METHODOIST HEALTHCARE - MEMPHIS HOSPITALS
AND METHODIST HEALTHCARE OLIVE BRANCH HOSPITAL
UNIFIED MEDICAL STAFF BYLAWS

2016
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PREAMBLE

This document describes:
- medical staff obligations to the Board
- qualifications for appointment
- process for privileging and re-privileging
- staff categories and duties applicable to each category
- medical staff structure organizational details investigations and corrective action
- safeguards which protect the rights and privileges of individual staff members
- hearings and appeals
- method of bylaws’ adoption and amendments, as well as adoption of other rules, regulations, and policies

This document is not and shall not be deemed to be a contract.
DEFINITIONS

administration: The hospital’s president, vice presidents, and other managing agents appointed by the Board to act on its behalf in the overall management of the hospital.

administrator/chief executive officer/CEO/president: The individual appointed by the Board to act in its behalf in the overall management of the hospital.

adverse decision: means that the Board denies, terminates, reduces, or suspends membership and/or clinical privileges of an applicant or medical staff member.

adverse recommendations: means that the MEC recommends that the Board deny or terminate an applicant’s medical staff membership or deny, reduce, suspend, or revoke clinical privileges.

allied health professionals (AHPs): licensed independent practitioners (LIPs) and supervised practitioners with complex privileges who are not members of the medical staff but are credentialed and privileged according to its credentials policies. Due process rights for AHPs are described in the credentials policies.

Board of Directors: Synonymous with “Board,” and “Governing Body”: means the individuals designated in the Hospital’s corporate bylaws as the body responsible for approving the medical staff bylaws, policies, rules and regulations, overseeing the credentialing process, approving/amending recommendations for granting and denying medical staff appointments and reappointments and clinical privileges and approving/amending recommendations regarding disciplinary or corrective action involving medical staff members and allied health providers. The Board/Governing Body may also include any committee authorized to act on behalf of the Governing Body

clinical departments and services: clinical departments means a grouping of practitioners according to clinical activities and interests. Services mean sub-divisions of a clinical department, established only when necessary.

clinical privileges: Permission granted by the Board, ordinarily acting on recommendations from the medical executive committee, to render specific types of care to patients at Methodist Healthcare – Memphis Hospitals, r Methodist Healthcare – Olive Branch Hospital (MHOBH), or Provider-based clinics.

completed application: An application for staff membership and/or clinical privileges, initial, renewal, or modification, that has been declared complete by a representative of the credentials committee, MEC, and the system CEO, or their designees. A completed application includes receipt of all information the applicant has been called upon to provide and validation/verification of that information in accordance with policy and procedure, and input of staff members, if solicited.

division: Means the division of the medical staff according to the propensity of its members to concentrate their activity in one of the five locations of Methodist Healthcare - Memphis Hospitals (University, North, South, Germantown, or Le Bonheur), MHOBH, or Provider-based clinics.

ex officio: By virtue of an office, or position held, without voting rights unless otherwise specified

executive officers: executive officers of the medical staff means representative to the Board, chief of staff, vice chief of staff, president, president-elect.

governance documents: bylaws as well as the supplemental documents that define specific details, rules, policies, and procedures for implementing provisions and processes of the bylaws; the supplemental
documents include, but are not limited to, rules and regulations, credentials policies, committee policies, peer review policies, department policies, and medical staff policies and procedures.

Hospital: means, unless the context suggests otherwise, Board plus administrative/executive staff plus medical staff.
Hospitals: as used in these governance documents, means both Methodist Healthcare-Memphis Hospitals (MH-MH), a single licensed and certified hospital within the Methodist Le Bonheur Healthcare (MLH) system AND Methodist Healthcare Olive Branch Hospital (MHOBH), a single licensed and certified hospital within the MLH system.

Provider-based Clinics: the medical practices that are clinically integrated into MHMH

Medical Executive Committee (MEC): The elected representatives of the medical staff, authorized to act on behalf of the medical staff except when otherwise specified.

Medical staff: The physicians (MD and DO), dentists, and oral surgeons approved by the Board for medical staff membership at MH-MH and/or MHOBH, subject to the provisions of these bylaws

medical staff appointment: Appointment to the medical staff and to a staff category. Medical staff appointment does not automatically confer specific clinical privileges nor assignment to either a staff category or to a specific clinical department. Appointment to a specific clinical department does not necessarily restrict the clinical privileges of a staff appointee.

medical staff organization: The formal structure of the medical staff

medical staff services department (MSSD): means the department at Methodist Le Bonheur Healthcare that coordinates and provides credentialing services and other services in support of the medical staff organization, also referred to as the medical staff office. MSSD may delegate portions of credentialing services to a centralized verifications service.

practitioners: medical staff members (physicians, dentists, and oral surgeons), and AHPs who provide services to patients in Methodist Healthcare - Memphis Hospitals and MHOBH

rules and regulations, credentials policies, committee policies, peer review policies, department and medical staff policies: supplemental medical staff governance documents that describe administrative procedures supporting processes described in the bylaws.
1. PURPOSE

The purpose of the medical staff is to organize the activities of qualified physicians, dentists, oral surgeons and other qualified practitioners who practice at the Hospitals (MH-MH and/or MHOBH) or provider-based clinics in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the Board. The medical staff provides oversight of care, treatment, and services provided by practitioners with privileges at the hospital or provider-based clinics. The members of the medical staff work together as an organized body to promote a uniform standard of quality patient care, treatment, and services and to offer advice, recommendations, and input to the system Chief Executive Officer (CEO), President, and the Board. The medical staff promulgates bylaws, policies, and procedures to determine its governance and administrative structures and the processes for carrying out its work, subject to the ultimate authority of the Board.

2. MEMBERSHIP

2.1 Eligibility

Membership on the Hospitals’ medical staff is a privilege that is extended only to professionally competent physicians, dentists, and oral surgeons who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated documents of the medical staff and Hospitals.

A. Education

Members of the medical staff shall be graduates of:
- A medical school accredited by the Liaison Committee on Medical Education (LCME); or
- A college of osteopathic medicine recognized and approved by the American Osteopathic Association (AOA); or
- A foreign medical school recognized by the Educational Commission for Foreign Medical Graduates; or
- A dental school approved by the Council on Dental Education of the American Dental Association.

B. Basic Professional Requirements

Applicants must:
- hold a current, valid and legal medical or dental license in the state of Tennessee (MH-MH facilities) and/or Mississippi (MHOBH) as described and set forth in the medical staff rules, regulations, credentials policies, policies, and related documents and;
- document training, experience, and current clinical competence in the clinical privileges requested at appointment, reappointment, and renewal or revision of clinical privileges;
• document their adherence to the ethics of their profession, their reputation, their physical and mental health status, and their ability to work well with others;
• practice in the community within a reasonable distance of Methodist Healthcare – Memphis Hospitals, MHOBH, or within 35 miles of the main campus for provider-based clinics, as applicable;
• and maintain continuous and uninterrupted professional liability insurance coverage of a minimum of one (1) million dollars per occurrence and three (3) million annual aggregate, without periods of non-coverage, and including either extended reporting (“tail”) or retroactive (“prior acts”) coverage from an insurance company licensed and approved to do business in Tennessee or Mississippi, as applicable, or Federal Tort Claims Act (FTCA) coverage provided by the Federal Government. Physicians who are employees of Methodist Le Bonheur Healthcare (MLH) or any of its affiliated corporations may be covered under the MLH self-insurance program. Other forms of self-insured coverage (including Risk Retention Groups) may be approved from time to time by the Board after consultation with the MEC.

C. Board Certification/Recertification

• All members of the medical staff shall be and remain board certified, where a specialty board exists, or show intent to become board certified in the specialty or subspecialty that is the primary focus of their medical practice (or board certification in a medical specialty or subspecialty as determined appropriate by the respective Department’s policies) within five (5) years of formal training completion or within the specific interval of time specified by the applicant’s specialty, whichever is less. The board must be recognized by the American Board of Medical Specialties (“ABMS”) or the American Osteopathic Association (“AOS”).

• If a period of clinical practice is required prior to board examination, the applicable board certification time period shall begin at the completion of the practice period. This Section 2.1C shall not be applicable to physicians who were members of the medical staff on January 1, 2004, and who thereafter maintain uninterrupted medical staff membership, unless such membership is reinstated within a three (3) month period. Additionally, this Section shall not be applicable to physicians who are initially appointed to the medical staff and at the time of such appointment, no specialty board existed and subsequent thereto, additional ABMS or AOS boards come into existence - provided that such physician maintains uninterrupted medical staff membership following his/her initial appointment, unless such membership is reinstated within a three (3) month period.

• Failure to attain and retain board certification within the required time shall result in automatic termination of staff membership, without right to hearing or appeal, effective at the end of the corresponding calendar year, except as provided in Section 2.1D.

D. Board Certification/Recertification Requirement Waivers and Extensions
During either the appointment or each re-appointment process the requirement for board certification may be waived by the Governing Body following a recommendation from the MEC under the following conditions:

- Board certification/recertification requirements may be waived on a temporary basis for a specified period of time not to exceed a period of twenty-four (24) months from the granting of such extension, provided the applicable board permits such an extension, to allow an opportunity to obtain appropriate certification/recertification. Such a waiver is non-renewable. Board certification/recertification requirements may be permanently waived where appropriate (e.g., Senior Active Staff member or Distinguished Faculty Member).

  a. Once taken, such action supersedes all individual board certification and re-certification requirements contained in any other medical staff policy, rule or regulation.

  b. Request for waiver of an individual board certification requirement on either a temporary or permanent basis may only be brought forward by a voting member of the Medical Executive Committee.

E. Effects of Other Affiliations

No practitioner shall be automatically entitled to membership on the medical staff, or to the exercise of particular clinical privileges merely because he is licensed to practice in this, or in any other state, or because he is a member of any professional organization, or because he is certified by any clinical board, or because he is a member of a medical school faculty, or because he had, or presently has, staff membership or privileges at another health care facility, or in another practice setting. Nor shall any practitioner be automatically entitled to appointment, reappointment, or particular privileges merely because he had, or presently has, staff membership or those particular privileges at these Hospitals or provider-based clinics.

F. Ethics and Conduct

Professional conduct shall be governed by the current Code of Ethics of the practitioner’s relevant professional organization as well as the current professional conduct determined by this medical staff and delineated in its governing documents. Every practitioner, at the time of appointment, and reappointment, and at any time during the appointment period, must demonstrate to the satisfaction of the Medical Executive Committee, and the Board, a willingness and capability, based on current attitude and evidence of performance, to work with and relate to other staff members, members of other health disciplines, hospital management, employees, patients, and the community in general, in a cooperative, professional manner that is essential for maintaining hospital operations appropriate to quality and efficient patient care.
G. Additional Eligibility Requirements for MHOBH

The medical staff and allied health practitioner (AHP) staff of MHOBH shall be comprised of individuals with the background, training, skills, expertise, and current clinical competence needed by the community served by the Hospital, and who are committed to the mission and objectives of MHOBH, including employment or alignment with Methodist Le Bonheur Healthcare and/or its affiliated entities or subsidiaries, as considered necessary by the Governing Body and/or MEC. Appointment to the medical staff and AHP staff shall be limited to practitioners who satisfy such criteria.

