NON DISCRIMINATION STATEMENT

In compliance with all applicable state and federal law, including the provisions of Sections 503 and 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, Vanderbilt University Medical Center does not discriminate on the basis of race, sex, religion, color, national or ethnic origin, age, disability, veteran status, or genetic information, or any other characteristic in its administration of policies, programs, or employment. In addition, Vanderbilt University Medical Center does not discriminate against individuals on the basis of their sexual orientation, gender identity, or gender expression. Inquiries of complaints should be directed to the Vanderbilt University Medical Center EEOC Office.
# Table of Contents

- **ARTICLE I. NAME** .........................................................................................................................5
- **ARTICLE II. PURPOSES AND RESPONSIBILITIES** .................................................................5
  2.1. PURPOSES ............................................................................................................................5
  2.2. RESPONSIBILITIES .............................................................................................................6
- **ARTICLE III. APPOINTMENT AND REAPPOINTMENT** .........................................................7
  3.1. NATURE OF MEDICAL STAFF MEMBERSHIP ...........................................................7
  3.2. GENERAL QUALIFICATIONS FOR APPOINTMENT/REAPPOINTMENT ..............................7
  3.3. PRE-APPLICATION PROCEDURES .................................................................................10
  3.4. APPLICATION FOR INITIAL APPOINTMENT ....................................................................11
  3.5. PROCESSING THE APPLICATION .....................................................................................14
  3.6. PROCESS FOR REVIEW/APPROVAL ..................................................................................17
  3.7. BASIC OBLIGATIONS ACCOMPANYING MEDICAL STAFF APPOINTMENT .....................21
  3.8. TERM OF APPOINTMENT ....................................................................................................22
  3.9. REAPPOINTMENT .............................................................................................................22
  3.10. LEAVE OF ABSENCE (LOA) ..........................................................................................26
  3.11. REINSTATEMENT OF CLINICAL PRIVILEGES AFTER LEAVE OF ABSENCE ..................26
- **ARTICLE IV. CLINICAL PRIVILEGES** .....................................................................................28
  4.1. GENERAL PRIVILEGES ......................................................................................................28
  4.2. LOCUM TENENS PRIVILEGES .........................................................................................30
  4.3. LEAVE OF ABSENCE FROM PRIVILEGES ......................................................................31
  4.4. TEMPORARY PRIVILEGES ..............................................................................................31
  4.5. CONSULTING/SINGLE CASE PRIVILEGES ....................................................................32
  4.6. TRAINING PRIVILEGES ....................................................................................................33
  4.7. DISASTER PRIVILEGES .....................................................................................................33
- **ARTICLE V. CATEGORIES OF THE MEDICAL STAFF** ..............................................................34
  5.1. CATEGORIES .......................................................................................................................34
  5.2. GENERAL QUALIFICATIONS FOR ALL CATEGORIES: ....................................................34
  5.3. ACTIVE ...............................................................................................................................35
  5.4. ACTIVE OFFSITE ...............................................................................................................36
  5.5. ADMINISTRATIVE .............................................................................................................36
  5.6. AFFILIATE ..........................................................................................................................37
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.7</td>
<td>MILITARY SURGEON TRAINEE</td>
<td>38</td>
</tr>
<tr>
<td>5.8</td>
<td>REFER AND FOLLOW</td>
<td>39</td>
</tr>
<tr>
<td>5.9</td>
<td>EMERITUS</td>
<td>40</td>
</tr>
<tr>
<td>5.10</td>
<td>REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>ARTICLE VI. PROFESSIONAL STAFF WITH PRIVILEGES AND ALLIED HEALTH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PRACTITIONERS</td>
<td>40</td>
</tr>
<tr>
<td>6.1</td>
<td>DESCRIPTION</td>
<td>40</td>
</tr>
<tr>
<td>6.2</td>
<td>CATEGORIES</td>
<td>41</td>
</tr>
<tr>
<td>6.3</td>
<td>PROFESSIONAL STAFF WITH PRIVILEGES</td>
<td>41</td>
</tr>
<tr>
<td>6.4</td>
<td>ALLIED HEALTH PRACTITIONIANS</td>
<td>49</td>
</tr>
<tr>
<td>6.5</td>
<td>DELEGATED CREDENTIALING OF ALLIED HEALTH PRACTITIONIERS FOR HEALTH PLANS</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>ARTICLE VII. CLINICAL SERVICES</td>
<td>54</td>
</tr>
<tr>
<td>7.1</td>
<td>DESIGNATION</td>
<td>54</td>
</tr>
<tr>
<td>7.2</td>
<td>REQUIREMENTS FOR AFFILIATION WITH SERVICES</td>
<td>55</td>
</tr>
<tr>
<td>7.3</td>
<td>FUNCTIONS OF CLINICAL SERVICES</td>
<td>55</td>
</tr>
<tr>
<td>7.4</td>
<td>CLINICAL SERVICE CHIEF</td>
<td>56</td>
</tr>
<tr>
<td></td>
<td>ARTICLE VIII. OFFICERS OF THE MEDICAL STAFF</td>
<td>58</td>
</tr>
<tr>
<td>8.1</td>
<td>THE OFFICERS OF THE MEDICAL STAFF</td>
<td>58</td>
</tr>
<tr>
<td>8.2</td>
<td>DUTIES OF OFFICERS</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>ARTICLE IX. FUNCTIONS AND COMMITTEES</td>
<td>59</td>
</tr>
<tr>
<td>9.1</td>
<td>ROLE AND FUNCTION OF COMMITTEES</td>
<td>59</td>
</tr>
<tr>
<td>9.2</td>
<td>MEDICAL CENTER MEDICAL BOARD</td>
<td>60</td>
</tr>
<tr>
<td>9.3</td>
<td>STANDING COMMITTEES</td>
<td>63</td>
</tr>
<tr>
<td>9.4</td>
<td>SUBCOMMITTEE</td>
<td>66</td>
</tr>
<tr>
<td>9.5</td>
<td>AD HOC COMMITTEES</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>ARTICLE X. MEETINGS</td>
<td>66</td>
</tr>
<tr>
<td>10.1</td>
<td>REGULAR MEETINGS</td>
<td>66</td>
</tr>
<tr>
<td>10.2</td>
<td>SPECIAL MEETINGS</td>
<td>67</td>
</tr>
<tr>
<td>10.3</td>
<td>SERVICE MEETINGS</td>
<td>67</td>
</tr>
<tr>
<td>10.4</td>
<td>MEETING PROCEDURES</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>ARTICLE XI. MEDICAL STAFF MEMBERSHIP CONSIDERATIONS</td>
<td>68</td>
</tr>
<tr>
<td>11.1</td>
<td>MEDICAL STAFF OBLIGATION</td>
<td>68</td>
</tr>
<tr>
<td>11.2</td>
<td>APPLICABILITY FOR CERTAIN PROCESSES</td>
<td>68</td>
</tr>
<tr>
<td>11.3</td>
<td>SPECIAL CONSIDERATION FOR MEDICAL STAFF LEADERSHIP</td>
<td>68</td>
</tr>
</tbody>
</table>
18.3. RULES AND REGULATIONS AND POLICIES AND PROCEDURES ..........88
18.4. DISPUTE RESOLUTION PROCESS .........................................................89
ARTICLE XIX. ADOPTION .............................................................................89
BYLAWS OF THE MEDICAL STAFF OF 
VANDERBILT UNIVERSITY MEDICAL 
CENTER

PREAMBLE

WHEREAS, The Vanderbilt University Medical Center is a not for profit 
corporation organized under the laws of the State of Tennessee; and whereas one of its 
activities is to operate acute care hospitals and clinics providing patient care, education 
and research and whereas it is recognized that the Medical Staff is responsible for the 
quality of medical care in all patient care areas of the Vanderbilt University Medical 
Center and must accept and discharge this responsibility to fulfill the Medical Center’s 
obligations to its patients, subject to the ultimate authority of The Vanderbilt University 
Medical Center Board; and whereas it is recognized that this responsibility must be 
carried out with the cooperative efforts of the Medical Staff, the Chiefs of Staff of the 
hospitals, the Chief Executive Officers of the hospitals, the Deputy Chief Executive 
Officer of the hospitals, and the Vanderbilt University Medical Center Board of Directors;

NOW, THEREFORE, these Bylaws shall serve as the charter for the creation of 
the Vanderbilt University Medical Center Medical Staff, shall define its organizational 
structure, governance and objectives, and set forth the eligibility criteria required for 
Membership as well as the obligations of each Member. The Physicians and Dentists 
practicing at Vanderbilt University Medical Center hereby organize themselves into a 
Medical Staff in conformity with these Bylaws.
DEFINITIONS

1. **Chief Executive Officer** means the chief administrative officer of the Vanderbilt University Medical Center to whom the Deputy Chief Executive Officer reports. The Chief Executive Officer reports to the Board.

2. **Chief Medical Officer** means the senior administrative officers of the Vanderbilt Medical Group who supervise operations of The Vanderbilt Clinics. The Chief Medical Officers report to the Deputy Chief Executive Officer.

3. **Clinical Service Chief** means each of those individuals appointed upon recommendation of the Chief Executive Officer to serve as the administrator over each individual clinical service designated in Article VII of these Bylaws.

4. **Chief of Staff** means each of those individuals appointed by the Deputy Chief Executive Officer to serve as the liaison between the Medical Center and Medical Staff, responsible for administration of the Medical Staff Bylaws and the Quality Assessment and Improvement activities of Vanderbilt University Medical Center (VUMC). Chiefs of Staff include the Chief of Clinical Staff – Vanderbilt University Medical Center who reports directly to the Deputy Chief Executive Officer and to whom the Chiefs of Staff of the respective hospitals (VUH, MCJCHV and VPH) report.

5. **Chief of Clinical Staff – VUMC** means the individual who oversees all Chief of Staff related activities and reports to the Deputy Chief Executive Officer.

6. **Credentials Committee** means a committee of the Medical Center Medical Board primarily responsible for peer review of all applicants seeking appointment or reappointment to Membership on the Medical/Professional Staff and/or clinical privileges or changes to clinical privileges to practice at VUMC.

7. **Deputy Chief Executive Officer** means the individual appointed by the Chief Executive Officer to be responsible for clinical affairs, performance improvement, and business development for Vanderbilt University Medical Center. This individual reports directly to the Chief Executive Officer. The Chief Executive Officers of each of the VUMC hospitals report to the Deputy Chief Executive Officer.

8. **Division** means a separate organizational component of the Vanderbilt University Medical Center established to be in general concordance with the clinical departments of the School of Medicine.
9. **Executive Committee** means the Executive Committee of the Medical Center Medical Board that is empowered to act on behalf of the Medical Center Medical Board.

10. **Ex-Officio** means a position by virtue of office and is without voting power unless otherwise stated.

11. **Governing Body** means the Vanderbilt University Medical Center Board of Directors (hereafter called the “VUMC Board”).

12. **House Staff** means all residents and clinical fellows who are in a postgraduate training program administered by the ACGME and must only function under the supervision of a Member of the Medical Staff who holds a faculty appointment with the School of Medicine.

13. **Locum Tenens** means a physician who provides services as a substitute for, and under the name of, an existing Medical Staff Member during a limited period of time (a maximum period of sixty (60) days for reimbursement purposes) during which the existing Medical Staff Member is absent or unable to provide some or all of the services that the existing Medical Staff Member normally would provide.

14. **Vanderbilt University Medical Center Board of Directors ("VUMC Board")** is responsible for certain matters relating to Vanderbilt University Medical Center as set forth in its Bylaws. It assists Vanderbilt University Medical Center in complying with the standards of The Joint Commission and is charged with approving the VUMC Medical Staff Bylaws, Rules, and Regulations and Policies and Procedures.

15. **Medical Center Medical Board (MCMB)** means the board of the Medical Staff with representation from all Clinical Services, and Vanderbilt University Medical Center Administration.

16. **Medical Staff** means all duly licensed medical physicians and dentists who have an academic appointment in the Vanderbilt University School of Medicine, and are clinically privileged to attend patients in the Vanderbilt University Hospital, the Vanderbilt Children’s Hospital, the Vanderbilt Psychiatric Hospital and Vanderbilt Clinics, as permitted by Medical Staff category and individual clinical privileges.

17. **Physician** means an appropriately licensed medical physician with a license to practice in accordance with the laws of the State of Tennessee, or an appropriately licensed dentist.
18. **Professional Staff with Privileges** means non-Medical Staff clinical professionals who are granted clinical privileges to provide direct patient care to patients of VUMC, exercising independent judgment within specific documented areas of professional competence, under a defined degree of supervision by a Member(s) of the Medical Staff consistent with applicable law.

19. **Provider Support Services** means the office that processes applications for Membership on the Medical/Professional Staff and applications and requests pertaining to clinical privileges, facilitates meetings of the Medical Center Medical Board, its committees, Executive Committee and otherwise provides support to the Medical/Professional Staff.

20. **Service** means each of the clinical service functions designated in Article VII of these Bylaws.

21. **Vanderbilt University Medical Center** (also referred to herein as “VUMC”) means all clinical areas of the Vanderbilt University Hospital, Monroe Carell Jr Children’s Hospital at Vanderbilt, the Vanderbilt Psychiatric Hospital, the Vanderbilt Medical Group and the Vanderbilt Clinic(s).
ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the Vanderbilt University Medical Center, which is hereinafter referred to as the “Medical Staff.” Vanderbilt University Medical Center is hereinafter referred to as “VUMC”.

ARTICLE II. PURPOSES AND RESPONSIBILITIES

The purposes of the Medical Staff are:

2.1.1. To be the organizational structure through which individual Physicians may be appointed to the Medical Staff, and fulfill the obligations of such appointment; and,

2.1.2. To serve as the primary mechanism for accountability to the VUMC Board, and/or its representatives for the appropriateness of professional performance and ethical conduct in patient care, teaching and research activities of each of its Members: and,

2.1.3. To provide patient care at VUMC at a level of quality and efficiency that is at least consistent with generally recognized standards of care; and,

2.1.4. To provide leadership in connection with medical education, house staff and Professional Staff with Privileges supervision, patient safety activities and oversight of processes for improving patient satisfaction; and,

2.1.5. To establish an appropriate level of professional performance of all licensed Physicians and Professional Staff with Privileges who practice at VUMC through appropriate peer review of performance; and,

2.1.6. To support appropriate standards for medical education as defined through the Academic Affiliation Agreement and in collaboration with the Vanderbilt University School of Medicine; and,

2.1.7. To establish and maintain rules and regulations for the conduct of the medical/professional staff; and,

2.1.8. To provide an orderly means by which Physicians and Professional Staff with Privileges can provide input to the Chiefs of Staff, the Chief Executive Officers of the hospitals, the Chief Executive Officer and the Deputy Chief Executive Officer, and the VUMC Board, and to provide a means of communication among these groups; and,

2.1.9. To support, in consonance with sound medical judgment, the rights of all patients of VUMC to equitable and humane treatment, particularly regarding privacy, dignity, confidentiality and open communication with those responsible for their medical care.
2.2. RESPONSIBILITIES

To accomplish the purposes enumerated above, the responsibilities of the Medical Staff include:

2.2.1. Participation in VUMC quality review and utilization management programs by engaging in activities to assess, maintain, and improve the quality and efficiency of medical care provided at VUMC, including without limitation:

A. Evaluating Physician, Professional Staff with Privileges and institutional performance through valid and reliable measurement systems based on objective, clinically-sound criteria;
B. Engaging in the ongoing monitoring of patient care practices;
C. Evaluating credentials for appointment and reappointment to the Medical/Professional Staff and for the delineation of clinical privileges that may be exercised by each individual Member of the Medical/Professional Staff;
D. Promoting appropriate use of VUMC resources in order to most efficiently meet patients’ medical, emotional, and social needs, consistent with sound health care resource utilization practice

2.2.2. Making recommendations concerning appointments and reappointments to the Medical/Professional Staff, and other clinical matters as appropriate.

2.2.3. Participation in the development, conduct of, and monitoring of medical education and training programs as well as clinical and laboratory research activities as appropriate.

2.2.4. To provide supervision and oversight of House staff, Professional Staff with Privileges, and other clinical professionals and,

2.2.5. Maintenance of Bylaws and policies that are consistent with sound professional practices, organizational principles, and regulatory and accreditation requirements.

2.2.6. Participation in VUMC’s long-range planning activities, identification of community health needs, and participation in developing and implementing appropriate institutional policies and programs to meet those needs.

2.2.7. Exercise of, through its officers, committee and other defined organizational components, the authority granted by these Bylaws in order to further the purposes and fulfill the responsibilities in this section and section 2.1 above in a timely manner and proper manner and to report to the VUMC Board.
ARTICLE III. APPOINTMENT AND REAPPOINTMENTvi

3.1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff is a privilege that is extended only to professionally competent Physicians who continuously meet the qualifications, obligations, responsibilities, standards and requirements stated in these Bylaws. Membership implies active participation in Medical Staff activities to an extent commensurate with the exercise of a Medical Staff Member’s staff category and clinical privileges, and as may otherwise be required by the Medical Staff Member’s clinical service.

3.2. GENERAL QUALIFICATIONS FOR APPOINTMENT/REAPPOINTMENT

Every Physician who applies for initial appointment to the Medical Staff or has an appointment, must, at the time of application and continuously thereafter, demonstrate to the satisfaction of the appropriate authorities of the Medical Staff and the VUMC Board the following qualifications and any additional qualifications and procedural requirements as are set forth in other sections of these Bylaws or in the Medical Staff Rules and Regulations and Policies and Procedures.

Applicant must be a salaried employee of Vanderbilt University Medical Center or of an affiliated entity wholly or jointly owned by VUMC or those entities with whom VUMC has entered into a contractual relationship for specific professional services, or alternately, must hold an academic appointment in the Vanderbilt University School of Medicine as specified under the Academic Affiliation Agreementvii.

3.2.1. Licensure: Hold a currently valid unrestricted license, or license of a form acceptable to the MCMB and VUMC Board, issued by the State of Tennessee to practice medicine or teach a new procedure or learn a new technique.

3.2.2. Board Certification: Be Board Certified (or an active candidate/board eligible candidate in the process of obtaining certification in) his/her specialty or related specialty, within the time frame as defined by each applicable U.S. and/or Canadian Board. Board certification and/or active candidacy/eligibility must be with a Member board of the American Board of Medical Specialties (ABMS) and/or American Osteopathic Boards (AOB), or other Boards as approved by MCMB from time to time.

When specialty boards have not established time frames for obtaining initial Board Certification, Certification must be obtained no later than four (4) years from Initial Appointment to the VUMC Medical Staff. When the applicant possesses comparable training, experience and competence but (1) Board Certification was not applicable at the time the applicant’s
training was completed or (2) the applicant is only certified in a non-U.S. or non-Canadian Board or 3) the board certification is in a specialty other than the primary division (department), the applicable Clinical Service Chief may submit a written request for a waiver of this requirement to the Credentials Committee Chair for action by the Credentials Committee with subsequent approval by the MCMB and the VUMC Board. However, Physicians must maintain their Certification by whatever re-certification process is outlined by their applicable Board.

If at the time of reappointment, it is determined a Physician has failed to maintain board certification, the Executive Committee of the MCMB shall consider granting an additional period of time, not to exceed four years (or two reappointment cycles) to obtain board certification.

3.2.3. Professional Education and Training: Be a graduate of an approved school of medicine or osteopathy or certified by the Educational Council for Foreign Medical Graduates; and satisfactory completion of an approved residency. For purposes of this section, an “approved” school is one accredited, throughout the Physician’s attendance, by the Liaison Committee on Medical Education or by the American Osteopathic Association. Additionally, an “approved residency” is one accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada.

3.2.4. Clinical Performance: Possess experience, clinical results and utilization practice patterns, to demonstrate a continuing ability to provide patient care services at an acceptable level of quality and efficiency given the current state of the healing arts and consistent with available resources.

3.2.5. Cooperativeness: Demonstrated ability to work with and relate to other Medical Staff Members, VUMC Administration and staff, the VUMC Board, visitors and the community in the cooperative, professional manner essential for maintaining an environment that is conducive to the provision of quality patient care in an efficient manner.

3.2.6. Satisfaction of Obligations: Demonstrate satisfactory compliance with the obligations accompanying appointment to the Medical Staff as set forth in these Bylaws, Rules and Regulations and Policies and Procedures and equitable participation, as determined by the appropriate Clinical Service Chiefs and the MCMB, in the discharge of Medical Staff obligations specific to the category of appointment.

3.2.7. Professional Ethics and Conduct: Demonstrated moral character and adherence to generally recognized standards of medical and professional ethics. Specifically, but without limitation, this requirement includes
refraining from: paying or accepting commissions or referral fees for professional services referrals; delegating the responsibility for diagnosis and care of patients to a Physician or allied health professional not qualified to undertake that responsibility; failing to seek appropriate consultation when medically indicated; failing to provide or arrange for appropriate and timely medical coverage and care for patients for whom he/she is responsible; failing to obtain required informed consent, and failing to follow appropriate requirements for billing and reimbursement for professional services. All Members of the Medical Staff are expected to fully comply with state and federal laws and accreditation requirements and to adhere to applicable Standards of Conduct as promulgated by Vanderbilt University and Vanderbilt University Medical Center and the Vanderbilt University Medical Center Compliance Program and other corporate integrity programs.

3.2.8. **Abilities:** Have and maintain the ability and qualifications to carry out, in a competent manner, all patient care and other required responsibilities.

3.2.9. **Background Checks:** Membership on the Medical Staff is contingent on a satisfactory background check. VUMC will conduct background checks on all Categories of Medical Staff Membership (as defined in Article V) and Professional Staff with Privileges (as defined in Article VI) in a manner consistent with VUMC policy. Background checks will be conducted upon initial credentialing. However, for those Medical/Professional Staff Members who were admitted to the Medical/Professional Staff prior to the effective date of this requirement, background checks will be performed at re-credentialing of such Medical Staff/Professional Staff with Privileges Members.

3.2.10. **Professional Liability Insurance:** Carry professional liability coverage of a kind and in an amount as established or approved on an annual basis by the VUMC Board in consultation with the Vanderbilt University Medical Center Office of Risk Management and Insurance. Information regarding current insurance requirements is available from Provider Support Services.

