into for the rendition of services within various specialties; provided that Medical Staff membership, staff category assignment or particular clinical privileges shall not be denied on the basis of such Exclusive Contracts to the extent that such membership, assignment or privileges pertain(s) to categories of medical services, specialties or sub-specialties not expressly subject to the exclusivity terms of the Exclusive Contract;

(4) On the basis that moratoriums that have been imposed by the Board with respect to the various specialties; provided that Medical Staff membership, staff category assignment or particular clinical privileges shall not be denied on the basis of such moratoriums to the extent that such membership, assignment or privileges pertain(s) to categories of medical services, specialties or sub-specialties not expressly subject to the terms of such moratoriums; or

(5) On the basis of any other economic consideration deemed by the Board to be in the best interest of the Health System.

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding three (3) years. If during this period, the Health System finds it possible to accept applications for staff positions for which the applicant is eligible, and the Health System has no obligation to applicants with prior pending status, the CEO or designee shall promptly so inform the applicant of the opportunity by Special Notice.

Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 6.2 for initial appointment shall apply.

**6.3**(o) **Appointment Considerations**

Each recommendation concerning the appointment of a Medical Staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant's experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant's proficiency in areas such as the following:

(1) **Patient Care** with the expectation that Physicians provide patient care that is compassionate, appropriate and effective;

(2) **Medical/Clinical Knowledge** of established and evolving biomedical clinical and social sciences, and the application of the same to patient care and educating others;

(3) **Practice-Based Learning and Improvement** through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;

(4) **Interpersonal and Communication Skills** that enable establishment and maintenance of professional working relationships with patients, patients' families, members of the Medical Staff, Health System Administration and employees, and others;

(5) **Professional** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and

(6) **Systems-Based Practice** reflecting an understanding of the context and systems in which health care is provided.

**6.3**(p) **Expedited Credentialing**

The following criteria will be used to deem an application eligible for expedited credentialing. All criteria must be met:

(1) The applicant has promptly returned all requested information;

(2) There are no negative or questionable recommendations;

(3) There are no discrepancies in information received from the applicant or references;

(4) The applicant completed a conventional education/training sequence;

(5) There are no reports of disciplinary/licensure actions or legal sanctions;

(6) There are no reports of malpractice cases within the past five (5) years. (Exceptions: if the applicant was named in a "blanket" type suit and was later dropped; if no money was exchanged and if there are no suits mentioned in the report received from the National Practitioners Data Bank.);

(7) The applicant has an unremarkable Medical Staff/employment history (i.e., no voluntary or involuntary termination/resignation of Medical Staff membership and/or clinical privileges);

(8) The applicant submits a reasonable request for clinical privileges based on experience, training, and competence and is in compliance with any and all applicable criteria;

(9) The applicant reports an acceptable health status;

(10) The applicant has never had third-party payer (e.g., Medicare, Medicaid, etc.) sanctions;

(11) The applicant has no felony indictments or convictions; and

(12) The applicant's history shows an ability to relate to others in a harmonious, collegial manner.

### **6.3**(q) **Expedited Credentialing Process**

The MEC will act on recommendations from the Credentials Committee for expedited appointment, clinical privileges and reappointment only when a quorum is present and the applicant's file is otherwise complete. The Board may elect to delegate the authority to render initial appointment, reappointment, and renewal or modification of clinical privileges decisions to the Officers' Council of the MEC. Following a favorable recommendation from the MEC on an application, the Officers' Council of the MEC may review and evaluate the qualifications and competence of the applicant applying for appointment, reappointment, or renewal or modification of clinical privileges and render its decision. A favorable decision by the Officers' Council of the MEC may be deemed as final action as long as the Board is informed of the committee's action at its next regularly scheduled meeting. The Board may accept the report and take no action, or it may refer any or all of the report back to the MEC for further evaluation and/or recommendation.

## 6.4 REAPPOINTMENT PROCESS

### **6.4**(a) **Information Form for Reappointment**

The QVO, the Health System or its designee, shall, at least ninety (90) days prior to the expiration date of the present staff appointment of each Medical Staff member, provide

each Medical Staff member with an application for reappointment. The CEO, or designee, shall, in like manner, provide each Medical Staff member with an appropriate delineation of privileges form. Each member who desires reappointment shall, at least ninety (90) days prior to such expiration date, send the interval form to the QVO, the Health System or its designee, and delineation of privileges form to the CEO, or designee, which must include prepayment of Medical Staff dues. Prepayment of Medical Staff dues is required for processing of applications for reappointment but such dues will be refunded in the event that reappointment to the Medical Staff is denied. Failure, without good cause, to so return the form or prepay dues shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership and clinical privileges at the expiration of the member's current term. A Physician whose membership is so terminated shall not be entitled to the procedural rights in the Fair Hearing Plan.

**6.4**(b) **Content of Reapplication Form**

The application for reappointment shall include, at a minimum, updated information regarding the following:

(1) Education: Continuing training, education, and experience during the preceding appointment period that qualifies the Medical Staff member for the privileges sought on reappointment;

(2) License: Current licensure, including but not limited to current State Medical License and a current DEA certificate (if applicable);

(3) Current mobile phone number and e-mail address;

(4) Health Status: Current physical and mental health status attestation only to the extent necessary to determine the Physician's ability to perform the functions of Medical Staff membership or to exercise the privileges requested;

(5) Previous Affiliations: The name and address of any other health care organization or practice setting where the Medical Staff member provided clinical services during the preceding appointment period;

(6) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary or involuntary relinquishment of, any of the following during the preceding appointment period:

(i) membership/fellowship in local, state or national professional organizations; or

(ii) board certification; or

(iii) license to practice any profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) number/controlled substance certificate (if applicable); or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; or

(vi) the Physician's management of patients which gave rise to investigation by the state medical board, a Health System or any other regulatory agency; or

(vii) participation in any private, federal or state health insurance program, including Medicare or Medicaid.

(7) Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;

(8) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these Bylaws, requiring that the Health System will be notified should the applicant's coverage change at any time. Each Physician must, at all times, keep the CEO or his/her designee, informed of changes in his/her professional liability coverage;

(9) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of departmental evaluations of care, including, but not limited to an evaluation by the Chief of the Clinical Department and by three (3) other physicians who are not a employer, employee, or relative/spouse of the Physician. Such evidence shall include as the results of the applicant's ongoing practice review, volumes and outcomes from organization(s) that currently privilege the applicant; including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Physicians who have not actively practiced in this Health System during the prior appointment period will have the burden of providing evidence of the Physician's professional practice review, volumes and outcomes from organizations that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment.

Referring physicians may be required to produce relevant medical record documentation and/or quality data from his/her primary practice location upon request of the Medical Staff leadership.

(10) Notification of Release & Immunity Provisions: The acknowledgments and statement of release; and

(11) Information on Ethics/Qualifications: Such other specific information about the staff member's professional ethics and qualifications that may bear on his/her ability to provide patient care in the Health System.

**6.4**(c) **Verification of Information**

The QVO, the Health System or its designee shall, in timely fashion, seek to collect and verify the additional credentials made available on each application for reappointment. The CEO, or designee, shall, in timely fashion (not less than ninety (90) days), seek to verify current clinical competency, including information regarding the Medical Staff member's professional activities, performance and other conduct in the Health System. The QVO, the Health System, or designee, and/or the CEO, or designee, shall promptly notify the staff

member of any problems in obtaining the information required. The Medical Staff member shall then have the burden of producing adequate information for a proper evaluation of his/her experience, training, current clinical competency, and physical and mental health status and of resolving any doubts about the information submitted.

When collection and verification are accomplished, the CEO or designee shall transmit the application for reappointment and supporting documents to the Chief of the appropriate clinical department. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the National Practitioner Data Bank, is complete.