As part of the ongoing process for evaluation and planning of patient care services, the MEC may recommend to the Governing Body that a particular patient care service be implemented or closed/discontinued. The Governing Body may also determine that a particular patient care service shall be staffed with an exclusive provider agreement. To avoid conflicts of interest in staffing certain hospital programs designed to competitively differentiate the hospital in quality, technology and/or service, the Governing Body may determine that such programs/services shall be staffed in such a manner as to exclude new practitioners and/or current medical staff/AHP members employed by or whose medical practices are managed by or affiliated with other hospitals, health systems, or subsidiaries thereof.

In the event that staffing of a patient care service is limited or modified as outlined above, the clinical privileges of impacted providers shall be modified accordingly and/or considered voluntary relinquishment of those clinical privileges. This voluntary relinquishment shall not be considered an adverse action; therefore, no right to a hearing and/or appeal in association with such decisions shall apply. In the event that all of a practitioner’s clinical privileges are impacted by such decisions, both the staff membership as well as clinical privileges shall be considered voluntarily relinquished, with no right to hearing and/or appeal.

As of October 1, 2013, the Governing Body has determined that practitioners employed by or under exclusive professional services arrangements with hospitals, healthcare systems, or any subsidiary thereof other than Methodist Le Bonheur Healthcare, shall not be eligible for medical staff membership and clinical privileges in the specialties/subspecialties of Cardiology, Medical Oncology, and Hematology at MHOBH.

2.2 Appointment, Reappointment

A. Application

An application for staff membership shall be for membership on the MH-MH and/or MHOBH medical staff. Each applicant shall return the completed application and other requested information to the Medical Staff Services Department with the fee currently required.
Credentials will be collected, verified, analyzed and processed in the manner defined in the credentials policies. Requirements for a complete application are delineated in the credentials policies.

Failure by the applicant to provide truthful, accurate, and complete information shall in itself be grounds for denial, or revocation of staff membership/appointment, reappointment and clinical privileges, without right to hearing or appellate review.

The applicant may not reapply for at least one (1) year, unless the Board determines otherwise.

B. Terms of Appointment

Initial appointment to the medical staff shall be made on a provisional basis by the Board, upon recommendation of the MEC, for a period not to exceed one (1) year. During the provisional term, the staff member shall not be eligible to hold office and shall not serve on medical staff committees, except as an ex officio member.

The provisional designation is removed when the MEC and Board receive satisfactory assurance that the practitioner is capable and willing to fulfill the responsibilities of appointment in the practitioner’s chosen area of clinical practice.

The provisional period may be extended once, for good cause, at the recommendation of the MEC and approval of the Board. If the member’s performance is not satisfactory at the end of the extension, then appointment, privileges, or a specific privilege (whatever has been the subject of the extension) shall not be granted. In that case, the member shall be entitled to rights of Hearing and Appellate review.

C. Reappointment

(1) Formal application for membership reappointment and privileges delineation must be made at the end of the provisional period and shall be for a period of time that is consistent with current accreditation and regulatory requirements and as defined in the credentials policies.

The Board reviews and acts on MEC recommendations regarding reappointment. Each medical staff member is provided an application for reappointment and delineation of clinical privileges.

(2) Failure by the applicant to provide truthful, accurate and complete information required by the reappointment process shall in itself be grounds for denial or revocation of continued appointment and/or reappointment and clinical privileges, without hearing or appellate review.
The member may not reapply for at least one (1) year, unless the Board determines otherwise.

D. Failure To Apply For Reappointment

The failure of a member to submit a completed reappointment application and any additional information requested within an appropriate timeframe, as defined in the credentials policies shall be deemed an automatic resignation of staff membership and privileges, without right of hearing or appellate review. The member must request a new application and follow the initial appointment process before either membership or clinical privileges may again be exercised.

E. Immunity from Liability

The following shall be express conditions to any practitioner's application for, or exercise of, clinical privileges at this hospital:

(1) First, that any act, communication, report, recommendation, or disclosure with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to fullest extent permitted by law.

(2) Second, that such privileges shall extend to appointees of the Hospital’s medical staff and its Board, its other practitioners, and Hospital's President and his representatives, and to third parties, who supply information to any of the foregoing who are authorized to receive, release or act upon the same. For the purpose of this section, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the Board or the medical staff.

(3) Third, that there shall, to the fullest extent permitted by law, be absolute immunity from civil liability arising from any such act, communication, report, recommendations, or disclosure, even where the information involved would otherwise be deemed privileged.

(4) Fourth, that such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to (1) application for appointment and clinical privileges, (2) periodic reappraisals for reappointment or clinical privileges, (3) corrective action, including precautionary or punitive suspension, (4) hearings and appellate review, (5) medical care evaluations, (6) utilization reviews and (7) other hospital, departmental, service or committee activities related to quality patient care and inter-professional conduct.
(5) Fifth, that the acts, communications, reports, recommendations and disclosures referred to in this section may relate to a practitioner's professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

(6) Sixth, that in furtherance of the foregoing, each practitioner shall, upon the request of the hospital, execute releases in accordance with the tenor and import of this section in favor of the individuals and organizations specified in paragraph two subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State.

(7) Seventh, that the consents, authorizations, releases, rights and privileges provided in these bylaws and in the medical staff governance documents for the protection of this hospital's members, other appropriate hospital officials and personnel and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this section.

(8) In addition to and in no way limiting the foregoing, any committee operating by virtue of these bylaws does so in accordance with T.C.A. 63-1-150 or Miss. Code Ann. 41-63-9, as applicable, as amended, modified, or succeeded thereafter.

2.3 Clinical Privileges

Practitioners exercise only those clinical privileges that are within the scope of their current licensure and are granted by the Board upon recommendation of MEC in accordance with criteria set forth in the credentials policies. Criteria include at a minimum: relevant education, training and experience; current demonstrated competence, health status, quality of care and ongoing quality monitoring of information regarding the individual’s professional performance and conduct, judgment, clinical, and/or technical skills.

Clinical privileges shall not be limited by department assignment. Members may admit patients as appropriate to their delineated clinical privileges.

Other practitioners, including other LIPs not eligible for medical staff membership, are also credentialed and granted privileges using the procedures delineated for medical staff. Process details for these Allied Health Professionals are described in the credentials policies.

A. Initial Privileges

Each applicant, as part of the initial application procedure, shall request those specific clinical privileges, which he/she wishes to exercise within the scope of such applicant’s medical license. It is the applicant's burden to provide objective evidence of current competence and qualifications in these clinical areas.
B. Periodic Review of Clinical Privileges

At reappointment time, delineations of specific clinical privileges must be requested by the practitioner, and approved by the Board, after recommendations by the Department Chair and the MEC. Criteria are set forth in the credentials policies and will include at a minimum, relevant education, training and experience, current demonstrated competence, health status, quality of care and ongoing quality monitoring of information regarding the practitioner’s professional performance and conduct, judgment, clinical, and/or technical skills.

C. Appointment and Privileges

All privileges are to be within the scope of the clinical privileges granted after the recommendation of the MEC and the approval of the Board and are separate and distinct from the decision regarding medical staff appointment/reappointment.

D. Telemedicine Privileges

Licensed independent practitioners providing care, treatment, and services to patients via telemedicine are privileged by MH-MH and/or MHOBH (the originating site). The process details for telemedicine privileging are located in the credentials policies.

E. Temporary Privileges

Temporary Privileges may be granted to fulfill important patient care or service needs or during the processing of an application. The process details for granting temporary privileges are defined in the credentials policies.

F. Emergency (Condition) Privileges

In case of an emergency, any staff member, to the degree permitted by his license and regardless of staff status, department assignment, or clinical privilege delineation may, and indeed should, assist in the care of the patient as a life-saving measure or to prevent serious harm.

G. Disaster Privileges

Volunteer physicians and other Licensed Independent Practitioners (LIPs) who do not possess medical staff membership and/or clinical privileges at MH-MH or MHOBH may be granted privileges in response to a disaster (when the Emergency Operations Plan has been activated) and the Hospital is unable to meet immediate patient needs. A disaster is defined as any officially declared emergency, whether it is local, state, or national that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain patient care, safety, or security functions. The CEO, executive medical staff leaders, department chairs and service chiefs, or their designee(s) have the option to grant disaster privileges on a case-by-case basis at their discretion. The process details for granting disaster privileges are delineated within the credentials policies.
2.4 Categories of the Medical Staff

The medical staff shall be divided into Active, Courtesy, Active Emeritus, Senior Active, Active Affiliate, and Affiliate.

A. Responsibilities

Regardless of the staff category, all staff members with clinical privileges must:

- provide timely and continuous care to their patients;
- complete patients’ medical records as specified in the medical staff rules and regulations;
- be subject to the rules and regulations and policies of all clinical departments in which privileges are held, to all medical staff policies, and to the authority of the MEC and the Board, through the chair of the department to which the individual is assigned with relevant input of other department chairs;
- be included in reviews of quality, efficiency, appropriateness, and accessibility of patient care, and respond to reasonable suggestions regarding quality, and efficient practice habits, if properly presented by individuals in authority;
- respond to reasonable requests to perform necessary medical staff organizational functions as may be required (e.g. committee or screening physician assignments);
- cooperate with procedures for renewing clinical privileges every two years; and
- follow applicable rules, regulations, policies, and procedural guidelines of the medical staff and hospital.

The attending LIP primarily responsible for the patient's care is responsible for the H&P. Specific rules, procedures and content for history and physical performance, completion, and updates are included in rules and regulations of the medical staff.

B. Active Medical Staff

Active medical staff shall be physicians or dentists who are active either at MH-MH or MHOBH and have signified willingness to accept such appointment and obligations.

- Activity shall be measured by their care for more than 25 patients per year (admissions, observation status patients, procedures, consultations, or other patient encounters) at MH-MH and/or MHOBH and any associated facilities operating under the same license number(s).
- Active members will participate in focused professional practice evaluations to establish competency for clinical privileges requested as necessary.
- All business of the medical staff shall be transacted by the Active members in association with Senior Active and Active Affiliate members.
- The Active members shall be eligible to hold office after three (3) years on the Active staff.
• The Active members shall also be eligible to vote.
• The Active Staff member may be required to provide Emergency Department coverage at their primary Hospital or Division and to accept assignment of patients that do not have an attending physician.

C. Courtesy Medical Staff

Courtesy medical staff shall consist of members who demonstrate a desire to utilize MH-MH and/or MHOBH occasionally.

• Courtesy medical staff members shall hold active staff appointments at other hospitals where they participate in performance improvement activities that meet The Joint Commission standards. They will supply evidence of satisfactory Ongoing Professional Practice Evaluations (as defined by current Joint Commission standards) at their primary hospital as part of their efforts to establish ongoing competency for clinical privileges.
• Courtesy members will participate in focused professional practice evaluations to establish competency for clinical privileges requested
• Members who routinely admit consult treat, provide procedures for, or otherwise have patient encounters with more than twenty-five (25) patients per year at either MH-MH and/or MHOBH and associated facilities operating under the same license number(s) will be promoted to Active Staff with its attendant prerogatives and responsibilities.
• The Courtesy Staff shall not be eligible to vote, cannot hold office, and cannot serve on standing medical staff committees.
• The Courtesy Staff member may be required to provide Emergency Department coverage at their primary Hospital or Division and to accept assignment of patients that do not have an attending physician.

