# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREAMBLE ..................................................................................</td>
</tr>
</tbody>
</table>

1. GENERAL .................................................................................. 2
   1.A. DEFINITIONS ....................................................................... | 2 |
   1.B. TIME LIMITS .......................................................................... | 5 |
   1.C. DELEGATION OF FUNCTIONS .................................................. | 6 |
   1.D. MEDICAL STAFF DUES .......................................................... | 6 |

2. CATEGORIES OF THE MEDICAL STAFF ........................................... 7
   2.A. ACTIVE STAFF ....................................................................... | 7 |
        2.A.1. Qualifications .......................................................... | 7 |
        2.A.2. Prerogatives .............................................................. | 7 |
        2.A.3. Responsibilities .......................................................... | 8 |
   2.B. COURTESY STAFF ................................................................. | 9 |
        2.B.1. Qualifications .......................................................... | 9 |
        2.B.2. Prerogatives and Responsibilities .................................. | 9 |
   2.C. CONSULTING STAFF ............................................................. | 10 |
        2.C.1. Qualifications .......................................................... | 10 |
        2.C.2. Prerogatives and Responsibilities .................................. | 11 |
   2.D. COMMUNITY AFFILIATE STAFF ........................................... 11
        2.D.1. Qualifications .......................................................... | 11 |
        2.D.2. Prerogatives and Responsibilities .................................. | 11 |
   2.E. COVERAGE STAFF ............................................................... | 12 |
2.E.1. Qualifications ................................................................. 12
2.E.2. Prerogatives and Responsibilities .................................. 13

2.F. HONORARY STAFF ......................................................... 13
2.F.1. Qualifications ............................................................... 13
2.F.2. Prerogatives and Responsibilities .................................. 14

3. OFFICERS ........................................................................ 15
3.A. DESIGNATION ................................................................. 15
3.B. ELIGIBILITY CRITERIA .................................................... 15
3.C. DUTIES ........................................................................... 16
3.C.1. President of the Medical Staff ....................................... 16
3.C.2. Vice-President/President-Elect ..................................... 17
3.D. NOMINATIONS ................................................................. 17
3.E. ELECTION ........................................................................ 17
3.F. TERM OF OFFICE ............................................................. 18
3.G. REMOVAL ......................................................................... 18
3.H. VACANCIES ..................................................................... 19

4. CLINICAL DEPARTMENTS ......................................................... 20
4.A. ORGANIZATION ............................................................... 20
4.B. DELEGATED DUTIES OF THE MEDICAL EXECUTIVE COMMITTEE ..... 20

5. MEDICAL STAFF COMMITTEES ......................................................... 22
5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS .................. 22
5.B. SELECTION OF MEDICAL EXECUTIVE COMMITTEE OFFICERS AND MEMBERS ................................................. 22
PREAMBLE

The Medical Staff shall be organized and operated under Bylaws, Rules & Regulations and policies approved by the governing body and is responsible for the quality of medical care provided to patients by the Hospital. Adoption and associated details that reside in the Medical Staff Bylaws cannot be delegated. Medical Staff Bylaws, Medical Staff Rules & Regulations and Medical Staff Policies and the Governing Body Bylaws must not conflict and are compatible with each other and compliant with law and regulation. The Medical Staff Bylaws, Rules and Regulations are not unilaterally amended. If a conflict exists between the Bylaws and any other document then the Bylaws supersede.
ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in these Bylaws and related documents:

(1) “ALLIED HEALTH PROFESSIONALS” ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the MSHA Hospital to provide patient care services within the MSHA Hospital. All AHPs are described as Licensed Independent Practitioners, Advanced Dependent Practitioners, or Dependent Practitioners in the Medical Staff Bylaws documents:

- “LICENSED INDEPENDENT PRACTITIONER” (hereinafter referred to as Category I practitioners) means a type of Allied Health Professional who is permitted by law and by the MSHA Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Category I practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the MSHA Hospital under the conditions set forth in these Bylaws (e.g., part-time physicians and moonlighting residents). See Appendix A to the AHP Policy.

- “ADVANCED DEPENDENT PRACTITIONER” (hereinafter referred to as Category II practitioners) means a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the MSHA Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement. See Appendix B to the AHP Policy.

- “DEPENDENT PRACTITIONER” (hereinafter referred to as Category III practitioners) means a type of Allied Health Professional who is permitted by law or the MSHA Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. See Appendix C to the AHP Policy.

(2) “BYLAWS RELATED DOCUMENTS” refers to the following subset of documents: Rules and Regulations, Credentials Policy, Policy on Allied Health Professionals, Unicoi County Memorial Hospital (UCMH) Medical Staff Organization Manual (MSOM), Medical Staff Policies (*see MSOM).
(3) “CHIEF EXECUTIVE OFFICER” or “CEO” means the individual appointed by the MSHA Board to act on its behalf in the overall management of each of the MSHA Hospitals.