**6.4**(d) **Action on Application**

The application for reappointment shall thereafter be processed as set forth and described in this Article for initial appointment. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

**6.4**(e) **Basis for Recommendations**

Each recommendation concerning the reappointment of a Medical Staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in Section 6.3(o) as they impact upon determinations regarding the member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules and Regulations, his/her cooperation with other Physicians and with patients, results of the Health System monitoring and evaluation process, including Physician-specific information compared to aggregate information from performance improvement activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the Health System.

## 6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A Medical Staff member may, at any time, request modification of his/her staff category or clinical privileges, by submitting the request in writing to the CEO or his/her designee. Such request shall be processed in substantially the same manner as provided in Section 6.4 for reappointment. No Medical Staff member may seek modification of clinical privileges or staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience.

## 6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

**6.6**(a) **Qualifications & Processing**

A Physician who is providing contract services to the Health System must meet the same qualifications for membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules and Regulations and must fulfill all of the obligations for his/her membership category as any other applicant or staff member.

**6.6**(b) **Requirements for Service**

In approving any such Physicians for Medical Staff membership, the Medical Staff must require that the services provided meet regulatory standards as required, are subject to appropriate quality controls, and are evaluated as part of the overall Health System's patient safety and quality improvement program.

**6.6**(c) **Termination**

If and to the extent expressly provided for in the contract for services, expiration or termination of any Exclusive Contract for services pursuant to this Section 6.6, shall automatically result in concurrent termination of Medical Staff membership and clinical privileges, provided that the foregoing shall not result in concurrent termination of Medical Staff membership and clinical privileges, or any parts thereof, pertaining to categories of medical services, specialties and/or sub-specialties not expressly subject to the exclusivity terms of the Exclusive Contract. Such termination shall not be deemed to be adverse (pursuant to Section 6.3(n) above) and, as such, shall not entitle an affected Physician to the procedural rights provided in the Fair Hearing Plan or result in a report to the National Practitioner Data Bank or pursuant to T.C.A. § 63-32-101 *et seq.*, T.C.A. § 68-11-218 or any similar law or regulation relating to the reporting of adverse actions.

## ARTICLE VII
## DETERMINATION OF CLINICAL PRIVILEGES

### 7.1 EXERCISE OF PRIVILEGES

Every Physician providing direct clinical services at this Health System shall, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those clinical privileges or services specifically granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the Physician to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of Physician, and each Physician shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

### 7.2 DELINEATION OF PRIVILEGES IN GENERAL

**7.2**(a) **Requests**

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the Physician's qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for Medical Staff membership, each Physician must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested.

**7.2**(b) **Basis for Privileges Determination**

Granting of clinical privileges shall be based upon community and Health System need, available facilities, equipment and number of qualified support personnel and resources as

well as on the Physician's education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from performance improvement activities, when available. For Physicians who have not actively practiced in the Health System within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Section 6.4(b)(8) herein. In addition, those Physicians seeking new, additional or renewed clinical privileges (accept those seeking emergency privileges) must meet all criteria for Medical Staff membership as described in Article VI of these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a staff member.

**7.2**(c) **Procedure**

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed three (3) years. The National Practitioner Data Bank shall be queried each time new privileges are requested.

**7.2**(d) **Limitations on Privileges**

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

## 7.3 SPECIAL PRIVILEGES FOR DENTAL, COSMETIC SURGERY AND PODIATRY

Requests for clinical privileges from dentists, oral surgeons, cosmetic surgeons and podiatrists shall be processed, evaluated and granted in the manner specified in Article VI. Surgical procedures performed by dentists, oral surgeons and cosmetic surgeons shall be under the overall supervision of the Chief of Surgery and surgical procedures performed by podiatrists shall be under the Chief of Orthopedic Surgery. Notwithstanding the foregoing, other dentists, oral surgeons, cosmetic surgeons and podiatrists shall participate in the review of the clinician through the performance improvement process. All dental, oral surgery, cosmetic surgery and podiatry patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A Physician member of the Medical Staff shall be responsible for admission evaluation, H&P, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

## 7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS

**7.4**(a) **Temporary Privileges**

Upon receipt of a written request, temporary privileges may be granted when there is a patient care need that mandates an authorization to practice for a limited period of time. In this situation only, the CEO, or designee, upon recommendation of the Officers' Council

of the MEC, may grant such privileges upon completion of the appropriate application, consent and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, current curriculum vitae, and the required National Practitioners Data Bank query. Additional requirements for temporary privileges shall include verification that there are no current or prior successful challenges to licensure or registration, and that the physician has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges or termination of Medical Staff membership at another facility.

Upon recommendation of the Chief of Staff or designee, the term of such privileges shall be established and recommended to the CEO. The terms of these privileges shall not exceed a total of one hundred and twenty (120) days.

**7.4**(b) **Conditions**

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting Physician's qualifications, ability and judgment to exercise the privileges granted. Special requirements for consultation and reporting may be imposed by the Chief of Staff or designee, including a requirement that the patients of such Physician be admitted upon dual admission with a member of the Active Staff. Before temporary privileges are granted, the applicant must acknowledge in writing receipt and having read the Medical Staff Bylaws, Rules and Regulations, and agrees to be bound by the terms thereof in all matters relating to the privileges granted.

**7.4**(c) **Termination**

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a Physician's qualifications or ability to exercise any or all of the privileges granted, the CEO may, after consultation with the Chief of Staff terminate any or all of such Physician's temporary privileges. Where the life or well-being of a patient is endangered by continued treatment by the Physician, the termination may be effected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the Physician's patients then in the Health System shall be assigned to another Physician by the Chief of Staff or designee. The wishes of the patient shall be considered, if feasible, in choosing a substitute Physician.

**7.4**(d) **Rights of the Physician**

A Physician shall not be entitled to the procedural rights afforded by these Bylaws because of his/her inability to obtain temporary or one-case privileges or because of any termination or suspension of such privileges unless otherwise required by law.

## 7.5 EMERGENCY & DISASTER PRIVILEGES

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm to a patient is likely to occur, or in which the life of a patient is in immediate danger, and delay in administering treatment would add to that danger. A "disaster" for purposes of this section is defined as a community-wide event or mass injury situation in which the number of existing, available Medical Staff members is not adequate to provide all clinical services required by the citizens served by this facility. In the case of an emergency, or disaster as defined herein, any Physician, or Licensed Practitioner (to include AHPs) (collectively, for this Section 7.5, "LP"),

to the degree permitted by his/her license and regardless of staff status or clinical privileges, shall, as approved by the CEO or his/her designee or the Chief of Staff, be permitted to do, and be assisted by Health System personnel in doing everything reasonable and necessary to save the life of a patient or to treat patients as needed.

Disaster privileges may be granted by the CEO, (or designee), or Chief of Staff when, and for so long as, the Health System's emergency management plan has been activated and the Health System is unable to handle the immediate patient needs. Prior to granting any disaster privileges the volunteer Physician, or LP, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one of the following: a current Health System picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or recognized, state or federal response organization or group; ID indicating the individual has been granted authority by a government entity to render patient care, treatment, and services in a disaster; or ID of a current Medical Staff member who possesses personal knowledge regarding the volunteer Physician's or LP's qualifications. The CEO and/or Chief of Staff are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the volunteer Physician or LP shall undergo the same verification process outlined in Section 7.4(a) for temporary privileges when required to address an emergency patient care need. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours it shall be done as soon as possible, and the Health System shall document in the emergency/disaster volunteer's credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the Physician or LP to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the granting of disaster privileges, the Chief of Staff, or his/her designee, shall review the decision to grant the volunteer Physician or LP disaster privileges, and shall, based on information obtained regarding the professional practice of the volunteer Physician or LIP, make a decision concerning the continuation of his/her disaster privileges.