D. Senior Active Medical Staff

Senior Active members are over the age of 60 and have served continuously on the Active Staff for 10 years.

• The Senior Active members shall be eligible to hold office, serve on committees, and vote.
• They shall, in association with the Active and Active Affiliate Staff, transact all business of the medical staff.
• They are not required to take Emergency Department call.

E. Active Emeritus

Active Emeritus staff members shall have served at least 30 years as members of the Active medical staff, or shall have reached age 65 and served as Active medical staff members continuously since completion of their provisional period.

They are precluded from admitting, consulting, documenting inpatient orders, and performing hospital procedures. Active Emeritus staff may refer and follow their patients in the hospital and may order outpatient treatments and services, including rehabilitation and respiratory therapy.
Active Emeritus staff members shall be eligible to hold office and serve on committees.

F. Provider-based Affiliate

Provider-based Affiliate members of the medical staff are limited to physicians who have provider-based status designated by Methodist Healthcare, are office-based and have no inpatient activity. They are precluded from admitting, consulting, writing inpatient orders, and performing procedures but may refer and follow their patients in the hospital. They may order outpatient treatments and services, including rehabilitation and respiratory therapy. They admit patients to the hospitalists of MH-MH and/or MHOBH.

Provider-based Affiliate staff members shall be eligible to hold office, serve on committees and vote on all matters presented at general and/or special meetings of the medical staff and at meetings of any medical staff department of which he/she is a member.

G. Affiliate Medical Staff

Affiliate members of the medical staff are limited to physicians who are office-based and have no inpatient hospital activity: no admissions, consultations, or procedures. Physicians who are primary care physicians (internists, family practitioners), dermatologists, or rheumatologists are among the specialties eligible for this category. They are precluded from admitting, consulting, writing inpatient orders, and performing procedures but may refer and follow their patients in the hospital. They may order outpatient treatments and services, including rehabilitation and respiratory therapy.

H. Honorary Status

An Honorary status designation is restricted to individuals recommended by the MEC and approved by the Board. Appointees to the honorary status designation shall consist of practitioners who have retired from practice or who are of outstanding reputation and the medical staff wishes to honor. Honorary Status designees
- Are not members of the medical staff
- Do not have clinical privileges.
- Do not require reappointment; appointees are not eligible for clinical privileges.
- Appointment to this status is discretionary and may be rescinded without right to hearing or appellate review.

I. Voting Eligibility
Active, Senior Active, Active Emeritus, and Provider-based Affiliate members are eligible to vote.

Provisional, Courtesy, Affiliate and Honorary are not eligible to vote. Additionally, any member whose core privileges are in abeyance is not eligible to vote.

3. **ORGANIZATIONAL STRUCTURE**

3.1 Officers, Terms, and Succession

Officers of the MH-MH MHOBH Unified Medical Staff shall be:

<table>
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<tr>
<th>Officer</th>
<th>TERM</th>
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<tbody>
<tr>
<td>President – Elect</td>
<td>1 year</td>
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<tr>
<td>President</td>
<td>1 year</td>
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<tr>
<td>Vice Chief of Staff</td>
<td>1 year</td>
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<tr>
<td>Chief of Staff</td>
<td>1 year</td>
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<tr>
<td>Representative to the Board</td>
<td>1 year</td>
</tr>
<tr>
<td>Associate Chief of Staff, each MH-MH Division and MHOBH</td>
<td>2 years</td>
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<tr>
<td>Associate Chief -Elect at each Division and MHOBH</td>
<td>2 years</td>
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Progression of Officers will be as follows: President Elect, President, Vice Chief of Staff, Chief of Staff and Representative to the Board.

Officers begin to serve on the first day of February following their election.

A. Eligibility Requirements

Only members who have been on the Active Staff (Active, Senior Active, Active Emeritus, Provider-based Affiliate) in good standing (no adverse recommendations concerning medical staff appointments/privileges, no DEA sanctions, no documented professional conduct or quality issues) for at least three (3) years and certified in the relevant specialty (unless the latter requirement is waived by the Board) are eligible.

Only members in the following category are eligible for leader positions:

- members with no employment by a competing healthcare entity (as determined by the Board of Directors) and no practice that is owned/managed/operated by a competing healthcare entity (as determined by the Board of Directors).

In order to avoid conflicting interest, any member who is employed or whose practice is managed or operated by a competing hospital/healthcare entity (as determined by the Board of Directors) is not eligible for medical staff leadership positions, either elected or appointed.

B. Selection of Officer Candidates
In selecting its officers, the medical staff considers the responsibilities involved and the interests, respect, cooperation, and skills (including written and oral communications skills) required to best provide medical staff participation in hospital affairs. Previous committee involvement will also be considered.

(1) Nominations

Officers:
A slate of candidate(s) for President-elect and Associate Chief(s)-elect is selected by a Nominating Committee composed of the Associate Chiefs of Staff and Associate Chiefs Elect from each MH-MH Division (University, South, North, Germantown, Le Bonheur) and MHOBH as well as the current department Chairpersons and is chaired by the Chief of Staff. Nominations will be presented to each Senior Leadership Council. Nominations are also allowed by the MEC and by the Board.

(2) Election

The President-elect and Associate Chief(s)-elect are elected by members of the general staff eligible to vote. The election is held by mailed, faxed, or emailed ballots. Results are determined by a majority of those voting.

(3) Vacancies

Vacancy in the office of President shall be filled by the President-Elect, who shall fill the unexpired term, then his/her own term in office.

Vacancy in the office of Chief of staff shall be filled by the Vice Chief of staff, who shall fill the unexpired term, then his/her own term in office.

Vacancies in elected positions are filled by special election as soon as is reasonably possible after the vacancy occurs.

C. Removal of Officers

Except as otherwise provided, removal of medical staff officers may be initiated by the Board, President of the Hospital, or the MEC. Such removal may be based upon failure to perform the duties of the position as described in these bylaws or upon conduct which reflects unfavorably upon the Office or the Hospital. Failure of an officer to maintain an Active staff status results in automatic removal from office.

In addition, the body which elected an officer may, by a 2/3 majority vote, remove any officer which they have elected.

The new officer shall be selected as outlined in the bylaws regarding Election of Officers.

D. Duties of Officers
The President shall:

- serve as the chief administrative officer of the medical staff;
- act in coordination and cooperation with the President of the hospital in all matters of mutual concern within the hospital;
- call, preside at, and be responsible for the agenda of all meetings of the general medical staff; (the Associate Chiefs shall plan and conduct Divisional and MHOBH Staff meetings);
- serve as Chair of the medical staff Executive Committee;
- serve as ex officio member of all other medical staff committees, without vote (unless otherwise specified by the committee);
- appoint committee members and chairpersons to all standing, special, and multi-disciplinary medical staff committees except the Executive Committee;
- appoint medical staff members to Hospital committees;
- be the spokesman for the medical staff in its external professional and public relations;
- represent the medical staff on the Board; and
- Assist the Chief of Staff in the appointment of or serve as MEC representative for the medical staff peer review/professional review hearings or proceedings.

Chief of Staff shall:

- be responsible for the overall functioning of the medical staff organization, and shall keep or cause to be kept a careful supervision over the clinical work in all Divisions, departments, and services;
- review and recommend temporary privileges for qualified individuals, with the approval of the Hospital President and input from the relevant Department Chairs;
- be responsible, along with the Associate Chiefs, for the enforcement of the medical staff bylaws, rules, and regulations, implementation of sanctions where these are indicated and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
- establish temporary rules and regulations until action can be taken by proper committee;
- along with the Divisional Associate Chiefs, represent the views, policies, needs and grievances of the medical staff to the Governing Body and to the President of the Hospital;
- receive, and interpret the policies of the Governing Body to the medical staff and report to the Governing Body on the performance and maintenance of quality with respect to the medical staff's delegated responsibility to provide medical care;
- be a representative of the medical staff on the Board of Directors; Appoint or serve as MEC representative for the medical staff peer review/professional review hearings or proceedings.
President–Elect:
In the absence of the President, the President-Elect assumes the President’s duties and authority. In addition, the President–Elect shall:

- serve on the MEC;
- automatically succeed the President when the latter fails to serve for any reason;
- perform such reasonable duties as shall be assigned to him by the President or by these bylaws; and
- succeed the President at the end of the President’s term.

Immediate Past President/Vice Chief of Staff:

In the absence of the Chief of Staff, Vice Chief of Staff assumes the duties and authority. In addition, the Vice Chief of Staff shall:

- serve on the MEC;
- perform other reasonable duties assigned to him/her by the medical staff bylaws, by the Hospital’s bylaws, or by the medical staff President or by the MEC;
- serve as a member of the Quality and Patient Safety Council(s) as well as the Credentials Committee;
- serve as Vice Chief of Staff.

Representative to the Board:

The Representative to the Board shall represent the medical staff on the Board of Directors and shall serve as a voting member of the Quality Committee of the Board.

Divisional and MHOBH Associate Chiefs shall:

- serve on the MEC;
- conduct meetings of their MH-MH Division or MHOBH;
- serve as liaison between staff members of their respective Division/MHOBH and the MEC;
- serve as liaison between members of the Division/MHOBH and members of the executive/management/nursing staff;
- chair the relevant Senior Leadership Council; and
- perform other reasonable duties assigned by the MEC or Chief of Staff.
- Additionally, the MHOBH Associate Chief of Staff shall serve as a voting member of the Quality Committee of the Board.

Associate Chief of Staff-Elect shall:

- serve on the MEC;
- assume the authority of the Associate Chief in his absence;
perform other reasonable duties assigned by the Associate Chief of the same Division/MHOBH.

E. Committees and Functions

(1) Types of Committees

There shall be a single MEC for MH-MH, MHOBH, and the Provider-based Clinics. There shall be a Senior Leadership Council (SLC) at each Division (University, North, South, Germantown, Le Bonheur), and at MHOBH. Primary Care Group Medical Board serves as a de facto SLC for the primary care provider-based clinics. The Primary Care Group Medical Board recommends a representative to the MEC, with appointment by the President of the Medical Staff. There shall be such other permanent and temporary committees of the staff as described in committee policies.

Permanent medical staff committees may be established by the MEC. Committees may be established by the SLCs for their respective locations. Temporary (ad hoc) committees may be established by the MEC, Senior Leadership Councils, or by a department or service.

(2) Medical Executive Committee

Membership

The voting Executive Committee members are fully licensed physician members of the medical staff actively practicing in the hospital or provider-based clinics

- Chief of Staff
- Vice Chief of Staff
- President
- President–Elect
- Medical Staff Representative to the Board
- Associate Chiefs of University, North, South, Germantown, Le Bonheur, and MHOBH
- Associate Chiefs Elect of University, North, South, Germantown, Le Bonheur, and MHOBH
- The Chair of each Clinical Department, or his designee, who may vote
- Credentials Chair
- Quality & Patient Safety Chair
- Chair of Peer Review Oversight Committee
- Sr. Vice President Clinical Effectiveness
- Provider-based Affiliate member(s) as appointed by the Medical Staff President if not represented on MEC

Ex Officio Members (WITHOUT VOTE)
• Sr. Vice President, Medical Education
• Chief Executive Officer or his/her designee
• Chief Nurse Executive

Guests may attend MEC meetings only upon invitation of the MEC chair.