3.2.11. **Effects of Other Affiliations:** No Physician shall be automatically entitled to appointment or reappointment or to the exercise of particular clinical privileges merely because the Physician:

A. is licensed to practice in this or in any other state; or
B. is certified by any clinical board; or
C. had, or presently has, staff appointment or privileges at another health care facility or in another practice setting; or
D. had, or presently has, a faculty appointment at Vanderbilt University School of Medicine; or
E. had, or presently has, Medical Staff appointment or those particular privileges at VUMC.

3.2.12. Nondiscrimination: No aspect of Medical Staff appointment or grant of particular clinical privileges shall be denied on the basis of: age; sex; race; creed; national origin; disability; sexual orientation; or type of procedure or patient (e.g. Medicaid) in which a provider specializes, provided a Physician is able to safely fulfill all applicable patient care or Medical Staff responsibilities and obligations. All allegations of discrimination related to appointment or grant of clinical privileges for any of these reasons will be referred to VUMC’s Equal Opportunity Office for investigation in accordance with their policies and procedures. Provider Support Services will additionally conduct an annual audit of VUMC's credentialing and re-credentialing procedures to ensure such procedures are not in violation of this Section, as well as periodic audits of any credentialing denials for potential discriminatory practices.

3.3. PRE-APPLICATION PROCEDURES

3.3.1. Form Preparation: The Executive Committee shall be responsible for developing, reviewing, and recommending any changes or updates to application/reapplication forms, including any application-request forms. All forms and revisions thereto shall be reviewed and approved by the VUMC Board, and shall conform to any applicable federal and state laws and regulations that mandate the use of particular forms or specific content.

3.3.2. Delegated Credentialing: In the event VUMC elects to utilize the credentialing processes contained in these Medical Staff Bylaws in the provision of delegated credentialing functions for designated health plans, VUMC may accept (for this limited purpose) credentialing applications/reapplications using the form provided by the Council on Affordable Quality Healthcare ("CAQH"). In such instance, however, VUMC may request supplemental information/documentation from any such applicant/reapplicant if the CAQH application fails to provide any documentation or information otherwise required by these Bylaws. Further, the CAQH application may only be utilized in the context of delegated health plan credentialing that is undertaken by VUMC pursuant to a formal agreement with such health plan. The CAQH application is not approved for use as an alternative to the forms approved in Section 3.3.1., above, for applications/reapplications for Medical Staff Membership and/or clinical privileges at VUMC.

3.3.3. Request for Application: Any individual seeking initial appointment to the Medical Staff and/or initial clinical privileges (a "pre-applicant") must fully complete and submit a One Packet Request Form to Provider Support Services. Pre-applicants may be administratively denied an application if
it is apparent that the pre-applicant does not meet the basic eligibility requirements for Medical Staff Membership and/or clinical privileges, as applicable. Any pre-applicant denied an application shall receive a written response to his or her request by Special Notice, explaining the general reason(s) for the denial, including any reasons based in whole or in part on the pre-applicant’s qualifications or any other basis, including economic factors and/or need-determinations. Otherwise, the pre-applicant will be provided an application via regular mail or email, as well as a copy of (or alternatively, access to) the Vanderbilt University Medical Center Medical Staff Bylaws, Rules and Regulations, and Policies. VUMC’s provision of an application pursuant to this Section does not, however, preclude a subsequent finding of administrative ineligibility or otherwise in any fashion guarantee that Medical Staff Membership and/or clinical privileges, as applicable, will be granted.

3.4. APPLICATION FOR INITIAL APPOINTMENT

3.4.1. Application Form: Any application for initial appointment must be fully completed, signed, and dated by the pre-applicant, and shall include an accurate and secure email address for VUMC to communicate with the applicant. Once a fully completed, signed, and dated application has been received and accepted by Provider Support Services, along with all required documentation, the pre-applicant shall be considered an applicant.

3.4.2. Content of Application for Initial Appointment: The application for initial appointment form shall include, but not necessarily be limited to, requests for:

A. Information pertaining to professional licensure including a request for information regarding previously successful or currently pending challenges, if any, to any licensure or registration or the voluntary or involuntary relinquishment of same;
B. DEA certification (if all six (6) schedules are not included, then written explanation of omission must be appended);
C. Professional education, training, and experience;
D. Information pertaining to malpractice coverage and claims history;
E. Health status relative to ability to perform privileges requested;
F. Information pertaining to hospital and practice affiliations including a request for information regarding voluntary or involuntary limitation, reduction, or loss or clinical privileges, or termination at any other healthcare institution or organization;
G. Membership in professional societies;
H. Peer recommendations;
I. Professional work history as a health professional during the past seven years or from date of pertinent licensure, whichever period is longer;
J. Request for clinical privileges;
K. Release form and attestations; and
L. HCFA Attestation Statement.

3.4.3. **Attachments to Application for Initial Appointment:** In addition to returning a signed, dated, and fully completed application, initial applicants are responsible for providing the following:

A. Copy of Board Certification certificate, if applicable;
B. Current and dated curriculum vitae (month/year format) outlining education and practice history with written explanations of gaps greater than thirty (30) days;
C. Copy of certificate evidencing professional liability insurance coverage; and
D. Any additional information required in response to questions on the application form.

3.4.4. **Nature of the Application/Attestations:** Upon signing and dating the application, applicants:

A. Attest to their qualifications to perform the clinical privileges requested;
B. Signify that they have read the Vanderbilt University Medical Center Bylaws, Rules, Regulations, and Policies and Procedures of the Medical Staff and agree to be bound by their provisions;
C. Agree to provide for continuous patient care within their professional scope of practice, licensure and/or certification, and subject to those clinical privileges that are granted to the applicant by VUMC;
D. Attest that the application is accurate and complete and that all credentialing bodies will be promptly and fully informed of any and all changes;
E. Signify their willingness to appear for interviews requested in regard to their application;
F. Signify their willingness to promptly provide any additional documentation and/or supplementary information that is requested in regard to their application;
G. Attest to the accuracy and security of the email address provided by the applicant to Provider Support Services on (or attendant to) the application, signify their willingness to ensure that this email address is updated as necessary by the applicant in order to ensure ongoing accuracy, and signify that the applicant is agreeable to receiving all notices and communications required or contemplated by these Bylaws via email (unless these Bylaws provide otherwise);
H. Provide supervision and oversight of VUMC staff and others for whom they have responsibility; and
I. Adhere to Vanderbilt University Medical Center Policies and Procedures for compliance.

3.4.5. Releases/Authorizations: By applying for Medical Staff Membership and/or clinical privileges, and by signing the application, each applicant agrees to fully release, discharge, and not initiate (or cause to be initiated) any claim, complaint, or request for damages or other relief against Vanderbilt University Medical Center, its employees, agents, Board of Directors, Medical Staff, Medical Staff Members, committees, and their representatives, resulting from any act or omission performed (or not performed) in good faith and in connection with, or otherwise related to, the evaluation of, and any communications and determinations made regarding, the applicant’s application or qualifications to obtain, or maintain, Medical Staff Membership and/or clinical privileges at VUMC. In addition, applicant:

A. Authorizes Vanderbilt University Medical Center and its representatives to review all records and documents they may deem material to the evaluation of applicant’s professional competence and other qualifications, including physical and mental health status, and professional and ethical qualifications;
B. Releases from any and all liability all individuals and organizations who provide requested information to Vanderbilt University Medical Center or its representatives concerning his or her competence, professional ethics, character, physical and mental health, quality of care, and other qualifications; and
C. Authorizes and consents to Vanderbilt University Medical Center representatives providing other organizations, including other healthcare facilities, managed care organizations, government payers, private payers, surveyors, and auditors, information concerning his/her professional competence, job duties, ethics, character and other qualifications, as necessary to complete accreditation, delegated credentialing functions, contracting, billing, and/or utilization review activities, or as otherwise permitted or required by law.

3.4.6. Continuing Duties of Applicants: It shall be a continuing duty on the part of all applicants to promptly update application information on an ongoing basis. This information shall include but not be limited to the following:

A. Voluntary or involuntary termination of appointment, limitation or reduction, or loss of privileges at any hospital, healthcare organization, or managed care organization, or any restriction of practice or severance from employment by a medical practice;
B. Any investigations, charges, limitations or revocation of professional license in the State of Tennessee or any other state;

C. Any investigations, charges, limitations, or corrective action by any professional organization;

D. Changes in physical or mental health which effect ability to practice medicine;

E. Any investigations, convictions, arrests, or charges related to any crime (other than minor traffic violations), including crimes involving child abuse;

F. Any "quality query" from any qualified peer review organization, or its equivalent;

G. Any investigations regarding reimbursement or billing practices;

H. Any professional investigations or sanctions including but not limited to Medicare or Medicaid/TennCare sanctions;

I. Notification of cancellation or proposed cancellation of professional liability insurance; and

J. Disclosure and updates of malpractice claims or other actions initiated or made known subsequent to appointment. Information should contain case number, style of case (i.e., Joe Jones on Behalf of the Estate of Jennie Jones vs. John Doe, M. D., Paul Doctor, M. D., and St. Martin's General Hospital), county in which the case is filed, patient's name, nature and summary of the action, and the name, address, and telephone number of the practitioner's attorney.

3.5. PROCESSING THE APPLICATION

3.5.1. Responsibility of Applicant: The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, ability to work with other professionals and non-professionals in the hospital, and other qualifications, and for resolving any doubts about such qualifications. The Physician has the right to review any and all information that he/she has provided in support of his/her application. Falsification of a Medical Staff application shall be grounds for denial of appointment or reappointment to the Medical Staff and/or termination of Membership and clinical privileges, as applicable.

3.5.2. Completion of Application: Upon receipt of an application, Provider Support Services will review the application for completeness. If the application is incomplete, the Physician will be notified in writing outlining the deficiencies in the submitted application.

A. Delegated Credentialing: In the event VUMC elects to utilize the credentialing processes contained in these Medical Staff Bylaws in the provision of delegated credentialing functions for designated health plans, Provider Support Services will notify any such initial applicant within five (5) business days of receiving an application
whether the application received is complete or incomplete. If the application is incomplete and the Physician responds with supplemental documentation/information, then upon receipt of all such responsive documentation/information, Provider Support Services will again notify any such initial applicant within five (5) business days regarding whether the application is complete or incomplete.

3.5.3. Verification of Information: Upon receipt of a complete application, Provider Support Services shall be responsible for verifying the information outlined below:

A. Verification of Tennessee license directly with the State Licensing Board, and other state licenses by receipt of information from either the appropriate State Licensing Board or the Federation of State Medical Boards;

B. Verification of graduation from medical school from the pertinent school, ECFMG, AMA or National Student Clearinghouse;

C. Verification of postgraduate professional training from the pertinent training program or AMA;

D. Verification of board certification through the use of the Directory of the American Board of Medical Specialties, directly from the appropriate specialty board by way of an appropriate electronic subscription service approved for primary source verification;

E. Verification and status of past and current hospital affiliations from pertinent hospital or through its official electronic query system;

F. Verification of work history as a health professional during the past seven years or from date of pertinent licensure, whichever period is longer, from those pertinent sources identified in the applicant’s curriculum vitae and/or application;

G. Current and past malpractice insurance information concerning coverage, claims, suits, and settlements during the past five years from malpractice carriers and National Practitioner Data Bank;

H. Information from the National Practitioner Data Bank;

I. Evidence of Medicare/Medicaid/TennCare Sanctions or investigations from both the Office of Inspector General and Excluded Parties Listing System websites;

J. Three peer references who are able to provide information, utilizing VUMC’s approved form(s), about the initial applicant’s current clinical competence, relationship with colleagues, and conduct (peer references must be from individuals practicing in a field similar to the applicant who are not family Members or current practice partners); alternatively, for reapplicants, a single peer recommendation, utilizing VUMC’s approved form(s) may be accepted/verified if the recommendation is based upon Ongoing
Professional Practice Evaluation data generated through VUMC’s process for OPPE; and

K. Any other relevant information requested from any person, organization, or society that has knowledge of the applicant’s clinical ability, ethical character, and ability to work with others. Sources for such verification may include the pertinent program director, department chair at primary hospital, peer evaluations, and/or other appropriate source depending on the nature of the information requested.

The above information may be obtained either in writing or verbally. If the information is obtained verbally, the person making the verification shall document in the practitioner's file the date, the person he/she spoke with, the status of affiliation or licensure, issuance and expiration dates where applicable, and the information provided. All information verified and included in the Physician’s credentials file shall be no more than 120 days old at the time of the final credentialing decision.

3.5.4. Inability to Obtain Information:

A. In the event that there is a delay in obtaining any required information outlined in Sections 3.4.2 and 3.5.3., above, or if clarification of information is needed, the applicant will be notified and informed of his/her responsibility to obtain the necessary information. Failure of the applicant to adequately respond to a request for the required information within thirty (30) days will result in discontinuance of the application process. The applicant shall be notified in writing, by certified mail that the application will be presented for withdrawal at the next regularly scheduled meeting of the Credentials Committee. This is an administrative action and shall not constitute an adverse action pursuant to the Vanderbilt University Medical Center Medical Staff Bylaws.

B. In the event Provider Support Services discovers, through the verification process, that a particular entity identified on the application has closed or otherwise ceased operations, the applicant shall be notified of this finding and shall assist Provider Support Services, to the extent reasonably possible, in obtaining the requested (or equivalent) information. If despite due diligence the verification remains outstanding, the verification will be deemed complete, and the file will be presented to the Clinical Service for review as outlined in Section 3.6.1., below, with the unverified item noted.

3.5.5. Applicant's Rights Regarding Information: Applicants shall be advised of the rights set forth below by way of receiving a copy of, or access to, the VUMC Medical Staff Bylaws, Rules and Regulations, and Policies:
A. The applicant has the right review information obtained from outside sources to support the applicant's credentialing application. However, as an exception to the foregoing right, the applicant shall not be entitled to review references, recommendations, or peer review/quality improvement protected documentation or information that is obtained in connection with an application.

B. The applicant has the right to correct erroneous (not falsified) information within the timeframes for processing the application that are established by these Bylaws. An applicant must correct erroneous information by way of written submission directed to Provider Support Services.

C. The applicant has the right, upon request, to be informed of the status of their credentialing application.

3.6. PROCESS FOR REVIEW/APPROVAL

All applications will be reviewed as outlined below:

3.6.1. Clinical Service Review: Once all required application documentation has been received and processed, and all verifications and references confirmed, the Chief of the applicable Service or Division shall then review the application. If the Chief of the applicable Service or Division is not available to review the application due to a conflict of interest, then the Chief of Staff, Chair of the Credentials Committee, and/or Chief Medical Officer may review the application. Any such reviewer (in the reviewer's complete discretion) may request an in-person interview with the applicant, and/or may request the applicant provide additional information or documentation deemed necessary for evaluation of the application. Upon completion of the review, the Clinical Service or Division Chief (or the alternate reviewer(s), if applicable), shall make a recommendation to the Credentials Committee regarding the approval or denial of the Medical Staff Membership, Medical Staff category, and clinical privileges sought by the applicant.

3.6.2. Credentials Committee Review: Following the Clinical Service review, Provider Support Services shall transmit the application, as well as the Clinical Service recommendation, to the Credentials Committee for a studied and thoughtful evaluation. The Credentials Committee may or may not, in its complete discretion, require the applicant to appear for an in-person interview and/or to provide additional information or documentation deemed by the Credentials Committee to be necessary for its evaluation of the application. Within thirty (30) days after receiving a complete application, and unless additional time is reasonably required in the discretion of the Credentials Committee to fully evaluate the application, the Credentials Committee shall reach a recommendation consistent with the procedures set forth below:
A. **Non-Issue Applications**: In the event the Credentials Committee determines that the applicant has submitted a "Non-Issue Application" and thus free from any concerns or circumstances noted in Section 3.6.2.B., below, and if the Credentials Committee determines that the application should be approved in all respects, the Credentials Committee shall forward its recommendation to the VUMC Board for expedited review and final determination, as set forth in Section 3.6.2.A., below.

B. **Issue Applications**: In the event the Credentials Committee determines that any of the following circumstances are present, the Credentials Committee shall treat the application as an "Issue Application" and shall forward its findings and recommendation(s) to the Executive Committee for review and final recommendation, as set forth in Section 3.6.3., below:

i. The Clinical Services has recommended denial, in full or in part, of the application (irrespective of the final recommendation from Credentials Committee);

ii. The Credentials Committee recommends denial, in full or in part, of the application (irrespective of the recommendation received from the Clinical Service);

iii. There is evidence of a current challenge or a previously successful challenge to licensure or registration (as applicable);

iv. There is evidence of applicant previously receiving an involuntary limitation, reduction, denial, or loss of clinical privileges at VUMC or at another hospital or facility;

v. There is evidence of applicant previously receiving an involuntary termination of Medical Staff Membership at VUMC or at another hospital or facility; and/or

vi. There is evidence of an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against, or settlement on behalf of, the applicant.

Additionally, if the Credentials Committee determines that an application is incomplete, it shall not treat the application as a Non-Issue Application. Rather, in such event, the Credentials Committee may request the necessary documentation/ information directly from the applicant, and/or may return the application to Provider Support Services with instructions to address the incomplete nature of the application.

3.6.3. **Executive Committee of the MCMB**: Following the Credentials Committee review, Provider Support Services shall transmit all Issue Applications to the Executive Committee for further evaluation. The Executive Committee may or may not, in its complete discretion, require the applicant to appear for an in-person interview and/or to provide additional information or documentation deemed by the Executive Committee to be necessary for
its evaluation of the application. If the Executive Committee determines that an application is incomplete, the Executive Committee may request the necessary documentation/information directly from the applicant, and/or may return the application to Provider Support Services with instructions to address the incomplete nature of the application. Within thirty (30) days after receiving a complete application, and unless additional time is reasonably required in the discretion of the Executive Committee to fully evaluate the application, the Executive Committee shall make a recommendation to the VUMC Board regarding the approval or denial of the Medical Staff Membership, Medical Staff category, and clinical privileges sought by the applicant. The Executive Committee shall include, or reference, the prior recommendations made by the Clinical Service and Credentials Committee with respect to the application.

3.6.4. **Adverse Recommendations:** If the recommendation of the Executive Committee (or recommendation of the VUMC Board if first made there) constitutes an "adverse recommendation," as set forth in Section 15.1.2., below, then Special Notice shall be provided to the applicant as required by Section 15.2.1., below, and the applicant shall be entitled to the hearing and appeal rights set forth in Article XV of these Bylaws. The Chief of Staff shall also inform the Chief Executive Officer of the relevant Hospital(s), Chief of Clinical Staff, VUMC, and the VUMC Deputy Chief Executive Officer.

3.6.5. **VUMC Board:** The VUMC Board, upon consideration of the recommendations made by the Medical Staff through the processes set forth in these Bylaws, shall make all final determinations regarding the grant or denial of medical staff Membership and clinical privileges at VUMC. In considering the application, the VUMC Board may or may not, in its complete discretion, require the applicant to appear for an in-person interview and/or to provide additional information or documentation deemed by the VUMC Board to be necessary for its evaluation of the application. If the VUMC Board determines that an application is incomplete, the VUMC Board may request the necessary documentation/information directly from the applicant, and/or may return the application to Provider Support Services with instructions to address the incomplete nature of the application. Within thirty (30) days after receiving a complete application, or (when applicable) in accordance with the hearing and appeal processes set forth in Article XV below, and unless additional time is reasonably required in the discretion of the VUMC Board or its Chairperson to fully evaluate the application, the VUMC Board shall reach a determination consistent with the procedures set forth below:

A. **Non-Issue Applications:** Non-Issue Applications that are forwarded to the VUMC Board by the Credentials Committee with a
recommendation for approval may be considered by the full VUMC Board, or by a sub-committee of the VUMC Board that consists of at least two (2) VUMC Board Members. If the VUMC Board determines that a Non-Issue application should be denied, in full or in part, then the VUMC Board shall provide Special Notice to the applicant as set forth in Section 3.6.6., above. If the VUMC Board determines that an application should be approved, then the VUMC Board shall provide notice to the applicant as set forth in Section 3.6.7., below.

B. Issue Applications: All Issue Applications shall be considered by the full VUMC Board. If the VUMC Board determines that an Issue Application should be denied, despite a favorable initial recommendation from the Executive Committee, the VUMC Board shall provide Special Notice to the applicant as set forth in Section 3.6.6., above. If the VUMC Board determines that an Issue Application should be approved, then the VUMC Board shall provide notice to the applicant as set forth in Section 3.6.7., below, or as otherwise may be required (if applicable) in accordance with the hearing and appeal processes set forth in Article XV, below.

3.6.6. Notification to Applicant: The applicant will receive written notification of his/her Medical Staff status and clinical privileges within thirty (30) days of the VUMC Board rendering its decision.

3.6.7. Delegated Credentialing: In the event VUMC elects to utilize the credentialing processes contained in these Medical Staff Bylaws in the provision of delegated credentialing functions for designated health plans, VUMC shall ensure timely completion of the process such that an initial applicant for participation in the designated health plan is notified of the results of the provider’s credentialing application within ninety (90) calendar days after notification to the applicant that his/her application is complete pursuant to Section 3.6.6., above.

3.6.8. Confidentiality: All credentialing-related committees and professional review bodies involved in VUMC’s credentialing and review processes constitute quality improvement/peer review committees pursuant to state and federal law. Accordingly, all credentials files and other information gathered/generated by these committees, and as part of the credentialing process, shall be strictly confidential and privileged to the fullest extent permitted by state and federal law, and shall be securely maintained within Provider Support Service. Access to such information is limited to the following: appropriate Provider Support Services staff, Members of those committees/boards directly involved in credentialing review pursuant to these Bylaws, the VUMC Deputy Chief Executive Officer, Chief Executive Officer of the relevant Hospital(s), the applicable Clinical Service Chief(s), the Chief Medical Officer, VUMC legal counsel, and
those other individuals appropriately authorized to access such information.

3.7. **BASIC OBLIGATIONS ACCOMPANYING MEDICAL STAFF APPOINTMENT**

Each appointee to the Medical Staff, including Physicians exercising temporary privileges regardless of his/her assigned Medical Staff category under the Bylaws, Rules and Regulations and Medical Staff Policies and Procedures, shall:

3.7.1. Provide his/her patients with care at the level of quality and efficiency generally recognized as appropriate at facilities such as VUMC and meet obligations for coverage and on-call responsibilities;

3.7.2. Abide by the Medical Staff Bylaws, Rules and Regulations, related policies and procedures, and all other policies and rules of the Medical Staff, VUMC, and applicable laws, regulations and accreditation standards;

3.7.3. Discharge such Medical Staff, Committee, Service, and VUMC functions for which he/she is responsible by Medical Staff category assignment, appointment, election, or otherwise;

3.7.4. Prepare and complete in a timely fashion all medical records and other required records for each patient he/she admits or in any way provides care to at VUMC;

A. A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring sedation services. The medical history and physical examination must be completed and documented by a Physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with pertinent state and federal law and regulation, and hospital policy.