In addition, each volunteer Physician or LP granted disaster privileges shall be issued a Health System ID (or if not practicable by time or other circumstances to issue an official Health System ID, then another form of identification) that clearly indicates the identity of the volunteer Physician or LP, and the scope of the volunteer Physician's or LP's disaster responsibilities and/or privileges. A member of the Medical Staff shall be assigned to each disaster volunteer Physician or LP for purposes of overseeing the professional performance of the volunteer Physician or LP through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the granting of privileges.

## 7.6 OBSERVATION PRIVILEGES

From time-to-time, it may be the request of a member of the Medical Staff to allow a Physician, which may include a visiting professor, who is not a member of the Medical Staff to observe a specific procedure within the Health System setting. While these activities are encouraged, the

following information must be submitted fourteen (14) days prior to the scheduled procedure/observation:

(1) Current curriculum vitae;

(2) Government issued form of identification

The Observation Physician must meet the Health System's current requirements set forth in the Health System's Compliance policies and the Physician must follow all applicable Health System policies and procedures.

## 7.7 NEW PROCEDURE PRIVILEGES

When a new or additional procedure is contemplated, the physician in question should apply for privileges to perform such procedure in the same manner in which he/she initially requested privileges to practice at the Health System. This should be done by written correspondence to the Medical Staff office stating his/her training and capability to perform such procedure. A new procedure is one that has been determined by the appropriate Department Chief to be efficacious and sufficiently different from procedures performed in the past to qualify as a new procedure, and has not been previously performed at the Health System. The Chief will submit a written recommendation concerning credentialing criteria to the Credentials Committee. No new procedure will be performed until the procedure and credentialing are approved by the Board. When requesting a new and/or additional privilege, the burden of proof will rest upon the applicant to provide documentation that the training, experience and/or course he/she attended is appropriate to the privileges being requested.

## ARTICLE VIII
## CORRECTIVE ACTION

### 8.1 ROUTINE CORRECTIVE ACTION

#### **8.1**(a) **Criteria for Initiation**

Whenever activities, omissions, or any professional conduct of a Physician with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive to Health System operations; or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; a request for corrective action against such Physician may be initiated by any officer of the Medical Staff, by the Clinical Chief of the Department of which the Physician is a member, by the Chairperson of any standing committee, by the CEO or his/her designee, or the Board. Procedural guidelines from the Health Care Quality Improvement Act of 1986, as amended, shall be followed and all corrective action shall be taken in good faith in the interest of quality patient care.

#### **8.1**(b) **Requests & Notices**

All requests for corrective action under this Section 8.1 shall be submitted in writing to the MEC or designee, and supported by reference to the specific activities or conduct which constitute the grounds for the request. The Chief of Staff or designee shall promptly notify the CEO or designee in writing of all requests for corrective action received by the MEC or designee and shall continue to keep the CEO or designee fully informed of all action taken in conjunction therewith.

#### **8.1**(c) **Investigation by the Medical Executive Committee**

The MEC, or its designee, shall begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner, or shall appoint an Ad Hoc Committee to investigate it. When the investigation involves an issue of impairment, the MEC shall assign the matter to an Ad Hoc Committee of three (3) members who shall operate apart from this corrective action process, pursuant to the provisions of the Medical Staff's impaired Physician policy. Within thirty (30) days after the investigation begins, a written report of the investigation by the Ad Hoc Committee shall be completed and submitted to the MEC.

#### **8.1**(d) **Medical Executive Committee Action**

Within sixty (60) days following receipt of the report, the MEC shall take action upon the request. Its action shall be reported in writing and may include, but not necessarily be limited to:

(1) Rejecting the request for corrective action;

(2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected Physician;

(3) Issuing a warning or a reprimand to which the Physician may write a rebuttal, if he/she so desires;

(4) Recommending terms of probation or required consultation;

(5) Recommending reduction, suspension or revocation of clinical privileges;

(6) Recommending reduction of staff category or limitation of any staff prerogatives; or

(7) Recommending suspension or revocation of staff membership.

**8.1**(e) **Procedural Rights**

Any action by the MEC pursuant to Section 8.1(d)(4), (5), (6) or (7) (where such action, if implemented, materially restricts a Physician's exercise of privileges) or any combination of such actions, shall entitle the Physician to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation, but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

**8.1**(f) **Other Action**

If the MEC's recommended action is as provided in Section 8.1(d)(1), (2), (3) or (d)(4) (where such action does not materially restrict a Physician's exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

**8.1**(g) **Board Action**

When routine corrective action is initiated by the Board pursuant to Section 1.2(2) or (3) of the Fair Hearing Plan, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board, and shall entitle the Physician to the procedural rights as specified in the Fair Hearing Plan.

**8.1**(h) **Intervention & Mediation**

(1) At any time prior to action by the MEC or Board (in absence of MEC action) the MEC, Board, any department or committee of the Medical Staff may authorize and direct a Medical Staff member to meet with another Medical Staff member as part of a collegial intervention or information to improve conduct or quality of care. Such intervention is discretionary and not required prior to any action or recommendation by the MEC, Board or any department or committee of the Medical Staff.

(2) At any time prior to final action by the Board regarding a matter which entitles or would entitle the staff member to invoke their right to the fair hearing process, the MEC, Board, any department or committee of the Medical Staff, may agree with a Medical Staff member to use an outside mediator to attempt to resolve all or part of a pending matter to improve conduct or quality of care. Such mediation is purely voluntary, discretionary and not required prior to any action or recommendation

by the MEC, Board or any department or committee of the Medical Staff. The MEC or designee, will designate the Medical Staff representative to the mediation. The mediator chosen must be agreed upon by the MEC or designee and the Medical Staff member. If a mediator is not agreed upon by both parties, no mediation may occur. Any proposed resolution determined during such mediation is subject to approval of the MEC and Board.

## 8.2 SUMMARY SUSPENSION

### **8.2**(a) **Criteria & Initiation**

Notwithstanding the provisions of Section 8.1 above, whenever a Physician willfully disregards these Bylaws or other Health System policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the Chief of Staff or designee, the CEO, or a member of the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. Subsequently, the CEO or designee shall, on behalf of the imposer of such suspension, promptly give Special Notice of the suspension to the Physician.

Immediately upon the imposition of summary suspension, the Chief of Staff or designee shall designate a Physician with appropriate clinical privileges to provide continued medical care for the suspended Physician's patients still in the Health System. The wishes of the patient shall be considered, if feasible, in the selection of the assigned Physician.

It shall be the duty of all Medical Staff members to cooperate with the Chief of Staff or designee and the CEO in enforcing all suspensions and in caring for the suspended Physician's patients.

### **8.2**(b) **Medical Executive Committee Action**

Within seven (7) days after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

### **8.2**(c) **Procedural Rights**

If the summary suspension is terminated or modified such that the Physician's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension.

Upon ratification of the summary suspension or modification which materially restricts the Physician's clinical privileges, the Physician shall be entitled to the procedural rights provided in Article IX and the Fair Hearing Plan. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

## 8.3 AUTOMATIC SUSPENSION

### **8.3**(a) **License**

(1) A Physician or AHP on the Health System's Medical Staff or Allied Health Professionals Providers Staff whose license, certificate, or other legal credential authorizing him/her to practice in Tennessee is revoked, relinquished, or suspended shall immediately and automatically be suspended from the staff and practicing in the Health System.

(2) A Physician or AHP on the Health System's Medical Staff or Allied Health Professionals Staff whose license has been reduced, restricted, limited, or placed on probation by the licensing board, shall promptly inform his/her Chief of the Clinical Department, giving full details thereof. The Chief of the Clinical Department may immediately limit the member's right to practice medicine to the same extent as the limitation(s). As soon as practical after such limitation, the Credentials Committee shall be convened to review and interview the Physician or AHP if necessary and consider the facts under which the license was reduced, restricted, limited or placed on probation. The Credentials Committee will transmit its findings and recommendation to the MEC.