(3) Removal from Membership

Any officer, department chair, or committee chair who is removed from his or her position in accordance with these bylaws automatically loses his membership on the MEC.

(4) Duties

The duties of the MEC shall be:

• To serve as the final decision-making body of the medical staff in accordance with the medical staff bylaws and to provide oversight for all medical staff functions;
• to represent and act on behalf of the staff, including equal attention to the needs of staff members at University, North, South, Germantown, Le Bonheur, MHOBH, and provider-based clinics, subject to such limitations as may be imposed by these bylaws;
• to coordinate the activities of, and to review and approve medical staff policies and procedures of, Divisions/MHOBH, medical staff Departments, Divisional/MHOBH Departments, medical staff leaders, and medical staff committees;
• account to the Board and to the staff for the overall quality and efficiency of professional patient care services provided in the hospital by individuals with clinical privileges, and coordinate the participation of the medical staff in organizational performance improvement activities;
• to recommend to the Board all matters relating to appointments, re-appointments, staff category, department assignments, and clinical privileges, and corrective actions;
• take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff appointees, including collegial and educational efforts and investigations when warranted;
• to make recommendations to the CEO and Board, on behalf of any of the Senior Leadership Councils, on medico-administrative and hospital management affairs, including patient care needs such as space, staff, and equipment;
• keep the medical staff up to date concerning licensure and accreditation status of the hospital;
• to resolve inter-divisional, inter-hospital, and inter-departmental conflicts when necessary and possible.

(5) Meetings
The MEC meets monthly and maintains a record of its proceedings and actions.

F. Senior Leadership Council

Each of the five locations (University, North, South, Germantown, Le Bonheur) and MHOBH shall have a Senior Leadership Council.

(1) Composition

The SLC is a council consisting of the Associate Chief, who shall serve as its chair, the Associate Chief-Elect, the facility CEO and Chief Operating Officer of the relevant location, the Chief Nursing Officer of the relevant location, Divisional Associate Chairpersons as appropriate, and other members as appointed by the Associate Chief of Staff.

(2) Duties

The duties of the SLC are to provide the forum and coordinating mechanism for relating medical staff functions to activities of hospital departments, including nursing, and administration. The SLC may appoint committees as needed.

(3) Meetings and Reports

The SLC shall meet as often as necessary to accomplish their assigned functions. A record of these proceedings shall be kept.

Relevant reports shall be made to the MEC, relevant clinical departments of the medical staff, nursing services, CEO, and relevant hospital departments.

3.2 Clinical Departments and Services

A. Departments and Services

The 4 Core Departments required for orderly functioning of the medical staff are:

- Department of Medicine
- Department of Surgery
- Department of Pediatrics
- Department of Obstetrics & Gynecology

Where applicable, each department shall have six divisions; University, North, South, Germantown, Le Bonheur, and MHOBH. Additional departments may exist as defined in Section 3.2C below. The list of active medical staff Departments, as listed in the department policies, will be maintained in the Medical Staff Services Department and reported at the annual medical staff meeting.
B. Obligations of a Clinical Department

Clinical departments shall be expected to meet quarterly; however, at the discretion of the Chair or MEC, any such meeting may be cancelled, postponed or scheduled more frequently as needed. The Chair shall notify the Medical Staff Services Department when such meetings are cancelled or postponed. There will be no attendance requirements. The MEC, in order to assess appropriate function, will evaluate all departments annually. In order to maintain its status, including voting membership on the MEC, an active department must fulfill the following requirements:

- Meet at appropriate intervals in a centralized, acceptable location with adequate physician participation
- Participate in the peer review process
- Participate in the quality, safety and performance improvement activities
- Participate in the credentialing process, including focused and ongoing professional practice evaluation.

If a department is not fulfilling its required functions, the MEC may recommend a change in leadership or disbanding of the department and incorporation of these functions into the appropriate Core Department as described in X.2 below.

C. Additional Departments or Services

Additional departments or clinical services within a department may be established as needed to efficiently and effectively accomplish required medical staff organizational functions. Physicians in approved medical specialties (ABMS or AOS) with at least 10 (ten) active members may apply to the Medical Executive Committee for departmental status with plans to meet the requirements of an active department as defined. The MEC may grant provisional, non-voting status during a 12-month period of review. At the end of that period, if the provisional department has fulfilled all requirements, then full voting status on MEC may be approved. The list of active medical staff Departments, as listed in the department policies, will be maintained in the Medical Staff Services Department and reported at the annual medical staff meeting.

D. Departmental and Service Positions

There shall be a Chair of each department. Where there are divisions of the Department, six (6) Associate Chairs (University, North, South, Germantown, Le Bonheur, and MHOBH) and one (1) Department Chair are established.

(1) Qualifications and Eligibility

In selection of department Chair, Associate Chair, and Service Chiefs, attention is paid to the responsibilities involved and the interests, respect, cooperation, and skills required to best provide medical staff participation in hospital affairs. The Chair and Associate Chair of each department and the Chief of each service shall have been members of the
Active staff in good standing (no adverse recommendations concerning medical staff appointments/privileges, no DEA sanctions, no professional conduct or quality issues) for at least three (3) years and certified in the relevant specialty unless the latter requirement is waived by the Board.

Note: The following provisions apply unless contractual arrangements determine the chair of the department.

Only members in the following category are eligible for leader positions:

- members with no employment by a competing healthcare entity (as determined by the Hospital’s Board of Directors) and no practice that is owned/managed/operated by a competing healthcare entity (as determined by the Hospital’s Board of Directors).

In order to avoid conflicting interest, any member who is employed or whose practice is managed or operated by a competing hospital/healthcare entity (as determined by the Hospital’s Board of Directors) is not eligible for medical staff leadership positions, either elected or appointed.

(2) Selection

Each department elects its Chair, subject to ratification by the MEC and the Board, by ballot to eligible voters and returned by mail or otherwise to the medical staff office.

If applicable, every division of every department elects its Associate Chair in the same manner, subject to ratification by the MEC and Board.

Each department Chair then appoints a Chief of each service within his department, if applicable.

(3) Terms of Office and Succession

Terms of Department Chair, Associate Chair, and Service Chiefs shall be two (2) years, and are limited to two (2) consecutive terms.

(4) Vacancy

Vacancies are filled in the same manner as initial selection, as soon as is reasonably possible.

Should a vacancy in the position of service Chief occur, the relevant clinical department chair appoints a new Chief of that service soon as is reasonably possible.

(5) Removal from Office
Removal of a department Chair may be initiated by 2/3 majority of Active department members voting, but is not final unless and until it has been ratified by both the MEC and the Board.

Removal of an Associate Chair may be initiated by 2/3 majority of the Divisional Department members voting, but is not final unless and until it has been ratified by both the MEC and the Board.

Service Chiefs may not be removed by the department Chair except with the approval of the MEC and Board.

(6) Responsibilities

Responsibilities of the department Chair, Associate Chair, or Service Chief, as applicable, include but are not necessarily limited to:

- Clinically related activities of the department; administratively related activities of the department, unless otherwise provided by the hospital.
- Continued surveillance of the professional performance of individuals in the department who have delineated clinical privileges, including focused professional practice evaluations.
- Counsel and advise individual members of the department or service when there are questions about clinical performance, utilization, ineffective or inefficient practice, professional behavior, or practicing outside the limits of clinical privileges that have been granted;
- act as spokesman for the department or service to such groups as the MEC and other medical staff/hospital committees, departments and services, hospital administration, nursing and other hospital departments, and the Board;
- act as primary spokesman for the department or service with regulatory or accreditation agencies.
- recommend appropriate clinical privileges for each individual or applicant to the department by analyzing appropriate information and data;
- recommend criteria for clinical privileges that are relevant to the care provided by the department;
- Determine qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide care, treatment, and services;
- Recommend space, resources and capital improvement needs for the department or service;
- Evaluate causes for, and participates in response to, untoward incidents involving members of the department or service;
- Assess and recommend to hospital administration off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;
• Lead integration of department or service into the primary functions of the hospital; lead coordination and integration of interdepartmental and intradepartmental services;
• Lead development and implementation of policies and procedures that guide and support provision of care, treatment, and services;
• Provide recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;
• Engage in continuous assessment and improvement of quality of care, treatment, and services;
• Ensure that appropriate and ongoing peer review is conducted at the department level;
• Assist in assessing orientation and continuing education needs of all practitioners in the department or service;
• With the help of relevant support personnel, plan and conduct meetings of the department or service; and
• Provide for Emergency Department coverage for respective Divisions with eligibility and rotations defined in departmental policies.

E. Meeting Requirements

(1) General Medical Staff and Divisional Meetings

The general medical staff and each Division, shall meet at least annually, Special meetings may be called at any time by the MEC, or by the Board, and are held at the time and place designated by the meeting notice.

(2) Clinical Departments and Services

Clinical departments and clinical services shall be expected to meet quarterly; provided however, at the discretion of the chair or MEC, any such meeting may be cancelled, postponed or scheduled more frequently as needed. The Chair shall notify the Medical Staff Services Department when any such meetings are cancelled or postponed. There will be no attendance requirements.

(3) Committees

The MEC meets at least monthly; other medical staff committees meet only as often as necessary to perform their assigned functions. Medical staff committees that are consolidated for MH-MH and MHOBH or MLH system medical staff committees meet according to their charter and as defined in the medical staff governance documents.

(4) Notice of Meetings

Notice of regular meetings of the general medical staff, of divisions, of departments, and of committees will be provided to members at least 14 days in advance and at least 48 hours in advance of special meetings. This notification may occur electronically, via fax, or via mail.
(5) **Quorum**

A quorum is defined as follows:

MEC: 25% of voting members. Once a quorum has been established, actions taken during the meeting are binding, unless the absence of a quorum is suggested before the vote is taken. Unannounced new business can be introduced only if a quorum is present.

Medical staff general meetings, Department meetings, SLCs, other medical staff committees: Those present.

(6) **Attendance Requirements**

Officers and department chairs are required to attend 50% of the meetings of the committees to which they are assigned or elected.

Excused absences may be granted from committee meetings by the committee’s Chair.

(7) **Minutes**

Minutes of the meetings include a record of attendance and actions taken. A record of minutes of medical staff meetings, SLC meetings, committee meetings, and medical staff Department meetings shall be maintained by the Medical Staff Services Department.

(8) **Majority Vote**

Except as otherwise specified, actions are by majority vote of members present and eligible to vote.

(9) **Rules of Order**

Wherever they do not conflict with these bylaws, and when parliamentary procedure is needed as determined by the chair, the latest edition of Roberts’ Rules of Order shall determine procedure.