B. An updated examination of the patient, including any changes in the patient’s condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring sedation services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a Physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with pertinent state and federal law and regulation, and hospital policy.

3.7.5. Provide patient care and interact with Physicians, Medical Staff, House Staff, professional staff, staff, patients and their families and all others in
a manner that does not discriminate on the basis of race, sex, religion, color, national or ethnic origin, disability, sexual orientation, military service, financial status, insurance status, or source of insurance;

3.7.6. Comply with all state and federal (e.g. EMTALA) laws and regulations pertaining to emergency treatment, acceptance, and transfer of patients;

3.7.7. Participate in the Organized Health Care Arrangement that exists due to the clinically integrated care provided by Staff Member and VUMC to patients at VUMC. Abide by VUMC policies and practices, regarding patient confidentiality including without limitation those practices set forth in the VUMC Notice of Privacy Practices, which shall serve as each Medical Staff Member’s Notice of Privacy Practices while the Staff Member is practicing at VUMC as such notice may be amended from time to time;

3.7.8. In the event of an emergency, any Physician is authorized, when better alternative sources of care are not reasonably available, to do everything possible to save a patient’s life or to save a patient from serious harm, to the degree permitted by the Physician’s license but regardless of Service or Division affiliation, staff category or privileges. A Physician exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up care.

Failure to continually satisfy any of these basic obligations constitutes grounds for non-reappointment or other corrective action pursuant to Article XII, XIII and XIV of these Bylaws, below.

3.8. TERM OF APPOINTMENT

3.8.1. Appointments to the Medical Staff and granting of clinical privileges are for a period of up to two (2) years.

3.8.2. Initial appointees to the Medical Staff are subject to a period of Focused Professional Evaluation as set forth in Section 4.1.5., below.

3.9. REAPPOINTMENT

Consistent with Section 3.8, above, the reappointment process shall be performed every twenty-four (24) months. An action, either termination or reappointment, must be rendered at the time of or prior to expiration of the two (2) year appointment cycle. Physicians, whose Board Certification in their area of practice and credentialing has lapsed (as determined by the recertification rules of the relevant Board) at the time of their reappointment cycle, must re-qualify at the next available opportunity or they will be terminated, if they fail to meet this requirement. Applications will be mailed or emailed by Provider Support Services to the reapplicant at least ninety (90) days prior to the appointment expiration date.
Generally, appointments are for a twenty-four (24) month period. An appointment not renewed within this period will automatically terminate as an expiration of appointment. Termination of an appointment in this way does not preclude the submission of a reapplication for Initial Application to re-establish Membership and/or clinical privileges.

3.9.1. **Terms of Reappointment:** Reappointment is not automatic. In addition to demonstrating ongoing compliance with all qualifications for initial appointment, ongoing compliance with the obligations of Medical Staff Membership and clinical privileges, and ongoing compliance with any requirements established from time to time by the MCMB, Executive Committee, and/or VUMC Board, the Member will be evaluated based upon, but not limited to:

A. Current clinical competence;
B. Ability to work with other professionals and others in the Hospital;
C. Information obtained from appropriate licensing boards and the National Practitioner Data Bank;
D. For Physicians who have previously been certified in more than one Board, Physician must maintain Certification in at least one Board relevant to his/her area of practice and credentialing;
E. For Physicians who have been appointed prior to May 16, 2003, based on a waiver of the Board Certification requirement and there have been no lapses in credentialing at VUMC, the applicable Chief of Service may submit a written request for a waiver of this requirement to the Credentials Committee Chairman for action by the Credentials Committee;
F. Professional liability claims and suits;
G. Physical and mental capabilities relative to his/her ability to perform the privileges requested; and
H. Other services and activities related to his/her professional contribution.

3.9.2. **Insufficient Activity for Evaluation:** Reappointment and reappraisal of clinical privileges focuses on a Member's clinical activity and demonstrated clinical competence as it relates to Medical Staff quality monitoring and evaluation activity.

A. A Physician, except a Members of the Emeritus Staff, who has not utilized the Hospital, exercised clinical privileges, and/or has not participated in Medical Staff activities with sufficient frequency to permit meaningful evaluation of the Physician's clinical competency or conduct, or who has otherwise failed to comply with Hospital or Clinical Service requirements in this regard, shall be ineligible for reappointment. As an exception to the foregoing, Physicians who can document admission(s), consultations, or cross coverage
activity may be considered for reappointment. In such instances, objective reports of clinical activity at their primary practice site must be submitted to allow an appropriate evaluation of the physician's request for clinical privileges.

B. Failure to be reappointed as outlined in Section 4.8.2., above, constitutes an administrative action that shall not require reporting to the National Practitioner Data Bank, nor shall it constitute an adverse recommendation as defined in the hearing and appeals procedures set forth in Article XV, below.

3.9.3. The Recredentialing Application: All applicants for reappointment shall have the same responsibilities and obligations set forth in Section 3.4.1., above. Consistent with these requirements and obligations, the applicant is required to return a signed, dated, and fully completed application and request for clinical privileges, which includes an updated, accurate, and secure email address for VUMC to communicate with the applicant, as well as the following:

A. Updated certificate of professional liability coverage;
B. Information pertaining to malpractice claims activity;
C. Work history since initial appointment or previous appointment;
D. Voluntary or involuntary changes in Membership, privileges, or status at other healthcare organizations;
E. Voluntary or involuntary relinquishment of licensure or registration;
F. Peer recommendations;
G. Health status relative to ability to perform the clinical privileges requested;
H. Requested clinical privileges;
I. Attestation statement;
J. Copy of board certificate if certified or recertified during the last two year period;
K. Release of information form; and
L. Any additional information needed to update the original application requirements.

3.9.4. Nature of Application/Attestations: All applicants for reappointment shall have the same continuing duties that are set forth in Section 3.4.4., above.

3.9.5. Releases and Authorizations: All applicants for reappointment shall have the same continuing duties that are set forth in Section 3.4.5., above.

3.9.6. Continuing Duties: All applicants for reappointment shall have the same continuing duties that are set forth in Section 3.4.6., above.

3.9.7. Failure to Return the Reappointment Application: Subject to 3.9.2. and 3.9.3., above, failure to return the application for reappointment (including
the documentation/information set forth in Section 3.9.3., above), before the end of the reappointment period shall be deemed a voluntary resignation from the Medical Staff and the practitioner's Membership and privileges shall lapse at the end of his/her current term. The Physician shall be notified prior to final action by the VUMC Board. This non-renewal shall constitute an administrative action that shall not require reporting to the National Practitioner Data Bank and shall not entitle the Physician to the hearing and appeal rights set forth in Article XV, below.

3.9.8. Reappointment Verification Process: Upon receipt of a completed (signed and dated) application (including the documentation/information set forth in Section 3.9.3., above), Provider Support Services will verify with accepted sources the contents of the application by collecting the following information:

A. Status of all current licensures (including out-of-state) with the appropriate medical board(s);
B. Status of current DEA;
C. Specialty Board status;
D. Status of affiliations with other hospitals or healthcare organizations;
E. Status of Malpractice Claims history for the past five years;
F. Information from the National Practitioner Data Bank; and
G. Medicare/Medicaid/TennCare sanctions and investigations from both the Office of Inspector General and Excluded Parties Listing System websites.

The above information may be obtained either in writing or verbally. If the information is obtained verbally, the person making the verification shall document in the Physician's file the date, the person he/she spoke with, the status of affiliation or licensure, issuance and expiration dates where applicable, and the information provided. All information verified and included in the Physician's credentials file shall be no more than 120 days old at the time of the final credentialing decision.

3.9.9. Inability to Obtain Information: The language set forth in Section 3.5.4., above, regarding inability to obtain information, shall fully apply to applications for reappointment.

A. Delegated Credentialing: In the event VUMC elects to utilize the credentialing processes contained in these Medical Staff Bylaws in the provision of delegated credentialing functions for designated health plans, then notwithstanding any language in these Bylaws to the contrary, the following exceptions may be made for purposes of reappointment:
i. If VUMC is not able to recredential a Physician for participation in the health plan within the two (2) year time period specified in these Bylaws because the Physician is on active military assignment, maternity leave, or sabbatical, Provider Support Services will document such circumstances and shall be permitted an additional sixty (60) days to recredential the Physician upon return to professional practice, as opposed to credentialing the physician as an initial applicant.

ii. Similarly, if VUMC terminates a Physician exclusively for administrative reasons, and not for any reasons related to clinical competency or professional conduct, then VUMC may reinstate the Physician within thirty (30) calendar days of the administrative termination, assuming the Physician otherwise remains fully eligible for the Physician’s appointment, as opposed to credentialing the Physician as an initial applicant.

3.9.10. Reapplicant's Rights Regarding Information: Applicants for reappointment shall have those same rights set forth in Section 3.5.5., above, regarding applications for initial appointment.

3.9.11. Review/Approval Process: The process for review and approval of applications for reappointment shall be the same as that set forth in Section 3.6., above, in regard to applications for initial appointment.

3.9.12. Confidentiality: The language set forth in Section 3.6.8., above, regarding confidentiality, shall fully apply to applications for reappointment.

3.10. LEAVE OF ABSENCE (LOA)

A Member of the Medical Staff who has obtained a LOA pursuant to Part VI, Chapter 4 of the Faculty Manual is also placed on a leave of absence from clinical practice at VUMC when a copy of the approved leave is submitted to the applicable Clinical Service Chief or Chief of Staff with a copy to Provider Support Services by the Physician, the Dean’s office, or the Physician's Clinical Service Chief or Chief of Staff which states the time period of the leave (if known), which generally may not exceed two years (excepting government service.) Such leave of absence is subject to conditions or limitations that the Dean’s office, the Chief of Staff or other VUMC administrator determines to be appropriate. During the leave of absence, the Physician shall not exercise his or her Clinical Privileges, and Medical Staff responsibilities and prerogatives shall be inactive.

3.11. REINSTATEMENT OF CLINICAL PRIVILEGES AFTER LEAVE OF ABSENCE

3.11.1. As soon as practicable before an intended return from leave of absence, a Medical Staff Member shall make written request to the applicable
Chief of Staff and applicable Clinical Service Chief, with a copy to Provider Support Services, for reinstatement of Medical Staff Membership and clinical privileges and shall provide documentation to support his/her request. Upon request, the Medical Staff Member shall provide a summary of relevant clinical and professional activities, if any, undertaken during the leave, as well as any additional information, including medical clearance to return to work if applicable, reasonably necessary to evaluate whether the Medical Staff Member is qualified to resume Medical Staff Membership and privileges. The Clinical Service Chief shall then make a recommendation for review and approval by the Credentials Committee and the MCMB regarding reinstating the returning Physician.

3.11.2. When a leave of absence has been granted for medical reasons, the Physician requesting reinstatement to the Medical Staff following the leave of absence is responsible for providing documentation of medical clearance from his or her treating provider that he or she meets all qualifications, obligations, and responsibilities for Medical Staff appointment and clinical privileges (as applicable) required by these Bylaws. The evidence presented by the Physician shall be reviewed by the appropriate Clinical Service Chief and/or Chief of Staff and presented to the Credentials Committee and the MCMB, who will act on the request.

3.11.3. If the Medical Staff Member’s request for reinstatement is recommended for approval by the Credentials Committee and MCMB, the Medical Staff Member shall be reinstated to Membership on the Medical Staff and his or her Clinical Privileges will be restored for the duration of the existing appointment cycle upon approval by the VUMC Board. If the request for reinstatement is not approved, the Physician may pursue informal problem resolution under Article XIV and as applicable the procedural rights under Article XVII of these Bylaws.

3.11.4. Except as provided in Section 3.9.9.1. (pertaining exclusively to delegated credentialing), in the event that the Medical Staff Member’s current appointment to the Medical Staff expires while the Medical Staff Member is on leave of absence and before the Medical Staff Member is reinstated, the Medical Staff Member must additionally, submit an application for reappointment, which shall be processed as set forth above, in accordance with this Article III.

3.11.5. Except as provided in Section 3.9.9.1. (pertaining exclusively to delegated credentialing), failure without good cause to request reinstatement prior to the expiration of a leave of absence shall constitute voluntary relinquishment of Medical Staff Membership and Clinical Privileges, and in such event, the Medical Staff Member shall not be entitled to the procedural rights under Article XV herein.
ARTICLE IV. CLINICAL PRIVILEGES

4.1. GENERAL PRIVILEGES

Each Medical Staff Member is entitled to exercise only those clinical privileges specifically granted to that Medical Staff Member, which specific privileges may be exercised only at VUMC patient service areas that are otherwise staffed and equipped to safely and appropriately provide the service the Medical Staff Member is privileged to provide. Each patient care setting is approved for certain procedures, treatments and types of care based upon the nature of the procedure, treatment or type of service and the resources necessary to safely and appropriately perform the service within the particular setting.

4.1.1. Basis for Determination of Clinical Privileges: Factors considered in connection with the determination of whether or not to grant clinical privileges include: prior medical education and training, current experience, utilization practice patterns, current ability to carry out all privileges in a competent manner and perform all essential functions associated with such privileges, and demonstrated current competence and judgment as documented and verified in each Physician’s credentials file.

Additional factors that may be used in determining privileges include the need for, and VUMC’s capability to support, the type of privileges being requested by the applicant, the geographic location of the Physician, availability of qualified medical coverage in the absence of the Physician, and an adequate level of professional liability insurance. Where appropriate, review of the records of patients treated by the Physician in other hospitals may also be considered.

4.1.2. Request for Initial Privileges: Every initial application for Medical Staff appointment must contain a request for the specific clinical privileges desired by the applicant. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges requested.

4.1.3. Re-determination of Clinical Privileges: Periodic re-determination of clinical privileges and the increase or curtailment of same in connection with reappraisal, including conclusion of the Focused Professional Evaluation period, or with a requested change in privileges shall be approved by the Executive Committee of the MCMB and the VUMC Board on the recommendations of the Credentials Committee. Such re-determination shall be based on the direct observation of care provided, comprehensive evaluation through ongoing monitoring and mandated peer and service review, review of the records of patients treated, or review of the records of the Medical Staff which document the evaluation of the Physician’s participation in the delivery of medical care. Any
change in clinical privileges shall be approved by the VUMC Board in accordance with the recommendation and review procedures of these Bylaws and Medical Staff Policies and Procedures.

4.1.4. **Request for Modification of Privileges:** A Physician’s request for additional privileges should be made in writing to the appropriate Clinical Service Chief for review and recommendation. The request must be accompanied by appropriate documentation of training and/or experience. If approval of the request is recommended by the applicable Clinical Service Chief, the request will be reviewed by the Credentials Committee, which shall make recommendation to the Executive Committee of the MCMB, which shall make its recommendation and forward it to the VUMC Board for final approval.

4.1.5. **Focused Professional Evaluation:** Initially granted privileges shall be followed by a period of focused professional evaluation in accordance with the Practitioner Performance Review Policy (OP 10-10.05).

For all new privileged providers, the Clinical Service Chief or designee will appoint one or more proctors, who are Active Members of the Medical Staff, to monitor the new providers and to submit a report to the Clinical Service Chief or designee at the end of the initial six (6) month work period. The proctor should be chosen based on (1) their seniority/leadership position in the new provider’s area of practice and (2) the likelihood that the practice pattern of the proctor will overlap with that of the new provider so that there will be an opportunity for personal interaction, sequential care, or procedural assistance. The provider’s privileges list will be made available to the proctor. In preparing the report to the Clinical Service Chief or designee, a proctor may use direct observation, retrospective medical record review, over-reads, procedure/surgery case lists as well as informal interviews with peers, house staff, and/or nursing service personnel to reach a conclusion.

Four (4) months after the provider’s start date, the Provider Support Services Office will send proctoring forms and a reminder to each proctor (copied to the Clinical Service Chief or designee) noting that the proctor’s report is due at six months after the provider’s start date.

The proctor’s report will become a part of the credentials file. The Clinical Service Chief or designee will review the proctor’s report as well as review quality and practice data from the ongoing professional practice review. The Clinical Service Chief or designee’s report will be submitted to the Credentials Committee for review.

4.1.6. **Professional Practice Evaluation:** All credentialed and privileged providers will undergo professional practice evaluation in accordance with the Practitioner Performance Review Policy (OP 10-10.05). Quality
metrics will be continuously collected for all privileged practitioners. Metrics will be summarized, compared to peer metrics, and forwarded to the practitioner’s Clinical Service Chief or designee a minimum of three (3) times during the two (2) year reappointment cycle.

At the Clinical Service Chief or designee’s discretion, related to concerns with a practitioner’s professional practice, the Clinical Service Chief or designee may request a six (6) month, proctor-supervised focused review. The selection and responsibilities of the proctor will be similar in all respects to the proctor selection and responsibilities associated with the focused review of new privileged practitioners. Concerns may be based on quality metrics or any formal and/or informal information brought to the Clinical Service Chief or designee’s attention.

At the time of recredentialing of the practitioner’s privileges, the quality metrics of the previous two (2) years will be collected and compared to peer metrics and made available to the Clinical Service Chief or designee and the Credentials Committee. The Clinical Service Chief or designee’s recommendation for recredentialing will be based on quality metrics and formal and/or information related to the practitioner’s professional performance in the areas of medical judgment, interpersonal skills, communications skills, and professionalism.

4.1.7. Failure to successfully complete a Focused Professional Practice Evaluation period, the initial period or one enacted for cause, may result in corrective action as outlined in Article XIII.

4.2. LOCUM TENENS PRIVILEGES

The duties and other terms and conditions of Locum Tenens privileges are required to be set forth in a written contract between VUMC and the Locum Tenens Status physician, which contract is required to be finalized and fully executed prior to the grant of such privileges. A Locum Tenens physician provides services as a substitute for, and under the name of, an existing Member of the Medical Staff for a limited period of time (a maximum period of sixty (60) days for reimbursement purposes) during which the existing Medical Staff Member is absent or unable to provide some or all of the services he or she would normally provide. A Locum Tenens physician is not an applicant for full Medical Staff Membership. Locum Tenens privileges may be requested by a VUMC Clinical Service Chief that demonstrates an immediate need for coverage by the physician that no current Member of the Medical Staff is able to provide. Locum Tenens privileges may be granted for a maximum of six (6) months upon determination by the appropriate Chief of Staff after verification that the arrangement proposed is in compliance with all current regulatory requirements. A grant of Locum Tenens privileges to any particular individual may be renewed only once.
4.2.1. **Prerogatives and Obligations of Physicians with Locum Tenens Privileges:**

A. Must meet the Clinic Service requirements;
B. May not vote or hold office in the Medical Staff organization;
C. May exercise only those privileges granted to them by the VUMC Board for the specific Service in which they are providing coverage;
D. Are not required to pay dues

4.3. **LEAVE OF ABSENCE FROM PRIVILEGES**

The status of Physicians who are on a leave of absence pursuant to Section 3.10 is Leave of Absence status.

4.3.1. **Prerogatives and Obligations of Physicians on Leave of Absence From Privileges:**

A. Shall not hold clinical privileges to admit, consult, or treat patients at VUMC;
B. Are able to attend meetings of the Medical Staff or Services, but are not eligible to vote at those meetings, or to hold office in the Medical Staff organization;
C. Physicians on Leave of Absence are not required to pay dues; and
D. May attend General Medical Staff meetings and Service meetings, but are not required to do so.

4.4. **TEMPORARY PRIVILEGES**

The applicable Clinical Service Chief may request in writing to the Chief of Staff Temporary Privileges for an applicant who has submitted a complete application and whose privileges are pending. Temporary Privileges may only be granted to those applicants who fulfill an important patient care need that cannot otherwise be met by the existing Members of the Medical Staff, who meet the basic qualifications and obligations, and only when the information available wholly supports a favorable determination regarding the applicant’s qualifications, ability, and judgment to exercise the privileges requested. Temporary Privileges may be granted to a Physician. Any Physician granted Temporary privileges is subject to the Bylaws, Policies and Procedures and Rules and Regulations in all matters relating to his/her activities at VUMC. Temporary Privileges are granted for a maximum period of ninety (90) days.

4.4.1. **Prerogatives of Physicians with Temporary Privileges:**

A. May vote in any committee to which they have been assigned, but may not vote in meetings of the Medical Staff or Clinical Services;
B. May not hold office in the Medical Staff organization;
C. Shall be encouraged to attend general Medical Staff meetings and Service meetings, but are not required to do so; and
D. May exercise such clinical privileges as have been granted by the Clinical Service Chief and Chief of Staff.

4.4.2. Obligations of Physicians with Temporary Privileges:

A. Meet the basic qualifications set forth in Article III and fulfill the responsibilities set forth in Article II;
B. Be located close enough to the Medical Center to provide continuous care to their patients or have coverage relationships approved by the Clinical Service Chief;
C. Pay any dues or fees that may be established by the MCMB; and appear when requested in those situations where a Physician’s patient’s clinical course of treatment is scheduled for case discussion as part of regular or specially convened quality assessment and review activities at a Service or Committee meeting.

4.5. CONSULTING/SINGLE CASE PRIVILEGES

Consulting/Single Case Privileges may be granted to Physicians who have requested privileges for the period of a single patient stay or to evaluate a VUMC patient for purposes of rendering an additional medical opinion regarding treatment options for the patient.

A Physician who is not an applicant for Medical Staff Membership may be granted Consulting/Single Case Privileges upon approval by the applicable Clinical Service Chief or designee, if in order to fulfill an important patient care need, it is necessary for the Physician, who possesses a specific skill needed by a specific patient, to provide care for the specific patient, or to fulfill a special request to render an additional medical opinion. Consulting/Single Case Privileges shall not exceed the length of stay of the specific patient. A physician may be granted Consulting/Single Case Privileges under this section for no more than two patients in a twelve-month period.

4.5.1. Prerogatives of Physicians with Consulting/Single Case Privileges:

A. May not hold office in the Medical Staff organization;
B. May exercise only those privileges granted to them by the VUMC Board for the specific patients requested.
C. Are not required to pay dues.
4.5.2. Obligations of Physicians with Consulting/Single Case Privileges:

A. Comply with all applicable provisions of these Bylaws and with VUMC policies and procedures while providing care to VUMC patients.