In case a limitation is not imposed, the Chief of the Clinical Department will make a full report to the Credentials Committee concerning the action taken by the licensing Board. The Credentials Committee will transmit its recommendation to the MEC.

Failure on the part of the Physician or AHP to report such disciplinary action shall, unless good cause is shown, result in a limitation of all or such portion of the Physician's or AHP's privileges as the Chief of the Clinical Department may deem appropriate. Such limitation shall remain in effect until the matter is resolved by subsequent action of the MEC or of the Board.

(3) A Physician or AHP on the Health System's Medical Staff or Allied Health Professionals Staff whose DEA number is revoked, suspended, limited or involuntarily or voluntarily relinquished in whole or in part, shall immediately and automatically be divested at least of his/her right to prescribe medications covered by the number. As soon as practicable after such automatic suspension, the MEC shall convene to review and consider the facts under which the DEA number was revoked, suspended, limited or involuntarily or voluntarily relinquished in whole or in part. The MEC may then take such corrective action as is appropriate to the facts disclosed in the investigation.

### **8.3**(b) **Medical Records**

(1) Automatic suspension of a Physician's privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules and Regulations. The suspension shall continue until such records are completed unless the Physician satisfies the Chief of Staff or designee that he/she has a justifiable reason for such omissions.

(2) Medical Records- Expulsion: Notwithstanding the provision of Section 8.3(c)(1), any staff member who accumulates thirty (30) or more CONSECUTIVE days of automatic suspension under said subsection 8.3(c)(1) may be expelled from the Medical Staff. In the event exercised, such expulsion shall be effective as of the first day after the thirtieth (30th) consecutive day of such automatic suspension.

If a Physician is suspended for more than three (3) times during the two (2) year appointment period, he/she may be dropped from the Medical Staff and must reapply for privileges.

**8.3**(c) **Failure to Appear/Cooperate**

Failure to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC (or failure to comply with these Bylaws, Rules and Regulations, Policies and Procedures after warning by the MEC) shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the physician or AHPs clinical privileges as the MEC may direct. In addition, failure to complete required initial training or training updates regarding electronic health information systems or other training as may be directed by the MEC from time to time may result in automatic suspension until such training is completed.

**8.3**(d) **Malpractice Insurance Coverage**

Any Physician or AHP unable to provide proof of current medical malpractice coverage in the amounts prescribed in these Bylaws will be automatically suspended until proof of such coverage is provided to the MEC and CEO or designate.

**8.3**(e) **Exclusions/Suspension from Medicare**

The clinical privileges and Medical Staff membership shall be immediately revoked for any Physician or AHP who becomes a "sanctioned individual" as defined in §1128(b)(8) of the Social Security Act [(42 U.S.C. §1320 a-7(b)(8)] and as such has been excluded from Medicare. Revocation pursuant to this section of the Bylaws does not preclude the staff member from subsequently applying for staff appointment after reinstatement by Medicare.

**8.3**(f) **Nonpayment of Dues**

Beginning on January 1, 2019, for members of the Medical Staff required to pay dues under these Bylaws, dues must be prepaid prior to processing of applications for appointment or reappointment to the Medical Staff but will be refunded in the event that such appointment or reappointment to the Medical Staff is denied.

**8.3**(g) **Automatic Suspension - Fair Hearing Plan Not Applicable**

No staff member whose privileges are automatically suspended under this Section 8.3, shall have the right of hearing or appeal as provided under Article IX of these Bylaws.

The Chief of Staff or designee shall designate a Physician to provide continued medical care for any suspended Physician's patients.

**8.3**(h) **Chief of Staff**

It shall be the duty of the Chief of Staff or designee to cooperate with the CEO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO or his/her designee shall collaborate with the Chief of Staff or designee to ensure that the Medical Staff is adequately informed of any staff members who have been suspended or expelled under this Section 8.3.

## 8.4 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and corrective action.

## 8.5 PROTECTION FROM LIABILITY

All members of the Board, the Medical Staff and Health System personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in Section 6.3(c) of these Bylaws.

## 8.6 SUMMARY SUPERVISION

Whenever criteria exist for initiating corrective action pursuant to this Article, in conjunction with any other action described herein, the Physician may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as a final determination is made regarding the Physician's privileges, which action shall not entitle the Physician to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. Any of the following shall have the right to impose supervision: Chief of Staff or designee, the CEO or designee, or a member of the MEC.

## 8.7 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final adverse decision pursuant to Section 8.1, 8.2 or 8.3 shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the Medical Staff or the Board may require.

# ARTICLE IX
# INTERVIEWS & HEARINGS

## 9.1 INTERVIEWS

When the MEC or designee or Board is considering initiating an adverse action concerning a Physician, it may in its discretion give the Physician an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The Physician shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

## 9.2 SPECIAL APPEARANCE

The MEC or designee may request the appearance of a Medical Staff member at a committee meeting when the committee is questioning the Physician's clinical course of treatment or the Physician's professional conduct. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these Bylaws. Whenever apparent suspected deviation from standard clinical practice or professional conduct is involved, seven (7) days advance notice of the time and place of the meeting shall be given to the Physician. When such Special Notice is given, it shall include a statement of the issue involved and that the Physician's appearance is mandatory. Failure of a Physician to appear at any meeting with respect to which he/she was given such Special Notice may, unless excused by the MEC upon a showing of good cause, result in disciplinary action up to and including suspension of all or such portion of the Physician's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary

## 9.3 HEARINGS

### **9.3**(a) **Procedure**

Whenever a Physician requests a hearing based upon or concerning a specific adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act of 1986, as amended.

### **9.3**(b) **Exceptions**

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of temporary privileges, terms of probation, nor any other actions which do not materially restrict the Physician's exercise of clinical privileges, shall give rise to any right to a hearing.

## 9.4 ADVERSE ACTION AFFECTING AHPS

Any adverse actions affecting AHPs shall be accomplished in accordance with Section 5.4 of these Bylaws.

# ARTICLE X
# OFFICERS

## 10.1 OFFICERS OF THE MEDICAL STAFF

**10.1**(a) Identification

The Officers of the Medical Staff shall be:

(1) Chief of Staff;

(2) Vice-Chief of Staff;

(3) Secretary; and

(4) Immediate Past Chief of Staff.

**10.1**(b) **Qualifications**

Officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their term of office. Failure of an Officer to maintain such status shall immediately create a vacancy in the office. Officers must be board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association or the American Board of Oral and Maxillofacial Surgery.

**10.1**(c) **Nominations**

(1) The Nominating Committee shall consist of the Chiefs of the clinical Departments of the Medical Staff. This committee shall offer one (1) or more nominees for the offices of Vice-Chief of Staff and Secretary to the Medical Staff at least sixty (60) days before the annual meeting.

Nominations may also be made by any member of the Medical Staff eligible to vote. Such nominations must be made in writing and received by the Medical Staff office no later than thirty (30) days prior to the annual meeting. The names of the Medical Staff nominees who are willing to serve and who meet the qualifications for office currently set forth herein shall be printed in alphabetical order of last name on the official ballots along with the names of the Nominating Committee nominees. In addition, the names of candidates may be written in on the official ballot. Any nominee or write-in candidate that does not meet the qualifications for serving as a general Officer of the Medical Staff as set forth herein or that has indicated an unwillingness to serve shall be automatically disqualified.

**10.1**(d) **Election**

The form for ballots in elections of the officers shall be established by or at the direction of the MEC. No ballots other than the official ballots shall be valid ballots. The official ballots shall indicate whether each candidate listed thereon is a Nominating Committee nominee or a Medical Staff nominee.

Notice of nominees and date of meeting shall be delivered to the Voting Members as soon as possible following the last day for submission of Medical Staff nominees, but not less than twenty (20) days prior to the election meeting. Voting shall be by those eligible, who are either present and voting at such meeting or voting by absentee ballot.