**4. CORRECTIVE ACTION**

4.1 **Investigations**

A. **Problem Identification**

Patterns or incidents that adversely affect, or could adversely affect patients, the medical staff, the hospital, or its employees, are addressed by clinical department
Chairs, service Chiefs, and/or the MEC and Board in a timely manner. Problem identification relating to a practitioner's clinical judgment or skills, compliance with hospital and/or medical staff rules, physical or mental status, efficient practice, or ethical conduct, may be obtained through information developed routinely in response to peer review, performance improvement activities, or by a complaint from a medical staff member, patient, or hospital employee.

B. Criteria for Initiation

A request for an investigation may be initiated by any member of the medical staff, the chief of staff, a department chairperson, the CEO, or the Board when information exists that a practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be:

- detrimental to patient safety or to the delivery of quality patient care within the hospital and/or provider-based clinic;
- unethical;
- contrary to the medical staff bylaws, associated rules and regulations, policies, related documents, or medical staff or hospital policies;
- in disregard of reasonable attempts to investigate and resolve issues or concerns about professional competency or conduct, including but not limited to failure to respond to requests for information or meetings with investigative committees; or
- below applicable professional standards of behavior or clinical management.

C. Initiation

A written request for investigation shall be sent to Medical Staff Services and forwarded to the MEC and its executive officers. The request shall be supported by reference to the specific activities or conduct of concern. Authorization by the MEC or its executive officers is required before the investigation is initiated. The executive officers may also initiate an investigation without a written request if they believe such investigation is warranted to protect patient safety or necessary to the delivery of quality patient care within the hospital. If the investigation is initiated by the MEC executive officers, the results of such investigation shall be brought to the MEC at its next regularly scheduled meeting.

D. Investigation

The MEC or its officers may conduct the investigations themselves or may assign the task to an appropriate standing or ad hoc committee of the medical staff. If an ad hoc or investigating committee is appointed, it will be composed of not less than two (2) physicians who may (but need not be) members of the medical staff; such committee should not include any individual in direct economic competition with the affected practitioner.

The investigation should address concerns about professional competence or conduct. The committee may review charts or other records, all documents it considers relevant, interview individuals, or any other evidence or information available
within a time period reasonable under the circumstances, usually no longer than ninety (90) days after appointment in most matters. The committee may consider all appropriate clinical literature and practice guidelines and use the resources of an external consultant if it deems them necessary. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams to inform its deliberation.

Contemporaneous evidence of the ongoing investigation, meeting minutes (if any), and letters to the practitioner or others will be maintained. A written report of the committee’s findings, conclusions, and recommendations will be forwarded to MEC as soon as practical.

The affected practitioner shall be informed of the appointment of the investigating committee and may, if desired by the committee, be invited to attend a meeting of the committee. Such an investigative proceeding, if used, is not a "Hearing" and should not be referred to as a "Hearing". (See Section 5.1 for definition of a "Hearing" and when the hearing right applies.) The procedural rules with respect to hearing or appeals do not apply and the individual being investigated shall not have the right to be represented by legal counsel nor to compel the medical staff to engage in external consultation.

Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action warranted by the circumstances, including precautionary suspension, recommendation of other suspension types requiring Board approval, termination of the investigative process, or other action.

At either its next regular meeting or at a special meeting, the MEC shall consider the findings and recommendations of the investigating committee and determine what, if any, remedy is appropriate.

A general or routine review of cases or of a particular practitioner is not an investigation.

E. Special Meeting Attendance Requirement

Whenever suspected deviation from standard clinical practice or professional conduct is identified, the medical staff President or other executive officer, applicable department or committee chair may require the practitioner to confer with him or with a standing ad hoc committee considering the matter. The member will be given notice of the conference at least 48 hours prior to the conference, will be provided with the date, time, location of the conference, and a statement of the issue involved. The practitioner will be informed that his appearance is mandatory. Failure to appear at any such meeting after two notices, will be considered a voluntary resignation from the medical staff. This relinquishment of membership and privileges will not give rise to a hearing or due process rights, but the member may withdraw this resignation by attending the requested meeting within 30 days. Should the member fail to attend the requested meeting within 30 days, he or she must apply for medical staff membership by completing an initial application.
4.2 Choosing a Remedy; Professional Review Action

Resolution may be by one or a combination of several remedies, which shall be chosen after considering the urgency, recurrence, frequency and/or severity of the specific pattern or incident, as well as whether or not an uncooperative attitude is encountered.

Ordinarily, the remedy selected shall be one or a combination of the following: counseling, admonition, required backup coverage, consultation, or proctoring, observation/monitoring, requirement for additional training or education, precautionary suspension (as a temporary action), punitive suspension, or a recommendation to the Board for modification or termination (revocation) of clinical privileges and/or membership status.

Any professional review action shall be taken:

- in the reasonable belief that the action was in the furtherance of quality health care (which term includes orderly operation of the hospital and/or provider-based clinic),
- after a reasonable effort to obtain the facts of the matter,
- in the reasonable belief that the action was warranted by the facts known after making reasonable efforts to obtain the facts, and
- with adequate notice and fair hearing procedures afforded to the practitioner involved, in accordance with these bylaws.

A. Collegial Intervention

The procedures described herein for formal corrective action or professional review action are not intended to forbid or restrict collegial intervention by medical staff leaders and hospital management to address questions relating to an individual’s clinical practice or professional competency or conduct, the goal of such efforts being to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Such collegial interventions are rather encouraged, and may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education. Such collegial intervention efforts by professional staff leaders and hospital management are part of the hospital’s performance improvement and professional and peer review activities. Documentation of such collegial intervention shall be included in the individual's confidential peer review file. Collegial intervention efforts are not mandatory, and shall be within the discretion of the appropriate professional staff leaders.

B. Medical Staff’s Obligation

The medical staff, through its responsible departments, individuals, committees, and/or groups:

- develops and evaluates objective information to determine whether there are reasonable grounds to conclude that a problem exists;
- brings the full authority of responsible officers, department chair, and committees to bear to resolve the issue in a timely manner, in the event an uncooperative stance is encountered;
• includes information about resolving the problem in the medical staff's report of its activities to the Governing Body.

C. Board’s Obligation

The Board is obliged to:

• review the medical staff's conclusions about the presence or absence of a problem and, as necessary, the objective information upon which that conclusion is based;
• instruct administration to provide needed support to the staff, such as information handlers, consultants, legal counsel, etc.;
• assure the staff of its support for reasonable, good faith efforts to resolve the issue;
• review, question, and approve, modify, or refer back to the MEC the resolution of the issue proposed/implemented by medical staff leaders;
• act on MEC recommendations in a timely manner; and
• take direct action in the event that the problem cannot be resolved by medical staff leaders to the Board's satisfaction, for whatever reason.

4.3 Restriction of Clinical Privileges, Reduction in Staff Category, Removal of Medical Appointment and/or Privileges

The Governing Body may, ordinarily upon the recommendation of the Medical Executive Committee, amend an individual’s privileges for the purpose of restricting the potential of harm to patients, other medical staff members, the hospital, provider-based clinics or its employees.

The remedy of complete expulsion from medical staff membership and removal of all clinical privileges may be taken by the Governing Body.

A. Precautionary Suspension

The Chief of Staff, CEO, the MEC, or the Chair of the Governing Body, with appropriate consultation with the Divisional Chief of Staff, shall each have the authority as independent action to invoke a precautionary suspension of all or any portion of the clinical privileges of the medical staff member in question, whenever failure to take such action may result in danger to the health and/or safety of any individual or may interfere with the orderly operation of the hospital or provider-based clinic. Such precautionary suspension is an interim step in the professional review activity, but is not a complete professional review action in and of itself. A precautionary suspension does not imply final finding of fact or responsibility for the situation that caused the suspension and does not become a professional review action even if the MEC upholds or sustains the precautionary suspension. No formal investigation is deemed to have been initiated until the appointment of an investigating committee. The mere gathering of information by the Medical Staff Office or Physician Quality personnel does not constitute a formal investigation.
A precautionary suspension is immediately effective, is immediately reported to all the appropriate individuals, and remains in effect until it is modified or revoked by the MEC or by the CEO or a remedy is effected following the provisions of this article of the medical staff bylaws.

Immediately upon the imposition of a precautionary suspension, the appropriate Department Chair, Divisional Associate Chief of Staff or Chief of Staff assigns to another medical staff member the responsibility for care of any hospitalized patients of the suspended individual.

At its next regular meeting or specially called meeting, after a precautionary suspension, the MEC shall review the action. The affected practitioner may request to be present at this meeting, which is not a hearing and is not to be construed as such. The MEC may continue the precautionary suspension, appoint an investigating committee, or take another action pursuant to this article. If the action taken entitles the affected practitioner to a hearing, then the Hearing and Appeals Procedure shall apply.

B. Punitive Suspension

A “punitive suspension” of all or any portion of a practitioner’s clinical privileges is a remedy, which may be recommended by the MEC and/or invoked by the Board in order to encourage behavioral modification deemed necessary for quality patient care and/or orderly operation of the hospital or provider-based clinic. When a punitive suspension is invoked, the practitioner shall be given appropriate written notice prior to the effective date in order that the practitioner may arrange alternative coverage or facilities for patients. If the practitioner fails to take such appropriate action, the appropriate Department Chair, Divisional Associate Chief of Staff or Chief of Staff assigns to another medical staff member the responsibility for care of any hospitalized patients of the suspended individual. If the punitive suspension action is specified to last for more than 30 days, the practitioner shall first be given notice and an opportunity to request a hearing pursuant to these bylaws before the punitive suspension is commenced. If the Board’s reconsidered decision after the hearing or any subsequent appellate review is to not impose the punitive suspension, the Board may take any other action deemed appropriate, but the practitioner shall not be entitled to another hearing on the same facts.

C. Suspension 6 Months or Longer

In the event that a suspension of all or part of a practitioners' clinical privileges has continued without resolution or reinstatement for 6 months or longer, the MEC shall review the situation and may recommend, and/or the Board of Directors may decide, that the practitioner's privileges in question (and medical staff membership, if all privileges are then under suspension) shall be terminated, or other appropriate action may be taken to resolve the matter. Any such decision shall be made upon consideration of all the facts and circumstances then available, and shall be subject to the right of hearing and appellate review as described in Section 5, if applicable, and if such rights have not already been clearly waived.
4.4 Effects of Other Actions on Medical Staff Membership and Clinical Privileges

A. Failure to Complete Medical Records

All portions of each patient's medical record shall be completed within the time period after the patient record is available to be completed, stated in medical staff rules and regulations. Failure to do so (unless there are acceptable extenuating circumstances) automatically results in (a) the record being defined as delinquent, (b) notification of delinquency to the practitioner, and (c) temporary suspension of admitting and clinical privileges until such time as the delinquent record is completed.

Failure to complete all aspects of any patient's medical record within thirty (30) calendar days after patient discharge constitutes voluntary relinquishment of staff membership and of all clinical and admitting privileges. This does not entitle the practitioner to the hearing or appeals process. Re-application to the staff is allowed immediately upon completion of the delinquent record(s).