(4) “CHIEF MEDICAL OFFICER” or “CMO” means the individual appointed by the MSHA Board to act on its behalf in Medical Staff affairs, in cooperation with the Presidents of the Medical Staff.

(5) “CLINICAL PRIVILEGES” means the authorization granted by the MSHA Board (or its designee) to render specific patient care services within the Hospital.

(6) “COMMUNITY BOARD” means the local advisory board at each MSHA Hospital to whom the MSHA Board of Directors has delegated certain rights and responsibilities.

(7) “CONSULTANT” means a physician who is either board certified or board eligible and must be certified within five years of specialty residency or fellowship in his/her (sub) specialist training. Consultants accept responsibility for the care of the patients per the Medical Staff Bylaws.

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

(9) “DAYS” means calendar days.


(11) “MEDICAL EXECUTIVE COMMITTEE” means the Medical Executive Committee of Unicoi County Memorial Hospital.

(12) “MEDICAL STAFF” means all physicians, dentists, and podiatrists who have been appointed to the Medical Staff and granted clinical privileges to treat patients at Unicoi County Memorial Hospital.

(13) “MEDICAL STAFF LEADER” means any Medical Staff officers, department chair or committee chair (as applicable).

(14) “MEMBER” means any physician, dentist, or podiatrist who has been granted Medical Staff appointment by the MSHA Board.

(15) “MSHA” means Mountain States Health Alliance.
“MSHA BOARD” means the Board of Directors of Mountain States Health Alliance, which has the overall responsibility for the MSHA Hospitals.

“HOSPITAL” means Unicoi County Memorial Hospital.

“NOTICE” means communication by regular U.S. mail, e-mail, facsimile, hospital mail, or in person.

“ORAL AND MAXILLOFACIAL SURGEON” means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.

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

“PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in the Hospital or in any facility operated by the Hospital, including outpatient facilities. A patient contact demonstrates, in a material way, competency in the delivery of medical services. Unless inappropriate for the specialty, i.e., radiology or pathology, it requires a face-to-face involvement in patient care, clinical assessment and associated documentation.

“PERMISSION TO PRACTICE” means the authorization granted to Allied Health Professionals by the MSHA Board to exercise clinical privileges or a scope of practice.

“PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).

“PODIATRIST” means a doctor of podiatric medicine (“D.P.M.”).

“SCOPE OF PRACTICE” means the authorization granted to a Category III practitioner by the MSHA Board to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician.

“SPECIAL NOTICE” means hand delivery, certified mail/return receipt requested, or overnight delivery service providing receipt.
(27) “SPECIAL PRIVILEGES” means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

(28) “SUPERVISING PHYSICIAN” means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with a Category II or Category III practitioner and to accept full responsibility for the actions of the Category II or Category III practitioner while he or she is practicing in the Hospital.

(29) “SUPERVISION” means the supervision of (or collaboration with) a Category II or Category III practitioner by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Category II or Category III practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist. “General” supervision means that the physician is immediately available by phone; “direct” supervision means that the physician is on the Hospital’s campus, and “personal” supervision means that the physician is in the same room.

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

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

* To the extent that there may be a conflict between the definitions found in these Bylaws and those in the other Bylaws Related Documents, the definitions set forth above shall govern.

1.B. TIME LIMITS

Time limits referred to in these Bylaws are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.
1.C. DELEGATION OF FUNCTIONS

Unless otherwise prohibited in the Bylaws or Bylaws Related Documents:

(1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

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

1.D. MEDICAL STAFF DUES

(1) Annual Medical Staff dues shall be as recommended by the MEC.

(2) Dues shall be payable annually upon request. Failure to pay dues shall result in ineligibility to apply for Medical Staff reappointment.

(3) Signatories to the Hospital’s Medical Staff account shall be the President of the Medical Staff, the Vice-President/President-Elect, and the CMO. Two signatures will be required.

(4) Any dues collected shall be used for Medical Staff education and leadership responsibilities.

(5) If an individual is appointed to more than one MSHA Hospital, he/she shall be required to pay dues only at his/her primary facility.
ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Policy and other Bylaws related documents are eligible to apply for appointment to one of the following categories:

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who demonstrate competency in medical services by:

(a) actively managing and participating in at least 20 patient contacts per two-year appointment term; and

(b) expressing a willingness to contribute to Medical Staff functions and/or demonstrating a commitment to the Medical Staff and Hospital through service on Hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 20 patient contacts during his/her two-year appointment term shall not be eligible to request Active Staff status at the time of his/her reappointment.