Absentee voting shall be by written or, as applicable, electronic ballot commencing five (5) business days prior to the General Medical Staff meeting. Voting members voting by absentee ballot are required to either complete a ballot in person or electronically (in a form and manner that shall be subject to approval by the MEC and that otherwise ensures the integrity of each vote cast) submitted to the Erlanger Health System Medical Affairs Office within five business days of the General Medical Staff meeting and absentee ballots will not be accepted after 3:00PM the day of the meeting. Voting may not be by proxy.

The Vice-Chief of Staff and Secretary to the Medical Staff shall be elected to two-year terms every even year at the annual meeting of the Medical Staff.

Immediately following adjournment of the Election Meeting, the Official Ballots shall be counted by or at the direction of the Chief of Staff.

Candidates shall be elected upon receiving a majority of the valid votes cast and approval by the Board. When three (3) or more candidates are running for an office and a majority vote of the Voting Members is not obtained for any one candidate, a runoff election shall then be held between the two (2) candidates having the highest number of votes. In addition, if there is a tied vote, there shall be a re-election.

**10.1**(e) **Removal**

Whenever the activities, professional conduct, physical or mental health status, or leadership abilities of a Medical Staff Officer are believed to be below the standards established by the Medical Staff or to be disruptive to the operations of the Health System, the Officer may be removed by the Board acting upon its own recommendation or by a two-thirds vote of the members of the Medical Staff eligible and present to vote for Medical Staff Officers. Reasons for removal may include, but shall not be limited to, violation of these Bylaws, breaches of confidentiality, or unethical behavior. Such removal shall not affect the Officer's Medical Staff membership or clinical privileges and shall not be considered an adverse action.

**10.1**(f) **Term of Elected Officers**

Each Officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following election. Each Officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

**10.1**(g) **Vacancies in Elected Office**

Vacancies in office, other than Chief of Staff, shall be filled by the MEC until such time as an election can be held. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term and the succeeding full term. If there is a vacancy in the office of Vice-Chief of Staff, that office need not be filled by election, but the MEC shall appoint an interim Officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

**10.1**(h) **Duties of Elected Officers**

(1) Chief of Staff. The Chief of Staff shall serve as the principal official of the Medical Staff. As such the Chief will:

(i) appoint multidisciplinary Medical Staff committees;

(ii) be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the Health System, and for the effectiveness of patient care evaluations and maintenance functions delegated to the Medical Staff, and work with the Board in implementation of the Board's quality, performance, and efficiency goals and other standards;

(iii) in concert with the MEC and clinical departments, develop and implement methods for credentials review, delineation of privileges, continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;

(iv) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and Health System management committees;

(v) report to the Board and the CEO concerning the opinions, policies, needs and grievances of the Medical Staff;

(vi) be responsible for enforcement and clarification of Medical Staff Bylaws and Rules and Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Physician;

(vii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff;

(viii) serve as a voting member and chairperson of the MEC and an ex-officio member of all other staff committees or functions;

(ix) assist in coordinating the educational activities of the Medical Staff;

(x) aid in coordinating the activities of the Health System administration and of nursing and other non-Physician patient care services with those of the Medical Staff;

(xi) serve as liaison for the Medical Staff in its external professional and public relations;

(xii) when indicated, confer with the CEO, CMO, CFO, CNO and Department or Section Clinical Chief as to whether there exists sufficient space, equipment, staffing, and financial resources, or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board; and

(xiii) assist the Department or Section Clinical Chiefs as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.; and

(xiv) be permitted expend funds derived from Medical Staff dues on behalf of the Medical Staff, including expenditures for Medical Staff activities and for obtaining the assistance of legal counsel and other professional assistance to protect and promote the interests of the Medical Staff, provided that documentation of all expenditures is provided to the Secretary and provided that prior approval of the MEC is required for total

expenditures greater than ten thousand dollars ($10,000) in any calendar year.

(2) Vice-Chief of Staff: The Vice-Chief of Staff shall be a member of the MEC, shall serve as a member of the Officers' Council of the MEC. The Vice-Chief of Staff shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC, or the Board. In the absence—temporary or permanent—of the Chief of Staff, the Vice-Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. At the conclusion of his/her term, the Vice-Chief of Staff shall assume the office of Chief of Staff for the next succeeding term.

(3) Secretary: The Secretary shall be a member of the MEC and the Officers' Council of the MEC and a member ex-officio of all other Medical Staff committees. The duties of the Secretary shall be to:

(i) give proper notice of all staff meetings on order of the appropriate authority;

(ii) ensure accurate and complete minutes for MEC and Medical Staff meetings;

(iii) ensure that an answer is rendered to all official Medical Staff correspondence;

(iv) ensure a roster of Medical Staff members is accurately maintained;

(v) maintain an accounting, and conduct periodic audits of the receipt and disbursement of funds derived from Medical Staff dues, provide reports to the MEC concerning the same and assist with related tax matters; and

(vi) perform such other duties as ordinarily pertain to his/her office or such additional duties as may be assigned to him/her by the Chief of Staff, the MEC, or the Board.

(4) Immediate Past Chief of Staff: The Immediate Past Chief of Staff shall be a member of the MEC, the Officers' Council of the MEC and perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

**10.1**(i) **Conflict of Interest of Medical Staff Leaders**

The best interest of the community, Medical Staff and the Health System are served by Medical Staff leaders (defined as any member of the MEC, Chief or Vice-Chief of any clinical Department, Officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Health System's Board) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision-making process of the Medical Staff may be altered by interests or relationships which might, either intentionally or coincidentally, bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Health System and the Medical Staff for relationships of any Medical Staff leader which may influence the decisions related to the Health System to be disclosed on a regular and contemporaneous basis.

No Medical Staff leader shall use his/her position to obtain or accrue any benefit. All Medical Staff leaders shall at all times avoid even the appearance of influencing the actions of any other Medical Staff member or employee of the Health System, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Annually, on or before January 1, each Medical Staff leader shall file with the MEC and Health System Office of Compliance a written statement describing each actual or proposed relationship of that member. This statement will include any economic or other relationships which in any way and to any degree may impact on the finances or operations of the Health System or its staff, or the Health System's relationship to the community, including but not limited to each of the following:

(1) Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the Physician, including, but not limited to member of the Governing Body, Medical Executive Committee, or clinical Section or Department Chief with an entity or facility that competes directly or indirectly with the Health System;

(2) Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Health System;

(3) Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Health System; or

(4) Business practices that may adversely affect the Health System or community.

A new Medical Staff leader shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is to be construed broadly, and a Medical Staff leader should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Health System. This disclosure procedure will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances, minimum allowable disclosures should be made.

Between annual disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each member's written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. A breach of these provisions is deemed sufficient grounds for removal of a breaching member by the remaining members of the MEC or the Board on majority vote.

## ARTICLE XI
## CLINICAL DEPARTMENTS & SECTIONS

### 11.1 CLINICAL DEPARTMENTS & SECTIONS

**11.1**(a) There shall be clinical departments of:

(1) Medicine, including internal medicine, internal medicine/peds, psychiatry, radiation oncology and all subspecialties thereof including outpatient and ambulatory care Physicians and the section of cardiology;

(2) Surgery, including general surgery and all subspecialties thereof, ophthalmology and outpatient services;

(3) Anesthesiology;

(4) Family Medicine;

(5) Emergency Medicine

(6) Obstetrics and Gynecology;

(7) Orthopedics;

(8) Pathology;

(9) Pediatrics, including internal medicine/pediatrics; and

(10) Radiology.

**11.1**(b) Further departmentalization of specialties may be made by unanimous vote of the MEC, subject to the Bylaws amendment procedures as described in Article XV of these Bylaws.