B. Must arrange appropriate coverage to meet the needs of their patients when they are unavailable or at distance from VUMC. This coverage must be arranged in advance.

4.6. TRAINING PRIVILEGES

A Physician who is not an applicant for Medical Staff Membership may be granted Training Privileges with approval of the applicable Clinical Service Chief or designee upon request by the Physician for a specific training opportunity or in order to fulfill an educational need as requested by the Clinical Service Chief. Training Privileges shall not exceed five (5) days or the length of the course of training as determined by the Clinical Service Chief.

4.6.1. Prerogatives and Obligations of Physicians with Training Privileges:

Single Case Medical Staff appointees:

A. May attend General Medical Staff Meetings and Service meetings, but are not required to do so;

B. May not hold office in the Medical Staff organization;

C. May exercise only those privileges granted to them by the VUMC Board for the training.

D. Are not required to pay dues.

E. Must comply with all applicable provisions of these Bylaws and with VUMC policies and procedures while training at VUMC.

4.7. DISASTER PRIVILEGES

4.7.1. In a Disaster, as defined in the VUMC Emergency Preparedness Activation Plan ("Disaster Plan"), any Physician who presents a valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following additional forms of identification may be granted Disaster Privileges:

A. a current medical license and primary source verification thereof, or

B. a current picture hospital ID card from a healthcare organization that clearly identifies professional designation, or

C. identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESARVHP), or other recognized state or federal response hospital or group, or
D. identification indicating that the individual has been granted authority to render patient care, treatment, and services in a disaster (such authority having been granted by a federal, state or municipal entity), or
E. confirmation by a medical staff Member(s) currently privileged by the hospital with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster, a current medical license and a valid photo ID issued by a state, federal or regulatory agency.

4.7.2. Provider Support Services verifies the credentials described above as practicable when the disaster is under control.

4.7.3. Disaster Privileges may be granted by the Deputy Chief Executive Officer or a Chief of Staff. These individuals may consider any Physician who presents evidence of possessing a medical license as described above, but are not required to grant Disaster Privileges to any individual and will make decisions regarding the grant of Disaster Privileges on a case-by-case basis.

4.7.4. Physicians are granted clinical privileges in accordance with the clinical privileges that they hold at their primary institution. The mechanisms used to manage Disaster Privileges and to readily identify physicians with Disaster Privileges are defined in the Disaster Plan. When the disaster no longer exists, Disaster Privileges automatically terminate in accordance with the Disaster Plan.

ARTICLE V. CATEGORIES OF THE MEDICAL STAFF

5.1. CATEGORIES

5.1.1. There shall be seven (7) categories of appointment to the Medical Staff:
A. Active
B. Active Offsite
C. Administrative
D. Affiliate
E. Military Surgeon Trainees
F. Refer and Follow
G. Emeritus

5.2. GENERAL QUALIFICATIONS FOR ALL CATEGORIES:

Every Physician who seeks or has a Medical Staff appointment must satisfy, at the time of application and appointment and continuously thereafter (unless otherwise specified), the basic qualifications and obligations set forth in Article III and be able to fulfill the responsibilities set forth in Article II. In addition, he/she
must satisfy any additional qualifications that attach to the staff category to which he/she seeks or holds an appointment.

5.3. **ACTIVE**

The Active staff consists of Physicians and Dentists who are Members of the Vanderbilt Medical Group and regularly practice at VUMC hospitals. They are responsible for organization and governance of the Medical Staff including holding office, voting at meetings of the Medical Staff and Clinical Services and serving on Medical Staff committees.

5.3.1. **Prerogatives of Active Medical Staff Status:** Active Medical Staff appointees may:

A. Vote on all matters presented at general and special meetings of the Medical Staff, Clinical Service, and committees of which he/she is a Member;
B. Hold office;
C. Exercise such clinical privileges as have been granted to the Medical Staff Member by the VUMC Board.

5.3.2. **Obligations of Active Medical Staff Status:** Active Medical Staff appointees must:

A. Attend Clinical Service meetings as required by their respective department unless excused by the Clinical Service Chief;
B. Be located close enough to the Medical Center to provide continuous care to their patients or have coverage relationships approved by the Clinical Service Chief;
C. Pay any dues or fees that may be established by the MCMB;
D. Participate equitably in the discharge of Medical Staff functions as reasonably assigned by the applicable Clinical Service Chief or Chair of the MCMB by participating in approved education and research programs; care of patients in the emergency department; giving consultation to other Medical Staff appointees consistent with his/her delineation of privileges; reviewing the performance of Physicians during the FPPE period; supervision of any physician assistant, nurse practitioner or other professional staff Member for whom the Medical Staff Member is a designated supervising physician, and fulfilling such other Medical Staff functions as may reasonably be required;
E. Establish and effectively communicate appropriate coverage to meet the needs of their patients when they are unavailable, out of town or at distance from the hospital. This coverage must be arranged in advance.
5.4. **ACTIVE OFFSITE**

The Active Offsite Staff consists of Physicians and Dentists who are Members of the Vanderbilt Medical Group, who do not hold faculty appointments, and who only practice offsite from the main VUMC campus. They are responsible for organization and governance of the Medical Staff including holding office, voting at meetings of the Medical Staff and Clinical Services and serving on Medical Staff committees.

5.4.1. **Prerogatives of Active Offsite Medical Staff Status:** Active Offsite Medical Staff appointees may:

A. Vote on all matters presented at general and special meetings of the Medical Staff, Clinical Service, and committees of which he/she is a Member;
B. Hold office;
C. Exercise such clinical privileges as have been granted to the Medical Staff Member by the VUMC Board.

5.4.2. **Obligations of Active Offsite Medical Staff Status:** Active Offsite Medical Staff appointees must:

A. Meet all Clinical Service requirements including Clinical Service meetings as required by their respective department unless excused by the Clinical Service Chief;
B. Pay any dues of fees that may be established by the MCMB;
C. Participate equitably in the discharge of Medical Staff functions as reasonably assigned by the applicable Clinical Service Chief or Chair of the MCMB by giving consultation to other Medical Staff appointees consistent with his/her delineation of clinical privileges; reviewing the performance of Physicians and Dentists during the period; supervision of any; supervision of any physician assistant, nurse practitioner or other professional staff Member for whom the Medical Staff Member is a designated supervising physician, and fulfilling such other Medical Staff functions as may reasonably be required;
D. Establish and effectively communicate appropriate coverage to meet the needs of their patients when they are unavailable, out of town or at distance from the hospital. This coverage must be arranged in advance.

5.5. **ADMINISTRATIVE**

Administrative Medical Staff Members are physicians who are Members of Vanderbilt Medial Group who are retained by the VUMC or the Medical Staff solely to perform ongoing medical administrative activities.
Members of this Medical Staff Category are charged with assisting the Medical Staff in carrying out medical-administrative functions, including, but not limited to quality assessment and improvement and utilization review and are not required to maintain board certification xv.

5.5.1. Administrative Staff includes Members who qualify through one of the following categories:

A. Serves in an academic leadership position of Vanderbilt University (e.g., Dean, Assistant Dean, etc.); or
B. Functions in a Hospital and/or VUMC leadership position requiring medical staff Membership as requested by Hospital and/or VUMC Administration; or
C. Serves as Director of a Residency Program at Vanderbilt University School of Medicine and is required to maintain Medical Staff Membership; or
D. Others as may be determined by the Chair of the MCMB (MCMB), Chief Executive Officers (CEO) of VUH and MCJCHV, Chief of Clinical Staff – VUMC, CMO and approved by the VUMC Board.

5.5.2. Prerogatives of Administrative Medical Staff Status: Administrative Medical Staff appointees:

A. May attend meetings of the Medical Staff and the Clinical Service of which he/she is a Member;
B. May hold office in the Medical Staff organization;
C. Serve as a voting Member of Medical Staff Committees;
D. Access the electronic health record;
E. May not admit, treat or otherwise consult on patients; and
F. May not exercise Clinical Privileges.

5.6. AFFILIATE

Affiliate Medical Staff Members are Physicians and Dentists who are qualified for Medical Staff Membership but who are not Members of Vanderbilt Medical Group and whose principal place of practice is not VUMC.

5.6.1. Prerogatives of Affiliate Medical Staff Status: Affiliate Medical Staff appointees:

A. May serve on any committee to which they have been assigned and vote in committee meetings and meetings of the Medical Staff;
B. May not hold office in the Medical Staff organization;
C. Shall be encouraged to attend General Medical Staff meetings and Service meetings but are not required to do so; and
D. May exercise such clinical privileges as have been granted by the VUMC Board.
5.6.2. **Obligations of Affiliate Medical Staff Status:** Affiliate Medical Staff appointees must:

A. Meet all Clinical Service requirements;
B. Provide appropriate coverage to meet the needs of their patients when they are unavailable, out of town or at distance from VUMC. This coverage must be arranged in advance and all covering Physician(s) must have clinical privileges at VUMC;
C. Pay any dues or fees that may be established by the MCMB;
D. Agree to the designation of an organized health care arrangement (“OHCA”) among the VUMC and Affiliate Medical Staff Members of the Medical Staff for purposes of facilitating compliance with the requirements of the Health Insurance Portability and Accountability Act (“HIPAA”);
E. Abide by the policies, practices and rules of the Medical Staff and VUMC regarding patient confidentiality including without limitation those practices set forth in the Vanderbilt University Medical Center Notice of Privacy Practices, as such notice may be amended from time to time;
F. Maintain no less than the minimum level of clinical activity necessary to allow for effective assessment of performance. Each Clinical Service establishes a minimum level of participation necessary to assess performance within the particular Service. A Physician may, upon request, be required to provide evidence of clinical performance at another institution in such form as may be required by the Clinical Service Chief, Credentials Committee, Executive Committee of the MCMB, MCMB, or the VUMC Board in order to allow an appropriate judgment to be made with respect to ability to exercise the clinical privileges requested;
G. Appear when requested where a Physician’s patient’s clinical course of treatment is scheduled for case discussion as part of regular or specially convened quality assessment and review activities at a Service or Committee meeting.

5.7. **MILITARY SURGEON TRAINEE**

Military Surgeon Trainee Staff shall consist of Active Duty Surgeons who have orders to participate, under contract, for a limited period of time at VUMC to maintain combat readiness. This category of Medical Staff is not a Member of VMG, is exempt from licensure under TCA 63-6-204 (a) (3), is not required to hold a faculty appointment, be board certified or carry individual professional liability insurance as coverage will be provided under Federal Tort Claims Act.
5.6.1 Prerogatives of Military Surgeon Trainee Medical Staff Members:

A. Shall not hold clinical privileges to admit, consult or treat patients at VUMC independently;
B. May attend meetings of the Medical Staff and Clinical Service of which he/she is a Member; may not vote or hold office;
C. May access the electronic medical record both remotely and while at the hospital.

5.6.2 Obligations of Military Surgeon Trainee Medical Staff Members:

D. May not electronically enter or give verbal orders or otherwise document in the medical record;
E. May not perform any procedures or provide any treatment independently.

5.8. REFER AND FOLLOW

Refer and Follow Medical Staff shall consist of Physicians and Dentists who refer patients for admission/treatment by Active Members of the Medical Staff wish to monitor their patients while they are in the hospital and access the patient’s medical record. There is no limitation to the number of patient contacts allowed. This category of Medical Staff is limited to Physicians and Dentists with Active or Affiliate Staff appointments who do not admit, consult or treat a sufficient number of patients at VUMC to maintain Active or Affiliate Staff status, but wish to continue to monitor their patients who receive care at VUMC hospitals. Members of this category may subsequently apply for Membership and clinical privileges in another Medical Staff category at any time. Membership in this Medical Staff category is not required for Physicians and Dentists who refer patients to other Members of the Medical Staff.

5.8.1. Prerogatives of Refer and Follow Medical Staff Status: Refer and Follow Members:

A. Shall not hold clinical privileges to admit, consult or treat patients at VUMC;
B. May attend meetings of the Medical Staff and Clinical Service of which he/she is a Member; may not vote or hold office;
C. May visit and follow his/her referred hospitalized patients;
D. May access the electronic medical record both remotely and at the hospital.

5.8.2. Obligations of Refer and Follow Medical Staff Status: Refer and Follow Members:

A. May not electronically enter or give verbal orders or otherwise document in the medical record;
B. May not perform any procedures or provide any treatment.

5.9. EMERITUS

The applicable Clinical Service Chief or Chief of Staff may recommend Emeritus Staff status for a Physician or Dentists who is retiring from the practice of medicine. Emeritus Staff Members shall consist of Physicians and Dentists who are Members of the Medical Staff of VUMC and are in good standing in the category to which they are assigned.

5.9.1. Prerogatives and Obligations of Emeritus Medical Staff Status: Emeritus Medical Staff appointees:

A. May be involved in educational activity but shall not hold clinical privileges to admit, consult, or treat patients at VUMC;
B. Are able to attend meetings of the Medical Staff or Services but are not eligible to vote at those meetings, or to hold office in the Medical Staff organization;
C. Emeritus Medical Staff appointees are not required to pay dues;
D. May attend General Medical Staff meetings and Service meetings but are not required to do so.

5.10. REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS

A Medical Staff Member may, either in connection with reappointment or at any other time, request modification of or addition to his/her Medical Staff category or Service assignment or clinical privileges by submitting a written application/request to the appropriate Clinical Service Chief. If approval of the request is recommended by the appropriate Chief of Staff, the request is forwarded for review by the Credentials Committee, which forwards its recommendation to the Executive Committee of the MCMB, and if approval is recommended by the Executive Committee, the recommendation is forwarded to the VUMC Board for final action.

ARTICLE VI. PROFESSIONAL STAFF WITH PRIVILEGES AND ALLIED HEALTH PRACTITIONERS

6.1. DESCRIPTION

The VUMC Board has approved certain non-physician health care providers for eligibility to apply for clinical privileges consistent with the requirements set forth in these Bylaws, and as may otherwise be required by the VUMC Board. These non-physician health care providers eligible for, and ultimately granted, clinical privileges will be classified into those categories described in Section 6.2.1., below.
6.2. CATEGORIES

6.2.1. Professional Staff with Privileges: The "Professional Staff with Privileges" ("PSP") include non-physician licensed independent and other clinical professionals who are granted clinical privileges to provide direct patient care to patients of VUMC, exercising independent judgment within specific documented areas of professional competence, under a defined degree of supervision by a Member(s) of the Medical Staff consistent with applicable law. Categories of PSP eligible for clinical privileges must be approved by the Executive Committee of the MCMB. Professional Staff with Privileges are credentialed as set forth in these Bylaws, and are granted clinical privileges as either a dependent or independent healthcare professional as defined by State laws and in these Bylaws. Professional Staff with Privileges are not eligible for Medical Staff Membership. They may provide patient care services only to the extent of and within the scope of the clinical privileges granted.

The Executive Committee of the MCMB has determined the categories of individuals eligible for Membership as Professional Staff with Privileges to be Optometrists (OD), Podiatrists (DPM), Clinical Psychologists (PhD), Physician Assistants (PA) and Advance Practice Registered Nurses (APRN) which includes: Certified Registered Nurse Anesthetists (CRNA), Certified Nurse Midwives (CNM), and Certified Nurse Practitioners (CNP).

6.2.2. Allied Health Practitioners. "Allied Health Practitioners" ("AHPs") shall refer to those practitioners at VUMC who are not eligible for Membership on either the Medical Staff or on the PSP, and who: (a) do not exercise independent medical judgment within the scope of their licenses or certificates, and/or (b) are not permitted by VUMC to practice independently. AHPs may include, as ultimately determined and approved by the VUMC Board, licensed clinical social workers, genetic counselors, behavioral analysts, physical therapists, occupational therapists, speech language pathologists, audiologists and other such practitioners required to have appropriate supervision.

6.3. PROFESSIONAL STAFF WITH PRIVILEGES

6.3.1. Prerogatives: Professional Staff with Privileges ("PSP") shall not be eligible to hold office within the Medical Staff organization. A Member of the Professional Staff with Privileges may attend Medical Staff or Clinical Service/Division meetings when invited to do so. Members of the PSP may admit patients to VUMC only if eligible for admitting privileges as allowed by state law and regulation, and only when granted admitting privileges by the Executive Committee and the VUMC Board. All patients admitted by Professional Staff with Privileges shall be under the care of a Physician.
6.3.2. Conditions and Requirements for Credentialing: Applicants for Membership on the PSP must meet all of the following criteria:

A. Must be a salaried employee of the Vanderbilt University Medical Center (Hospital, School of Medicine, or School of Nursing) or of an affiliated entity wholly or jointly owned by VUMC or those entities with whom VUMC has entered into a contractual relationship for specific professional services, or alternatively, must hold an academic appointment in either the Vanderbilt University School of Nursing or Medicine;

B. Must be properly licensed or certified by an appropriate professional organization or agency, or must be otherwise qualified by education or clinical experience to provide clinical care within their area of expertise as part of a Clinical Service;

C. Must provide satisfactory evidence of training to practice in their specialty.

D. Must be covered by Vanderbilt University professional liability insurance, or alternatively, must hold current professional liability insurance at levels acceptable to Vanderbilt University Medical Center Office of Risk and Insurance Management; and

E. If an advanced practice nurse, physician assistant, or if otherwise required by law, must identify supervising and/or collaborating physician acceptable to VUMC.

6.3.3. Scope of Practice: Members of the PSP shall work within their specialty scope of practice, as determined by their education, training and national certification, and in a manner consistent with those clinical privileges granted to the Member by VUMC. All Members of the PSP who are Advanced Practice Nurses, Physician Assistants, or who are otherwise required by virtue of their scope of practice or clinical privileges, must additionally work in collaboration with, and under the supervision of, a physician who is an Active Member of the Medical Staff or Affiliate Member of the Medical Staff who is also a Member of an entity wholly or jointly owned by Vanderbilt.

6.3.4. Nature of Application: Applicants for initial appointment and reappointment to the PSP shall submit fully completed (dated and signed) application forms, which have been developed and approved pursuant to Section 3.4.1., above. Additionally, Section 3.4.2., above, shall be applicable to any Member of the PSP that is subject to delegated credentialing. Upon signing an application, and by operation of that signature, an applicant for appointment to the PSP agrees to all those attestations set forth in Section 3.4.3., as well as all terms of release/authorization set forth in Section 3.4.5., above.

6.3.5. Content of an Initial Application: The initial application form shall include, but not necessarily be limited to, a request for:
A. Current licensure and certification status;
B. Disciplinary actions, investigations, and suspensions;
C. Education, training, and experience;
D. Professional associations and affiliations;
E. Peer recommendations;
F. Health status relative to the performance of the privileges requested;
G. Criminal history;
H. Voluntary or involuntary restrictions, reductions, or terminations of privileges or employment at other healthcare institutions or organizations; and
I. Disciplinary actions or investigations by regulatory agencies or state and/or federal government programs.

6.3.6. Responsibility of the Applicant: It is the responsibility of the PSP to return a signed, fully completed application with the following:

A. Current copy of Tennessee licensure and appropriate certification;
B. Copies of certificate(s) evidencing completion of education and training;
C. Copy of insurance certificate evidencing professional liability coverage with limits acceptable to Vanderbilt (currently $1,000,000 per occurrence/ $3,000,000 annual aggregate);
D. If applicable, a Signed Practice Protocol Summary, as well as the Signed Practice Protocol as requested
E. Current and dated copy of curriculum vitae (mo/yr format) outlining work history and written explanation of any and all lapses in chronology.

6.3.7. Applicant's Burden: Any applicant to the PSP shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, ability to work with other professionals, and for resolving any doubts about such qualifications. Falsification of an application shall be grounds for denial of and/or termination of clinical privileges.

6.3.8. Delegated Credentialing/Initial Appointment: In the event VUMC elects to utilize the credentialing process set forth herein for applicants to the PSP in the provision of delegated credentialing functions for designated health plans, Provider Support Services will notify any such initial applicant, within five (5) business days of receiving a PSP application, regarding whether the application received is complete or incomplete. If the application is incomplete and the practitioner responds with supplemental documentation/information, then upon receipt of all such responsive documentation/information, Provider Support Services will again notify any
such initial applicant within five (5) business days regarding whether the
application is complete or incomplete.

6.3.9. Inability to Obtain Information: The language set forth in Section 3.5.4.,
above, regarding inability to obtain information, shall fully apply to
applications for initial appointment and reappointment to the PSP.

A. Delegated Credentialing/Reappointment: In the event VUMC elects
to utilize the credentialing processes contained in these Medical
Staff Bylaws in the provision of delegated credentialing functions for
designated health plans, then notwithstanding any language in
these Bylaws to the contrary, the following exceptions may be
made for purposes of reappointment:

i. If VUMC is not able to recredential a practitioner for participation
in the health plan within the two (2) year time period specified in
these Bylaws because the practitioner is on active military
assignment, maternity leave, or sabbatical, Provider Support
Services will document such circumstances and shall be
permitted an additional sixty (60) days to recredential the
practitioner upon return to professional practice, as opposed to
credentialing the practitioner as an initial applicant.

ii. Similarly, if VUMC terminates a practitioner exclusively for
administrative reasons, and not for any reasons related to
clinical competency or professional conduct, then VUMC may
reinstate the practitioner within thirty (30) calendar days of the
administrative termination, assuming the practitioner otherwise
remains fully eligible for the practitioner’s appointment, as
opposed to credentialing the practitioner as an initial applicant.

6.3.10. Verification Process: Applications for clinical privileges and designation
as a Member of the PSP shall be processed, and competence verified,
in a manner similar to a Physician applying for Medical Staff Membership
and clinical privileges. Accordingly, Provider Support Services shall, at a
minimum, verify the following:

A. Current licensure and certification;
B. Education and training (highest levels);
C. National Practitioner Data Bank query;
D. Peer recommendations;
E. Work history as a health professional during the past seven years
or from date of pertinent licensure, whichever period is longer;
F. Professional liability claims history (past five years);
G. Current hospital affiliations; and
H. Medicare/Medicaid/TennCare sanctions and investigations from
both the Office of Inspector General and Excluded Parties Listing
System websites.
6.3.11. **Continuing Duties of PSP Members:** All applicants to, and Members of, the PSP shall have the same continuing duties that are set forth in Section 3.4.6., above. Additionally, any Members of the PSP that are APNs or PAs shall provide immediate notice of any modification, termination, or replacement of a practice protocol or any other supervisory agreement that is required for licensure, or that is otherwise required by VUMC to exercise clinical privileges.