** The member must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, or Community Affiliate).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients without limitation, except as otherwise provided in the Bylaws;

(b) vote in all general and special meetings of the Medical Staff and applicable department and committee meetings;
(c) hold office, serve as department chairs, if applicable, serve on Medical Staff committees, and serve as chairs of committees;

(d) exercise such clinical privileges as are granted to them; and

(e) attend meetings of the MEC (without vote) so long as notice is given to the President of the Medical Staff. Attendance and participation at such meetings shall be at the discretion of the President of the Medical Staff. The Active Staff members shall leave for any discussion of confidential peer review issues.

2.A.3. Responsibilities:

(a) Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(1) serving on committees, as requested;

(2) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

(3) providing care for unassigned patients;

(4) participating in the evaluation of new members of the Medical Staff;

(5) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(6) accepting inpatient consultations, when requested;

(7) paying application fees, dues, and assessments; and

(8) performing assigned duties.

(b) Active Staff members who attain the age of 60 may be excused from emergency call and unassigned patient responsibilities. The MEC may also, in the interest of patient care and/or Medical Staff hardship, revoke a previous exemption from Emergency Department coverage that has been granted.
2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are involved in more than one, but fewer than 20, patient contacts per two-year appointment term;

(b) are members in good standing of the Active Staff at another accredited hospital (unless this requirement is waived by the MSHA Board after considering the recommendations of the MEC);

(c) meet all the same threshold eligibility criteria as other Medical Staff members, including specifically those relating to availability and response times with respect to the care of their patients; and

(d) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual’s office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his/her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than one patient contact during his/her two-year appointment term must request another staff category that best reflects his/her relationship to the Medical Staff and the Hospital (options – Consulting or Community Affiliate).

** Any member who has more than 20 patient contacts during his/her two-year appointment term must request Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff and department meetings (without vote);
(b) may not hold office or serve as department chairs or committee chairs, unless waived by the MSHA Board;

(c) may be invited to serve on committees (with vote);

(d) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but:
   
   (1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician, and

   (2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and

   (3) will be required to provide specialty coverage if the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes;

(f) shall exercise such clinical privileges as are granted to them; and

(g) shall pay application fees, dues, and assessments.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff;

(b) provide services at the Hospital only at the request of other members of the Medical Staff;

(c) are members in good standing of the Active Staff at another accredited hospital (unless this requirement is waived by the MSHA Board after considering the recommendations of the MEC); and

(d) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical
competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual’s office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians). Any data or other information submitted from an external source to satisfy this requirement must be deemed acceptable by the Credentials Committee.

2.C.2. Prerogatives and Responsibilities:

Consulting Staff members:

(a) may evaluate and treat (but not admit) patients in conjunction with other members of the Medical Staff;

(b) may not hold office or serve as department chairs or committee chairs;

(c) may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings, without vote;

(d) are excused from providing specialty coverage for the Emergency Department and providing care for unassigned patients, unless the MEC finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) shall cooperate in the professional practice evaluation and performance improvement processes; and

(f) shall pay application fees, dues, and assessments.

2.D. COMMUNITY AFFILIATE STAFF

2.D.1. Qualifications:

The Community Affiliate Staff consists of those physicians, dentists, oral surgeons, and podiatrists who have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Community Affiliate Staff as outlined in Section 2.D.2.

2.D.2. Prerogatives and Responsibilities:

Community Affiliate Staff members:

(a) may attend and vote at meetings of the Medical Staff and applicable departments;
(b) may hold office, serve as department chairs and committee chairs, and serve on committees (with vote);

(c) may attend educational activities sponsored by the Medical Staff and the Hospital;

(d) may refer patients to members of the Active Staff for admission and/or care;

(e) are encouraged to submit their outpatient records for inclusion in the Hospital’s medical records for any patients who are referred;

(f) are also encouraged to communicate directly with the hospitalists and other Active Staff members about the care of any patients referred, as well as to visit any such patients;

(g) may review the medical records and test results (via paper or electronic access) for any patients who are referred in accordance with information security policies and state and federal regulations;

(h) may refer patients to the Hospital’s diagnostic facilities and order such tests;

(i) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write/document inpatient or outpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(j) must accept referrals from the Emergency Department for follow-up care;

(k) must accept referrals from hospitalized patients requiring outpatient primary care; and

(l) are required to pay application fees, but not required to pay dues or assessments.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff shall consist of physicians, dentists, oral surgeons, and podiatrists who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or their coverage group;

(b) are members in good standing of the Active Staff at another accredited hospital (unless this requirement is waived by the MSHA Board after considering the recommendations of the MEC);
(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual’s office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians);

(d) are not required to satisfy the response time requirements set forth in the Credentials Policy, except for those times when they are providing coverage; and

(e) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member that is being covered (i.e., the Active Staff member’s own patients or unassigned patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for unassigned patients, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff and department meetings (without vote);

(d) may not hold office or serve as department chairs or committee chairs; and

(e) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote).