### 11.2 CLINICAL DEPARTMENT FUNCTIONS

The primary function of each clinical department is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the clinical department. To carry out this overall function, each clinical department shall:

**11.2**(a) Require that patient care evaluations be performed and that appointees exercising privileges within the clinical department be reviewed on an ongoing basis and upon application for reappointment;

**11.2**(b) Establish guidelines for the granting of clinical privileges within the clinical department and submit the recommendations as required under these Bylaws regarding the specific clinical privileges for applicants and reapplicants for clinical privileges;

**11.2**(c) Conduct, participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in current professional practices and standards;

**11.2**(d) Monitor on an ongoing basis the compliance of its clinical department members with these Bylaws, and the Rules and Regulations, policies, procedures and other standards of the Health System;

**11.2**(e) Monitor on an ongoing basis the compliance of its clinical department members with applicable professional standards;

**11.2**(f) Coordinate the patient care provided by the clinical department's members with nursing, administrative, and other non-Medical Staff services;

**11.2**(g) Foster an atmosphere of professional decorum within the clinical department;

**11.2**(h) Review all deaths occurring in the clinical department and all unexpected patient care events and report findings to the MEC; and

**11.2**(i) Submit written reports or minutes of clinical department meetings to the MEC on a regular basis concerning:

(1) Findings of the clinical department's review and evaluation activities, actions taken thereon, and the results thereof;

(2) Recommendations for maintaining and improving the quality of care provided in the clinical department and in the Health System; and

(3) Such other matters as may be requested from time to time by the MEC.

**11.2**(j) Make recommendations to the MEC subject to Board approval of the kinds, types, and amounts of data to be collected and evaluated to allow the Medical Staff to conduct an evidence-based analysis of the quality of professional practice of its members; and receive regular reports from clinical department subcommittees regarding all pertinent recommendations and actions by the subcommittees.

## 11.3 SECTIONS

In addition to the clinical departments of the Medical Staff, there may be clinical sections within the Medical Staff, as determined by the MEC. The various sections within the Medical Staff shall not constitute clinical departments as that term is used herein without the express designation by the MEC and the Board. Each clinical section shall be headed by a clinical chief selected in the manner and having the authority and responsibilities set forth in these Bylaws. The purpose of the clinical sections shall be to provide specialized care within the Health System and to monitor and evaluate the quality of care rendered in the clinical section and to be accountable to the clinical department to which such section is assigned for the discharge of these functions.

## 11.4 CHIEFS OF DEPARTMENT

**11.4**(a) Each clinical department shall have a Chief, who shall be approved by the Board after election by the clinical department members and shall be a member of the Active Staff and must be Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association or the American Board of Oral and Maxillofacial Surgery. Voting shall be by those eligible who are either present and voting at such meeting or voting by absentee ballot. Absentee voting, as provided herein, shall be

by written or, as applicable, electronic ballot commencing five (5) business days prior to the formal vote. Voting members voting by absentee ballot are required to complete a ballot in person or electronically (in a form and manner that shall be subject to approval by the MEC and that otherwise ensures the integrity of each vote cast) submitted to the Erlanger Health System Medical Affairs Office within five business days of the formal vote and absentee ballots will not be accepted after 3:00PM the day of the meeting. Voting may not be by proxy.

**11.4**(b) The responsibilities of the Clinical Department Chief include:

(1) Accountability to the MEC for all professional and Medical Staff administrative activities within the clinical department;

(2) Continuing review of the professional performance qualifications and competence of the Medical Staff members and AHPs who exercise privileges in the clinical department;

(3) Assuring that a formal process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients served by the clinical departments is carried out;

(4) Assuring the participation of clinical department members in clinical department orientation, continuing education programs and required meetings;

(5) Collaborate with the appropriate academic chair(s);

(6) Assuring participation in risk management activities related to the clinical aspects of patient care and safety;

(7) Assuring that required performance improvement and quality control functions including surgical case review, blood usage review, drug usage evaluation, medical record review, pharmacy and nutrition, risk management, safety, infection control and utilization review, are performed within the clinical department, and that findings from such activities are properly integrated with the primary functions of the clinical department level;

(8) Recommending criteria for clinical privileges and specific clinical privileges for each member of the clinical department;

(9) Implementing within the clinical department any actions or programs designated by the MEC;

(10) Assisting in the preparation of reports as may be required by the MEC, the CEO or the Board;

(11) Developing, implementing and enforcing the Medical Staff Bylaws, Rules and Regulations, and policies and procedures that guide and support the provision of services;

(12) Participating in every phase of administration with other clinical departments or clinical sections, in cooperation with nursing, Health System administration and the Board;

(13) Assessing and recommending to the CEO any off-site sources for needed patient care services not provided by the department or organization;

(14) Making recommendations for a sufficient number of qualified and competent persons to provide care or services within the clinical department; and

(15) Appoint such committees as are necessary to conduct the functions of the clinical department and designate a chairperson and secretary for each.

## 11.5 ORGANIZATION OF CLINICAL DEPARTMENT

**11.5**(a) All organized clinical departments shall have written rules and regulations which govern the activity of the clinical department. These rules and regulations shall be approved by the Board. The exercise of clinical privileges within any clinical department is subject to the clinical department rules and regulations and to the authority of the Clinical Department Chief.

**11.5**(b) Each clinical department may meet separately but such meetings shall not release the members from their obligations to attend the general meetings of the Medical Staff as provided in Article XIII of these Bylaws. Written minutes must be maintained and furnished to the MEC.

**11.5**(c) Each staff member, at the time of appointment, shall be assigned his/her primary clinical department and he/she may only vote for the Chief of that Clinical Department. The Physician's designation of clinical department shall be approved by the MEC and shall be the clinical department in which the Physician's practice is concentrated. Should the Physician exercise privileges relevant to the care in more than one (1) clinical department, each clinical department shall make a recommendation to the MEC regarding the granting of such privileges.

**11.5**(d) Each clinical department shall have a Clinical Chief, Clinical Chief Elect and Secretary who are elected by majority vote of the members of that clinical department and subject to ultimate Board approval (except for Pathology, Radiology, Emergency Medicine, and Anesthesiology--which the Clinical Chiefs are elected by the MEC; Chiefs-Elect and Secretaries for these clinical departments are recommended by the Clinical Chiefs and approved by the MEC). Each Medical Staff Clinical Department officer shall be a member of the Active Medical Staff, must be Board certified by a Board recognized by the American Board of Medical Specialties, the American Osteopathic Association or the American Board of Oral and Maxillofacial Surgery, shall have demonstrated ability in at least one (1) of the clinical areas covered by the clinical department, and shall be willing and able to faithfully discharge the functions of his/her office.

**11.5**(e) The Chief-Elect shall serve as a member of the clinical department's Medical Quality Improvement Committee. In the temporary or permanent absence of the Chief, the Chief-Elect shall assume all the duties and authority of the Chief.

**11.5**(f) The Clinical Department Secretary shall keep a record of attendance of each member of the clinical department present at the clinical department's meetings, keep full minutes on all business transacted; and in the temporary or permanent absence of the Clinical Department Chief-Elect, assume all duties and authority of the Chief.

**11.5**(g) Clinical Department officers shall serve two (2) year terms and shall be elected, removed from office and appointed to fill vacancies pursuant to the provisions related to Medical Staff Officers in Article X (except for Pathology, Radiology, Emergency Medicine and Anesthesiology officers—which may be removed by the MEC).

**11.5**(h) Each clinical department shall ensure participation of Physicians within each department, as determined by the MEC, in the Health System's Medical Quality Improvement Committee (MQIC).