6.3.12. **Recredentialing Requirements:** Recredentialing of PSP Members shall be performed at least every two years. On an ongoing basis and at the time of recredentialing, the PSP Member’s file shall be re-verified and updated. A recredentialing evaluation shall include, but not be limited to:

A. Valid, unrestricted State license and certification;
B. Professional liability claims history;
C. Health status relative to the performance of the privileges requested;
D. Criminal history;
E. Continued good standing at the practitioner's primary care facility;
F. Work history since initial appointment or previous reappointment; and
G. Voluntary or involuntary investigations, sanctions, restrictions, reductions, terminations or disciplinary actions by any healthcare institution, employer, state or federal agency or program.

H. In addition to the above, recredentialing shall also include a review of data concerning:

   i. any complaints by Physicians, other Members of the PSP, patients, or any other individuals regarding, or implicating, the quality of care provided by the practitioner; and
   ii. routine quality reviews.

6.3.13. **Time Period for Processing:** At the time of initial credentialing and recredentialing, information verified and included in the PSP's credentials file shall be no more than 120 days old at the time of the final credentialing decision.
6.3.14. **PSP Rights Regarding Information**: Applicants for initial appointment and reappointment to the PSP shall have those same rights set forth in Section 3.5.5., above.

6.3.15. **Review and Approval Process**: The review and approval process for initial applicants and reapplicants to the PSP shall be the same as the process for applicants and reapplicants to the Medical Staff, as set forth in Section 3.6., above.

6.3.16. **Notification to Applicant**: The applicant will receive written notification of his/her appointment status and clinical privileges within thirty (30) days of the VUMC Board rendering its decision.

6.3.17. **Confidentiality**: The language set forth in Section 3.6.8., above, regarding confidentiality, shall apply to applications for the PSP.

6.3.18. **Unfavorable Recommendation**: When the recommendation of the Executive Committee is adverse to the applicant, the Chief of Staff shall immediately so inform the Chief Executive Officer of the relevant Hospital(s), Chief of Clinical Staff, VUMC, the Deputy Chief Executive Officer and the applicant by prompt written notice by certified or registered mail, return receipt requested, and the applicant shall be entitled to the hearing and appeal rights set forth in Section 6.3.24., below.

6.3.19. **Reapplication after an Unfavorable Decision**: An applicant may reapply and be reconsidered one year after receiving an unfavorable decision.

6.3.20. **Corrective Action**: Any Member of the Medical Staff, any VUMC Administrator, any Member of the Professional Staff, or a Chief of Staff, may initiate a request for corrective action.

Proposed corrective action, including a request for an investigation, is made to the appropriate Chief of Staff or the Chair of the Executive Committee and must include reference to the specific activities or conduct which constitute the grounds for the request and the name of the person submitting the request.

Upon receipt of a proposal for corrective action, the appropriate Chief of Staff or Chair of the Executive Committee of the MCMB may act on the proposal or direct that an investigation be undertaken. No such investigative process shall be deemed a “hearing” as described in these Bylaws.

As soon as it is practicable after the conclusion of the investigative process, if any, the appropriate Chief of Staff or Chair of the Executive Committee of the MCMB shall act on the proposal and make its recommendation to the Executive Committee. Any recommendation by the
Executive Committee which constitutes grounds for a hearing as set forth in these Bylaws shall entitle the PSP Member to the hearing and appeal rights set forth in Section 6.3.24., below.

6.3.21. Summary Suspension: Whenever a PSP: (1) willfully disregards or violates in any material respect these Bylaws or other VUMC policies; (2) engages in conduct that necessitates immediate action to protect the life of any patient(s) or to reduce the likelihood of injury or damage to the health or safety of any patient, VUMC personnel or others; or (3) engages in conduct that poses a serious threat of disruption to the operations of VUMC, then any Medical Staff Member, Nursing Staff Member, Member of the PSP may take immediate steps necessary to request initiation of Summary Suspension.

Authority to initiate Summary Suspension is vested in each of the following:

A. Affected Member’s Clinical Service Chief, or designee;
B. Affected Member’s Chief(s) of Staff, or designee;
C. Chair, Executive Committee of the MCMB, or designee;
D. Deputy Chief Executive Officer, or designee;
E. Chief Executive Officer, or designee; and/or
F. Chief Medical Officers.

6.3.22. Notice of Summary Suspension: Any of the aforementioned individuals may summarily suspend the PSP Member’s clinical privileges. Such summary suspension shall become immediately effective upon imposition and the appropriate Chief(s) of Staff or designee shall communicate as soon as practicably possible the Summary Suspension to the following:

A. Affected PSP Member's Clinical Service Chief;
B. Chair of the Executive Committee of the MCMB;
C. Office of Legal Affairs;
D. Chief of Clinical Staff – VUMC;
E. Deputy Chief Executive Officer;
F. Chair of Joint Practice and Credentials Committees;
G. Affected PSP Member’s Collaborating/Supervising Physician(s), as applicable; and
H. Chief Medical Officers.

6.3.23. Automatic Suspension: A PSP Member’s designation and clinical privileges shall be automatically terminated without entitlement to the procedural rights set forth in 6.3.24. below if: 1) the PSP’s license to practice in Tennessee is revoked, restricted, suspended, or has expired; or 2) the PSP's collaborating or supervising physician withdraws his/her collaborative/supervisory responsibilities or is no longer a Member of the Active Medical Staff (unless the PSP’s collaborating or supervising
physician is substituted in a manner consistent with these Bylaws and VUMC policy). Notice shall be given to the PSP, the PSP’s collaborative/supervising physician(s), the appropriate Chief of Staff and Chair of the Joint Practice and Credentials Committees.

6.3.24. Hearings and Appellate Review: PSP applicants and Members are not applicants/Members of the Medical Staff, and therefore, are not entitled to the hearing and appeal processes reserved for such Physicians. Rather such applicants/Members shall be entitled to the notice and due process set forth below.

A. **Grounds for Hearing:** Summary suspension or a recommendation of denial for, or suspension or termination of, a PSP Member’s clinical privileges (an “adverse recommendation”) shall be grounds for a hearing.

B. **Notice and Request for Hearing:** The notice of an adverse recommendation provided to a PSP applicant/Member shall advise that the applicant/Member has thirty (30) days within which to submit a written request for a hearing to the Chair of the Executive Committee. The subject practitioner shall additionally have the right to representation by an attorney or other person of the practitioner’s choice. If a request is not timely submitted, the applicant’s/Member’s right to a hearing and appellate review shall be deemed waived, and the adverse recommendation shall be final.

C. **Scheduling a Hearing:** When a timely request for a hearing has been submitted, the Chair of the Executive Committee shall schedule a hearing within 30 days (but no sooner than 10 days) from the date of the receipt of the request.

D. **Hearing Panel:** The Chair of the Executive Committee of the MCMB shall appoint a Hearing Panel of three PSP Members that are not in direct economic competition with the subject practitioner. One Member of the Hearing Panel shall be designated by the Chairperson of the Executive Committee to serve as the Chairperson of the Hearing Panel.

E. **Hearing Procedures:** At the hearing, the Chairperson of the Hearing Panel shall determine the order of presenting evidence and argument and shall act to assure that all participants have a reasonable opportunity to be heard and to present all relevant evidence. Both sides shall have the right to ask questions of the Members of the Hearing Panel to determine whether they are impermissibly biased and to challenge such Members, to call and examine witnesses, to introduce evidence, to cross-examine witnesses, and to otherwise rebut any evidence. The rules of law relating to the examination of witnesses and presentation of evidence shall not apply, but the evidence must be of the sort which responsible persons are accustomed to rely upon in the conduct of
serious affairs. The Hearing Panel may question the witnesses or call additional witnesses in its discretion. A record, either by a court report or other reliable means, shall be made of the hearing.

F. Decision and Report: After the hearing, the Hearing Panel shall conduct its deliberations and render its decision and accompanying report, which shall explain the basis of its decision, within fifteen (15) days of the hearing. The decision and report shall be delivered to the Executive Committee and the affected practitioner. The decision of the Hearing Panel is final, subject only to the right of appeal to the VUMC Board.

G. Request for Appeal: Within ten (10) days of the date that the Hearing Panel decision and report is delivered to the affected practitioner and the Executive Committee, either the affected practitioner or the Executive Committee of the MCMB may request appellate review by the VUMC Board. The request shall be in writing, include a brief statement of the reason(s) justifying appeal, and delivered to the Deputy Chief Executive Officer and the Chairperson of the Executive Committee. If the request is not timely filed, the decision of the Hearing Panel is final.

H. Appellate Review: Within thirty (30) days of requesting appellate review, the parties shall submit written statements in support of their position on appeal to the VUMC Board with a copy to the other party. Thereafter, within thirty (30) days, the VUMC Board shall affirm, modify, or reverse the Hearing Panel’s decision or, in the VUMC Board’s discretion, remand the matter for further review by the Hearing Panel. The VUMC Board’s decision shall be in writing, with copies to both parties and the Hearing Panel. Unless the VUMC Board remands the matter for further review by the Hearing Panel, the decision of the VUMC Board is final, without the right to further review.

6.4. ALLIED HEALTH PRACTITIONERS

6.4.1. Credentialing AHPs for Clinical Privileges: AHPs eligible to render professional services at VUMC shall be credentialed to render such services pursuant to VUMC's Policy and Procedure for the Credentialing of Allied Health Practitioners. Consistent with this policy, all AHP applicants must meet the following minimum criteria:

A. Applicant must be a salaried employee of VUMC (Hospital, School of Medicine, or School of Nursing) or of an affiliated entity wholly or jointly owned by VUMC or those entities with whom VUMC has entered into a contractual relationship for specific professional services, or alternatively, the applicant must hold an academic appointment in the Vanderbilt University School of Nursing or Medicine;
B. Applicant must be properly licensed or certified by an appropriate professional organization or agency, or must be otherwise qualified by education or clinical experience to provide clinical care within their area of expertise as part of a Clinical Service;
C. Applicant must provide satisfactory evidence of training to practice in his/her area of expertise;
D. Applicant must be covered by Vanderbilt University professional liability insurance or other insurance coverage at levels acceptable to Vanderbilt University Medical Center Office of Risk and Insurance Management; and
E. Applicant must meet all other requires set forth in, or referenced by, VUMC's Policy and Procedure for the Credentialing of Allied Health Practitioners.

6.4.2. **Delegated Credentialing of AHPs to Health Plans:** In the event VUMC elects to utilize the credentialing processes contained in these Medical Staff Bylaws in the provision of delegated credentialing functions for designated health plans, VUMC shall utilize the process set forth in Section 6.5., below, to credential AHPs that are eligible to participate in the designated health plan.

6.5. **DELEGATED CREDENTIALING OF ALLIED HEALTH PRACTITIONERS FOR HEALTH PLANS**

In the event VUMC elects to undertake delegated credentialing functions on behalf of a health plan, the process set forth below shall apply exclusively to the credentialing of AHPs eligible for participation in the designated health plans:

6.5.1. **Nature of Application:** AHPs shall submit fully completed (dated and signed) application forms, which have been developed in consultation with the MCMB and approved by the VUMC Board. VUMC will also accept (for the limited purpose of delegated credentialing) credentialing applications/reapplications using the form provided by the Council on Affordable Quality Healthcare ("CAQH"). In such instance, however, VUMC may request supplemental information/documentation from any such applicant/reapplicant if the CAQH application fails to provide any documentation or information otherwise required by these Bylaws.

Upon signing an application, and by operation of that signature, an applicant agrees to all those attestations and all terms of release/authorization set forth in Section 6.3.4., above.

6.5.2. **Content of an Initial Application:** The initial application form shall include, but not necessarily be limited to, a request for the same information referenced in Sections 6.3.4 and 6.3.5, above.
6.5.3. **Responsibility of the Applicant:** It is the responsibility of the AHP to return a signed, fully completed application with same information referenced in Section 6.3.6, above.

6.5.4. **Applicant's Burden:** Each AHP shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, ability to work with other professionals, and for resolving any doubts about such qualifications. Falsification of an application shall be grounds for denial of and/or termination of clinical privileges.

6.5.5. **Incomplete Application:** Incomplete applications shall be treated in the same manner as set forth in Section 6.3.8., above. Provider Support Services will notify any initial applicant within five (5) business days of receiving an AHP’s application whether the application received is complete or incomplete. If the application is incomplete and the provider responds with supplemental documentation/information, then upon receipt of all such responsive documentation/information, Provider Support Services will again notify any such initial applicant within five (5) business days regarding whether the application is complete or incomplete.

6.5.6. **Verification Process:** Applications for delegated credentialing for AHPs shall be subject to the same verification process that is set forth in Section 6.3.10., above.

6.5.7. **Continuing Duties of AHPs:** AHPs shall have the same continuing duties that are set forth in Section 6.3.11., above.

6.5.8. **Recredentialing Requirements:** Recredentialing of AHPs shall be performed at least every two years. On an ongoing basis and at the time of recredentialing, the AHP file shall be reverified and updated. A recredentialing evaluation shall include, but not be limited to, the same information that is set forth in Section 6.3.12, above.

6.5.9. **Time Period for Processing:** At the time of initial credentialing and recredentialing, information verified and included in the AHP’s credentials file shall be no more than 120 days old at the time of the final credentialing decision.

6.5.10. **Inability to Obtain Information:** The language set forth in Section 6.3.9., above, regarding inability to obtain information, shall apply to AHP applications for reappointment.
6.5.11. **Reapplicant’s Rights Regarding Information:** Applicants for reappointment shall have those same rights set forth in Section 6.3.14., above, regarding applications for initial appointment.

6.5.12. **Review and Approval Process:** Once all required application documentation has been received and processed, and all verifications and references confirmed, Provider Support Services shall transmit the application to the Credentials Committee for a studied and thoughtful evaluation. The Credentials Committee may or may not, in its discretion, require the applicant to appear for an in-person interview and/or to provide additional information or documentation deemed by the Credentials Committee to be necessary for its evaluation of the application. Within thirty (30) days after receiving a complete application, and unless additional time is reasonably required in the discretion of the Credentials Committee to fully evaluate the application, the Credentials Committee shall reach a recommendation regarding the approval or denial of the applicant. In the event the Credentials Committee recommends approval of the AHP, the recommendation shall be promptly communicated to the designated health plan for final approval pursuant to terms of VUMC’s agreement with the designated health plan.

6.5.13. **Confidentiality:** The language set forth in Section 6.3.17., above, regarding confidentiality, shall apply to applications for participation by an AHP.

6.5.14. **Unfavorable Recommendation:** In the event the recommendation of the Credentials Committee is adverse to the applicant, the Chairperson of the Credentials Committee shall notify the applicant, who shall then be entitled to the procedural rights set forth in Section 6.3.24., above.

6.5.15. **Reapplication after an Unfavorable Decision:** An applicant may reapply and be reconsidered one year after receiving an unfavorable decision.

6.5.16. **Corrective Action:** Any Member of the Medical Staff, any VUMC Administrator, any Member of the Professional Staff, or a Chief of Staff, may initiate a request for corrective action in relation to an AHP’s participation in a health plan. Proposed corrective action, including a request for an investigation, is made to the Credentials Committee and must include reference to the specific activities or conduct which constitute the grounds for the request and the name of the person submitting the request.

Upon receipt of a proposal for corrective action, the Credentials Committee may act on the proposal or direct that an investigation be undertaken. No such investigative process shall be deemed a “hearing” as described in these Bylaws.
As soon as it is practicable after the conclusion of the investigative process, if any, the Credentials Committee shall act on the proposal and make its recommendation to the designated health plan for final action pursuant to terms of VUMC’s agreement with the designated health plan.

6.5.17. **Summary Suspension:** An AHP’s credentials to participate in a health plan may be summarily suspended, when deemed reasonably necessary, pursuant to the same process set forth in Section 6.3.21, above.

6.5.18. **Automatic Suspension:** An AHP’s credentials to participate in a health plan may be automatically suspended under the same or similar circumstances set forth in Section 6.3.23, above. Additionally, if an AHP’s employment or affiliation with VUMC is restricted, suspends, or terminates for any reason, the AHP’s credentials to participate in the health plan shall equally be restricted, suspended, or terminated (as applicable).

6.5.19. **Hearing Rights:** AHPs are not Members of the Medical Staff or the PSP, and therefore, are not entitled to the hearing and appeal processes reserved for such Members. Rather, when such hearing and appeals processes are applicable to an AHP’s credentials to participate in a health plan, the AHP shall be entitled to the notice and due process set forth below.

A. **Notice and Request for Hearing:** An AHP shall be given written notice of an adverse recommendation and shall be advised that the AHP has thirty (30) days within which to submit a written request for a hearing to the Chairperson of the Executive Committee. The AHP shall additionally have the right to representation by an attorney or other person of the AHP’s choice. If a request is not timely submitted, then the AHP’s right to a hearing and appellate review shall be deemed waived, and the adverse recommendation shall be final.

B. **Scheduling a Hearing:** When a timely request for a hearing has been submitted, the Chairperson of the Executive Committee shall schedule a hearing within 30 days (but no sooner than 10 days) from the date of the receipt of the request.

C. **Hearing Panel:** The Chairperson of the Executive Committee shall appoint three (3) Members of the Executive Committee to serve as the Hearing Panel. One Member of the Hearing Panel shall be designated by the Chairperson of the Executive Committee to serve as the Chairperson of the Hearing Panel.

D. **Hearing Procedures:** At the hearing, the Chairperson of the Hearing Panel shall determine the order of presenting evidence and argument and shall act to assure that all participants have a reasonable opportunity to be heard and to present all relevant
evidence. Both sides shall have the right to call and examine witnesses, to introduce evidence, to cross-examine witnesses, and to otherwise rebut any evidence. The rules of law relating to the examination of witnesses and presentation of evidence shall not apply, but the evidence must be of the sort which responsible persons are accustomed to rely upon in the conduct of serious affairs. The Hearing Panel may question the witnesses or call additional witnesses in its discretion. A record, either by a court report or other reliable means, shall be made of the hearing.

E. Decision and Report: After the hearing, the Hearing Panel shall conduct its deliberations and render its decision and accompanying report, which shall explain the basis of its decision, within fifteen (15) days of the hearing. The decision and report shall be promptly communicated to the designated health plan for final determination pursuant to terms of VUMC’s agreement with the designated health plan.

ARTICLE VII. CLINICAL SERVICES

7.1. DESIGNATION

7.1.1. Current Clinical Services are:

A. ANESTHESIOLOGY
B. EMERGENCY MEDICINE
C. MEDICINE
D. NEUROLOGY
E. OBSTETRICS/GYNECOLOGY
F. OPHTHALMOLOGY
G. ORTHOPAEDIC SURGERY
H. OTOLARYNGOLOGY
I. PATHOLOGY
J. PEDIATRICS
K. PHYSICAL MEDICINE & REHABILITATION
L. PSYCHIATRY
M. RADIOLOGY & RADIOLOGICAL SCIENCES
N. RADIATION ONCOLOGY
O. SURGICAL SCIENCES

7.1.2. Divisions: The Clinical Services may recommend the establishment of clinical service divisions within the Service upon the recommendation of the Clinical Service Chief. Such clinical service divisions shall be subject to the approval of the Executive Committee of the MCMB and the VUMC Board.
7.2. REQUIREMENTS FOR AFFILIATION WITH SERVICES

Each Clinical Service and its clinical service divisions are separate organizational components of the Medical Staff, and every Medical Staff appointee must have a primary affiliation with the Clinical Service and its clinical service division in which he/she holds an academic appointment. This appointment should most closely reflect the appointee’s professional training, experience, and current practice. In exceptional circumstances a Medical Staff Member holding a faculty appointment in more than one department, and following recommendation by the respective Clinical Service Chiefs and approval of the VUMC Board, may be granted appointment(s) and clinical privileges in those other Clinical Services or clinical service divisions. The exercise of clinical privileges of the designated Clinical Service or clinical service division is always subject to the authority of the Clinical Service Chief or clinical service division. Providers who are actively engaging in work in multiple Clinical Services or clinical service divisions are required to maintain appropriate privileges for each Clinical Service.

7.3. FUNCTIONS OF CLINICAL SERVICES

7.3.1. General Provisions: The Clinical Services fulfill certain clinical, administrative, quality review/utilization management, and collegial and education functions as set forth in Section 7.3.2 below. Each Clinical Service and its clinical service divisions must meet as required by these Bylaws for the purpose of receiving reports on the findings of review and evaluation of the quality and efficiency of care provided to patients served by the Service and for such other purposes as may be necessary to carry out the required functions.

The primary purpose of such activities and subsequent reports is to improve the quality of patient care. Accordingly, all such activities and subsequent reports to findings are privileged under T.C.A. §63-1-150 and 68-11-272.

Each Clinical Service or a combined group of clinical services shall meet as a medical peer review committee of the Medical Staff as required to receive, review and consider performance improvement activities related to patient care. Minutes shall be made of such meetings to provide a record of reviews, evaluations and actions undertaken.

7.3.2. Service Functions: Each Service shall:

A. Establish, implement and monitor its appointees’ adherence to clinical standards, policies, procedures and practices relevant to the various clinical disciplines under its jurisdiction;
B. Provide an inter-specialty and inter-service forum for matters of clinical concern and for resolving clinical issues arising out of the interface between its appointees’ activities and the activities of other patient care and administrative services;

C. Develop consistency in the patient care data, standards, policies, procedures and practices within the Service and across any of its constituent Divisions;

D. Develop, with assistance from the various clinical service divisions, specialists and sub specialists, criteria for use in making credentials recommendations on initial appointments, reappointments, grants of clinical privileges, concluding the FPPE period, and other credentials matters, and make recommendations on these matters as required by the Medical Staff Credentialing Policies and Procedures;

E. Provide a forum for its appointees to contribute their professional views and insights to the formulation of the Service, Medical Staff and VUMC policies and plans;

F. Communicate, through the Clinical Service Chief, formulated policies and plans back to its appointees for implementation;

G. Make recommendations, through its Clinical Service Chief, to the MCMB, the Deputy Chief Executive Officer, and other components, as appropriate, concerning the short and long-term allocation and acquisition of resources to and provision of services by VUMC and the Service.

H. Conduct ongoing review of core quality indicators and improvement through identified patient care centers; and

I. Report all findings of studies and other activities performed under paragraphs 7.3.2 to the MCMB through the appropriate committee mechanisms of the institution.