B. Actions by Government Agencies or Insurers

Any adverse action taken by any licensure board, professional liability insurance company, court, or governmental agency must be promptly reported to the MEC and to the President/CEO. An individual’s membership and clinical privileges shall be automatically suspended (or restricted as stated) without right of hearing or appellate review if any of the following occur:

(1) Licensure

If a practitioner’s state license to practice is revoked, suspended, limited for disciplinary reasons, expired, not renewed by the relevant state licensing agency, or voluntarily relinquished by the individual, then staff membership and privileges are automatically revoked, suspended, or limited to at least the same extent. If a practitioner’s license has been revoked, the practitioner must re-apply, if membership and/or clinical privileges are again desired, when/if the license is re-instated, except that if the license has been revoked solely due to failure to file renewal forms and fees with the Board of Medical Licensure or has expired in accordance with the provisions of the license issued, the practitioner may be re-instated upon adequate evidence of issuance of new license.

(2) Lapse of Professional Liability Insurance Coverage

If a staff member’s professional liability insurance coverage is terminated, cancelled, non-renewed, lapses, or coverage terms are changed in any way creating a gap or gaps in coverage, the member will be deemed to have voluntarily relinquished membership and privileges, and must reapply before again exercising membership rights or clinical privileges. Appropriate insurance to cover any gaps must be confirmed prior to consideration for membership and privileges.
(3) Controlled Substance Authorization

If a practitioner’s federal or state controlled substance certificate is revoked, terminated, suspended, expired or not renewed by the relevant federal or state issuing agency, or voluntarily relinquished by the individual, then staff membership and privileges are automatically revoked, terminated, or suspended without right of hearing or appellate review and the practitioner must re-apply, if membership and/or clinical privileges are again desired. However, if the federal or state controlled substance certificate has been revoked, terminated, suspended, expired or not renewed solely due to failure to file renewal forms and fees with the federal or state issuing agency, the practitioner may be re-instated upon adequate evidence of the new federal or state controlled substance certificate.

The placement of conditions or restrictions on an individual’s federal or state controlled substances certificate shall result in automatic revocation or suspension of clinical privileges to prescribe controlled substances to the same extent as the conditions or restriction placed by the agency.

(4) Medicare, Medicaid and TennCare Participation

Termination, exclusion, or preclusion from participation in the Medicare, Medicaid, or TennCare programs, as evidenced by being listed on the OIG Exclusions listing, shall result in automatic suspension of all clinical privileges. If the suspension has not been removed due to restoration of participation within six (6) months, the practitioner’s membership and clinical privileges will be deemed to have been voluntarily relinquished, and the practitioner must reapply before again exercising clinical privileges.

(5) Criminal Activity

Conviction or a plea of guilty or nolo contendere pertaining to any felony involving (1) controlled substances (2) illegal drugs, (3) Medicare, Medicaid, TennCare, or insurance fraud or abuse, or (4) violence against another. In the event of indictment for any of the above offenses, the individual shall be reported to the CEO, MEC and Board for investigation and any recommendation or action deemed appropriate.

(6) Failure to Participate in an Evaluation

A practitioner who fails to participate in an evaluation of his/her qualifications for membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills) shall be considered to have automatically relinquished all privileges. These privileges will be restored upon compliance with the requirement for an evaluation. Failure to comply
within 30 days will be considered a voluntary resignation from the medical staff.

Except as otherwise stated above, automatic suspension, restriction, revocation, and/or relinquishment of clinical privileges shall take effect immediately, without right to hearing or appellate review (unless otherwise determined by the Board), and continue until the matter is resolved and a request for reinstatement has been approved by the Credentials Committee, MEC, and Board.

5. HEARING AND APPEAL PROCEDURE

5.1 Definitions:

“Hearing” means notice and an opportunity to be heard, in a formal proceeding, with some mechanism for making a verbatim transcript, following a recommendation that is adverse to the applicant or staff member, by the MEC, or following an action by the Board if the Board's is the first adverse decision.

“Appeal” means review, by an appellate review panel, if a decision remains adverse, of the findings and actions preceding this appellate review.

5.2 Actions that do not entitle medical staff member or applicant to hearing or appeal

Actions taken pursuant to the following do not entitle the member or applicant to any hearing or appeal rights under these bylaws:

- Failure to process a request for privileges when the applicant/member does not meet eligibility criteria to hold that privilege;
- Failure to report within 10 business days (upon member’s notification) any adverse actions on privileges or licensure between appointment/reappointment;
- Automatic relinquishment or voluntary resignation of appointment or privileges;
- Determination that an applicant for membership does not meet the requisite qualifications/criteria for membership;
- Ineligibility to request membership or privileges or continue privileges because a relevant specialty is covered under an exclusive provider agreement;
- Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted or if exhaustion of due process rights is pending;
- Proctoring, monitoring, and any other performance monitoring requirements imposing any provisional period imposed under these bylaws or in order to fulfill TJC standards on focused professional practice evaluation;
- Any recommendation voluntarily accepted by the practitioner;
- Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within one year of a final adverse decision regarding such request as outlined in the reapplication process of the bylaws;
- Any requirement to complete, including, but not limited to, an educational assessment, physical assessment, or behavioral/psychological assessment;
- Grant of conditional appointment or appointment for a limited duration;
• Appointment or reappointment for a duration less than 24 months;
• A denial, reduction, or termination of temporary, emergency, locum tenens or other
  privileges granted in accordance with the medical license categories determined by
  the Tennessee Board of Medical Examiners or Mississippi Board of Medical
  Examiners, as applicable, (set forth and described in the medical staff rules,
  regulations, credentials policies, policies and other documents), other than full
  medical license and distinguished faculty;
• Exclusive Contracts.
  • No due process rights such as a hearing shall be granted to a member who
    loses clinical privileges related to an exclusive contract because the hospital
    has executed an exclusive contract with a practitioner or entity (the “exclusive
    provider”) and the member is not employed by or affiliated with the exclusive
    provider.
  • Physicians who are terminated by or voluntarily leave an exclusive provider
    for any reason shall automatically lose clinical privileges related to the
    exclusive contract at the hospital. Such physician shall not be entitled to a
    hearing or other due process rights enumerated in these bylaws.

5.3 Grounds for Hearing

Unless precluded by Section 5.2 above or otherwise in these bylaws, only the following
recommendations/actions provide cause to request a hearing/appeal:

• Denial of medical staff reappointment or initial appointment;
• Involuntary reduction, restriction, or revocation, or denial of clinical
  privilege(s) or requested additional clinical privilege(s);
• Termination of medical staff appointment; or
• Punitive suspension of privileges, in whole or in part, for a period of 31 days
  or longer.

5.4 Request for Hearing

When an action is taken which, according to these bylaws, entitles an individual to a
hearing, such individual shall be given notice promptly by the CEO, in writing, return
receipt requested, or by personal delivery to the individual or to the individual’s office
staff. The notice shall include a statement of the specific action taken or recommended to
the Board.

The applicant or staff member has thirty (30) days following receipt of such notice to
request a hearing. The request must be by written notice, return receipt requested, to the
CEO, or by personal delivery to the CEO or to the CEO’s office staff. If a hearing
request is not received within thirty (30) days, the applicant or staff member has waived
the right to hearing and to any appellate review and has accepted the action which
becomes effective immediately.

5.5 One Hearing

No applicant or staff member shall be entitled to more than one hearing upon the same
issue or issues.
5.6 Arrangements for the Hearing

The CEO schedules the hearing and provides notice, in writing, return receipt requested, or by personal delivery to the individual who asked for the hearing, or to the individual’s office staff, of its time, place, and date, which shall not be less than thirty (30) days after the date of this notice, but as soon thereafter as possible, considering the schedules and availability of all concerned. The written notification shall include a statement of the reasons for the actions taken, as well as those acts, omissions, charges, and violations which serve as the grounds for the action if applicable, together with the identity of patient records and any other relevant information supporting the action, and list of witnesses (if any) expected to testify at the hearing on behalf of the professional body recommending the adverse action. The statement and attached information may be amended or added to at any time, even during the hearing, if additional material is relevant to the hearing, and provided that the person requesting the hearing and counsel have sufficient time to study the additional information and offer rebuttal.

At the hospital’s option, the hearing shall be conducted before an arbitrator mutually acceptable to the physician and the CEO, or before a hearing officer who is appointed by the chief executive officer and who is not in direct economic competition with the physician involved, or before a panel of individuals who are appointed by the CEO and who are not in direct economic competition with the practitioner involved. The arbitrator, hearing officer, or panel shall adhere to the bylaws and governance documents of the medical staff.

If a hearing officer is used, the hearing officer may be an attorney at law, a physician, or some other individual capable of conducting the hearing. The hearing officer shall not act as prosecuting officer or as advocate to either side at the hearing.

If an adverse recommendation of the MEC has led to the hearing, the Chief of Staff shall appoint a member of the MEC, who may be assisted by an attorney, to represent it and to present evidence supporting the adverse recommendation.

5.7 Presiding Officer

The Chief Executive Officer may appoint a presiding officer for the hearing panel, usually an attorney. The presiding officer shall adhere to the bylaws, rules and regulations, and related governance documents of the medical staff. The presiding officer may be legal counsel to the hospital, but if so appointed, must not act as a prosecuting officer or as an advocate for the Board or medical staff. The hospital’s legal counsel as presiding officer may participate in private deliberations of the hearing panel, and may provide legal advice to it, but is not entitled to vote on its recommendations. Following the hearing, the hospital’s legal counsel may continue to advise the Board and medical staff of the matter.

If no presiding officer is appointed, the hearing officer or the specified chair of the hearing panel is also the presiding officer.

The presiding officer ensures that all participants have a reasonable opportunity to be heard, maintains order, determines the order of procedure of the hearing in accordance with these bylaws, and makes rulings on questions pertaining to matters of procedure and
admissibility of evidence. It is understood that the presiding officer at all times is concerned that all relevant information be made available to the hearing panel for its deliberations and recommendations to the Board. The presiding officer may make official mention of matters relating to the issues under consideration which may be judicially noticed by the courts of this state. All participants in the hearing are informed of such matters, and they are noted in the record of the hearing. Either party may request that a matter be officially mentioned or may provide a counter argument to be included in the hearing record.

5.8 The Hearing Panel

If a hearing panel is to be used, the CEO, after considering the recommendations of the Chief of Staff, appoints a hearing panel of not less than three persons. Knowledge of the matter being considered does not preclude appointment to the hearing panel, but medical staff members who have actively participated in the consideration of the matter at any previous level are not eligible for appointment to the hearing panel. Employment by, coinvestment interest with, or a contract with the hospital does not preclude an individual from serving on a hearing panel. A hearing panel chair is designated. The hearing panel chair shall adhere to the bylaws, rules and regulations, and related governance documents of the medical staff.

5.9 Advisory Panel or Individual

In appropriate cases, an advisory panel or individual may be appointed to assist the hearing panel, hearing officer, or arbitrator, without vote.

5.10 Representation

The individual requesting the hearing may be represented by an attorney or other person of the individual's choice, whose appearance shall be announced in writing at least ten (10) days prior to the date of hearing. The hospital may be represented by counsel in all hearings and proceedings, whose appearance shall be announced in the same manner.