## 11.6 CLINICAL SECTION CHIEF

**11.6**(a) Chiefs of Clinical Section shall be selected by the Board upon recommendation of the MEC. The Chief of each section shall have the following duties with respect to his/her section:

(1) Account to the appropriate Clinical Department Chief and to the MEC for all professional activities within the clinical section;

(2) Develop and implement clinical section programs in cooperation with the Clinical Department Chief;

(3) Maintain continuing review of the professional performance of all Medical Staff and AHP Staff appointees having clinical privileges in the clinical section and report regularly thereon to the Clinical Department Chief;

(4) Implement within his/her clinical section any actions or programs designated by the MEC;

(5) Participate in every phase of administration of his/her clinical section in cooperation with the Clinical Department Chief, the nursing section, other Health System and/or Medical Staff clinical departments, administration and the Board;

(6) Assist in the preparation of such annual reports regarding the clinical section as may be required by the MEC, the CEO or the Board;

(7) As applicable, establish a system for adequate professional coverage within the clinical section, including an on-call system, which shall be fair and non-discriminatory; and

Perform such other duties as may reasonably be requested by the Chief of Staff, the MEC, the Clinical Department Chief or the Board.

# ARTICLE XII
# COMMITTEES & FUNCTIONS

## 12.1 GENERAL PROVISIONS

**12.1**(a) The Standing Committees and the functions of the Medical Staff are set forth below. The MEC shall appoint special or ad hoc committees to perform functions that are not within the stated functions of one (1) of the standing committees.

**12.1**(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.

**12.1**(c) All information pertaining to activities performed by the Medical Staff and its committees and clinical departments shall be privileged and confidential to the full extent provided by law.

**12.1**(d) The CEO or designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

## 12.2 MEDICAL EXECUTIVE COMMITTEE

### **12.2**(a) **Composition**

Members of the committee shall include the following:

(1) The Chief of Staff, who shall act as Chairperson;
(2) The Vice-Chief of Staff;
(3) The Immediate Past Chief of Staff;
(4) Credentials Committee Chairperson;
(5) The Dean of the College of Medicine, Chattanooga Unit;
(6) The Chiefs of all Departments;
(7) Secretary to the Medical Staff
(8) The Chief Medical Officer at Health System's Baroness Campus;
(9) The CEO or designee (ex-officio); and
(10) Ex-officio members who will serve without vote may include:
    (i) Senior Administrative representatives; and
    (ii) Medical Directors, if designated, of the major campuses

### **12.2**(b) **Functions**

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Health System administration and the Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings, within the scope of its responsibilities as defined below. When approval of procedural details related to credentialing, corrective action, or selection and duties of clinical department leadership are delegated to the MEC, it shall represent to the Board the organized Medical Staff's views on issues of patient safety and quality of care. All Active Medical Staff members shall be eligible to serve on the MEC. The functions and responsibilities of the MEC shall include, at least the following:

(1) Receiving and acting upon clinical department and committee reports;

(2) Implementing the approved policies of the Medical Staff;

(3) Recommending to the Board all matters relating to appointments and reappointments, the delineation of clinical privileges, staff category and corrective action;

(4) Fulfilling the Medical Staff's accountability to the Board for the quality of the overall medical care rendered to the patients in the Health System;

(5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions;

(6) Assuring regular reporting of performance improvement and other Medical Staff issues to the MEC and to the Board and communicating findings, conclusions, recommendations and actions to improve performance to the Board and appropriate Medical Staff members;

(7) Assuring an annual evaluation of the effectiveness of the Health System's performance improvement program is conducted;

(8) Developing and monitoring compliance with these Bylaws, the Rules and Regulations, policies and other Health System standards;

(9) Recommending action to the CEO on matters of a medico-administrative nature;

(10) Developing and implementing programs to inform the Medical Staff about Physician health and recognition of illness and impairment in Physicians, and addressing prevention of physical, emotional and psychological illness;

(11) Requesting evaluation of Physicians in instances where there is doubt about an applicant's ability to perform the privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that a Physician to the Medical Staff may not be complying with the Bylaws, may be rendering care below the standards established for Physicians to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or clinical privileges without limitation, further training, or other safeguards;

(12) Making recommendations to the Board regarding the Medical Staff structure and the mechanisms for review of credentials and delineation of privileges, fair hearing procedures and the mechanism by which Medical Staff membership may be terminated;

(13) Participating in identifying community health needs and in setting Health System goals and implementing programs to meet those needs;

(14) Evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;

(15) Developing and implementing programs for continuing medical education for the Medical Staff; and

(16) Overseeing Medical Staff funds derived from dues, including overseeing payment of dues and disbursements of funds, and voting on whether to disburse funds for Medical Staff activities when such a vote is required or when the MEC decides to hold such a vote.

**12.2(c) Meetings**

The MEC shall meet as needed, but at least ten (10) times per year and maintain a record of its proceedings and actions. Such records shall be maintained for a period of not less than ten (10) years.

**12.2(d) Special Meetings of the Medical Executive Committee**

A special meeting of the MEC may be called by the Chief of the Medical Staff, when a majority of the MEC can be convened.

## 12.3 MEDICAL STAFF FUNCTIONS

**12.3**(a) **Composition of Committees**

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff.

**12.3**(b) **Functions**

The functions of the staff are to:

(1) Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas, such as intensive care units; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, surgical, outpatient, home care and ambulatory care services;

(2) Conduct or coordinate appropriate performance improvement reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record, core measures and other appropriate reviews;

(3) Conduct or coordinate utilization review activities;

(4) Assist the Health System in providing continuing education opportunities responsive to performance improvement activities, new state-of-the-art developments, services provided within the Health System and other perceived needs;

(5) Develop and maintain surveillance over drug utilization policies and practices;

(6) Provide for appropriate Physician involvement in and approval of the multi-disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Health System patient care and administrative services;

(7) Ensure that when the findings of assessment processes are relevant to an individual's performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a Physician's competence;

(8) Investigate and control nosocomial infections and monitor the Health System's infection control program;

(9) Plan for response to fire and other disasters, for Health System growth and development, and for the provision of services required to meet the needs of the community;

(10) Direct staff organizational activities, including staff Bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Health System administration, and review and maintenance of Health System accreditation;

(11) Provide as part of the Health System and Medical Staff's obligation to protect patients and others in the organization from harm, a mechanism for addressing the health of all licensed individual Physicians including an Impaired Practitioner Policy (attached hereto as Appendix "B" and incorporated herein by reference). The purpose of this mechanism is to provide education about Physician health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of Physicians who suffer from a potentially impairing condition. The Impaired Practitioner Policy affords resources separate from the corrective action process to address Physician health. The policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling or referrals;

(12) Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical privileges:

(i) medical assessment and treatment of patients;

(ii) use of medications, use of blood and blood components;

(iii) use of operative and other procedure(s);

(iv) efficiency of clinical practice patterns; and

(v) significant departure from established patterns of clinical practice.

(13) Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:

(i) education of patients and families;

(ii) coordination of care, treatment and services with other practitioners and Health System personnel, as relevant to the care of an individual patient;

(iii) accurate, timely and legible completion of patients' medical records including history and physicals;

(iv) Patient satisfaction;

(v) Sentinel events; and

(vi) Patient safety.

(14) Recommend to the Board policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a Physician's performance and evaluation of a Physician's performance by peers.

(15) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules and Regulations, and review same on a regular basis;

(16) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;

(17) Review, on a periodic basis, professional practice evaluations and applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments;

(18) Investigate any breach of ethics that is reported to it;

(19) Review AHP appeals of adverse privilege determinations as provided in Section 5.4(b);

(20) To prepare and recommend a slate of nominees for the officers of the Medical Staff; and

Provide leadership in activities related to patient safety.

**12.3**(c) **Meetings**

These functions shall be performed as required by state and federal regulatory requirements, accrediting agencies and as deemed appropriate by the MEC and the Board.

## ARTICLE XIII
## MEETINGS

### 13.1 ANNUAL STAFF MEETING

**13.1**(a) **Meeting Time**

Unless otherwise set by the MEC, the annual Medical Staff meeting shall be held in the fourth quarter of the calendar year, at a date, time and place determined by the MEC.