2.F. HONORARY STAFF

2.F.1. Qualifications:

(a) The Honorary Staff shall consist of practitioners who have retired from the practice of medicine in this Hospital, attained the age of 60, served for more than 10 years and who are in good standing.
(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

(c) If the individual requests to change staff privilege category from Honorary Staff, the individual is required to submit an appointment application through defined processes.

2.F.2. Prerogatives and Responsibilities:

Honorary Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff meetings (without vote);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office, serve as department chairs or committee chairs; and

(f) are not required to pay application fees, dues, or assessments.
ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the President of the Medical Staff and the Vice President/President-Elect.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the MEC and approved by the MSHA Board. They must:

1. be appointed in good standing to the Active Staff, and have served on the Active Staff for at least two years;

2. be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process;

3. have no pending adverse recommendations or pending investigations concerning Medical Staff membership or clinical privileges;

4. not presently be serving as Medical Staff officer(s), Board member(s), or department chair(s) at any other non-MSHA hospital and shall not so serve during their term of office;

5. be willing to faithfully fulfill the duties and responsibilities of the position;

6. have experience in a leadership position, or other involvement in performance improvement functions;

7. have demonstrated an ability to work well with others; and

8. not have any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital. This does not apply to services provided within a practitioner’s office and billed under the same provider number used by the practitioner. All candidates are required to disclose in writing any such conflicting financial relationships prior to election, and there shall be a continuing obligation during office to disclose in writing any such conflicting relationship which may arise after taking office.
All such individuals are required to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office.

3.C. DUTIES

3.C.1. President of the Medical Staff:

The President of the Medical Staff shall:

(a) work in coordination and cooperation with the CEO, CMO or designee(s) in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies, concerns, and needs of the Medical Staff as a whole, and report on the activities to the CEO, CMO or designee(s), the Community Board, and the MSHA Board;

(c) make a report to the Community Board and the MSHA Board, in conjunction with the MEC, regarding the following:

(1) quality;

(2) efficiency of clinical services;

(3) effectiveness of the performance improvement;

(4) professional practice evaluation;

(5) functions delegated to the Medical Staff;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(e) appoint committee chairs and committee members;

(f) serve as chair of the MEC (with vote, as necessary) and be a member of all other Medical Staff committees, ex officio, without vote;

(g) enforce adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital;

(h) recommend Medical Staff representatives to Hospital committees;

(i) serve as the spokesperson for the Medical Staff in its external professional and public relations (when requested); and
(j) perform all functions authorized in all applicable policies, including collegial intervention in the Credentials Policy and Bylaws Related Documents.

3.C.2. Vice-President/President-Elect:

The Vice-President/President-Elect shall:

(a) assume all duties of the President of the Medical Staff and act with full authority as President in his or her absence;

(b) serve on the MEC and the Credentials Committee; and

(c) assume all such additional duties as are assigned by the President of the Medical Staff or the MEC.

3.D. NOMINATIONS

(1) The MEC shall appoint a Nominating Committee for all general and special elections. This Committee shall consist of the President of the Medical Staff, Past President, Vice-President/President-Elect, three Active Staff members, the CEO and the CMO.

(2) The Nominating Committee shall convene at least 45 days prior to the election and shall submit to the President of the Medical Staff the names of one or more qualified nominees for each office and for each at-large member of the MEC. Notice of the nominees shall be provided to the Medical Staff at least 30 days prior to the election.

(3) Nominations may also be submitted in writing by petition signed by at least five Active Staff members at least 10 days prior to the election. In order for a nomination to be placed on the ballot, the candidate must meet the qualifications in Section 3.B of these Bylaws, in the judgment of the Nominating Committee, and be willing to serve. Nominations from the floor shall not be accepted.

(4) The Nominating Committee will elaborate on the process, including time frame, the count, and accountability for managing results.

3.E. ELECTION

(1) Except for at-large members of the MEC, candidates receiving a majority of the written votes cast at the meeting shall be elected, subject to the Community Board confirmation. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.
(2) For at-large members of the MEC, the three individuals receiving the highest number of votes shall be elected. In the case of a tie vote with greater than three individuals, the President of the Medical Staff shall identify the three at-large members from the tie pool of individuals.

(3) In the alternative, at the discretion of the MEC, the election shall be held solely by written ballot returned to the Medical Staff Department. Ballots may be returned in person, by mail, by facsimile, or by e-mail ballot. All ballots must be received in the Medical Staff Department by the day of the election.