### 7.4. CLINICAL SERVICE CHIEF

#### 7.4.1. Procedure for Appointment of Clinical Service Chiefs

The VUMC Board shall appoint the Clinical Service Chiefs. The Chief Executive Officer shall make recommendations to the VUMC Board regarding individuals to serve as a Clinical Service Chief and the decision of the VUMC Board shall be final.

#### 7.4.2. Qualifications for Clinical Service Chief

Each Clinical Service Chief shall be:

A. A Member of the Active Medical Staff;

B. Chair of the applicable clinical department in the Vanderbilt University School of Medicine or another senior faculty Member as designated by the Chair and approved by the Dean; and

C. Recognized for his or her superior training, clinical expertise, and nationally recognized academic reputation.
7.4.3. **Term of Appointment**: The term of appointment of a Clinical Service Chief or clinical service division Chief shall coincide with his/her tenure as Chair/Chief of the corresponding unit at the Vanderbilt University School of Medicine.

7.4.4. **Termination of Appointment**: The VUMC Board may terminate an appointment in coordination with the Vanderbilt University School of Medicine when appropriate, and after the Deputy Chief Executive Officer formally consults with the MCMB regarding such proposed termination. The appointment of a Clinical Service Chief whose appointment is provided for in an oral or written contract shall automatically terminate upon termination of such contract if the contract so states.

7.4.5. **Vacancies**: In the event of a vacancy in the position of a Clinical Service Chief, the Chief Executive Officer/Deputy Chief Executive Officer, in concert with the Dean of the Medical School, shall appoint a qualified Physician to serve as Acting Clinical Service Chief (with subsequent ratification by the VUMC Board).

7.4.6. **Responsibilities**: Each Clinical Service Chief is responsible to the VUMC Board, through the Executive Committee of the MCMB and MCMB for all professional activities of the Clinical Service. The Clinical Service Chief, through the appropriate Chief(s) of Staff, is responsible to and subject to the direction of the Deputy Chief Executive Officer for all administrative activities of that Clinical Service. The Clinical Service Chief shall provide administrative supervision over all clinical work coming within the scope of the Clinical Service. The responsibilities of the Clinical Service Chief shall include, but not be limited to, the following:

A. Delineating clinical privileges for the service;
B. Recommending the criteria for clinical privileges;
C. Recommending clinical privileges for each Service Member;
D. Conducting, participating and making recommendations regarding orientation and continuing medical education programs pertinent to the clinical practice of the Service;
E. Appointment to the appropriate Medical Staff categories.
F. Appointing Service Members to serve as Physician advisors who will, at times, be called upon to review care being rendered by another Service Member, the purpose of which is to assist in appropriate utilization management;
G. Recommending standards for patient care, assuring that the quality and appropriateness of patient care provided within the Service are monitored and evaluated;
H. Initiating corrective action when necessary;
I. Conducting the administrative duties of the Service including, but not limited to:
J. Conducting Service meetings;
K. Serving as a Member of the Executive Committee of the MCMB and MCMB and implementing its actions and policies;
L. Enforcing the Medical Staff Bylaws, Rules and Regulations and policies within the Service;
M. Integrating the Service into the primary functions of VUMC;
N. Developing and implementing policies and procedures that guide and support the provision of clinical services;
O. Assisting in the development of recommendations for a sufficient number of qualified and competent persons to provide care;
P. Assisting in the determination of the qualifications and competence of personnel who are not licensed independent Physicians and who provide patient care services; and
Q. Assisting in the development of recommendations for the use of space, resources, off-site services, and outside contracting needed by the Service; and
R. Coordinating and integrating interdepartmental and intradepartmental services; and
S. Maintaining quality control programs.

ARTICLE VIII. OFFICERS OF THE MEDICAL STAFF

8.1. THE OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be the Chair of the MCMB, the Deputy Chair of the MCMB, and the Immediate Past Chair of the MCMB.

8.1.1. Eligibility: The officers of the Medical Staff shall be Members of the Active Medical Staff.

8.1.2. Term of Office: The officers of the Medical Staff shall serve two (2) year terms commencing on the first day of the Medical Staff year following their election (July 1).

8.1.3. Removal of an Officer: Removal of an officer may be made:

A. By presentation of a petition to the Chief of Clinical Staff – VUMC and the Deputy Chief Executive Officer which has been signed by a majority of the Members of the MCMB. This petition shall outline the deficiencies in the performance of the officer’s duties; and
B. Upon an affirmative two-third (2/3) vote of the MCMB responding.

8.1.4. Vacancies in Elected Office: A vacancy in the office of Chair is filled by succession of the Deputy Chair who shall serve the remainder of the unexpired term. If the Deputy Chair is unable to serve the remainder of the
unexpired term, a special election shall be held by the MCMB to fill the
unexpired term of the Chair.

A vacancy in the office of Deputy Chair is filled by a special election to be
conducted as soon as possible by the MCMB and in the same manner.

8.1.5. Voting Procedure: The election of officers shall be made in accordance
with the voting procedure specified in Section 10.2.1 of these Bylaws.

8.1.6. Election: Officers are elected at the annual Medical Staff meeting.

8.2. DUTIES OF OFFICERS

8.2.1. Duties of the Chair: The Chair of the MCMB shall be the presiding officer
at all meetings of the MCMB, the Executive Committee of the MCMB,
Administrative Affairs Committee and all general Medical Staff meetings.
The duties of the Chair may include:

A. Monitoring the enforcement of the Medical Staff Bylaws, Rules and
   Regulations and Policies and Procedures with the Chiefs of Staff;
B. Presenting the views, policies, needs and concerns of the Medical
   Staff to the Chiefs of Staff, the Deputy Chief Executive Officer, the
   Chief Executive Officers of the hospitals, the Chief Executive
   Officer and the VUMC Board.

8.2.2. Duties of the Deputy Chair: Whenever the Chair of the MCMB is unable to
fulfill the duties of the office by reason of illness or other absence, the
Deputy Chair will assume the duties and exercise the authority of the
office of the Chair. In addition, the Deputy Chair shall serve as a Member
of the Credentials Committee and the Administrative Affairs Committee
and be responsible for those additional duties delegated to him or her by
the Chair of the MCMB or the VUMC Board.

8.2.3. Duties of the Immediate Past Chair: Whenever the Chair and the Deputy
Chair of the MCMB are both unable to fulfill the duties of their offices by
reason of illness or other absence, the Immediate Past Chair will assume
the duties and exercise the authority of the Office of the Chair. The
Immediate Past Chair shall also be responsible for those duties delegated
to him or her by the Chair of the MCMB or the VUMC Board.

ARTICLE IX. FUNCTIONS AND COMMITTEES

9.1. ROLE AND FUNCTION OF COMMITTEES

9.1.1. Coordination of Medical Staff action: The Committees of the Medical Staff
are critically important to Medical Staff operations. They provide inter-
specialty and interdisciplinary coordination of continuing Medical Staff
action for appropriate patient care, effective utilization of hospital services
and provision of Medical Staff representation and participation in activities affecting the discharge of Medical Staff responsibilities. All committees, whether charged by the Bylaws or ad-hoc, shall be governed by a separate Committee Manual.

9.1.2. Advisory to MCMB: Unless otherwise specified, committees are advisory to the MCMB and report at least annually to the MCMB. Minutes shall be recorded, forwarded to Provider Support Services and reported to the MCMB.

9.1.3. Appointments and terms of committee Membership: Chair, Vice-Chair and/or Co-Chair of Committees and Subcommittees are appointed by the MCMB upon recommendation of the appropriate Chief of Staff and the Chair of MCMB. Members of committees are appointed by the Chair of the Committee, the appropriate Chief of Staff and the Chair of MCMB. The term for committee positions will be two years and renewable.

9.1.4. Confidentiality: All committee Members are required to hold the information discussed within them (both verbal and written) as privileged and confidential (as defined in T.C.A., § 63-1-150 and 68-11-272) and such information may not be further released or utilized in any other context.

9.1.5. Quorum for Committees of the Medical Staff: Unless otherwise specified herein, 25% of the voting Members (or their designees) present of any Committee shall constitute a quorum.

9.1.6. Non-Physician Committee Members: Non-Physician Members of Medical Staff Committees, unless otherwise specified in these Bylaws or the Committee Manual and approved by the MCMB, shall be non-voting ex-officio Members. They shall be appointed by the Chair of the Committee, the Chiefs of Staff and Chair of MCMB.

9.2. MEDICAL CENTER MEDICAL BOARD

The Medical Center Medical Board is the principal committee of the Medical Staff, to which all standing and ad hoc committees report. The MCMB is empowered to act on behalf of the Medical Staff as a whole between meetings of the Medical Staff by recommending to the VUMC Board professional policies to be followed by the Medical Staff.

9.2.1. Recommendations of the MCMB to the VUMC Board shall include, but not be limited to, the following:

A. Suggestions for changes and improvements to promote quality patient care;
B. Structure of the Medical Staff;
C. Application and/or reapplication fees;
D. The mechanism used to review credentials and to delineate individual clinical privileges;
E. The mechanism to evaluate and revise, when appropriate, the organization of Medical Staff quality monitoring activities;
F. The mechanism(s) by which Membership on the Medical Staff may be terminated; and
G. The mechanism for Hearing and Appellate Review procedures.

9.2.2. Composition of the Medical Center Medical Board: The Membership of the Medical Center Medical Board shall include:

A. Voting Members:

1. Officers of the Medical Staff;
2. Chief of Clinical Staff, Vanderbilt University Medical Center;
3. Chief of Staff, Vanderbilt University Hospital;
4. Chief of Staff, Monroe Carell Jr. Children’s Hospital at Vanderbilt;
5. Chief of Staff, Vanderbilt Psychiatric Hospital;
6. Surgeon in Chief, Monroe Carell Jr. Children’s Hospital at Vanderbilt;
7. Chair, Credentials Committee;
8. Chief Medical Officer, Vanderbilt Medical Group;
9. Assistant Chief Medical Officer, VMG Williamson;
10. Designated Institutional Official for Graduate Medical Education;
11. Clinical Service Chiefs;
12. Chair, Health Record Executive Committee;
13. Director, Diagnostic Laboratory;
14. Four (4) Representatives from the Department of Medicine to be appointed by the Clinical Service Chief of Medicine biennially;
15. One biennially elected Member from:
   a. Surgery
   b. Pediatrics
   c. Obstetrics/Gynecology
16. Three “at large” Members elected at the annual meeting of the Medical Staff.

Note: A voting Member may send a non-voting designee when he/she is unable to attend

B. Ex-Officio Members without Vote:

1. Chief Executive Officer, Vanderbilt University Hospital;
2. Chief Executive Officer, Monroe Carell Jr. Children’s Hospital at Vanderbilt;
3. Executive Chief Nursing Officer and Chief Nursing Officers – Vanderbilt University Hospital and Clinics, MCJCHV and VPH;
4. *Senior Vice President for Quality, Safety and Risk Prevention;
5. Chief Executive Officer; Vanderbilt University Medical Center;
6. Deputy Chief Executive Officer; Vanderbilt University Medical Center;
7. Dean of the School of Medicine;
8. Dean of the School of Nursing or Designee;
9. Representatives from Office of Legal Affairs;
10. Compliance and Corporate Integrity Officer;
11. Chair, Ethics Committee;
12. Chief Operating Officer, Vanderbilt University Hospital and Clinics;
13. Chief Operating Officer, Vanderbilt Psychiatric Hospital;
14. Executive Director of Risk and Insurance Management;
15. Medical Director, Stallworth Rehabilitation Hospital;
16. Senior Associate Dean for Diversity Affairs, Vanderbilt University School of Medicine;
17. President of the House Staff Advisory Council;
18. Such other persons as may be determined by the Chair of the MCMB, Chief Executive Officers (CEO) of VUH and MCJCHV, Chief of Clinical Staff – VUMC, CMO and approved by the VUMC Board.
   *Becomes a voting Member when held by a Member of the Medical Staff.

**Note:** A non-voting Member may send a non-voting designee when he/she is unable to attend.

9.2.3. **Functions of the Medical Center Medical Board:** The duties and authority of the Medical Center Medical Board are to:

A. Represent and act on behalf of the Medical Staff in all matters as otherwise provided in these Bylaws;

B. Receive, coordinate and act upon, as necessary, the written reports and recommendations of the Services and the standing and ad hoc committees directly responsible to it and to hear oral reports from time to time as required or requested;

C. Coordinate, or oversee coordination of, the activities of and policies adopted by the Medical Staff, Clinical Services, other clinical units and committees;

D. Implement the approved policies of the Medical Staff, or monitor that such policies are implemented by the Services, other clinical units and committees;

E. Review and report to the Medical Staff changes in these Bylaws and Rules and Regulations;
F. Inform the Medical Staff on Joint Commission accreditation programs and the accreditation status of the hospitals;

G. Review and approve the appointment of chairmen of standing committees, except as otherwise provided;

H. Recommend to the VUMC Board, as required in these Bylaws, the Medical Staff Credentialing Policies and Procedures and related policies concerning matters relating to appointments and reappointments, category and Service assignments, clinical privileges, and disciplinary action;

I. Take reasonable steps to monitor professional ethical conduct and competent clinical performance on the part of Medical Staff appointees, including initiating investigations and initiating and pursuing disciplinary action, when warranted;

J. Account to the VUMC Board by written report for the quality and efficiency of medical care provided to patients at VUMC, including a summary of specific findings, action and follow-up; and

K. Make recommendations to the Chief Executive Officer on medico-administrative, VUMC management and planning matters.

9.2.4. Elected Representatives: Each Clinical Service having an elected representative on the MCMB shall hold a biennial election to select such representative. Elected representatives shall serve not more than two (2) calendar two (2) year terms of office.

9.2.5. Meeting Requirements: The MCMB shall generally meet on a monthly basis if there is business to conduct, and a permanent record of the proceedings and actions shall be maintained.

9.3. STANDING COMMITTEES

The Committees of the Medical Center Medical Board shall be:

9.3.1. Executive Committee

   A. Meetings: The Executive Committee shall meet monthly or more often as necessary.
   B. Purpose: The Executive Committee is empowered to act on behalf of the MCMB between its regularly scheduled meetings. It shall have the following responsibilities:
      1. To recommend to the VUMC Board all matters relating to Corrective Action as outlined in Article XIII of these Bylaws;
      2. To recommend to the VUMC Board Medical and Professional Staff appointments, staff categories and clinical privileges (as applicable);
      3. To receive reports of standing committees and ad hoc committees at the request of the Chair of the Executive Committee;
4. To review preliminary work for the MCMB including, but not limited to new concepts, launch ideas, new policies, etc.;
5. To review and approve all new delineation of clinical privilege forms including, but not limited to cross-departmental procedures;
6. To follow-up on the implementation of recommendations and decisions of the MCMB.

C. The Composition of the Executive Committee of the MCMB shall be:

**Voting Members:**
1. Officers of the Medical Staff;
2. Chief of Clinical Staff, Vanderbilt University Medical Center;
3. Chief of Staff, Vanderbilt University Hospital;
4. Chief of Staff, Monroe Carell Jr. Children’s Hospital at Vanderbilt;
5. Chief of Staff, Vanderbilt Psychiatric Hospital;
6. Chair, Credentials Committee
7. Chief Medical Officer;
8. Designated Institutional Official for Graduate Medical Education;
9. Clinical Service Chiefs
10. Deputy Chief Executive Officer, Vanderbilt University Medical Center.

**Note:** A Voting Member may send a non-voting designee when he/she is unable to attend.

**Non-Voting Members:**
1. Chief Executive Officer, Vanderbilt University Medical Center;
2. Chief Executive Officer, Vanderbilt University Hospital and Clinics;
3. Chief Executive Officer, Monroe Carell Jr. Children’s Hospital at Vanderbilt;
4. Executive Chief Nursing Officer;
5. Chief Nursing Officers (Vanderbilt University Hospital & Monroe Carell Jr. Children’s Hospital at Vanderbilt);
6. Representatives from the Office of the Legal Affairs;
7. *Senior Vice President for Quality, Safety and Risk Preventions;
8. Such other persons as may be determined by the Chair of the MCMB, Chief Executive Officers (CEO) of VUH and MCJCHV, Chief of Clinical Staff – VUMC, CMO and approved by the VUMC Board.
*Becomes a voting Member when held by a Member of the Medical Staff.

**Note:** A Non-Voting Member may send a non-voting designee when he/she is unable to attend.

9.3.2. **Administrative Affairs Committee**

The Administrative Affairs Committee shall consist of at least five (5) Members of the Active Medical Staff, and representation from the Office of Legal Affairs and the Office of Accreditation and Standards. It shall meet quarterly if there is business to conduct or more often as necessary. The duties of the Administrative Affairs Committee shall be:

A. To perform an ongoing review of the Medical Staff Bylaws, Rules and Regulations and Policies and Procedures and to make recommendations for revisions as necessary to promote quality patient care, efficient utilization of resources and effective Medical Staff leadership.

B. To monitor and identify actions of the MCMB that require revisions to the Bylaws and Rules and Regulations, and to facilitate incorporation of necessary revisions into those governing documents.

9.3.3. **Credentials Committee**

The Credentials Committee shall consist of nine (9) Members of the Active Medical Staff so selected as to insure representation of the major clinical specialties, including behavioral health, the hospital-based specialties and the Medical Staff at large. It shall meet at least quarterly. Its duties shall be:

A. To evaluate the credentials and performance of all applicants for Medical Staff Membership for reappointment and determine whether each application satisfies the required qualifications in Article III, and will fulfill the responsibilities set forth in Article II of these Bylaws. The selection of persons to be recommended for appointments shall be based upon a thorough review of the qualifications of each applicant. No applicant shall be denied Medical Staff Membership on the basis of sex, race, creed, color or national origin, or on the basis of any other criterion not pertaining to the qualifications and requirements in Articles II and III.

B. To review recommendations from the Joint Practice Committee regarding the credentials, performance, and supervisory arrangements (as applicable) of all Professional Staff with
Privileges and Allied Health Practitioners who apply for credentialing and/or privileges to practice at VUMC.

C. To report to the Executive Committee of the MCMB on each applicant for Medical Staff or other professional staff including Professional Staff with Privileges and recommend to the VUMC Board. Reports and recommendations regarding Medical Staff and other professional staff appointment and delineation of privileges shall include consideration of any recommendations from the Clinical Service in which the candidate requests privileges.

9.4. SUBCOMMITTEE

The Subcommittee of the Credentials Committee shall be:

9.4.1. Joint Practice Committee

The primary responsibility of the Joint Practice Committee is to evaluate the credentials and performance of Professional Staff with Privileges and Allied Health Practitioners who apply for credentialing and/or privileges to practice at VUMC and determine whether each applicant satisfies the required qualifications and applicable supervisory requirements based upon a thorough review of the qualifications of each applicant and proposed supervising physician as applicable. No applicant shall be denied Professional Staff Membership on the basis of sex, race, creed, color or national origin, or on the basis of any other criterion not pertaining to professional competency and conduct.

This committee may be expanded, combined with another committee, or inactivated by the Executive Committee of the MCMB to meet changing circumstances.

9.5. AD HOC COMMITTEES

Ad Hoc Committees may be recommended to the MCMB by the Chief of Staff and/or the Chair of the MCMB to consider specific subjects. Such a committee will automatically be discharged on submission of its final report to the MCMB.

ARTICLE X. MEETINGS

10.1. REGULAR MEETINGS

There shall be a minimum of one annual meeting of the Medical Staff. The agenda for the meeting shall be publicized to all Members of the Medical Staff in advance of the meeting date.
10.1.1. **Quorum for General Medical Staff Meetings:** Fifty (50) Members of the Active Medical Staff shall constitute a quorum.

10.2. **SPECIAL MEETINGS**

Special meetings may be called at any time by the Chair of the MCMB or by the MCMB itself at the request of any fifteen (15) Members of the Active Medical Staff. At least seven (7) days’ notice will be given for any special meeting.

10.2.1. **Quorum for Special Meetings:** Fifty (50) Members of the Active Medical Staff shall constitute a quorum for special meetings.

10.3. **SERVICE MEETINGS**

Each Clinical Service or a combined group of Clinical Services shall meet as a committee of the Medical Staff as required to receive, review and consider performance improvement activities related to patient care. Minutes shall be made of such meetings to provide a record of reviews, evaluations, and actions undertaken and shall constitute medical review activities pursuant to T.C.A. §63-1-150 and 68-11-272. Clinical Service meetings are held by respective Services at a time and a place designated by the Clinical Service Chief with a frequency dictated by the activities of each individual Service. Service meetings may be cancelled or rescheduled from time to time at the discretion of the Clinical Service Chief.

All Members of the Active Medical Staff are required to attend Clinical Service meetings as required by their respective Service unless excused by the Clinical Service Chief. Unexcused absences in excess of the number permitted by the Service may result in reduction or termination of Staff status and/or clinical privileges.

10.3.1. **Quorum for Service Meetings:** 25% of the voting Membership of a Service shall constitute a quorum.

10.4. **MEETING PROCEDURES**

10.4.1. **Basis for Determining a Voting Result:** A quorum of the eligible Members shall be present for the election of officers and all other formal votes by the Medical Staff or its committees or services. Election shall be determined by a majority vote of those present where there are two nominees or issues being presented. Where there are more than two nominees or issues, the candidate or issue with the greater number of votes shall be elected. Abstention shall not constitute an affirmative or negative vote.

10.4.2. **Rules of Order:** The rules contained in Robert’s Rules of Order shall govern the proceedings of the Medical Staff in all cases where they are
applicable and in which they are not inconsistent with these Bylaws,
Rules and Regulations, or Policies and Procedures of the Medical Staff.

ARTICLE XI. MEDICAL STAFF MEMBERSHIP CONSIDERATIONS

11.1. MEDICAL STAFF OBLIGATION

Every Physician appointed to the Medical Staff has the responsibility for reporting
to a Chief of Staff, Clinical Service Chief or Chair of the MCMB, conduct by
another Member of the Medical Staff that is reasonably likely to be detrimental to
patient safety, detrimental to the delivery of patient care, disruptive to Hospital
operations, or actions that constitute fraud, abuse or illegal activity under state or
federal law. Chiefs of Staff and Clinical Service Chiefs have an additional
obligation to cross communicate concerns brought to their attention.

11.2. APPLICABILITY FOR CERTAIN PROCESSES

Medical Staff Members that hold a Faculty Appointment are also subject to the
terms of the Vanderbilt University Faculty Manual. All reviews, investigations, and
corrective actions conducted under these Bylaws shall be limited in their scope to
the provisions of these Bylaws. Investigations or disciplinary actions for a faculty
Member may, at the discretion of the relevant Dean, be conducted under the
procedures contained within the Faculty Manual of Vanderbilt University.