5.11 Specified Rights

The person requesting the hearing and the hospital may:

- call and examine witnesses;
- introduce exhibits;
- cross-examine witnesses, on matters relevant to the issues;
- provide rebuttals for any evidence presented;
- submit a written statement at the close of the hearing.

Even if the person requesting the hearing decides not to participate on his/her own behalf, he/she may still be called as a witness.

5.12 Presentation of the Evidence
It is incumbent on the MEC or the Board, whichever made the decision that prompted the hearing initially, to come forward with evidence in support of its recommendation. With that exception, the burden of proof is on the person who requested the hearing.

5.13 Ultimate Burden of Proof

After all evidence has been submitted by both sides, the hearing panel (or hearing officer or arbitrator) shall recommend against the individual who requested the hearing unless it finds that the individual has proven with a preponderance of evidence that the recommendation or decision which prompted the hearing was unreasonable, arbitrary, capricious, unsupported by credible evidence, or otherwise unfounded.

The “hearsay rule” shall not apply, and the sole standard for admissibility shall be relevancy to the charges or any offered defense or justification. Evidence may include medical charts, witnesses, either live or by deposition, as well as affidavits, witness statements, and any other documentary or physical evidence.

Peer review findings and/or records of other individual medical staff members are not considered relevant evidence and may not be introduced at the hearing.

5.14 Admissibility of Evidence

Any evidence shall be admitted by the presiding officer at the hearing which is relevant to the issues before the hearing panel (or hearing officer or arbitrator) and is the sort of evidence upon which reasonable persons are accustomed to rely in the conduct of serious affairs without regard to the admissibility of such evidence in a court of law. The hearing panel (or hearing officer or arbitrator) may itself question witnesses, call additional witnesses, and request documentation of charges or claims made. Members of any advisory panel may also question witnesses.

5.15 List of Witnesses

Each party must provide the other in writing, at least ten (10) days in advance of the hearing, a written list of names and addresses of witnesses to be called. The witness list of either party may be amended at any time during the course of the hearing for good cause shown.

5.16 Failure to Respond or Appear

If the person requesting the hearing or appeal fails to respond in writing within twenty (20) days of receiving actual notice (or of receipt of notice by certified mail communication) regarding scheduling of the hearing or appeal, or arrangements for conduct of the hearing or appeal, or, without good cause, fails to appear at the time the hearing or appeal is scheduled, this constitutes voluntary acceptance of the recommendations or actions pending, which then become effective immediately.

5.17 Postponements and Extensions

Postponements and extensions may be requested by any of the participants, but will be permitted by the hearing panel (or hearing officer or arbitrator) only for good cause.
5.18 Hearing Record
A record of the hearing is maintained by a reporter retained by the hospital. Copies of the record prior to deliberations may be obtained by the applicant or staff member upon payment of any reasonable charges associated with the preparation thereof.

5.19 Attendance by Panel Members
No quorum is required in order for the hearing to proceed, but the decision of the hearing panel must be by majority of all those appointed to the hearing panel (if a hearing panel is used).

5.20 Conclusion of the Hearing Procedure
After both parties have concluded their presentation of oral and written evidence, the hearing is closed.

5.21 Recommendation
Within twenty (20) days after conclusion of the hearing and receipt of the transcript, and following any private deliberations that may be necessary, a recommendation and a report containing the reasons for the recommendation shall be delivered to the Chief Executive Officer. The recommendation must be based on the evidence produced at the hearing.

Upon presentation of its recommendation and report, the hearing body's obligation is fulfilled.

5.22 Further Distribution of Hearing Recommendation and Report
The CEO sends a copy of the report and recommendation, return receipt requested, to the person who requested the hearing, and to the body whose adverse recommendation (MEC or Board) initiated these procedures. This body then reviews the matter and decides whether to modify its original recommendation or action, considering the findings of the hearing. If the recommendation or decision is still adverse, the CEO gives written notice to the individual who requested the hearing.

5.23 Request for an Appeal
Within thirty (30) days of receiving such notice, the applicant or staff member may request appellate review. This request must be by written notice, return receipt requested to the CEO, or by personal delivery to the CEO or the CEO’s office staff, and must include a brief statement of the grounds/reasons for the appeal, as follows:

- substantial failure on the part of the medical staff or Board to comply with these bylaws in the conduct of proceedings affecting the applicant or staff member;
- that the recommendation was made arbitrarily, capriciously, or with prejudice;
- that recommendation of the MEC or the decision of the Board was not supported by evidence.
If appellate review is not requested within the thirty (30) day time period, the applicant or staff member has accepted the decision and the action taken is immediately effective. (See 5.24 Appeal: Procedure Details.)

5.24 Appeal: Procedural Details

Arrangements for Appellate Review

When an appeal is requested, the Board Chair, within 45 days of receiving such request, schedules and arranges for an appellate review. Note of the time, date, and place of the appellate review is given to the appealing party. The date of appellate review must be not less than thirty (30) days nor more than sixty (60) days after the request is received. When the individual appealing is under suspension, then the appellate review is held as soon as arrangements can reasonably be made, but not more than sixty (60) days from receiving the appeal request. The stated times within which appellate review must be accomplished may be extended by the Board Chair for good cause.

5.25 Appellate Review Panel and Procedures

The Board Chair schedules an appellate review by the Board. The Board considers the record upon which the recommendation or action being appealed was made.

The Board may request a member of the MEC, Board, or an attorney to support or represent the prior action or decision, which led to the appellate review.

The Board may accept additional oral or written evidence only if the party seeking to admit additional evidence can demonstrate being deprived of the opportunity to admit it at the hearing which preceded this appellate review.

Each of the two parties in the matter have the right to present a written statement in support of their position on the appeal and, in its sole discretion, the Board may allow a representative of each party to appear personally and make oral arguments.

Following the appellate review, the Governing Body shall find against the individual who requested the appellate review, unless it finds one or more of the grounds stipulated in 5.23 above.

The Board may accept, modify, or reverse the prior recommendation, action or decision in question, sometimes after requested further review by any appointed panel or individual, for good cause. When further review is necessary, a report back to the Board shall be accomplished within thirty (30) days, unless a reasonable extension is granted by the Board. The final Board decision is arrived at within sixty (60) days after the conclusion of appellate review, and is provided in writing to the affected individual and to the MEC, including a statement of the basis for the decision, in person or by certified mail.

The decision of the Board following the appeal is final and effective immediately.

5.26 Only One Appeal
There is no exception to the rule that the applicant or staff member is entitled to only one appellate review of any single matter.

5.27 Reapplication

An applicant to the medical staff or a medical staff Member (as the case may be) may not reapply for membership and/or privileges as applicable, for at least one (1) year (unless the Board determines otherwise) after:

(a) An MEC recommendation for denial or termination from the medical staff or specific privileges from which no hearing is requested or is waived; or

(b) An MEC recommendation for denial or termination from the medical staff or specific privileges after completion of a hearing, when no appellate review is requested or is waived; or

(c) Any final decision by the Board, after hearing and appellate review.

6. INDEMNIFY AND HOLD HARMLESS AND PROFESSIONAL LIABILITY

6.1 Indemnify and Hold Harmless

When the Board expressly delegates certain of its duties to Members of the medical staff, it is the intention of the Hospital to indemnify and hold harmless such participating persons for their good faith and without malice performance of such duties and responsibilities. Such delegated duties include service on the various committees provided in the medical staff bylaws, such committees as the Board of Directors may designate or such committees as may be required by law, regulation or accreditation agency. It is the intention of the Hospital that such service be conducted under and pursuant to Tenn. Code Annotated 63-1-150 or Miss. Code Ann. 41-63-9, as applicable (as hereafter may be amended, modified, or succeeded), and any other applicable state and federal laws. In consideration of such service by Members of the medical staff in fulfilling their duties and responsibilities, the Hospital, to the extent not prohibited by law, shall defend, indemnify and hold harmless any medical staff Member for such committee participation when done in good faith and without malice in the performance and discharge of their delegated duties from any claim, suit, action or judgment, whether threatened, pending or finally completed litigation of a civil, administrative or investigative nature, and related to such service.

So long as the Member of the medical staff shall assist and cooperate with Hospital in Hospital’s defense of any such claim, action, suit or proceeding, indemnification shall include expenses (reasonable in nature) and attorney fees for the counsel selected by Hospital to represent Member of the medical staff, any judgments, fines and any settlement amounts in connection with the defense or settlement of such claim, action, suit or proceeding. Any such indemnification is conditioned upon the fulfillment of the Member of the medical staff’s obligation to act in good faith and without malice and in a manner reasonably believed to be consistent with the duties delegated to such Member of the medical staff by the Board in fulfillment of its duties and responsibilities.
6.2 Professional Liability

Notwithstanding anything herein to the contrary, no indemnification hereunder shall include nor shall be provided for any actions and/or claims arising from alleged negligent or wrongful acts or failures to act or misconduct committed by a Member of the medical staff in connection with specific patient care and treatment or other professional services which he or she may personally perform, supervise, or be responsible for in their independent practice of medicine.

6.3 Non-Exclusive Right

The indemnification provided by this Section 6.0 shall not be deemed exclusive of any other rights to which those indemnified may be entitled under any contract, agreement or otherwise, both as to actions taken in an official capacity and as to actions taken in another capacity while holding such office, and shall continue as to a person who has ceased to be Department Chair, committee member or otherwise performed delegated duties and shall inure to the benefit of the heirs, executors and administrators of such indemnified person.

7. SUPPLEMENTAL MEDICAL STAFF DOCUMENTS/GOVERNANCE DOCUMENTS

Specific rules and procedures for implementing provisions and processes of these bylaws may be included in rules and regulations of the medical staff as well as the credentials policies, committee policies, peer review policies, Department policies, and medical staff policies and/or procedures (collectively called “governance documents”).

Agreement to abide by the bylaws includes agreement to abide by any accompanying governance documents that are subject to MEC approval and, like the bylaws, subject to Board approval.

Existing governance documents are deemed to continue in effect unless and until they are amended or replaced by action of the MEC, subject to Board approval.

8. AMENDMENT AND ADOPTION

Proposed new or amended bylaws shall be presented to the MEC, which reports on these recommendations either favorably or unfavorably, for action by the medical staff.

The medical staff may act upon proposed new or amended bylaws by any of the following methods, as determined by the MEC:

- by ballots to all eligible voters and returned by mail or otherwise to the medical staff office within twenty (20) days of mailing, by a 2/3 majority vote of all eligible voters responding within the time limit

- at the next regular meeting of the medical staff, or at a special meeting called for such purpose, by a 2/3 majority vote of eligible voters present

Amendments are effective when approved by the Board.
The medical staff bylaws and related documents are thoroughly reviewed at least annually and revised as necessary.

9. CONFLICT RESOLUTION

Whenever the Board is contemplating taking action regarding the medical staff governance documents which is contrary to the recommendation of the medical staff, the Board shall by written notice to the President of the medical staff, inform the medical staff of its concerns, the reasons, and the date by which the medical staff’s response is requested.