3.F. TERM OF OFFICE

Officers shall serve for a term of two (2) years or until a successor is elected. Officers may be re-elected.

3.G. REMOVAL

(1) Removal of an elected officer or an at-large member of the MEC may be effectuated by a two-thirds vote of the MEC, or by a two-thirds vote of the Active Staff, or by the MSHA Board. Prior to taking action, the MSHA Board, or its designee, shall engage in dialogue with the MEC. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 3.B of these Bylaws; for example, failure to disclose financial relationships or investment interests that compete with the Hospital;

(c) failure to perform the duties of the position held;

(d) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(e) an infirmity or impairment that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC, the Active Staff, or the MSHA Board, as applicable, prior to a vote on removal. Any removal must be finally approved by the MSHA Board.
3.H. VACANCIES

A vacancy in the office of President of the Medical Staff shall be filled by the Vice-President/President-Elect, who shall serve until the end of the President’s unexpired term. In the event there is a vacancy in another office, the MEC shall appoint an individual to fill the office for the remainder of the term or until a special election can be held, in the discretion of the MEC. In the event of a vacancy of the Vice President position, special elections must be held in accordance with the Bylaws.
ARTICLE 4

CLINICAL DEPARTMENTS

4.A. ORGANIZATION

The Medical Staff shall be organized as one department and committee as listed in the UCMH Medical Staff Organization Manual. However, based upon medical staff composition, Medical Directorships may be utilized to complete required medical staff functions as specialty departments do not currently exist.

(1) Subject to the approval of the Community Board and the MEC, the MEC may create new departments, create divisions within departments, committees or specialty service lines or otherwise reorganize the department(s) or committee(s) structure.

(2) Subject to the approval of the Community Board and the MEC, the MEC may eliminate departments, divisions within departments, committees, or specialty service lines.

(3) Closure of departments or medical specialty service delivery must be subject to the approval of the Community Board and the MEC.

4.B. DELEGATED DUTIES OF THE MEDICAL EXECUTIVE COMMITTEE

Medical Directors are responsible for the following, either individually or in collaboration with Hospital personnel:

(1) coordinating all clinically-related activities of the department;

(2) coordinating all administratively-related activities of the department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE) as outlined in the Professional Practice Evaluation Policy;

(4) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(5) evaluating requests for clinical privileges for each member of the department;

(6) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the department or the Hospital;
integrating the department into the primary functions of the Hospital;

coordinating and integrating interdepartmental and intradepartmental services;

developing and implementing policies and procedures that guide and support the provision of care, treatment, and services;

making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, or services;

determining the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

continuously assessing and improving the quality of care, treatment, and services provided within the department;

enforcing and sustaining quality monitoring programs, as appropriate;

providing for the orientation and continuing education of all persons in the department;

making recommendations for space and other resources needed by the department; and

performing all functions authorized in the Credentials Policy and Bylaws Related Documents, including collegial intervention efforts.
ARTICLE 5

MEDICAL STAFF COMMITTEES

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

This Article and the UCMH Medical Staff Organization Manual outline the Medical Staff committees that carry out peer and other performance improvement functions that are delegated to the Medical Staff by the MSHA Board.

5.B. SELECTION OF MEDICAL EXECUTIVE COMMITTEE OFFICERS AND MEMBERS

(1) Except as otherwise indicated, all committee members shall be appointed by the Medical Executive Committee. Committee members shall be selected based on the criteria set forth in Section 3.B of these Bylaws.

(2) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO or designee. All such representatives shall serve on the Medical Executive Committee, without vote.

5.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each function described in these Bylaws or in the UCMH Medical Staff Organization Manual shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each function shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

5.D. MEDICAL EXECUTIVE COMMITTEE

5.D.1. Composition:

(a) The MEC shall include the President of the Medical Staff, the Vice-President/President-Elect, and four (4) members elected at-large from the Medical Staff. No more than two members from any one group practice may serve on the MEC at the same time.

(b) The President of the Medical Staff shall chair the MEC.

(c) The CEO and CMO shall be ex officio members of the MEC, without vote.
(d) Other individuals may be invited to MEC meetings such as the CNO and Quality Coordinator(s), (without vote) as deemed appropriate by the President of the Medical Staff.

5.D.2. Duties:

The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings (the officers are empowered to act in urgent situations between MEC meetings);

(b) recommending to approve or not approve directly to the Community Board and/or MSHA Board on at least the following:

(1) the Medical Staff’s structure;

(2) the mechanism used to review credentials and to delineate individual clinical privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of clinical privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(c) consulting with administration on quality-related aspects of contracts for patient care services;

(d) receiving and acting on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate;

(e) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;
(f) providing leadership in activities related to patient safety; for example, oversight and execution of safety initiatives requested from the Community Board;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) ensuring that, at least every three years, the Bylaws, and Bylaw Related Documents processes and policies of the Medical Staff are reviewed and updated as needed; and

(i) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, or Bylaws Related Documents.