11.3. SPECIAL CONSIDERATION FOR MEDICAL STAFF LEADERSHIP

If the Informal Problem Resolution or Corrective Action requested involves the
Chief of a Clinical Service, an officer of the MCMB, a Chief of Staff, the Chief
Executive Officer or Deputy Chief Executive Officer, the Executive Committee of
the MCMB in coordination with the appropriate Chief(s) of Staff shall arrange for
another appropriate Member of the Active Medical Staff to provide coverage for
any necessary functions of that office pending resolution of the Corrective Action.

11.4. PEER REVIEW PROTECTIONS

All peer review activities pursuant to these Bylaws and related Medical Staff
documents shall be performed by "medical peer review committees" in
accordance with federal and state law. Medical peer review committees include,
but are not limited to:

A. all standing and ad hoc Medical Staff and Hospital committees;
B. investigating committees;
C. hearing panels;
D. the VUMC Board and its committees;
E. any individual acting for or on behalf of any such entity, including but not
limited to Clinical Service Chiefs, committee chairs and Members, officers
of the Medical Staff, and experts or consultants retained to assist in peer review activities; and

F. all Clinical Services.

All reports, recommendations, actions, and minutes made or taken by medical peer review committees are confidential and privileged and are subject to all applicable privileges under federal and state law. All medical peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq. Peer review protections include, without limitation, processes under Informal Problem Resolution, Corrective Action and Hearing and Appellate Review Procedures.

11.5. TIMEFRAMES

The time frames established in these Bylaws may be extended for reasonable cause by the MCMB or the VUMC Board, whichever is appropriate.

ARTICLE XII. INFORMAL PROBLEM RESOLUTION

The MCMB may undertake informal problem resolution with a Medical Staff Member in order to maintain the requirements of, and standards set by, these Bylaws. Informal problem resolution is not Corrective Action and may be initiated to address issues through other available processes, prior to and/or in lieu of Corrective Action which is undertaken as necessary pursuant to Article XIII.

12.1. COMPLAINTS

Any Member of the Medical Staff, Nursing Staff, other Professional Staff or Member of the administration or administrator may bring a concern or complaint regarding the clinical performance or professional conduct, as delineated in VUMC policies, of a Member of the Medical Staff to the attention of the appropriate Clinical Service Chief, appropriate Chief of Staff and/or the Chair of the MCMB. The Clinical Service Chief will notify the appropriate Chief of Staff or Chair of the MCMB if a faculty action has been initiated for clinical performance or professional conduct. The Chief of Staff and/or Chair of the MCMB will evaluate the concern. If the concern or complaint does not pose a threat of harm, injury, health or safety to any patients, VUMC personnel or others, or disruption to the orderly operation of VUMC, the informal problem resolution process may be initiated by the appropriate Chief of Staff and/or the Chair of the MCMB to determine whether the concern may be resolved informally or through other action, including Departmental FPPE, Investigative Suspension or request for Corrective Action.
12.2. **NOTIFICATION**

The appropriate Chief of Staff shall notify the Affected Physician of the concern or complaint and review expectations of maintenance of confidentiality, including, but not limited to no communication regarding the concern or complaint either directly or indirectly in a manner that may interfere with the review process.

12.3. **INFORMAL RESOLUTION CONFERENCE**

The appropriate Chief of Staff, and the Chair of the MCMB, shall evaluate the grounds for an expressed concern or complaint and, if appropriate, arrange an informal resolution conference with the Affected Physician. The appropriate Chief of Staff and the Chair of the MCMB may conduct the informal conference or may appoint a panel consisting of impartial Members of the Executive Committee of the MCMB. In no event shall the person initiating the complaint participate on the panel. The informal conference shall include a review of the issue(s) with the Affected Physician and recommendation of resolution of the problem. The Affected Physician is not permitted to have a personal advisor, including without limitation an attorney, at an informal problem resolution conference. Should the Affected Physician decline to participate in the informal problem resolution conference, the process will proceed with acknowledgement of his/her declination of participation.

During the meeting, the Affected Physician shall be advised of the nature of the concern or complaint that was reported and shall be requested to provide his/her response and/or perspective concerning the concern or complaint. The Affected Physician shall be advised that, if the concern or complaint occurred as reported, his/her conduct was inappropriate and inconsistently with the standards of these Bylaws and VUMC. The identity of the individual who submitted the concern or complaint shall not be disclosed at this time, unless the appropriate Chief of Staff or Chair of the MCMB agrees in advance that it is appropriate to do so. In this case, the Affected Physician shall be advised that any retaliation against the individual reporting the concern or complaint will be grounds for immediate exclusion from all VUMC facilities.

12.4. **RESOLUTION**

Any mutually agreed upon resolution resulting from the Informal Resolution Conference and is reduced to writing, pursuant to this Article shall be final and gives rise to no right of Hearing or Appeal. Disposition of complaints shall be included in the report of informal resolution. Records of resolution and/or disposition of complaints will be placed in the Affected Physician’s credentials file.
12.5. REPORT OF INFORMAL RESOLUTION CONFERENCE

Following the agreed upon resolution, a written report outlining the substance of the concern or complaint and the resolution shall be prepared, signed by the Clinical Service Chief and appropriate Chief of Staff and placed in the Affected Physician's credentials file. If the problem is not resolved, the Chair of the MCMB shall refer the matter for Investigative Suspension, Summary Suspension, or Corrective Action pursuant to Article XIII.

ARTICLE XIII. CORRECTIVE ACTION

13.1. CRITERIA FOR INITIATION

Members of the Medical Staff have the responsibility to request Corrective Action in the event that they have knowledge of activities, demeanor or conduct of another Member of the Medical Staff that is reasonably likely to be:

A. Detrimental to the delivery of patient care, patient safety or to the safety of others;
B. Below applicable professional standards;
C. Unethical or illegal;
D. Contrary to these Bylaws, Rules and Regulations or Policies and Procedures of the Medical Staff;
E. Disruptive to the operations of VUMC;
F. Indicative of a violation of the VUMC alcohol and drug use policy.

13.2. REQUEST FOR CORRECTIVE ACTION

Any Member of the Medical Staff, any VUMC administrator, or Dean or designee of the School of Medicine, or the School of Nursing, may initiate a request for Corrective Action. A request for corrective action is made to the appropriate Chief of Staff or the Chair of the MCMB, and must include reference to the specific activities or conduct that constitutes the grounds for the request and the name of the person submitting the request.

13.3. CORRECTIVE ACTION MAY INCLUDE, BUT NOT LIMITED TO:

A. Issuing a verbal warning or letter of reprimand or admonition;
B. Imposing terms of probation, or requirements of consultation, monitoring, or supervision;
C. Modifying, suspending, or terminating clinical privileges;
D. Reducing Medical Staff category or limiting certain Medical Staff prerogatives;
E. Suspending or terminating Medical Staff appointment; and/or
F. Other appropriate measures.
13.4. INVESTIGATIVE SUSPENSION OF CLINICAL PRIVILEGES

13.4.1. Grounds for Investigative Suspension

A. The Chiefs of Staff, the Chief Medical Officer, the applicable Clinical Service Chief, the Chair of the MCMB, the Chief Executive Officer, the Deputy Chief Executive Officer, shall each have the authority to suspend or restrict all or any portion of an individual's clinical privileges in order to investigate and determine whether the Affected Physician’s clinical performance or professional conduct may result in danger to the health and/or safety of any patient, VUMC personnel or others, or may pose a threat of disruption to the operations of VUMC. Investigative Suspension may also be imposed in the event a Physician is arrested or charged with a crime (other than minor traffic violations). Prior to any such suspension, if in his or her discretion there is time and such action is warranted, the Chiefs of Staff, the Chief Medical Officer, the applicable Clinical Service Chief, the Chair of the MCMB, the Chief Executive Officer, the Deputy Chief Executive Officer, may consult with any of the others prior to reaching the decision to suspend. If after the investigation, a determination is made that the Affected Physician’s clinical performance or professional conduct may result in imminent danger to the health and/or safety of any patient, VUMC personnel or others, or may pose a threat of disruption to the operations of VUMC, then the matter may be referred for Summary Suspension or further Corrective Action.

B. The appropriate Chief of Staff shall immediately and personally notify the Affected Physician of the Investigative Suspension (e.g., telephone, email, in person, etc.) and the concern or complaint. The appropriate Chief of Staff shall review with the Affected Physician the expectations of maintenance of confidentiality, including, but not limited to no communication regarding the concern or complaint either directly or indirectly in a manner that may interfere with the review process. Additionally, the Affected Physician shall be advised that any retaliation against any individual involved in reporting the concern or complaint will be grounds for immediate exclusion from all VUMC facilities. The imposition of an Investigative Suspension is effective immediately.

C. Immediately upon Suspension of an Affected Physician, the applicable Clinical Service Chief or designee, shall arrange for alternative medical coverage for the patients of the Affected Physician who are in a VUMC Hospital, with due consideration for the wishes of the patient(s).
D. A Physician under suspension of clinical privileges by operation of this provision shall not be entitled to the procedural rights provided under Hearing and Appellate Review Procedures set forth in Article XV.

E. Following the imposition of Investigative Suspension, the Chair of the MCMB shall, within fourteen (14) calendar days from the imposition of the Investigative Suspension, appoint an investigating committee and notify the Members of the Executive Committee of the MCMB of the Suspension. The investigating committee will be provided a list of allegations and be charged with a determination of findings of fact for the allegations. The investigating committee shall meet with, interview and inform the Affected Physician that he/she may provide a written response to the investigating committee unless waived by the Affected Physician, as well as, any other individuals with relevant information within fourteen (14) calendar days from the date of appointment of the investigating committee and no longer than twenty-eight (28) calendar days from the imposition of the Investigative Suspension.

Upon conclusion of the investigation, the investigating committee shall report to the Executive Committee of the MCMB the findings of their investigation. The Executive Committee of the MCMB shall deliberate and make a recommendation to continue the suspension with Corrective Action, lift the suspension with conditions and/or Corrective Action or lift the suspension without conditions or requirements. The decision of the Executive Committee shall be documented in its minutes and the VUMC Board notified of the actions and outcomes.

13.5. SUMMARY SUSPENSION

13.5.1. Criteria For Initiation: Whenever a Medical Staff Member: (1) willfully disregards or violates in any material respect these Bylaws or other VUMC policies; (2) engages in conduct that necessitates immediate action to protect the life of any patient(s) or to reduce the likelihood of injury or damage to the health or safety of any patient, VUMC personnel or others; or (3) engages in conduct that poses a serious threat of disruption to the operations of VUMC, then processes may be initiated in accordance with the provisions of this Section.

13.5.2. Authority to initiate Summary Suspension: Authority to initiate Summary Suspension is vested in each of the following:

A. Affected Physician’s Clinical Service Chief or designee
B. Affected Physician’s Chief(s) of Staff or designee
13.5.3. Notifications: The appropriate Chief(s) of Staff or designee shall be notified immediately of any Summary Suspension and then shall communicate as soon as practically possible the Summary Suspension to the following:

A. Affected Physician’s Clinical Service Chief
B. Chair of the MCMB
C. Office of Legal Affairs
D. Chief of Clinical Staff - VUMC
E. The Chief Executive Officer
F. The Deputy Chief Executive Officer

The appropriate Chief of Staff shall immediately and personally notify the Affected Physician of the Summary Suspension (e.g., telephone, email, in person, etc.) and the concern or complaint. The appropriate Chief of Staff shall review with the Affected Physician the expectations of maintenance of confidentiality, including, but not limited to no communication regarding the concern or complaint either directly or indirectly in a manner that may interfere with the review process. Additionally, the Affected Physician shall be advised that any retaliation against any individual involved in reporting the concern or complaint will be grounds for immediate exclusion from all VUMC facilities. The imposition of a Summary Suspension is effective immediately. Notification of Summary Suspension will be placed in the Affected Physician’s credentials file.

13.5.4. Alternative Medical Coverage: Immediately upon Summary Suspension of an Affected Physician, the applicable Clinical Service Chief or designee, shall arrange for alternative medical coverage for the patients of the Affected Physician who are in a VUMC hospital, with due consideration for the wishes of the patient(s).

13.5.5. MCMB Action: Following the imposition of Summary Suspension, the Chair of the MCMB shall, within fourteen (14) calendar days from the imposition of the Summary Suspension, appoint an investigating committee and notify the Members of the Executive Committee of the MCMB of the suspension. The investigating committee will be provided a list of allegations and be charged with a determination of findings of fact for the allegations. The investigating committee shall meet with, interview and inform the Affected Physician that he/she may provide a written response to the investigating committee unless waived, as well as, any other individuals with relevant information within fourteen (14)
calendar days from the date of appointment of the investigating committee and no longer than twenty-eight (28) calendar days from the imposition of the Summary Suspension. Upon conclusion of the investigation, the ad hoc committee shall report to the Executive Committee of the MCMB the findings of their investigation and a copy will be placed in the Affected Physician’s credentials file. The Affected Physician will also receive a copy of the report of the investigating committee. The Executive Committee of the MCMB shall deliberate and make a recommendation to continue the suspension with Corrective Action, lift the suspension with conditions and/or Corrective Action or lift the suspension without additional medical staff action.

13.5.6. Investigating Committee: The Investigating Committee shall conduct its investigation, which may in its sole discretion include an interview of the Affected Physician and other individuals, and shall submit a report of its findings and recommendation to the Executive Committee of the MCMB within fourteen (14) calendar days from the date of appointment of the investigating committee and no longer than twenty-eight (28) calendar days from the imposition of the Summary Suspension or Corrective Action.

13.5.7. Executive Committee Action: After evaluating the report of the investigative Committee, the Executive Committee, with participation of the Affected Physician’s Clinical Service Chief and the appropriate Chief of Staff, shall propose action within thirty (30) calendar days of receipt of the investigative Committee’s report (“Proposed Action”). The Proposed Action may include, without limitation:

A. For a finding that no corrective action is warranted;
B. Issuing a verbal warning or letter of reprimand or admonition;
C. Imposing terms of probation, or requirements of consultation, monitoring, or supervision;
D. Modifying, suspending, or terminating clinical privileges;
E. Reducing Medical Staff category or limiting certain Medical Staff prerogatives;
F. Suspending or terminating Medical Staff appointment; and/or
G. Other appropriate measures.

13.5.8. Notice to the Affected Physician: Within five (5) calendar days of the Proposed Action, the appropriate Chief of Staff shall notify the Affected Physician of the recommendation of the Executive Committee. Notice of any recommendation that is adverse to the Affected Physician shall be in writing and made by personal delivery or by certified mail, return receipt requested and a copy placed in the Affected Physician’s credentials file.

13.5.9. Procedural Rights: Subject to the exceptions set forth in Section 15.1.3, any Proposed Action that is adverse to the Affected Physician as defined in Section 15.1.2, shall, upon timely and proper request as provided in
Section 15.2.2 entitle the affected Physician to the Hearing and Appellate Review rights set forth in Article XV. A Summary Suspension in place for greater than thirty (30) calendar days constitutes a reportable event under the National Practitioner Data Bank (NPDB) Guidelines and report will be submitted to the NPDB within the required timeframes.

ARTICLE XIV. AUTOMATIC SUSPENSION OR TERMINATION

14.1. CRITERIA FOR INITIATION

If a Member of the Medical Staff fails to maintain a legal credential necessary for authorization to practice, or fails to maintain any other qualification necessary for Medical Staff Membership or clinical privileges, the Medical Staff Member shall be immediately and automatically suspended from practicing and his or her Medical Staff Membership may be automatically terminated. The following circumstances constitute grounds for automatic suspension, and if appropriate, automatic termination.

A. **Loss of License:** A Member whose license or other credentials authorizing him or her to practice in the state is revoked or suspended shall immediately and automatically be suspended from practicing at VUMC as of the date that notice of such revocation or suspension is actually received by VUMC. Additionally, if a Medical Staff Member fails to maintain a current license, he/she shall be automatically suspended from the Medical Staff on the day that such license expires. If within thirty (30) days such license is not renewed, his/her Medical Staff Membership shall be automatically terminated.

B. **Conviction of a felony.**

C. **OIG Exclusion:** Medical Staff Members who are excluded from participation in government health care programs including Medicare, Medicaid and TennCare, shall immediately and automatically be suspended from practicing at VUMC on the date that notice is received by VUMC that the Medical Staff Member is on the OIG exclusion list. If within thirty (30) days, the Medical Staff Member is not removed from the OIG exclusion list, the Medical Staff Member’s Membership shall be automatically terminated.

D. **Loss of Faculty Appointment:** Clinical privileges and Medical Staff Membership automatically terminate upon termination of a Medical Staff Member’s faculty appointment.

E. **Inability to obtain or maintain professional liability insurance:** If a Member of the Medical Staff fails to maintain professional liability insurance as required by these Bylaws, or if coverage is revoked, Medical Staff
Membership is automatically suspended on the day such coverage expires. If within thirty (30) days the Medical Staff Member does not obtain coverage, his or her Medical Staff Membership is automatically terminated.

F. Failure to continuously meet the General Qualifications for Appointment/Reappointment set forth in Article III.

G. Loss of Drug Enforcement Agency (“DEA”) number: In the event that a Medical Staff Member’s DEA number is revoked or suspended, the Medical Staff Member shall be immediately and automatically divested of the right to prescribe medications covered by the number as of the date that such notice is received by VUMC. The Executive Committee of the MCMB may take further action as appropriate to the facts disclosed pursuant to its investigation. If the Medical Staff Member fails to maintain a current DEA registration necessary for his or her practice, he or she shall be automatically suspended from Membership on the Medical Staff on the day such registration expires. If within thirty (30) days such registration is not renewed, his or her Medical Staff Membership shall be automatically terminated.

H. Failure to obtain and maintain Board Certification as required by 3.2.2 of these Bylaws may also result in automatic suspension.

I. Failure to comply with the Medical Records completion requirement as outlined in these Medical Staff Bylaws, Rules & Regulations and Hospital policy.

14.2. NATURE OF SUSPENSION/TERMINATION

In the event of Automatic Suspension or Termination of Medical Staff Membership and clinical privileges based on the provisions of this Article, the affected Physician shall not be entitled to a Hearing and Appellate Review under Article XV herein with respect to such suspension and/or termination. Upon request, however, the Affected Physician may be afforded the opportunity to present evidence to the Executive Committee of the MCMB for the limited purpose of refuting the information resulting in the suspension.

14.3. REVIEW

As soon as reasonably possible after initiation of an automatic suspension, the appropriate Chief of Staff, or his designee, shall make an immediate inquiry and review the facts and circumstances under which the Automatic Suspension/Termination was initiated. The inquiry may include requests for information from the concerned authority, the Affected Physician and others, and be followed by such measure, interim or otherwise, that may be considered
appropriate and in the best interests of patient care, the Medical Staff, and VUMC.

14.4. EXECUTIVE COMMITTEE ACTION

Upon any final termination pursuant to this section, the Executive Committee of the MCMB shall notify the VUMC Board of the Physician's termination of all clinical privileges and Medical Staff Membership.

14.5. MEDICAL RECORDS

A temporary suspension of a Medical Staff Member's clinical privileges may be imposed for failure to complete medical records in accordance with these Bylaws, Rules and Regulations, VUMC Medical Records policies and standards established by the Medical Staff Member’s Clinical Service. Summary suspension for failure to complete medical records may be initiated by the applicable Clinical Service Chief after consultation with the appropriate Chief of Staff. Such temporary Suspension shall be effective upon Special Notice from the Clinical Service Chief, clinical service division Chief or Chief of Staff to the Affected Physician, and shall remain in effect until the medical records are satisfactorily completed and in compliance with all applicable requirements.

ARTICLE XV. HEARING AND APPELLATE REVIEW PROCEDURES

15.1. HEARINGS

15.1.1. Criteria for Initiation of MCMB Action: Subject to the exceptions set forth in Section 15.1.3, any action proposed by the Executive Committee that is adverse to the Affected Physician as defined in Section 15.1.2 below, shall, upon timely and proper request as provided in Section 15.2.2 entitle the Affected Physician to the Hearing and Appellate Review rights set forth in this Article.

15.1.2. Definition of Adverse Recommendation: Only the following recommendations by the Executive Committee of the MCMB shall be considered adverse to the Affected Physician and shall entitle the Affected Physician to the procedural rights afforded by this Article:

A. Denial of initial Medical Staff appointment unless resulting from failure to meet General Qualifications outlined in Article IV of these Bylaws;

B. Denial of reappointment unless specifically identified as an administrative action pursuant to these Bylaws;

C. Suspension or revocation of Medical Staff Membership;
D. Denial of requested appointment to, or advancement in a Medical Staff category, or a reduction in category;

E. Suspension or revocation of admitting privileges;

F. Suspension, revocation, or limitation of requested clinical privileges, or any other Medical Staff Membership privilege related to the provision of patient care, other than temporary clinical privileges;

G. Requirement of mandatory consultation, monitoring or supervision (not including any supervision required during the FPPE period under Section 4.1.5., which shall be reported to have been successfully completed).

15.1.3. Exceptions to Hearing Rights: Notwithstanding any provision in these Bylaws, Rules and Regulations, or Policies and Procedures to the contrary, the following actions or recommended actions do not entitle the Affected Physician to a hearing or other procedural rights in this Article:

A. Any action voluntarily imposed or accepted by the Affected Physician

B. Investigative Suspension or Automatic Suspension pursuant to Section 13.4., and Article XIV, above.

C. Any action taken or recommended with respect to Temporary, Locum Tenens, Consulting/Single Case, Training, or Disaster Privileges.

15.2. REQUEST FOR A HEARING

15.2.1. Notification: The Deputy Chief Executive Officer or the Chief Executive Officer or the applicable Chief of Staff as his/her designee, shall within five (5) days of receiving written notice of proposed adverse action against the Affected Physician, provide Special Notice to the Affected Physician (herein referred to as the “Notice”). The Notice shall inform the Affected Physician of the action proposed and the reasons for the proposed action. The Notice also shall inform the Affected Physician that he/she has thirty (30) calendar days following the date of the Notice to request a Hearing on the proposed action, that the request must satisfy the requirements of Section 15.2.2, and that failure to request a hearing within the time period and in the proper manner constitutes a waiver of rights to a hearing and to an appellate review on the matter that is the subject of the Notice.