**13.1**(b) **Order of Business & Agenda**

The order of business at an annual meeting shall be determined by the Chief of Staff. The agenda shall include:

(1) Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;

(2) Administrative reports from the CEO or designee, the Chief of Staff and appropriate Clinical Department Chiefs and the Dean of the College of Medicine;

(3) The election of officers and other officials of the Medical Staff when required by these Bylaws;

(4) Recommendations for maintenance and improvement of patient care; and

(5) Other old or new business.

## 13.2 REGULAR STAFF MEETINGS

### 13.2(a) Meeting Frequency & Time

The Medical Staff shall meet at least annually and this meeting will be designated as the Annual Staff Meeting. The Medical Staff may, by resolution, designate the time for holding additional meetings and no notice other than such resolution shall then be required. If the date, hour or place of a staff meeting must be changed for any reason, the notice procedure in Section 13.3 shall be followed.

### 13.2(b) Order of Business & Agenda

The order of business at any additional meeting shall be determined by the Chief of Staff.

### 13.2(c) Special Meetings

Special meetings of the Medical Staff may be called at any time by the Board, the Chief of the Medical Staff, the Chief Medical Officer, the MEC or not less than one-third members of the Active Staff and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

## 13.3 NOTICE OF MEETINGS

The MEC may, by resolution, provide the time for holding meetings of the Medical Staff and no notice other than such resolution shall be required. If a special meeting is called or if the date, hour and place of a staff meeting has not otherwise been announced, the Secretary of the MEC shall give written notice stating the place, day and hour of the meeting, delivered either personally or by mail (electronic or otherwise), to each person entitled to be present there at not less than five (5) days nor more than thirty (30) days before the date of such meeting, except as required by Section 15.2(a) of these bylaws. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

## 13.4 QUORUM

### 13.4(a) General Staff Meeting

The voting members of the Active Staff who are present at any staff meeting shall constitute a quorum for the transaction of all business at the meeting. Written, signed proxies will not be permitted in any voting at any meeting.

**13.4**(b) **Committee Meetings**

The members of a committee who are present, but not less than two (2) members, shall constitute a quorum at any meeting of such committee; except that the MEC and MQIC shall require fifty (50%) percent of members to constitute a quorum.

## 13.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting of the committee, if a unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote. Voting shall be by those eligible who are either present and voting at such meeting or voting by absentee ballot. Absentee voting, as provided herein, shall be by written or, as applicable, electronic ballot commencing five (5) business days prior to the formal vote. Voting members voting by absentee ballot are required to complete a ballot in person or electronically (in a form and manner that shall be subject to approval by the MEC and that otherwise ensures the integrity of each vote cast) submitted to the Erlanger Health System Medical Affairs Office within five business days of the formal vote and absentee ballots will not be accepted after 3:00PM the day of the meeting. Voting may not be by proxy.

## 13.6 MINUTES

Minutes of all meetings shall be prepared by the Secretary of the meeting or designee and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer, approved by the attendees and forwarded to the MEC. A permanent file of the minutes of each meeting shall be maintained. Complete and detailed minutes must be written and maintained.

## 13.7 ATTENDANCE

**13.7**(a) **Regular Attendance**

Attendance at Medical Staff, Committee, Department or Section meetings is encouraged.

# ARTICLE XIV
# GENERAL PROVISIONS

## 14.1 STAFF RULES & REGULATIONS

Subject to approval by the Board, the MEC shall adopt Rules and Regulations necessary to implement more specifically the general principles found within these Bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the Health System. Such Rules and Regulations shall be considered a part of these Bylaws, except that they may be amended or repealed at any MEC meeting at which a quorum is present by a two-thirds (2/3) affirmative vote of the members of the MEC entitled to vote. Such changes shall become effective when approved by the Board. The Rules and Regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, Health System policies, and current practices with respect to Medical Staff organization and functions.

## 14.2 PROFESSIONAL LIABILITY INSURANCE

Each Physician or AHP granted clinical privileges in the Health System shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions thereto, or, should the state have no minimum statutory requirement, in an amount not less than $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate. Such insurance shall be with a carrier reasonably acceptable to the Health System, and shall be on an occurrence basis or, if on a claims made basis, the practitioner shall agree to obtain tail coverage covering his/her practice at the Health System. He/she shall also be responsible for advising the MEC and the CEO of any change in such professional liability coverage.

## 14.3 CONSTRUCTION OF TERMS & HEADINGS

Words used in these Bylaws shall be read as the masculine or feminine gender and as the singular and plural, as the context requires. The captions or headings in these Bylaws are for convenience and are not intended to limit or define the scope or effect of any provision of these Bylaws.

## 14.4 FORMS

Application forms and any other prescribed forms required by these Bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be developed by the CEO or designee, subject to adoption by the Board after considering the advice of the MEC. Such forms shall meet all applicable legal requirements, including non-discrimination requirements

## 14.5 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

### 14.5(a) Reports to be Confidential

Information with respect to any practitioner, including applicants, Medical Staff members or AHPs, submitted, collected or prepared by any representative of the Health System including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

### 14.5(b) Release from Liability

No representative of the Health System, including its Board, CEO, administrative employees, Medical Staff or third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the Health System including its Board, CEO or designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the Health System, provided such disclosure or representation is in good faith and without malice.

**14.5**(c) **Action in Good Faith**

The representatives of the Health System, including its Board, CEO, administrative employees and Medical Staff shall not be liable to a practitioner for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

## 14.6 DUES

Except where otherwise stated in these Bylaws, Members of the Medical Staff shall pay dues in connection with appointment and reappointment to the Medical Staff. The amount of dues shall be determined by the MEC and ratified by the Medical Staff voting in person or by absentee ballot at a regular or special meeting at which a quorum is present.

## ARTICLE XV
## ADOPTION & AMENDMENT OF BYLAWS

### 15.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Health System, the Board, and the community.

### 15.2 ADOPTION, AMENDMENT & REVIEWS

The Bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the Bylaws and Rules and Regulations will be revised to reflect changes in regulatory requirements, Health System policies, and current practices with respect to the Medical Staff organization and functions.

#### **15.2**(a) **Medical Staff**

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of a two-thirds of the Medical Staff members eligible to vote, who are either present and voting at such meeting or voting by absentee ballot, provided at least twenty (20) days written notice, accompanied by the proposed bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of the Board. Absentee voting, as provided herein, shall be by written or, as applicable, electronic ballot commencing five business days prior to the formal vote. Voting members voting by absentee ballot are required to complete a ballot in person or electronically (in a form and manner that shall be subject to approval by the MEC and that otherwise ensures the integrity of each vote cast) submitted to the Erlanger Health System Medical Affairs Office within five (5) business days of the formal vote and absentee ballots will not be accepted after 3:00PM the day of the meeting. Voting may not be by proxy.

#### **15.2**(b) **Board**

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of two-thirds of the Board after receiving the recommendations of the Medical Staff. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these Bylaws), and shall advise the staff of the basis for its action in this regard.

### 15.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these Bylaws approved as set forth herein shall be documented by either:

**15.3**(a) Appending to these Bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Board and approved by legal counsel as to form; or

**15.3**(b) Restating the Bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these Bylaws since their last restatement, which restated Bylaws shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Board approved by legal counsel as to form.

Each member of the Medical Staff shall be given a copy of any amendments to these Bylaws in a timely manner.

**MEDICAL STAFF BYLAWS**
**ADOPTED & APPROVED:**

**MEDICAL STAFF:**

By: _____ _____
Chief of Staff Date

**BOARD:**

By: _____ _____
Chairperson Date

**ERLANGER HEALTH SYSTEM:**

By: _____ _____
Chief Executive Officer Date

**APPROVED AS TO FORM:**

By: _____ _____
Chief Legal Officer for Erlanger Health Date