If the medical staff’s response satisfies the Board’s concerns, the Board shall forward its favorable response to the medical staff. If the medical staff’s response fails to satisfy the Board’s concerns or if no medical staff response is received, the matter will be referred to a special combined committee composed of three (3) representatives from both the MEC and the Board appointed respectively by the President of the medical staff and the Chair of the Board. The CEO will attend as an ex-officio member, without vote. This special combined committee will submit a written recommendation to the Board.

The Board’s action after receiving the committee’s recommendation shall be effective as the final decision. Such final decisions are effective as of the date of the Board action or at such later date as specified by the Board.

10. UNIFICATION OF HOSPITAL MEDICAL STAFFS

This document serves as the bylaws for the unified medical staff of Methodist Healthcare Memphis Hospitals and Methodist Healthcare – Olive Branch Hospital (MHOBH). Under the structure of the unified medical staff, the following conditions apply:

1) Each separately accredited hospital’s medical staff (MH-MH and MHOBH) must vote by majority to either accept the unified and integrated medical staff structure or to opt out of such structure and maintain a separate and distinct hospital medical staff.

2) The unified medical staff takes into account each separately accredited hospital’s unique circumstances and any significant differences in patient populations and services offered.

3) The unified medical staff establishes processes to ensure the needs and concerns of MH-MH and MHOBH medical staff members are given due consideration and that issues localized to particular hospitals are duly considered and addressed.

4) The unified medical staff may be dissolved upon a 2/3 majority vote of the active medical staff of MH-MH or MHOBH.

- Members may present a petition to MEC stating their wish to revert to separate medical staffs; it must be signed by 10% of active members privileged at the specific hospital. Upon receipt and review of a proper petition, MEC shall direct that vote will occur by the active medical staff of that hospital eligible to vote.

- Voting would be conducted by distributing ballots (electronically or otherwise) to all eligible voters, to be returned to the medical staff office within twenty (20) days. The vote is decided by a 2/3 majority vote of all eligible voters responding within the time limit.
• Such request for dissolution of the unified medical staff may not occur more than once in a two year period.
• Members will be advised annually of their rights to opt out of the unified medical staff. This notification will occur at the annual medical staff meeting.
## REVISION LOG

Unified Medical Staff Bylaw - Amendments

<table>
<thead>
<tr>
<th>Revision #</th>
<th>Reference</th>
<th>Subject of Revision</th>
<th>Board Approved</th>
</tr>
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<tbody>
<tr>
<td>Original</td>
<td>Reformatting, streamlining</td>
<td>January 24, 2007</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>2.1, B</td>
<td>Addition regarding malpractice coverage and regarding</td>
<td>February 2008</td>
</tr>
<tr>
<td>2</td>
<td>9.0</td>
<td>Addition - Conflict Resolution</td>
<td>February 2008</td>
</tr>
<tr>
<td>3</td>
<td>3.1</td>
<td>Replacing Quality Management Committee with Performance Excellence Committee</td>
<td>February 2009</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>Maintenance “plan to policies”</td>
<td></td>
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<tr>
<td>5</td>
<td>2.3</td>
<td>Expanding the verbiage for the privileging and re-privileging process for other practitioners (LIP) not eligible for medical staff membership</td>
<td>February 16, 2011</td>
</tr>
<tr>
<td>6</td>
<td>2.3 D &amp; G</td>
<td>Inclusion of disaster and telemedicine privileging in the bylaws</td>
<td>February 16, 2011</td>
</tr>
<tr>
<td>7</td>
<td>2.4</td>
<td>Requirements for completing and documenting medical histories and physical examinations</td>
<td>February 16, 2011</td>
</tr>
<tr>
<td>8</td>
<td>3.2, E 1.0</td>
<td>Correction word omitted - added the word “time”</td>
<td>April 2011</td>
</tr>
<tr>
<td>9</td>
<td>2.4</td>
<td>Addition of new staff category “Active Affiliate”</td>
<td>February 28, 2013</td>
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<tr>
<td>10</td>
<td>4.1, C &amp; 4.3</td>
<td>Language update requested by Board.</td>
<td>February 28, 2013</td>
</tr>
<tr>
<td>11</td>
<td>3.1 D &amp; 3.1 (2)</td>
<td>Update a change in committee name Performance Excellence to Quality &amp; Patient Safety</td>
<td>February 28, 2013</td>
</tr>
<tr>
<td>12</td>
<td>3.1, 2</td>
<td>Added MEC membership “An active affiliate member as appointed by the President”</td>
<td>February 28, 2013</td>
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<tr>
<td>13</td>
<td>3.1, A</td>
<td>Eligibility &amp; qualification requirements for Officers</td>
<td>February 28, 2013</td>
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<tr>
<td>14</td>
<td>3.2, D</td>
<td>Eligibility &amp; qualifications requirements for Department and Service Positions</td>
<td>February 28, 2013</td>
</tr>
<tr>
<td>15</td>
<td>3.2, D,3</td>
<td>Terms of Department Chair, Associate Chair and Service Chiefs shall be two year and are limited to two consecutive terms</td>
<td>December 12, 2013</td>
</tr>
<tr>
<td>16</td>
<td>2.4, E</td>
<td>Addition of Active Emeritus. This recognized those physicians who have had a long membership tenure.</td>
<td>December 12, 2013</td>
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<tr>
<td>17</td>
<td>2.4, I</td>
<td>Defines the categories eligible for voting</td>
<td>December 12, 2013</td>
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<tr>
<td>18</td>
<td>3.2, D 2</td>
<td>This revision allows for voting by ballot electronic or otherwise</td>
<td>February 27, 2014</td>
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<tr>
<td>18</td>
<td>10.0</td>
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<tr>
<td>Unification of Hospital Staffs</td>
<td>Added this section for unification of Olive Branch Hospital</td>
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<td>October 30, 2014.</td>
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<tr>
<th>19</th>
<th>Preamble</th>
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<tbody>
<tr>
<td>Bullet points or preamble are modified to reflect the language of MHOBH Bylaws</td>
<td></td>
</tr>
<tr>
<td>Updated Bylaws to include MHOBH wherever other facilities are mentioned and to also include MHOBH officers as appropriate.</td>
<td></td>
</tr>
<tr>
<td>October 30, 2014</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definitions</th>
<th>1. Defined Board of Directors and its responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Updated definition that reflect inclusion of Olive Branch medical staff and increase to 6 Associate Chiefs and potentially 6 Associate Department Chairs.</td>
<td></td>
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</tbody>
</table>

| 2.1 G Membership Eligibility | Added specific eligibility requirements for Olive Branch from the MHOBH current Bylaws. In summary, this addition addresses MHOBH medical staff composition and evaluation and planning of patient care services. |

| 2.2, E 8 Appointment , Reappointment: Immunity from Liability and 6.1 Indemnify and Hold Harmless | Added Miss Code Ann. 41-63-9 as applicable |

| 2.4 Categories of the Medical Staff | Updated the voting eligibility for the different categories. |

| 3.1 D Organizational Structure: Duties of Officers | 1.) Added the description of duties for Representative to the Board |
| 2.) Added the “MHBOH Associate Chief of Staff shall serve as a voting member of the Quality Committee of the Board.” |

| 3.2 E (3) Clinical Departments and Services: Committees | Added the following verbiage: **Medical staff committees that are consolidated for MH-MH and MHOBH or MLH system medical staff committees meet according to their charter and as defined in the medical staff governance documents.** |

| 5.2 Actions that do not entitle medical staff member or applicant to hearing or appeal | A denial, reduction, or termination of temporary, emergency, locum tenens or other privileges granted in accordance with the medical license categories determined by the Tennessee Board of Medical Examiners or Mississippi Board of Medical Examiners, as applicable, (set forth and described in the Medical Staff Rules, Regulations, Credentials Policies, Policies and other documents), other than full medical license and distinguished faculty; |

<p>| 4.4, A, Effects of Other | Completion of medical records requirement is changed from the MHOBH Bylaws which |</p>
<table>
<thead>
<tr>
<th>Actions on Medical Staff Membership and Clinical Privileges: Failure to Complete Medical Records</th>
<th>states 23 days to the current MH-MH requirement of 30 days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unified Bylaws</td>
<td>Added MHOBH throughout the document as necessary and where every all MLH facilities were listed.</td>
</tr>
<tr>
<td>20</td>
<td>2.1.B Member/Basic</td>
</tr>
<tr>
<td>2.1.E Member/Affil</td>
<td>Add to last sentence, &quot;...Hospitals or provider-based clinics.&quot;</td>
</tr>
<tr>
<td>2.4 Categories</td>
<td>Remove &quot;Active Affiliate&quot; category. Add a new category of &quot;Provider-based Affiliate.&quot;</td>
</tr>
<tr>
<td>2.4 Categories</td>
<td>Remove Active Affiliate Category. Physicians currently in this category who are office-based and NOT in a PBC will become Affiliate members. Physicians currently in this category who are in an office-based PBC, will become Provider-based Affiliates.</td>
</tr>
<tr>
<td>2.4 Categories</td>
<td>Add new category for Provider-based Affiliate.</td>
</tr>
<tr>
<td>2.4 Categories</td>
<td>Remove Active Affiliate as voting member in Section 2.4.I Add Provider-based Affiliate as a voting member. Add, Voting members actively practice in the hospitals and/or provider-based clinics.</td>
</tr>
<tr>
<td>3.1 Org/Committee</td>
<td>Remove Active Affiliate as eligible to serve in Section 3.1.A Add Provider-based Affiliate as a eligible to serve.</td>
</tr>
<tr>
<td>3.1 Org/Eligibility</td>
<td>Add to 3.1.E(1), Redefine entities to include PCG BCs as an SLC equivalent, with the PCG Medical Board recommending a representative to the MEC, with appointment by the President of the Medical Staff. The PCG Medical Board serves as a de facto SLC for the primary care PBCs.</td>
</tr>
<tr>
<td>3.1 Org/Committee</td>
<td>Amend 3.1.E(2)to include PBC representatives as voting members of MEC as recommended by each PBC entity and appointed by the President of the Medical Staff, if the entity is not already represented on MEC.</td>
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<td></td>
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<tr>
<td>Section</td>
<td>Action</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>3.1 Org/Committee</td>
<td>Add to 3.1.E.4, second bullet, &quot;...Le Bonheur, MHOBH, and provider-based clinics...&quot;</td>
</tr>
<tr>
<td>4.1 Corrective</td>
<td>Add to 4.1.B, first bullet, &quot;...with the hospital and/or provider-based clinic.&quot;</td>
</tr>
<tr>
<td>4.2 Remedy</td>
<td>Add to 4.2 first bullet, &quot;...orderly operation of the hospital and/or provider-based clinic.&quot;</td>
</tr>
<tr>
<td>4.3 Restriction</td>
<td>Add to first sentence, &quot;...the hospital, provider-based clinics, or its employees.&quot;</td>
</tr>
<tr>
<td>4.3 Restriction</td>
<td>Add to 4.3.A, precautionary suspension, &quot;...orderly operation of the hospital or provider-based clinic.&quot;</td>
</tr>
<tr>
<td>4.3 Restriction</td>
<td>Add to 4.3.B, punitive suspension, &quot;...orderly operation of the hospital or provider-based clinic.&quot;</td>
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