15.2.2. Request for Hearing: The Affected Physician shall have thirty (30) calendar days after his/her receipt of the Notice to file a written request for a hearing. The request must be in writing and delivered to the Deputy
Chief Executive Officer or appropriate Chief of Staff (by certified mail return receipt requested, overnight mail or hand delivery).

15.2.3. Failure to Request a Hearing: Failure by the Affected Physician to request a Hearing within the time and in the manner herein above provided constitutes a waiver of his/her right to such hearing and to any appellate review to which he/she might otherwise have been entitled.

15.2.4. Waiver: A waiver constitutes acceptance of the action or recommendation, which shall become and remain effective immediately. Such decision shall be reported to the Executive Committee of the MCMB, which shall report the decision to the VUMC Board as a final action.

15.3. NOTICE OF TIME AND PLACE FOR A HEARING

15.3.1. Upon timely and proper request for a hearing, the Executive Committee of the MCMB shall appoint a Hearing Committee and a Hearing Officer (see Section 15.4), which shall schedule and arrange for a Hearing. At least fourteen (14) calendar days prior to the date for the hearing, the Hearing Committee shall notify the Affected Physician, in writing, of the place, time, and date of the hearing. When an Affected Physician under summary suspension timely requests a hearing it should be scheduled as soon as arrangements may reasonably be made, but not later than fourteen (14) days from the date that the summary suspension was imposed on the Affected Physician. The notice shall inform the Affected Physician of his/her rights with respect to the hearing, which rights shall include the following:

A. Right to be accompanied by an attorney or other person of the Affected Physician’s choice, pursuant to the provisions and limitations expressed in Section 15.5.6;

B. Right to call, examine and cross-examine witnesses or independent experts;

C. Right to present evidence determined to be relevant by the Hearing Officer, regardless of its admissibility in a court of law;

D. Right to have a record made of the proceedings, copies of which may be obtained by the Affected Physician upon payment of any reasonable charges associated with the preparation thereof;

E. Right to submit an oral or written statement at the close of the hearing.

15.3.2. Hearing Committee Requirements: The Notice of Hearing shall state in concise language the acts or omissions of the Affected Physician, a list
of proposed witnesses or independent experts, if any, expected to testify at the request of the Hearing Committee, a brief statement of information each witness may testify about, a list of specific or representative patient charts being questioned and/or, the other documents that were considered in making the adverse recommendation or decision.

15.3.3. **Affected Physician Requirements:** At least seven (7) days prior to the Hearing date, the Affected Physician shall provide the Hearing Officer a list of witnesses and/or independent experts to be called, a brief summary of the information that each is expected to present and copies of any documents to be offered at the hearing.

15.4. **COMPOSITION OF THE HEARING COMMITTEE**

15.4.1. The Hearing Committee shall consist of not fewer than five (5) Active Members of the Medical Staff, none of whom have brought the complaint against the Affected Physician, none of whom were involved in any of the prior deliberations, and each of whom shall be appointed by the appropriate Chief(s) of Staff in consultation with the Chair of the MCMB and one of whom is in the Affected Physician’s area, or related area of practice. In addition, the Affected Physician shall have the right, at his or her option, to have one additional physician Member of the Active Medical Staff of his or her choosing to serve on the Hearing Committee. If the Affected Physician makes such a request, the additional physician shall be appointed by the applicable Chief of Staff if there is such an additional physician reasonably available and qualified.

15.4.2. **Hearing Officer:** The Executive Committee of the MCMB shall appoint an impartial hearing officer (“Hearing Officer”) to preside at the hearing. The Hearing Officer shall maintain decorum and order such that all participants in the Hearing have a reasonable opportunity to present relevant oral and written evidence, and shall be entitled to determine the order of the procedure during the Hearing and shall make rulings on procedure and the admissibility of evidence. The Hearing Officer may participate in the deliberations.

15.5. **CONDUCT OF HEARING**

15.5.1. **Purpose:** The Hearing is a confidential medical peer review activity as defined in T.C.A. §63-1-150 and 68-11-272. Access to the proceedings is restricted to those participating in the hearing.

15.5.2. **Quorum for the Hearing Committee:** There shall be at least a majority of the Members of the Hearing Committee present in order for the Hearing to proceed. If a Hearing Committee Member is absent from any part of the hearing deliberations, the Hearing Officer may rule that such Member may not participate further in the hearing or deliberations or in
the decision of the Hearing Committee. A Hearing Committee Member may participate by phone for good cause shown at the discretion of the Hearing Officer.

15.5.3. **Record of Hearing**: An accurate record of the Hearing must be kept. The Hearing Committee shall select the recording method, such as court reporter, electronic recording unit, detailed transcription, or detailed minutes of proceedings. The recording method used must be sufficiently detailed and accurate that an informed and valid judgment can be made by persons that may later review the record and render a recommendation or decision based upon its contents. An Affected Physician who requests an alternative recording method shall bear the additional cost, if any, of that recording method, if the alternate recording method is approved by the Hearing Committee.

15.5.4. **Personal Appearance**: The personal appearance of the Affected Physician is required throughout the Hearing, unless such personal presence is excused for any specified time by the Hearing Committee. The presence of the Affected Physician’s attorney or other representative does not constitute the personal presence of the Affected Physician. An affected Physician who fails, without good cause or prior approved excuse, to appear and proceed at such Hearing shall be deemed to have waived the right to a Hearing and Appellate Review and to have accepted the prior adverse recommendation or decision as a final action.

15.5.5. **Extension of Time**: Postponement of hearings beyond the time set forth in these Bylaws shall be made only for good cause shown and upon the mutual agreement of the Affected Physician and the Hearing Committee.

15.5.6. **Representation**: The Affected Physician shall be entitled to have an attorney or other person of his/her choice present during the Hearing. If the Affected Physician chooses to have someone accompany him at a hearing, this person’s participation shall consist of providing private advice and counsel to the Affected Physician, but shall not present evidence, examine or cross-examine witnesses or independent experts or make statements directly to the Hearing panel.

15.5.7. **Rights of the Parties**: Each of the parties shall have the following rights during the Hearing:

A. To call and personally examine witnesses or independent experts;

B. To introduce other relevant evidence or exhibits;

C. To cross-examine any witness on any matter relevant to the issue of the hearing;
D. To challenge any witness for prejudice or bias;

E. To rebut any evidence

F. The Hearing Committee shall have the right to call and question the Affected Physician, even if the Affected Physician does not testify in his/her own behalf.

15.5.8. **Evidence:** The Hearing is an administrative hearing and need not follow strict rules of evidence. The Hearing Officer will determine the relevancy of evidence and admit any matter upon which, in the Hearing Officer’s judgment, reasonable persons would customarily rely upon in the conduct of business affairs. Any relevant information or evidence shall be considered. The affected Physician shall, prior to or during the hearing, be entitled to submit a written summary concerning any issue relevant to the Hearings which shall become a part of the Hearing record. The Hearing Committee may also accept any and all relevant evidence or memoranda submitted by a witness, Member of the Hearing Committee, or other interested party. The affected Physician and a representative of the Hearing Committee shall also have the right to make a verbal summary statement and submit a written statement at the close of the hearing, and such written statement shall become a part of the record.

15.5.9. **Burden of Proof:** Facts shall be presented by the Hearing Committee and witnesses or independent experts in support of the recommended adverse recommendation or decision. The Hearing Committee shall examine or cross-examine witnesses and independent experts. The Affected Physician shall have the burden of proof, to establish that the adverse recommendation is not reasonably supported by the evidence or is otherwise arbitrary or capricious.

15.5.10. **Availability of Witnesses or Independent Experts:** Witnesses or independent experts who cannot be available at the time of scheduled hearings may, in the discretion of the Hearing Officer, be examined or cross-examined by telephone conference call or in such manner as the Hearing Officer may decide.

15.5.11. **New Evidence and Issues:** The parties may be permitted, prior to the adjournment of the Hearing and at the sole discretion of the Hearing Officer, to present relevant new issues or evidence not identified in the Notice or the information submitted by the Affected Physician pursuant to Section 15.3.3 only when the new information was not reasonably known at the time of submission of the Notice or the information provided pursuant to Section 15.3.3, as applicable.
15.5.12. **Prerogatives of the Hearing Officer:** Procedural issues relating to hearings not covered in these Bylaws shall be determined by the Hearing Officer.

15.5.13. **Recesses and Adjournment:** The Hearing Committee may recess the Hearing and reconvene the same for the convenience of the participants, or for the purpose of obtaining new or additional evidence or consultation among its Members. Upon conclusion of the presentation of evidence, the Hearing Officer adjourns the Hearing and it shall be deemed complete. The Hearing Committee will then set a time for and conduct its deliberations.

15.5.14. **Hearing Committee Report:** Within ten (10) calendar days after final adjournment of the Hearing, the Hearing Committee shall submit a written report and summary of findings along with the Hearing record and all other documentation to the Executive Committee of the MCMB. The report may recommend confirmation, modification or rejection of the original adverse recommendation or decision, but such report shall be only advisory in nature and not binding on the MCMB.

15.5.15. **Executive Committee Action:** Within fourteen (14) calendar days after receipt of the Hearing Committee Report, the Executive Committee shall meet, consider the finding of the Hearing Committee, make a recommendation based upon the Hearing Committee report for proposed action regarding the Affected Physician, and submit such recommendation to the MCMB.

15.5.16. **MCMB Action:** After receiving the Hearing Committee’s report, the MCMB shall act upon such report and advise the Affected Physician in writing of its decision within fourteen (14) calendar days following such meeting.

Effect of Result Favorable to Affected Physician: If the decision of the MCMB is favorable to the Affected Physician, the matter shall be deemed resolved unless the Chief Executive Officer or the Deputy Chief Executive Officer decides to appeal the decision to an Appellate Review Body (defined below) specially convened to determine the outcome of such appeal.

Effect of Result Adverse to the Affected Physician: If the decision of the MCMB is adverse to the Affected Physician, notice of the result from the MCMB to the Affected Physician shall inform the Affected Physician of his or her right to request an appellate review by an Appellate Review Body specially convened to determine the outcome of such appeal.

15.5.17. **Notice of Appeal:** The Affected Physician shall have fourteen (14) days from receipt of notice of an adverse decision by the MCMB, to request
appellate review of the decision by providing written notice to the Deputy Chief Executive Officer or the Chair of the MCMB by Special Notice. The Deputy Chief Executive Officer or the Chair of the MCMB shall notify the Chair of the VUMC Board regarding the appeal.

15.5.18. **Scope of Appellate Review:** The Appellate Review Body (defined below) shall conduct the appellate review based upon the record on which the adverse decision is based, and the Affected Physician’s written statement provided for below.

15.5.19. **Waiver:** If the Affected Physician does not request an appellate review within fourteen (14) calendar days, the Affected Physician shall be deemed to have waived his/her rights to the appellate review and to have accepted the adverse decision, which shall become final and not eligible for appeal, effective immediately upon such waiver.

15.5.20. **Notice of Time and Place for the Appellate Review:** Within thirty (30) calendar days after receipt of notice of request for appellate review, the Chair of the VUMC Board shall schedule a date for such appellate review, provided, however, that an appellate review for an Affected Physician who is under a summary suspension then in effect shall be held as soon as arrangements for it may reasonably be made, but not later than fourteen (14) days after the Chair of the VUMC Board received the request.

15.5.21. **Appellate Review Body:** The appellate review shall be conducted by the VUMC Board or a duly appointed Appellate Review Committee of not less than five (5) impartial Members appointed by the Chair of the VUMC Board. Participants on the Appellate Review Committee shall not include direct competitors, Members of the original Hearing committee or Members of the Executive Committee of the MCMB.

15.5.22. **Rights of the Physician:** The Affected Physician shall have access to the report and record (and transcription, if any) of the Hearing Committee and all other material considered by the Hearing Committee in making the adverse decision. The Affected Physician may submit a written statement in his/her own behalf, in which those factual and procedural matters with which he/she disagrees and reasons for such disagreement shall be specified. This written statement may cover any procedural matters to which the appeal is related. Such written statement shall be submitted to the Deputy Chief Executive Officer or the Chair of the MCMB for delivery to the VUMC Board at least seven (7) calendar days prior to the scheduled date for the Appellate Review.

15.5.23. **Procedure.** The Appellate Review Committee shall review the record created in the proceedings and shall consider the written statements submitted pursuant to Section 15.5.22 for the purpose of determining
whether the adverse decision against the Affected Physician was warranted, and was not arbitrary or capricious.

15.5.24. Submission of New or Additional Information: New or additional matters not raised during the original review, the hearing, or in the Hearing Committee report, and not otherwise reflected in the record, shall be introduced during the appellate review only when the new information was not reasonably available for presentation and consideration by the Hearing Committee, and the Appellate Review Committee shall, in its sole discretion, determine whether such matters shall be accepted for review and document its reasons for its decision to accept or reject any new information requested to be considered.

15.5.25. Action by Appellate Review Body: The VUMC Board or Appellate Review Committee shall, within five (5) calendar days of the conclusion of its appellate review, notify the Affected Physician and the Deputy Chief Executive Officer in writing of the final decision of the Appellate Review Body.

ARTICLE XVI. NATIONAL PRACTITIONER DATA BANK REPORTING REQUIREMENTS

In compliance with Federal and State laws, any professional review action based on a Physician’s competence or conduct which results in denial, revocation, suspension, limitation, or reduction of clinical privileges and which is final, shall be reported to the National Practitioner Data Bank (NPDB) and the applicable state board, if so required.

A report shall also be made in the event of resignation or surrender of clinical privileges by a Member of the Medical Staff while under or in lieu of undergoing investigation. The report shall be made only after all Hearing and Appellate Review procedures provided by Articles XI through XIII of these Bylaws are final. This report shall be made by the institution's authorized representative within fifteen (15) days of the final action of the VUMC Board in accordance with established policies and procedures. Any such report shall be made a permanent part of the Physician's credentials file.

Reporting to the NPDB and state board may not be required in instances which involve administrative or voluntary changes in status, privileges, or Medical Staff Membership where no corrective action is pending or anticipated.

ARTICLE XVII. GENERAL PROVISIONS

17.1. MEDICAL STAFF RULES AND REGULATIONS, POLICIES AND PROCEDURES
The MCMB shall adopt such rules and regulations and policies and procedures as may be necessary to implement more specifically the general principles or requirements found in these Bylaws.

Such Rules & Regulations and Policies shall relate to the proper conduct of Medical Staff activities as well as embody the level of practice that is to be required of each Medical Staff Member in the Hospitals. Such Rules and Regulations and Policies shall be a part of these Bylaws.

17.2. CONSTRUCTION OF TERMS AND HEADINGS

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

ARTICLE XVIII. AMENDMENT

18.1. AMENDMENT UPON INITIATION BY MEDICAL STAFF

A proposed amendment to these Bylaws may be requested by the Chief of Staff, the Chief Executive Officer or an Active Medical Staff Member. Any such proposed amendment shall be referred to the Administrative Affairs Committee which shall report on it at the next regular meeting of the MCMB (MCMB) or at a special meeting called for such purpose.

Following a favorable vote by the MCMB, each Member of the Active Medical Staff will be eligible to vote on the proposed amendment(s) by mail, email, or in person within thirty (30) calendar days of the distribution of a ballot. Ballots may be distributed by mail, e-mail or in the Medical Staff Member mailboxes at the Hospitals.

In addition to the process set forth above, the Medical Staff may directly consider a proposed amendment to these Bylaws upon the written request of at least twenty-five (25%) of the Active Medical Staff. At least ten (10) days prior to a vote on any proposed amendment, the proposed amendment will be communicated to the Administrative Affairs Committee and MCMB for consideration. Amendments so adopted shall be effective when approved by the VUMC Board.

The Medical Staff Bylaws, Rules and Regulations and Policies and Procedures will be published on the Vanderbilt University Medical Center Policy Database Website.

18.2. AMENDMENT UPON INITIATION BY THE VUMC BOARD
These Bylaws may also be amended upon initiation by the VUMC Board at any regular or special meeting of the VUMC Board. A copy of each proposed amendment to these Medical Staff Bylaws shall be distributed to each Medical Staff Member at least thirty (30) days in advance of the meeting at which the VUMC Board proposes to take final action thereon. Any amendments approved by the VUMC Board also shall require approval by the Medical Staff as provided herein.

18.3. RULES AND REGULATIONS AND POLICIES AND PROCEDURES

The Medical Staff shall adopt, or assure the adoption of, such Rules and Regulations and Policies as may be necessary to implement more specifically the general principles found within these Bylaws, subject to approval of the VUMC Board.

Such Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff activities as well as embody the level of practice that is to be required of each Medical Staff Member in the Hospitals. Such Rules and Regulations and Policies shall be a part of the Medical Staff Bylaws.

The Medical Staff hereby delegates to the MCMB (MCMB) the authority to propose and adopt such Rules and Regulations and Policies, subject to the limitations set forth below.

The MCMB will furnish to all Members of the Active Medical Staff, for review and comment, a written copy of any proposed Rule or Regulation, or any amendment thereto, at least ten (10) days prior to the meeting at which such matter will be considered; provided, however, in the event there is a documented need for an urgent amendment to a Rule or Regulation to comply with law or regulation, the MCMB may provisionally adopt, and the VUMC Board may provisionally approve, such urgent amendment without prior notification to the Medical Staff. In such cases, the Medical Staff will be immediately notified by the MCMB and the Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. The MCMB shall notify the Medical Staff of its approval of a Policy or any amendment thereto.

Further, any such matter shall be submitted to a vote of the Active Medical Staff at the written request of at least twenty-five percent (25%) of the Active Medical Staff, received within thirty (30) days following approval of such Rule, Regulation or Policy, or amendment thereto, by the MCMB.

Such matter shall be considered at a special meeting of the Medical Staff.

Further, the Medical Staff may directly adopt a Rule, Regulation or Policy, or any amendment thereto, at any annual or special meeting, to the extent such action is requested in writing by at least twenty-five percent (25%) of the Active Medical Staff. Notice of such proposed Medical Staff action shall be given to the MCMB by the Chief of Staff at least ten (10) days prior to the meeting at which such
matter will be considered. Such changes shall become effective when approved by the VUMC Board.

Further, the VUMC Board shall also have the right to propose changes to such Rules, Regulations and Policies, subject to approval by the MCMB and/or Medical Staff, as set forth above, and the VUMC Board.

18.4. DISPUTE RESOLUTION PROCESS

To the extent a conflict arises between at least twenty-five percent (25%) of the Active Medical Staff and the MCMB (MCMB) on issues including, but not limited to, proposed adoption of or amendments to these Bylaws, Rules, Regulations or Policies, the following dispute resolution process shall be followed as determined by the Chief of Staff and the Deputy Chief Executive Officer before either the MCMB or the Medical Staff takes an action contrary to an action, proposed action or position of the other group:

18.4.1. The Chief of Staff shall appoint at least two MCMB Members to represent the MCMB. The at-large Members of the MCMB will, in consultation with the Deputy Chief Executive Officer, select at least two Active Medical Staff Members not on the MCMB to represent the Medical Staff in connection with the dispute.

18.4.2. Such appointed representatives shall meet in good faith to attempt to resolve the dispute.

18.4.3. In the event the dispute has not been resolved after at least two meetings of the representatives over at least a thirty (30) day period, this dispute resolution process shall terminate, and the Medical Staff and MCMB may proceed to take such actions as are otherwise authorized by these Bylaws, or applicable Rules, Regulations and Policies.

ARTICLE XIX. ADOPTION

These Bylaws together with the Rules and Regulations and Policies and Procedures shall become effective and shall replace any previous Bylaws, Rules and Regulations and Policies and Procedures when approved by the VUMC Board.

*These Bylaws have been adopted by the MCMB which is a Medical Review Committee within the meaning of T.C.A. §63-1-150 and 68-11-272. The functions of the MCMB include, among other things, the evaluation and improvement of the quality of medical and health care rendered by Vanderbilt University Medical Center and the determination that health care services were performed in compliance with applicable standards of care. The findings, conclusions, and recommendations of committees constituted under*
these Bylaws are privileged under T.C.A. §63-1-150 and 68-11-272 and shall not be public records nor available for court subpoena or for discovery proceedings by any third party.

Revision History:

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<td>1</td>
<td>01/27/16</td>
<td>Medical Staff</td>
<td>Change of ownership new documents</td>
</tr>
<tr>
<td>2</td>
<td>08/03/16</td>
<td>VUMC Board</td>
<td>Routine updates</td>
</tr>
<tr>
<td>3</td>
<td>09/13/17</td>
<td>VUMC Board</td>
<td>Major rewrite of several sections</td>
</tr>
<tr>
<td>4</td>
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<td>5</td>
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</tbody>
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Endnotes

i Definition modified to eliminate sentence, “The Chiefs of Service report to the appropriate Chief of Staff.” – September 2017
ii Dentists added back to Medical Staff – September 2017
iii “Unlimited” removed to align with changes made relative to change of ownership – June 2016
iv Dentists added back to definition – September 2017
v Definition for “Vanderbilt Health Services” removed – June 2016
vi Article III overhauled to incorporate Medical Staff Policies & Procedures into Bylaws and add delegated credentialing requirements – September 2017
vii Paragraph added following removal of requirement for faculty appointment for all medical staff members – September 2017
viii Section revised to reflect changes accompanying credentials committee reorganization – June 2016
ix Immunization Policy requirements removed from basic obligations accompanying medical staff appointment and moved to enterprise-wide policy enforcement – June 2016
x The sentence, “The requirement of Faculty Appointment, Section 3.2.2 will be waived for Consulting/Single Case, Locum Tenens, Training Privileges and Disaster Privileges” was removed when requirement for faculty appointment was eliminated from Basic Qualifications section – September 2017
xi CME requirements removed from privileging and moved to departments for licensure – June 2016
xii Added to allow physicians who do not practice on “main campus” to be credentialed and privileged without a faculty appointment – September 2017
xiii Added to allow for Active Duty surgeons to maintain “combat readiness” under an agreement with the military – September 2017
xiv Added to permit category specific requirements – September 2017
xv Board Certification requirement removed – September 2017
xvi Article VI overhauled to incorporate Medical Staff Policies & Procedures into Bylaws and add delegated credentialing requirements – September 2017
xvii Conducting Expedited Credentials Committee removed due to deletion of this from Bylaws – September 2017
xviii New Article added as part of Corrective Action overhaul – September 2017
xix Article underwent major rewrite – September 2017
xx Article underwent major rewrite – September 2017
xli Automatic suspension for failure to meet immunization policy requirements removed – June 2016