5.D.3. Meetings, Reports and Recommendations:

The MEC shall meet at least monthly and shall maintain a permanent record of its proceedings and actions.

5.E. CREDENTIALS COMMITTEE

5.E.1. Composition:

(a) The Credentials Committee shall consist of the members of the MEC who possess the qualifications set forth in Section 3.B of these Bylaws and who are broadly representative of the major clinical specialties of the Medical Staff. Particular consideration is to be given to Past Presidents of the Medical Staff and to other physicians knowledgeable in the credentialing and quality improvement processes.

(b) All new members of this Committee, either prior to beginning to serve on the Committee or while serving on the Committee, must obtain specific education and training regarding the credentialing process.

5.E.2. Duties:

The Credentials Committee function shall:

(a) in accordance with the Credentialing Policy, review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) in accordance with the Policy on Allied Health Professionals, review the credentials of all applicants seeking to practice as Licensed Independent Practitioners or Dependent Practitioners, conduct a thorough review of the
applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(c) review, as may be requested, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff or Allied Health Professional Staff and, as a result of such review, make a written report of its findings and recommendations; and

(d) review and make recommendations regarding appropriate threshold eligibility criteria for clinical privileges within the Hospital, including specifically as set forth in Section 4.A.4 (“Clinical Privileges for New Procedures”) and Section 4.A.5 (“Clinical Privileges That Cross Specialty Lines”) of the Credentialing Policy.

5.E.3. Meetings, Reports and Recommendations:

The Credentials Committee shall meet as necessary to accomplish its functions and shall maintain a permanent record of its proceedings and actions.

5.F. PERFORMANCE IMPROVEMENT FUNCTIONS

(1) As approved by the Medical Staff, Hospital leadership and/or the Unicoi County Memorial Hospital Community Board or MSHA Board, the Medical Staff is actively involved in the measurement, assessment, and improvement of at least the following:

(a) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(b) the Hospital’s and individual practitioners’ performance on The Joint Commission and Centers for Medicare & Medicaid Services (“CMS”) core measures;

(c) medical assessment and treatment of patients;

(d) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(e) the utilization of blood and blood components, including review of significant transfusion reactions;

(f) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(g) appropriateness of clinical practice patterns;
(h) significant departures from established patterns of clinical practice;

(i) use of information about adverse privileging determinations regarding any practitioner;

(j) the use of developed criteria for autopsies;

(k) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(l) nosocomial infections and the potential for infection;

(m) unnecessary procedures or treatment;

(n) appropriate resource utilization;

(o) education of patients and families in care management;

(p) coordination of care, treatment, and services with other practitioners and Hospital personnel;

(q) accurate, timely, and legible completion of medical records;

(r) the required content and quality of history and physical examinations, as well as the time frames required for completion, as described in Appendix A of these Bylaws;

(s) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual’s performance;

(t) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members and the MSHA Board; and

(u) when applicable, compliant use of electronic health information systems including provider order entry, clinical documentation and results review.

(2) A description of the committees that carry out systematic monitoring and performance improvement functions, including their composition, duties, and reporting requirements, is contained in the UCMH Medical Staff Organization Manual.
5.G. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the UCMH Medical Staff Organization Manual, the MEC may, by resolution and upon approval of the MSHA Board and without amendment of these Bylaws, establish additional committees to perform one or more staff functions. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual, a standing committee, or a special committee shall be performed by the MEC.

5.H. SPECIAL COMMITTEES

Special committees shall be created by the MEC and their members and chairs shall be appointed by the President of the Medical Staff. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.
ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is July 1 to June 30.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet at least semiannually.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the President of the Medical Staff, the MEC, the CEO, the MSHA Board, or by a petition signed by not less than one-fourth of the voting members.

6.C. DEPARTMENT AND COMMITTEE MEETINGS (WHEN APPLICABLE)

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the UCMH Medical Staff Organization Manual, each department and committee shall meet as necessary to accomplish their functions, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer, the President of the Medical Staff, the MEC, the CEO, or by a petition signed by not less than one-fourth of the voting members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least one week in advance of the meetings. Notice may also be provided by posting in a designated location at least one week prior to the meetings. All notices shall state the date, time, and place of the meetings.
When a special meeting of the Medical Staff, a department, and/or a committee is called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting), hours to exclude weekends and recognized federal holidays. Posting may not be the sole mechanism used for providing notice of any special meeting.

The attendance of any individual at any meeting shall constitute a waiver of that individual’s objection to the notice given for the meeting.

**6.D.2. Quorum and Voting:**

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. Exceptions to this general rule are as follows:

1. for meetings of the MEC, the Credentials Committee, and the Medical Staff Quality Review Committee (“MSQRC”), the presence of at least 50% of the voting members of the committee shall constitute a quorum; and

2. for any amendments to these Medical Staff Bylaws, the Credentials Policy, or the Policy on Allied Health Professionals that are presented to the voting members of the Medical Staff by written ballot or e-mail, at least 50% of the voting staff shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(c) As an alternative to a formal meeting, the voting members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, or telephone, and their votes returned to the Presiding Officer or designee by the method designated in the notice. Except for amendments to these Bylaws, the Credentials Policy, or the Policy on Allied Health Professionals and actions by the MEC, the Credentials Committee, and the MSQRC (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer or designee by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by telephone conference or video conference.

**6.D.3. Agenda:**

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

Robert’s Rules of Order shall not be binding at meetings and elections, but may be used for reference in the discretion of the Presiding Officer for the meeting. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings. The Presiding Officer shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be authenticated by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC, the CEO, the Community Board, and the MSHA Board.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

Members of the Medical Staff who have access to or are the subjects of credentialing and/or peer review information agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality may result in the imposition of disciplinary action. Confidentiality is important to maintain in the setting of credentialing and peer review in order for all parties involved to be able to fully avail themselves of the protections from disclosure to outside third parties provided by Tennessee statute as well as the federal Health Care Quality Improvement Act.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC, the Credentials Committee, and the MSQRC is required. All members are required to attend at least 75% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) In order to maintain voting privileges, Active and Community Affiliate Staff members are expected to attend 50% of Medical Staff meetings each year. Officers and members of the MEC fulfilling the requirements of that role are
deemed to have maintained appropriate attendance levels. Active and Community Affiliate Staff members must participate in applicable department and committee meetings.
ARTICLE 7

CONFLICT OF INTEREST

(a) When performing a function outlined in these Bylaws, the Credentials Policy, or the Policy on Allied Health Professionals, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another individual, the individual with a conflict shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual may be asked, and may answer, any questions concerning the matter before leaving.

(b) The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the President of the Medical Staff or applicable committee chair or department chair by any other member with knowledge of it.

(c) The fact that a Medical Staff member is in the same specialty as the individual whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No Medical Staff member has a right to compel a determination that a conflict exists on the part of another Medical Staff member.

(d) The fact that a department chair, committee member, or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

(e) Medical Staff members shall also be bound by corporate conflict of interest and compliance policies adopted by the MSHA Board to the extent those policies apply to the Medical Staff member in question.
ARTICLE 8

INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by the MSHA corporate bylaws and applicable law.
ARTICLE 9

BASIC STEPS AND DETAILS FOR APPOINTMENT AND PRIVILEGING

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Allied Health Professionals in a more expansive form.

9.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of clinical privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, and ability to safely and competently perform the clinical privileges requested as set forth in the Credentials and Allied Health Professional Policies.

9.B. PROCESS FOR PRIVILEGING

Requests for privileges are provided to the applicable department chair, who reviews the individual’s education, training, and experience and prepares a report (on a form provided by the Medical Staff Services Department) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair’s assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant privileges is favorable, it is forwarded to the MSHA Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

9.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable department chair, who reviews the individual’s education, training, and experience and prepares a report (on a form provided by the Medical Staff Services Department) stating whether the individual meets all qualifications. The Credentials Committee then reviews the chair’s assessment, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the MSHA Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.
9.D. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and clinical privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:
   (i) timely complete medical records;
   (ii) satisfy threshold eligibility criteria;
   (iii) provide requested information; or
   (iv) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted by the CEO and CMO.

(2) Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

9.E. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, the President of the Medical Staff, the chair of a clinical department, the CMO, or the CEO is authorized to suspend or restrict all or any portion of an individual’s clinical privileges pending an investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the CEO and the CMO or the MEC.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 days.

(5) Prior to, or as part of, this review, the individual will be given an opportunity to meet with the MEC.
9.F. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or clinical privileges based on concerns about (a) clinical competence or practice; (b) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.


(1) The hearing will begin no sooner than 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members and there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the Hearing Panel.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

(7) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the MSHA Board.
ARTICLE 10

AMENDMENTS

10.A. MEDICAL STAFF BYLAWS

(1) Neither the MEC, the Medical Staff, nor the MSHA Board shall unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the MEC or by a petition signed by at least 10% of the voting members of the Medical Staff.

(3) All proposed amendments must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC shall, in its discretion, provide a report on them either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted on at any meeting if notice has been provided at least 14 days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(4) The MEC may also present proposed amendments to the voting staff by written ballot or e-mail. Along with the proposed amendments, the MEC shall, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, (i) the amendment must be voted on by at least 50% of the voting staff, and (ii) the amendment must receive a majority of the votes cast.

(5) The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws which are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.

(6) All amendments shall be effective only after approval by the MSHA Board.

(7) If the MSHA Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the MSHA Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the MSHA Board’s rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

10.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there are Bylaws Related Documents as catalogued in the MSOM, Article 5, that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a
scope of practice. All Medical Staff policies, bylaws related documents, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this Section.

(2) All proposed amendments to the Credentials Policy or the Policy on Allied Health Professionals must be reviewed by the MECs of the MSHA Tennessee hospitals that are subject to said policies (individually or jointly) prior to a vote by the relevant MSHA Medical Staffs. The MECs shall report on any proposed amendments either favorably or unfavorably at the next regular meeting of the relevant MSHA Medical Staffs, or at a special meeting called for such purpose. The proposed amendments may be voted on at any meeting of a MSHA Medical Staff if notice has been provided at least 14 days prior to the meeting. To be adopted by a MSHA Medical Staff, the amendment must receive a majority of the votes cast by the voting staff at the meeting.

(3) The MECs of the MSHA Tennessee hospitals that are subject to the Credentials Policy and the Policy on Allied Health Professionals may also present proposed amendments to those policies to the voting staff by regular mail or electronic mail ballot if notice has been provided at least 14 days prior to the date that the ballots are to be returned. Along with the proposed amendments, the MECs shall provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast by the Medical Staff, so long as the amendment is voted on by at least 50% of the staff eligible to vote.

(4) Medical Staff Rules and Regulations, as may be necessary to implement more specifically the general principles of conduct found in these Bylaws, shall be adopted and amended in accordance with this Section. Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges at Unicoi County Memorial Hospital, shall act as an aid to evaluating performance under, and compliance with, these standards, and shall have the same force and effect as the Bylaws. An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to this document shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.

(5) An amendment to the UCMH Medical Staff Organization Manual may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to this document shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place, and any voting member may submit written comments on the amendments to the MEC.
(6) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required, with the exception of those policies currently listed in the Medical Staff Organization Manual. For those policies listed in the Medical Staff Organization Manual, notice of all proposed amendments to such policies shall be provided to each voting member of the Medical Staff at least 14 days prior to the MEC meeting when the vote is to take place.

(7) Amendments to Medical Staff policies and Rules and Regulations may also be proposed by a petition signed by at least five of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the MEC, which may comment on the amendments before they are forwarded to the MSHA Board for its final action.

(8) With regard to MEC recommendations concerning adoption of, and/or changes to Bylaws related documents: If the MSHA Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference among the designees of the MSHA Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the MSHA Board’s rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request.

(9) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any present Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

10.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations;

(b) a new policy proposed or adopted by the MEC; or

(c) proposed amendments to an existing policy that is under the authority of the MEC;

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 10% of the voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.
(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the voting members of the Medical Staff, to the MSHA Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(4) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Governing Body. Communication from Medical Staff members to the Governing Body will be directed through the CEO, who will forward the request for communication to the Chair of the MSHA Board. The CEO will also provide notification to the MEC by informing the President of the Medical Staff of all such exchanges. The Chair of the MSHA Board will determine the manner and method of the MSHA Board’s response to the Medical Staff member(s).
ARTICLE 11

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the MSHA Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

April 1, 2014
(Date)  
President of the Medical Staff  
Unicoi County Memorial Hospital

Approved by the MSHA Board:

April 5, 2014
(Date)  
Chair  
MSHA Board of Directors
APPENDIX A

HISTORY AND PHYSICAL EXAMINATIONS

The requirements for completing and documenting medical histories and physical examinations as required by CMS CoP and The Joint Commission Standard MS.01.01.01:

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient’s medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness;
- review of systems;
- personal medical history, including medications and allergies;
- family medical history;
- social history, including any abuse or neglect;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- data reviewed;
- assessments, including problem list;
- plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.
In the case of a pediatric patient, the history and physical examination report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(b) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient’s medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record.

(3) The update of the history and physical examination must (i) reflect any changes in the patient’s condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient’s condition.

(c) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until a complete history and physical examination is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record a complete history and physical, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient’s heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a full history and physical examination.
(d) **Short Stay Documentation Requirements**

For ambulatory or same day procedures, a Short Stay History and Physical Form, approved by the MEC, may be utilized. These forms shall document the chief complaint or reason for the procedure, the relevant history of the present illness or injury, and the patient’s current clinical condition/physical findings.